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	165220	A. BUILDING _____ B. WING _____	12/06/2023

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AZRIA HEALTH PRAIRIE RIDGE	**608 PRAIRIE STREET MEDIAPOLIS, IA 52637**

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F 000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #115142-C and #115251-C and Facility Reported Incident #117225-I, conducted November 27, 2023 to December 6, 2023. Complaint #115142-C and #115251-C were substantiated. Facility Reported Incident #117225-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		

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

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practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

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

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This Requirement is not met as evidenced by:
Based on observation, record review, resident and staff interview, the facility failed to ensure
Based on observation, resident and staff interviews, clinical record review, the facility failed to ensure the dignity of two of three reviewed (Residents #3 and #7). The facility reported a census of 48 residents.

Findings included:
1. The Minimum Data Set (MDS) dated 10/9/23 identified Resident #3 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 13 and had the following diagnoses: Atrial Fibrillation (an abnormal heart rhythm), Pneumonia and Arthritis. The MDS also identified Resident #3 required substantial assistance with oral hygiene, upper body dressing and totally dependent on staff for toileting, showering, lower body dressing, putting on foot wear and repositioning. The MDS also

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F 550	Continued From page 2 identified Resident #3 with an indwelling catheter. Observations of Resident #3 revealed the urinary drainage bag was not placed in a dignity bag on 11/27/23 at the following times: 10:35 AM as she sat up in her wheelchair in her room with urinary drainage bag which had not been placed in a dignity bag under wheelchair seat. 11:00 AM assessment unchanged 11:30 AM assessment unchanged 12:05 PM as she sat up in her wheelchair in the main dining room. The urinary drainage bag which had not been placed in a dignity bag was visible underneath the wheelchair seat. She sat at the table directly in front of the entrance to the kitchen where multiple staff members had walked past her to enter the kitchen. 12:22 PM she remained in the main dining room eating lunch with the urinary drainage bag still not placed in a dignity bag. 1:30 PM as she sat up in her wheelchair in her room with the urinary drainage bag without a dignity bag and highly visible to anyone walking past the room in the hallway. 2:00 PM assessment unchanged. 3:00 PM assessment unchanged. 3:30 PM assessment unchanged. On 11/2/23, the care plan identified Resident #3 with the problem of an impaired urinary elimination pattern due to urinary retention resultant with the need for a catheter and failed to direct staff to place the drainage bag in a dignity bag for privacy. 2. The Minimum Data Set (MDS) dated 11/9/23 identified Resident #7 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and	F 550		

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had the following diagnoses: Diabetes Disorder, Gastrostomy and Anxiety Disorder. It also identified Resident #7 required substantial assistance with showers/baths, dressing, putting on footwear and turning from side to side. It did not identify the resident with a feeding tube and identified she was on a therapeutic diet.

Observations of the resident revealed the resident did not have the GT drainage bag placed in a dignity bag on the following dates and times:
11/27/23 at 11:01 AM asleep in bed with the GT drainage bag which had not been placed in a dignity bag and visible from the hallway.
11/27/23 at 12:08 PM assessment unchanged
11/27/23 at 12:30 PM as she sat up in her wheelchair in her room, GT drainage bag remains without a dignity bag and visible from the hallway.
11/27/23 at 12:45 PM assessment unchanged
11/27/23 1:28 PM assessment unchanged
11/27/23 at 2:06 PM assessment unchanged
11/27/23 at 2:13 PM Surveyor asked Kelly, CNA if she could make the resident's bed.
11/27/23 from 2:15 PM to 2:26 during an observation of a transfer with a mechanical lift, Staff G, CNA and Staff H, CNA entered the room. Neither CNA had placed the GT drainage bag in a dignity bag prior to leaving the room.
11/28/23 at 6:22 AM asleep in bed with the GT drainage bag which had not been placed in a dignity bag and visible from the hallway.
11/28/23 at 7:54 AM as she sat up in bed, with the GT drainage bag which had not been placed in a dignity bag and visible from the hallway.
11/28/23 at 10:36 AM asleep in bed with the GT drainage bag which had not been placed in a dignity bag and visible from the hallway.
11/28/23 at 11:16 AM as she sat up in her wheelchair in her room with the GT drainage bag which had not been placed in a dignity bag and

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visible from the hallway.
11/28/23 at 11:17 AM after Staff B, RN entered room and drained the GT drainage bag, she did not place it in a dignity bag before she left the room.
11/29/23 at 7:30 AM asleep in bed with the GT drainage bag which had not been placed in a dignity bag however, on the left side of the bed and not visible from the hallway.
11/29/23 at 8:40 AM as she sat up in her wheelchair in her room with the GT drainage bag which had not been placed in a dignity bag and visible from the hallway.

In an interview on 11/29/23 at 10:19 AM, Resident #7 reported she used to have a cover for her bag (GT bag), but one of the aides had thrown it in the laundry and she never saw it after that, it had been a few years ago.

On 5/18/23, the care plan identified Resident #7 with the problem of an actual alteration in her Gastrointestinal Tract related to gastroparesis/gastric outlet obstruction requiring G-tube (Gastric Tube) placement for decompression and failed to direct staff to place the drainage bag in a dignity bag for privacy.

In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported a resident that has a urinary drainage bag or bag for GT drainage should always have the bag placed in a dignity bag. The bag and tubing should never be placed on the floor.

In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported a resident that has a urinary drainage bag or bag for GT drainage should always have the bag placed in a dignity bag. The bag and tubing should never be placed on the

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F 550	Continued From page 5 floor. In an interview on 11/30/23 at 12:30 PM, Staff E, CNA reported a resident that has a urinary drainage bag or bag for GT drainage should always have the bag placed in a dignity bag. The bag and tubing should never be placed on the floor. In an interview on 11/30/23 at 12:47 PM, Staff F, CNA reported a resident that has a urinary drainage bag or bag for GT drainage should always have the bag placed in a dignity bag. The bag and tubing should never be placed on the floor. In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported a resident that has a urinary drainage bag or bag for GT drainage should always have the bag placed in a dignity bag. The bag and tubing should never be placed on the floor. A review of the facility policy titled: Urinary Catheter Care dated as last revised September 2014 did not address the need to place the drainage bag in a dignity bag,	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This Requirement is not met as evidenced by: Based on observation, interviews, record review, and the facility policy, the facility failed to have the	F 558		

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call light within reach for a resident while in bed for 1 of 1 residents reviewed for call lights (Resident #35). The facility reported a census of 48.

Findings include:

The MDS (Minimum Data Set) assessment dated 10/12/23 revealed Resident #35 scored a 11 out of 15 on the BIMS (Brief Interview Mental Status) which indicated moderately impaired cognition. The MDS revealed impairment on both sides of his lower extremities and resident used a wheelchair. The MDS revealed the medical diagnosis of Parkinsonism, unspecified.

The Care Plan revealed a focus area dated 11/18/21 of increased risk for actual/potential limitations in my ability to perform my ADL (Activities of Daily Living) related to generalized weakness and cognitive deficits. The interventions dated 1/24/22 revealed encouraged use of the bell to call for assistance.

The Care Plan revealed a focus area initiated on 11/18/21 and revised on 8/15/23 of risk for falls related to impaired mobility and decreased safety awareness. The interventions dated 5/29/22 revealed the resident's call light within reach and encouraged the resident to use for assistance as needed.

During an observation on 11/27/23 at 11:19 AM, Resident #35 laid in bed, call light was against the wall on the floor by the bed, not within reach of the resident.

During an observation on 11/28/23 at 8:21 AM, Resident #35 laid in bed, call light on the floor against the wall by the resident's bed, not within

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reach of the resident.

During an observation on 11/29/23 at 8:26 AM, Resident #35 laid in bed, call light on the floor next to the wall and not within reach of the resident.

During an interview on 11/30/23 at 10:46 AM, Staff A, LPN (Licensed Practical Nurse) queried on where call lights needed to be located and she stated within reach of the resident. Staff A asked if she considered a call light on the floor by the wall within reach and she stated no.

During an interview on 11/30/23 at 11:09 AM, Staff C, ADON (Assistant Director of Nursing) asked where call lights needed to be located and she stated near the resident, within reach. Staff C asked if she considered a call light within reach if the call light laid on the floor next to the wall and she stated no, not unless the resident was independent.

During an interview on 11/30/23 at 12:41 PM, Staff E, CNA (Certified Nurse Assistant) queried if a call light needed to be within reach of the resident and she stated yes. Staff E asked what she considered within reach and she stated if the resident in the recliner she pinned it to the chair, and if the resident in bed she pinned it on the bed where the resident could reach it. Staff E asked if the call light laid on the floor if she considered it within reach of the resident and she stated no.

During an interview on 12/4/23 at 9:42 AM, the DON (Director of Nursing) queried on where the call light needed to be located and he stated within the resident's reach. The DON asked if the call light laid on the floor next to the wall if he considered that within reach and he stated no. He

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F 558	Continued From page 8 stated the staff supposed to make sure the call light within reach as per standards of care. The Answering the Call Light Policy dated 10/22 revealed the following information: a. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578		

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has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This Requirement is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to document the resident's Advance Directives for two of two residents reviewed (Residents #103 and #203). The facility reported a census of 48 residents.

Findings included:
1. At the time of the survey, the admission MDS for Resident #103 had not been completed. A review of the electronic medical record (EMR) list of medical diagnoses included: cerebral infarction due to embolism, muscle weakness and multiple fractures of ribs on the left side.

A review of the progress notes dated 11/22/23 at 5:10 PM revealed Resident #103 as alert and oriented to person, time and place.

On 11/27/23, a review of the EMR revealed no documentation to address Resident #103's preference for Advance Directives (legal documents that provide instructions for medical care and only go into effect if you cannot communicate your own wishes).

On 11/27/23, a review of the facility notebook for IPOSTs (Iowa Physician Orders for Scope and Treatment which communicates the resident's preferences for key life-sustaining treatments

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such as CPR) did not have documentation to address Resident #103's preferences for Advance Directives.
A review of the admission progress note dated 11/22/23 at 5:10 PM, Resident #103 arrived at the facility and had been identified as alert and oriented to name, place and time.

On 11/28/23 at 7:00 AM, a review of the EMR revealed no documentation on the face sheet, the physician orders, the medication administration record or care plan to address the Advance Directives.

On 11/28/23 at 10:30 AM, the facility provided a copy of the IPOST signed by the resident on 11/28/23.

In an interview on 11/28/23 at 7:04 AM, when asked about Advance Directives, Resident #103 reported in the event his heart stopped, he chose not to have CPR done.

In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported the following:
a. Staff would find information on the resident's code status in a 3 ring binder behind the nurse's station on the shelf, alphabetized and IPOSTs and advance directives
b. If the staff could not find any information on the resident regarding code status, the staff would have to do CPR
c. If there wasn't an order on admission, the social worker has been responsible for notifying the doctor to obtain an order.
d. When a resident is first admitted, orders for Advance Directives should be obtained within 24 hours.

In an interview on 11/29/23 at 11:33 AM, Staff

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F 578	Continued From page 11 B,RN, reported the following: a. Staff would find information on the resident's code status in a binder at the nurse's station which has all the current IPOST, advance directives. b. If the staff could not find any information on the resident regarding code status, the staff would have to do CPR c. If there wasn't an order on admission, the social worker has been responsible for notifying the doctor to obtain an order. d. When a resident is first admitted, orders for Advance Directives should be obtained within 24 hours. In an interview on 11/30/23 at 12:30 PM, Staff E, CNA reported the following: a. If she did not know what the resident's code status was and it was not in the computer, she would ask the nurse and thought there was a book at the nurse's station to address it. b. If the staff could not find any information on the resident regarding code status, if the resident coded, she would check with the nurse to see what the code status is. In an interview on 11/30/23 at 12:47 PM, Staff F, CNA reported the following: a. If she did not know what the resident's code status was and it was not in the computer, she would ask the DON and find someone that knew. b. If the staff could not find any information on the resident regarding code status, if the resident coded, she would start CPR. In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported the following: a. Staff would find information on the resident's code status in a notebook at the nurse's station which has all the IPOSTS in it.	F 578		

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F 578	Continued From page 12 b. If the staff could not find any information on the resident regarding code status, the staff would have to start CPR c. If there wasn't an order on admission, the nurse on duty or the social worker is responsible for notifying the doctor to obtain an order. d. When a resident is first admitted, he would expect the order for Advance Directives to be obtained as soon as possible. A review of the facility policy titled: Advance Directives dated as last revised September 2022 had documentation of the following: Determining Existence of Advance Directive a. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, above the existence of any written advance directives. b. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Resident #203 admitted to facility on 11/24/23. The Admission Progress Note dated 11/24/23 at 1:19 PM documented received report from nurse at the hospital. 93 year old male, DNR/DNI (Do not resuscitate/Do not incubate). The Baseline Care Plan dated 11/27/23 at 10:05 section Advanced Directives/Code Status was left blank. Record Review completed on 11/28/23 at 9:41 AM and the EMR (Electronic Record Review) lacked documentation of physician orders for advanced directives, documentation for advanced directives.	F 578		

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F 578	Continued From page 13 During an interview on 11/28/23 at 3:09 PM, Staff I, Social Services stated the facility always did their own advanced directives unless the resident already filled out an IPOST (Iowa Physician Orders for Scope of Treatment) or had a living will. She stated the resident was a full code status until the advanced directives were signed by the doctor. She stated she reviewed the advanced directives with Resident #203 wife today. Staff I asked when advanced directives needed completed and she stated normally on the day of admission and usually done in a couple of days after admission. The IPOST completed on 11/28/23 and signed by the doctor. (4 days after admission and resident/resident representative requested DNR) During an interview on 12/4/23 at 9:43 AM, the DON (Director of Nursing) queried on when advanced directives needed completed and he stated they should be attempted on admission. The DON stated advanced directives and the IPOST were voluntary and when not completed the resident considered a full code. The DON asked in what time frame he expected the advanced directives be completed and he stated it depended on why they were not completed and they might be waiting on the POA (Power of Attorney).	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		

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F 580	Continued From page 14 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580	Continued From page 15 under §483.15(c)(9). This Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure physician notification occurred for heart rate per parameters included the resident's Care Plan for one of one residents reviewed for physician notification (Resident #4). The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #4 dated 10/5/23 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The Care Plan dated 7/14/21 documented, The resident is on Digoxin Therapy r/t (related to) atrial fibrillation. The Intervention dated 7/14/21 documented, Report to physician if pulse falls below 60 or rises above 110 or if you detect skipped beats or other changes in rhythm. Review of documentation of the resident's pulse for October 2023 and November 2023 revealed the following dates, times, and documentation of heart rate less than 60. Documentation of the resident's heart rate on 10/1/23 and 10/2/23 revealed the following instances of heart rate less than 60: a. 10/1/23 at 2:35 PM: 37 bpm (beats per minute) b. 10/1/23 at 3:20 PM: 45 bpm b. 10/1/23 at 3:35 PM: 53 bpm c. 10/1/23 at 4:05 PM: 44 bpm d. 10/1/23 at 4:35 PM: 48 bpm e. 10/1/23 at 5:35 PM: 47 bpm	F 580		

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F 580	Continued From page 16 f. 10/1/23 at 6:12 PM: 48 bpm g. 10/1/23 at 6:35 PM: 52 bpm h. 10/1/23 at 7:35 PM: 50 bpm i. 10/1/23 at 8:35 PM: 48 bpm j. 10/2/23 at 5:25 AM: 55 bpm Documentation of the resident's heart rate during the time period of 10/4/23 through 10/8/23 revealed the following instances of heart rate less than 60: a. 10/4/23 at 10:04 AM: 53 bpm b. 10/4/23 at 1:36 PM: 53 bpm c. 10/5/23 at 9:53 AM: 56 bpm d. 10/6/23 at 8:18 AM: 55 bpm e. 10/7/23 at 10:03 AM: 55 bpm f. 10/8/23 at 8:39 AM: 57 bpm On 11/30/23 at 10:48 AM, Staff A, Licensed Practical Nurse (LPN) explained if she notified the physician, it would be charted in the progress note and transfer form. On 11/30/23 at 11:47 AM, Staff B, Registered Nurse (RN) acknowledged contact to the physician would be in the progress note. On 12/4/23 at 10:02 AM, the Director of Nursing (DON) explained physician notification documentation would be in the progress note. The Facility Policy titled [Facility] Change in a Resident's Condition or Status revised 2/21 documented, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).	F 580		
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		

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F 584 SS=D	Continued From page 17 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 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	F 584		

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sound levels.
This Requirement is not met as evidenced by:
Based on observation, interview, and facility policy review, the facility failed to provide a homelike environment by cleaning and removing stains and dried food on a resident's recliner for 1 of 2 residents reviewed for cleanliness of the building (Resident #22). The facility reported a census of 48.

Findings include:

The MDS (Minimum Data Set) assessment dated 9/21/23 revealed Resident #22 scored a 15 out of 15 on the BIMS (Brief Interview for Mental Status) which indicated cognition intact. The MDS revealed medical diagnoses of stroke and hemiplegia following cerebral infarction affecting the right dominant side.

During an observation on 11/27/23 at 10:58 AM, Resident #22 right side seat cushion on the recliner dirty with dried food and stains on it. Incontinent pad on the recliner had a brown mark smeared on the end of it by the stains on the seat.

During an interview on 11/27/23 at 10:58 AM, Resident #22 stated the staff spend about 10 minutes in his room to clean. He stated he ate in his chair and could of spilled something.

During an observation on 11/28/23 at 8:54 AM, Resident #22 recliner chair had dried food and stains on the left and right arm. The left side of the recliner left arm of his recliner chair had white chunks of food dried on it. The seat on the recliner had a dried food and on it.

During an observation on 11/29/23 at 8:33 AM,

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Resident #22 sat in his recliner and the arms of his recliner had dried food/stains on them and the left side of his recliner had white dried food on it.

During an observation on 11/30/23 at 10:57 AM, Resident #22 recliner had an incontinent pad on the seat cushion and the arms of the recliner chair had dried food/stains and white thick food stuck to the left side of the chair.

During an interview on 11/30/23 at 12:22 PM, Staff J, Housekeeping queried who responsibility it was to clean the furniture and she stated she cleaned the furniture when they had stains n them. She stated Resident #22 sat in his chair often when she cleaned his room. She stated the maintenance staff will tell her if she needed to clean a recliner and her boss also told her and showed her things that needed done.

During an interview on 11/30/23 at 12:30 PM, Staff K, Housekeeping Manager, stated she was responsible for cleaning the furniture and the resident's chair would be cleaned by the end of the day.

During an interview on 11/30/23 at 12:38 PM, Staff K, stated she looked at the chair and they were cleaning it now. She stated the chair looked dingy, and she would ask if they could get him a different one.

During an interview on 12/4/23 at 12:54 PM, the Administrator queried on her expectation of the resident's furniture being cleaned and she stated she expected it to be clean. She stated they removed the resident's recliner, cleaned it, and replaced it with a different one. The Administrator asked if she saw the recliner and she stated yes. The Administrator asked her thoughts on the

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F 584	Continued From page 20 recliner and she stated it did not live up to our expectations. The Daily Patient Room Cleaning Policy dated 10/7/16 did not address cleaning the furniture. The Deep Clean Checkoff List Policy dated 9/5/17 revealed the following information: a. Make sure to inform resident(s) you ' re deep cleaning their room. Let resident(s) know we will be in their room for 30 minutes and if they could leave for that time it would be greatly appreciated. You must move the bed, dresser, and any large objects so you can clean behind it. This room must be sanitized, dusted, and dirt free when you are done. 1. Clean and wipe down all chairs (legs and backs not just where you sit).	F 584		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 605		

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F 605	Continued From page 21 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This Requirement is not met as evidenced by: Based on observation, interviews, record review, and the facility policy review, the facility failed to ensure residents free from chemical restraints when narcotics pain medication administered for management of resident's behavior for 1 of 5 residents reviewed for unnecessary medications (Resident #15). The facility reported a census of 48. Findings include: The MDS (Minimum Data Set) assessment dated 11/9/23 revealed Resident #15 scored a 2 out of 15 BIMS (Brief Interview of Mental Status) exam, which indicated severely impaired cognition. The MDS revealed the resident unable to answer presence of pain; the resident received scheduled pain medications; resident received or offered PRN pain medications; and the resident didn't receive non-medication intervention for pain. The MDS revealed the medical diagnoses received an antipsychotics, antidepressant, anti-anxiety, and an opioid. The Care Plan revealed a focus area dated 5/29/22 for increased risks for actual/potential limitation (s) in my ability to perform my ADL	F 605		

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(Activities of Daily Living) related to impaired mobility and impaired cognition. The interventions dated 5/29/22 revealed resident often refused showers and must be reapproached.

The Care Plan revealed a focus area initiated on 5/10/23 and revised on 10/3/23 for resident had days she may become agitated and verbally aggressive towards staff and others due to poor impulse control secondary to Dementia. The resident may also becomes anxious and/or tearful at times. The interventions dated 5/10/23 revealed analysis of key times, places, circumstances, triggers, and what de-escalated behavior and document; assessed and anticipated resident's needs for food, thirst, toileting needs, comfort level, body positioning, pain etc.; assessed resident's understanding of the situation and allowed time for the resident to express self and feelings towards the situation; gave the resident as many choices as possible about care and activities.

The EMR (Electronic Medical Record) revealed the following diagnoses:
a. unspecified dementia, severe, with agitation
b. anxiety disorder, unspecified
c. major depressive disorder, single episode, unspecified
d. low back pain, unspecified
e. unspecified osteoarthritis, unspecified site
f. rheumatoid arthritis, unspecified

The Physician Orders revealed the following medications:
a. ordered 12/1/21- sertraline HCl tablet 100 mg- Give 1 tablet by mouth one time a day for antidepressant
b. ordered 12/6/21: Tylenol Extra Strength tablet 500 mg (Acetaminophen)- Give 1 tablet by mouth

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F 605	Continued From page 23 every 4 hours as needed for pain or fever c. ordered 2/2/23- trazodone HCl (hydrochloride) oral tablet 50 mg- Give 50 mg by mouth at bedtime for depression d. ordered 4/11/23: Tylenol Extra Strength oral tablet 500 mg (Acetaminophen)- Give 1 tablet by mouth every morning and at bedtime for pain e. ordered 4/30/23- lorazepam concentrate 2 mg/ml- Give 0.5 ml by mouth four times a day for anxiety Do not change times per provider order. f. ordered 5/1/23- aripiprazole tablet 2 mg- Give 1 tablet by mouth one time a day for dementia aggression g. ordered 7/21/23- morphine sulfate (concentrate) solution 20 mg/ml (milligrams/millliliters)- Give 5 mg by mouth every 4 hours as needed for pain The August MAR (Medication Administration Record) documented the following times the prescribed morphine administered to Resident #15: a. 8/2/23 at 6:31 PM, pain level 8 b. 8/8/23 at 8:19 PM, pain level 5 c. 8/12/23 at 3:06 PM, pain level 8 d. 8/29/23 at 6:26 PM, pain level 5 e. 8/31/23 at 11:09 PM, pain level 4 The September MAR documented the following times the prescribed morphine administered to Resident #15: a. 9/2/23 at 2:37 PM, pain level 3 b. 9/3/23 at 5:27 PM, pain level 5 c. 9/7/23 at 10:30 PM, pain level 5 d. 9/10/23 at 4:07 PM, pain level 6 e. 9/13/23 at 4:39 PM, pain level 6 f. 9/16/23 at 5:25 PM, pain level 6 g. 9/19/23 at 4:33 PM, pain level 7 h. 9/24/23 at 2:55 PM, pain level 6 i. 9/30/23 at 5:57 PM, pain level 8	F 605		

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The October MAR documented the following times the prescribed morphine administered to Resident #15:
a. 10/7/23 at 11:46 AM, pain level 9
b. 10/12/23 at 3:58 PM, pain level 0
c. 10/15/23 at 2:38 PM, pain level 5
d. 10/29/23 at 4:55 PM, pain level 6

The November MAR documented the following times the prescribed morphine administered to Resident #15:
a. 11/2/23 at 9:19 AM, pain level 7
b. 11/3/23 at 9:16 AM, pain level 7
c. 11/8/23 at 1:39 PM, pain level 6
d. 11/11/23 at 7:32 AM, pain level 7
e. 11/15/23 at 10:22 AM, pain level 7
f. 11/21/23 at 10:20 AM, pain level 7
g. 11/25/23 at 1:54 PM, pain level 7

The MAR's for August, September, October, and November revealed resident never received the PRN (as needed) Tylenol for pain.

The Behavior Note dated 8/2/23 at 5:04 PM revealed the resident tearful, appeared anxious, combative with cares and exit seeked.

The Behavior Note dated 8/12/23 at 5:57 PM revealed the resident yelled out, became combative with staff, appeared anxious and tearful, exit seeking. Gave PRN morphine.

The Behavior Note dated 8/29/23 at 9:10 PM revealed the resident tearful and appeared anxious, yelled out, and became combative at times.

The Progress Note dated 9/2/23 5:29 PM revealed the resident tearful at beginning of shift

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AZRIA HEALTH PRAIRIE RIDGE	608 PRAIRIE STREET MEDIAPOLIS, IA 52637

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and when asked if in pain resident reported yes but unable to verbalize where. prn morphine given with good results. (The MAR documented a pain level of 3)

The Behavior Note dated 9/3/23 at 6:04 PM, the resident tearful and appears to be cried, yelled out, gave prn morphine, no other behaviors noted.

The Behavior Note dated 9/10/23 at 5:26 PM, the resident wandered the hallways, yelled out "E', tearful and appeared anxious.

The Progress Note dated 9/13/23 at 5:11 PM, the resident yelled out, exit seeked, resistant to cares, tearful and appeared anxious.

The Behavior Note dated 9/16/23 at 5:20 PM, the resident tearful and appeared anxious, resistant to cares.

The Behavior Note dated 9/24/23 at 5:20 PM, the resident cried and yelled out, appeared anxious, resistant to cares and combative with staff.

The Behavior Note dated 9/30/23 at 4:37 PM, the resident yelled out, resistive to cares. resident attempted to spit out medications. resident became combative with staff.

The Behavior Note dated 10/12/23 at 8:42 PM, the resident became very anxious, wandered and become agitated with redirection. PRN Morphine utilized and appeared to be effective. Resident able to eat in MDR (Main Dining Room) without any further behaviors.

The Behavior Note dated 10/15/23 at 5:24 PM, the resident yelled out, cried, and appeared

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anxious.

The Behavior Note dated 10/29/23 at 4:59 PM, the resident yelled out, combative with staff during cares.

The Behavior Note dated 11/2/23 at 1:27 PM, the resident very tearful and called out this AM. PRN morphine given with relief noted. Compliant with cares and medications.

The Behavior Note dated 11/3/23 at 1:43 PM, the resident tearful this AM. PRN morphine given with relief noted. Compliant with cares and medications.

The Behavior Note dated 11/8/23 at 1:35 PM, the resident called out and restless after lunch. PRN morphine given.

The Behavior Note dated 11/11/23 at 1:30 PM, the resident tearful and yelled out this AM. PRN morphine given with relief noted. Compliant with cares and medications.

The Behavior Note dated 11/15/23 at 2:02 PM, the resident yelled, hit and kicked after being bathed this AM. Repeated yelling out and agitated behavior. PRN morphine given with relief noted.

The Behavior Note dated 11/21/23 at 1:25 PM, the resident very tearful and called out this AM. PRN morphine given with relief noted.

During an observation on 11/27/23 at 10:31 AM, Resident #15 sat in her wheelchair in the hallways. She had a lamb stuffed animal on her lap.

During an observation on 11/27/23 at 1:38 PM,

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the resident sat in the wheelchair in the common area and held her stuffed animal. Staff asked her if she wanted to lay down.

During an observation on 11/27/23 at 1:40 PM, the resident in her wheelchair and make sounds and self propelled herself in the common room.

During an observation on 11/28/23 at 1:46 PM, resident laid in her bed in her room and slept. Resident's head propped up on a pillow.

During an observation on 11/30/23 at 10:56 AM, resident in her wheelchair in the hallway and had a blanket over her. She is smiling and in good spirits when people walk by and talk to her.

During an interview 11/30/23 at 9:26 AM, the DON (Director of Nursing) stated Resident #15 prescribed morphine for low back pain because she experienced tearfulness and behaviors. He stated the doctor put her on a two week trial and it appeared effective so they kept her on it. He stated it wasn't ordered for behaviors. The DON asked why the morphine used instead of the PRN Tylenol and he stated for the severity of pain. He stated the resident unable to give a numerical number so they physical signs and symptoms. The DON what he considered severity of pain and he stated anything over a 5.

During an interview on 11/30/23 at 10:38 AM, Staff A, LPN (Licensed Practical Nurse) queried on Resident #15 behaviors and she stated the resident had bad sundowning and they waited to wake her up to help with her behaviors. She stated the resident didn't like her showers and became tearful for an hour or two after her showers. She stated the resident didn't like to go the bathroom. She stated they tried to fill out the

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resident and redirect and reapproach as needed. Staff A asked how Resident #15 displayed pain and she stated she kept repeating things and would tense up. Staff A stated she never gave her morphine and only gave her Tylenol.

During an interview on 11/30/23 at 11:13 AM, Staff C, ADON (Assistant Director of Nursing) queried on Resident #15 behaviors and she stated the resident got anxious, scared, and non-verbal most of the time and wouldn't say how she felt. She stated other times the resident perfectly happy. She stated the resident's behaviors depended on how she woke up in the morning. Staff C stated the resident didn't like to be helped or changed positions. Staff C asked about Resident #15 pain and she stated the resident pain displayed by her behaviors and physically. She stated she cried and not happy the whole day. She stated she wasn't sure if pain caused the behaviors. Staff C stated Resident #15 couldn't voice pain but the staff could tell the resident was in discomfort.

During an interview on 11/30/23 at 11:51 AM Staff B, RN (Registered Nurse) queried on Resident #15 behaviors and she typically the resident yelled out, tearful, hit, kicked, or pinched staff. Staff B asked what the cause of the resident's behaviors were and Staff B stated she was unsure if they were caused by the resident's dementia or pain. She stated the resident calmed down after the PRN morphine but didn't know if it was from the narcotic effect or the relief of pain. Staff B asked if the staff did an other interventions prior to the administration of morphine and she yes they did one on one time with the resident and gave her the stuffed animal, had other residents talk to her. Staff B stated she was bad at charting the other measures she took prior to

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F 605	Continued From page 29 administration of the morphine. Staff B asked how the resident was in pain and she stated she tried to hold up the pain card for the resident and the resident would only say "E" and other times the resident showed facial grimacing. During an interview on 12/04/23 at 9:54 AM, the DON queried on the resident order for PRN morphine and PRN Tylenol and the expectation of use of Tylenol prior to morphine and he stated it depended on the documentation and if the resident asked for pain medication. He stated he didn't know why the resident didn't ask for Tylenol and if not utilized the medication needed reviewed to see if needed discontinued. Discussed with the DON the progress notes and pain level when giving morphine and the documentation revealed morphine effective. The DON asked his expectation for use of morphine and he stated it depended on the documentation because morphine can potentially be a chemical restraint. The Use of Restraints Policy dated April 2017 did not address the use of chemical restraints.	F 605		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;	F 622		

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F 622	Continued From page 30 (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include:	F 622		

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F 622	Continued From page 31 (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This Requirement is not met as evidenced by: Based on record review, interviews, and the facility policy review, the facility failed to provide the required documentation needed for transfers to the hospital for 1 of 3 residents reviewed for hospitalizations (Resident #22). The facility reported a census of 48. Findings include:	F 622		

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The MDS (Minimum Data Set) assessment dated 9/21/23 revealed Resident #22 scored a 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam, which indicated cognition intact. The MDS revealed medical diagnosis for anxiety disorder and depression.

The Social Work Progress Note dated 4/3/23 at 1:21 PM revealed the staff reported Resident #22 make gestures with a gait belt, gestures of wrapping it around his neck and hanging himself. The DON (put one on one in place immediately. Social Services had a conversation with Resident #22 about his gesture of hanging himself and he denied it. However with further conversation he stated that he cried all of the time and felt sad all the time. Social Services expressed to Resident #22 that they would need to send him to the hospital for evaluation, when comments like that were made the facility take them very serious. Resident #22 stated that he understood and he was willing to go to the hospital.

The Progress Note dated 4/3/23 at 5:28 PM revealed the resident sent to ER (Emergency Room) at 4:00 PM via facility van.

The Progress Note dated 4/3/23 at 9:03 PM revealed resident admitted to geri psych at the local hospital per ER nurse.

The Progress Note dated 10/8/23 at 2:30 PM, revealed at 2:15 PM reported resident found on the floor. On assessment resident complained pain in lower back and tailbone area. When trying to get vitals and check ROM (Range of Motion) resident became combative with a history of doing so. Resident kicking walker and and hit staff. Let him know if he would not let us assess him, the hospital needed to check him out.

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Resident started hitting again. Called on call doctor. New order to send to ED (Emergency Department). DON notified at 2:20 PM. Wife notified at 2:25 PM. Ambulance called at 2:27 PM.

During an interview on 11/27/23 at 11:06 AM, Resident #22 stated he went to the hospital a couple of times and the last time he went was 2 months ago when he fell.

The Review of the EMR (Electronic Medical Record) lacked documentation of the E-interact transfer form-V5 for Resident #22.

During an interview on 11/30/23 at 10:43 AM, Staff A, LPN (Licensed Practical Nurse) queried what needed documented when a resident transfers and she stated the condition of the resident, notification of the doctor, the times the DON, doctor, and family notified and anyone else called, when the resident transferred out, the assessment, and the assessment forms. Staff A asked what paperwork sent with resident and she stated the IPOST (Iowa Physicians Orders for Scope of Treatment), medication sheet, and face page. She stated she also documented when the resident transferred out and called down to the ER and gave report.

During an interview on 11/30/23 at 11:20 AM, Staff C, ADON (Assistant Director of Nursing) queried on what she documented when a resident transferred and she stated vitals, reason the resident left the facility, family and doctor notified, order from doctor, and what lead up to discharging to the hospital. She stated she filled out a transfer form and let the hospital know if resident could walk and if resident oriented. Staff C asked what paperwork the facility sent with

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F 622	Continued From page 34 transfer and she stated the MAR (Medication Administration Record), advance directives, and transfer form. Staff C asked what documentation needed documented in the progress note and she stated the family notified, when called 911, when called the doctor, what was wrong with the patient, if the resident transferred by ambulance or with family member, the time the resident left, and when we called and gave report to the ER. During an interview on 12/4/23 at 9:43 AM, the DON (Director of Nursing) queried on the expectations for documentation with transfers and he stated the transfer evaluation needed completed and assessments, and the doctor's notification. The Transfer or Discharge, Facility Initiated Policy dated October 2022 revealed the following documentation: a. When a resident transferred or discharged from the facility, the following information documented in the medical record: 1. The basis for the transfer or discharge and if the resident was transferred or discharged because his or her needs cannot be met at the facility the documentation will include: a. the specific resident needs that cannot be met; b. the facility's attempt to meet those needs; c. the receiving facility's service(s) that were available to meet those needs b. Appropriate notice provided to the resident and/or legal representative c. The date and time of the transfer or discharge d. The new location of the resident e. The mode of transportation f. A summary of the resident's overall medical, physical, and mental condition g. Disposition of personal effects	F 622		

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F 622	Continued From page 35 h. Disposition of medications i. Others as appropriate or as necessary j. The signature of the person recording the data in the medical record	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		

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under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 623	Continued From page 37 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This Requirement is not met as evidenced by: Based on record review, interviews, and the facility policy, the facility failed to consistently notify the ombudsman of a resident's transfer to the hospital for 1 of 3 residents reviewed for hospitalization (Resident #22). The facility reported a census of 48. Findings include: The MDS (Minimum Data Set) assessment dated 9/21/23 revealed Resident #22 scored a 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam, which indicated cognition intact. The MDS revealed medical diagnosis for anxiety disorder and depression. The Progress Note dated 10/8/23 at 2:30 PM, revealed at 2:15 PM reported resident found on the floor. On assessment resident complained pain in lower back and tailbone area. When trying to get vitals and check ROM (Range of Motion)	F 623		

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AZRIA HEALTH PRAIRIE RIDGE	608 PRAIRIE STREET MEDIAPOLIS, IA 52637

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resident became combative with a history of doing so. Resident kicking walker and and hit staff. Let him know if he would not let us assess him, the hospital needed to check him out. Resident started hitting again. Called on call doctor. New order to send to ED (Emergency Department). DON notified at 2:20 PM. Wife notified at 2:25 PM. Ambulance called at 2:27 PM.

During an interview on 11/27/23 at 11:06 AM, Resident #22 stated he went to the hospital a couple of times and the last time he went was 2 months ago when he fell.

Review of Ombudsman Notification provided by the facility did not include notification for Resident #22's hospitalization described in the resident's progress notes.

During an interview on 12/4/23 at 9:26 AM, Staff I, Social Services queried on when they notified the ombudsman and she stated once a month they sent them a report on all voluntary discharges and transfers to the hospital. Staff I asked if a resident transferred to the hospital and not admitted would the ombudsman be notified and she stated yes, anybody that left the facility was on the report. She stated the facility had a new business office manager and she was in training. Staff I stated the October report documented inpatient hospital transfers but not the transfers to the hospital. Staff I stated she didn't see Resident #22 on the report.

During the interview on 12/05/23 at 9:26 AM, the Administrator queried on her expectations for notification to the Ombudsman and she stated notification need sent monthly and she set up for her to receive the report they send to the

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F 623	Continued From page 39 ombudsman as well. The Administrator asked what needed to be included on the report and she stated hospitalization, any discharges including non-voluntary and voluntary, anyone who left the facility. The Transfer and Discharge, Facility Initiated dated October 2022 revealed the following information: a. A copy of notice sent to the Office of the Long Term Care Ombudsman at the same time of the notice of the transfer or discharge provided to the resident or resident representative. b. Notice of Transfer provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (example in monthly list of residents that include all notice content requirements). A copy of the transfer form and supporting progress note will suffice (example- copy of transfer form provided to resident and EMS (Emergency Medical Services at time of transfer, resident representative notified and requests/declines copy of transfer form at this time.)	F 623		
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	F 636		

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by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(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

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mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This Requirement is not met as evidenced by:
Based on record review, staff interviews, and the facility policy the facility failed to complete the annual MDS (Minimum Data Set) assessment within a timely manner for 3 of 15 residents reviewed for annual MDS assessments (Resident #15, #22, #35). The facility reported a census of 48.

Findings include:

Resident #35 MDS annual assessment ARD (Assessment Reference Date)/Target Date dated 10/12/23 completed on 11/8/23 and accepted/locked on 5/22/23.

Resident #22 MDS annual assessment ARD/Target Date dated 9/21/23 and not completed until 10/17/23 and accepted/locked on 10/17/23.

Resident #15 MDS annual assessment ARD/Target Date dated 8/17/23 and not completed until 9/12/23 and accepted/locked on 9/12/23.

During an interview on 11/30/23 at 12:05 PM, Staff L, MDS coordinator queried on who did the MDS assessments and she stated she did. Staff L informed the resident whose annual MDS assessments not completed timely and she stated she couldn't make excuses, it was black and white. She stated the old DON (Director of Nursing) left in the middle of September and she been pulled to the floor 7 or 8 times. She stated

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F 636	Continued From page 42 she knew the MDS assessments were behind. She stated the DON was good about not pulling her to the floor. During an interview on 12/4/23 at 9:43 AM, the DON queried on when annual assessments needed completed and he stated he wasn't familiar with MDS, and would hope they get them done quickly, within the time frame. The Resident Assessment Policy dated March 2022 revealed the following information: a. The resident assessment coordinator was responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: 1. Quarterly Assessment; b. All resident assessments completed within the previous 15 months are maintained in the resident ' s active clinical record. The results of the assessments are used to develop, review and revise the resident ' s comprehensive care plan.	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 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:	F 637		

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F 637	Continued From page 43 Based on observation, interview, and record review the facility failed to ensure timely completion of a significant change Minimum Data Set (MDS) assessment for one of one resident reviewed for significant change assessments (Resident #14). The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #14 revealed the assessment reference date 8/25/23. The completion date for the assessment revealed 9/20/23. The Care Plan dated 10/13/23 documented, I am receiving Hospice Services through [Redacted] due to end stage dementia, Parkinson's disease, COPD (Chronic Obstructive Pulmonary Disease), and dysphagia. On 11/30/23 at 12:04 PM when queried as to the timeframe to complete significant change assessments, the Minimum Data Set (MDS) Coordinator acknowledged 14 days from the date a significant change determined. The MDS Coordinator acknowledged she was behind, and was pulled to work the floor. The Facility Policy titled [Facility] Resident Assessments dated March 2022 documented, OBRA-Required Assessments - are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes.	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	F 638		

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F 638	Continued From page 44 quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This Requirement is not met as evidenced by: 4. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #4, Assessment Reference Date 10/5/23, revealed a completion date of 11/7/23. The Facility Policy titled [Facility] Resident Assessments dated March 2022 documented, 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments - conducted for all residents in the facility...(2) Quarterly Assessment. Based on record review, staff interviews, and the facility policy the facility failed to complete the quarterly MDS (Minimum Data Set) assessment in a timely manner for 4 of 15 residents reviewed for quarterly MDS assessments (Resident #4, #22, #35, #46). The facility reported a census of 48. 1. Resident #35 MDS quarterly assessment ARD (Assessment Reference Date)/Target Date dated 4/20/23 completed on 5/22/23 and accepted/locked on 4/11/23. 2. Resident #22 MDS quarterly assessment ARD/Target Date dated 7/1/23 and not completed until 7/16/23 and accepted/locked on 7/17/23. 3. Resident #46 MDS quarterly assessment ARD/Target Date dated 10/15/23 and not completed until 11/16/23 and accepted/locked on 11/16/23.	F 638		

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F 638	Continued From page 45 During an interview on 11/30/23 at 12:05 PM, Staff L, MDS coordinator queried on who did the MDS assessments and she stated she did. Staff L informed the resident whose quarterly MDS assessments not completed timely and she stated she couldn't make excuses, it was black and white. She stated the old DON (Director of Nursing) left in the middle of September and she been pulled to the floor 7 or 8 times. She stated she knew the MDS assessments were behind. She stated the DON was good about not pulling her to the floor. During an interview on 12/4/23 at 9:43 AM, the DON queried on when quarterly assessments needed completed and he stated within 3 months. He stated he wasn't familiar with MDS, and would hope they get them done quickly, within the time frame.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This Requirement is not met as evidenced by: Based on observation, interview, clincial record review, and facility policy review the facility failed to ensure accurate completion of the Minimum Data Set (MDS) assessment to address use of bed rails, gastrostomy tube, and weight loss for two of fifteen residents reviewed for MDS accuracy (Resident #7, Resident #11). The facility reported a census of 48 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/9/23 revealed the resident scored 6 out	F 641		

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of 15 on a Brief Interview for Mental Status (BIMS) exam which indicated severely impaired cognition. Per the assessment, Resident #11 did not have a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Per the assessment, a bed rail was not used in bed.

The Dietary Progress Note dated 11/2/23 at 7:51 PM documented, WT (weight) - 97#(11/2)[BMI (body mass index)= 20.3...RD (Registered Dietician) notes significant weight loss (-)10.2% X 3 mos using wt of 108#(8/01) as comparison weight.

On 11/29/23 at 8:35 AM, observation of Resident #11 revealed the resident in her wheelchiar in her room. Resident #11's bed observed to have partial rails bilaterally on the resident's bed, with one rail up and one rail down.

The Physician Order dated 6/11/21 documented, Halo/grab barsx2 for bed mobility and positioning. No directions specified for order.

On 11/30/23 at 12:09 PM, the Minimum Data Set (MDS) Coordinator explained Section K completed by the Registered Dietician, and further explained per her understanding bed rails would only be positive if considered a restraint. Per the MDS Coordinator, residents used the side rails/positioning bars for bed mobility/transfer assistance and none were considered a restraint. Per MDS Coordinator, staff did set up assistance with the rails.

2. The Minimum Data Set (MDS) dated 11/9/23 identified Resident #7 as cognitively intact with a BIMS

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F 641	Continued From page 47 (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Diabetes Disorder, Gastrostomy and Anxiety Disorder. It also identified Resident #7 required substantial assistance with showers/baths, dressing, putting on footwear and turning from side to side. It did not identify the resident with a feeding tube and identified she was on a therapeutic diet. A review of the physician orders revealed the following: 5/12/23 G-Tube is to be clamped during meals and Med Pass and for 30 minutes after otherwise to vent at all times every shift for Gastric Outlet Obstruction. 5/17/23 Drain Gastric Drainage bag and record output every shift for Drain Gastric Drainage bag and record output On 6/6/23, the care plan identified Resident #7 with the problem of an actual/potential alteration in elimination pattern due to history of constipation and directed the staff to follow these interventions: a. Follow facility bowel protocol for bowel management. b. Give medications as ordered for constipation. c. Monitor/document/report PRN (as needed) signs and symptoms of complications related to constipation: Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, Bradycardia (slow, low pulse), Abdominal distension, vomiting, small loose or stools, fecal smearing, Bowel sounds, Diaphoresis, Abdomen: tenderness, guarding, rigidity, fecal compaction. d. Observe and report to my Healthcare Provider any signs and symptoms of changes of bowel patterns, pain, discomforts, skin around site or stoma.	F 641		

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F 641	Continued From page 48 In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported the following: a. If a resident has a GT, this should be addressed on the MDS. b. She could not recall when Resident #7 had her Gtube inserted, it had been this year for decompression, probably in April c. There should not be any reason why the GT was not addressed on her last MDS. d. The MDS coordinator is responsible for entering data into the MDS. In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported the following: a. If a resident has a GT, this should be addressed on the MDS. b. She could not recall the exact date when Resident #7 had her GT inserted, she thought spring of 2023. c. She could not think of any reason why the GT would not be addressed on the last MDS. d. The MDS coordinator is responsible for entering data into the MDS In an interview on 11/30/23 at 12:15 PM, the MDS Coordinator reported the following: a. Resident #7 had her GT inserted 5/12/23 b. The GT should have been addressed on the MDS. She reported that Section K was filled out by the dietitian and since she is not receiving feedings through the GT, it is basically there for decompression. c. She is reported she is behind on completing MDSs as she had been pulled to work the floor to administer medications or work as a CNA. In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported the following: a. If a resident has a GT, this should be	F 641		

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addressed on the MDS.
b. When asked why the GT was not addressed on the last MDS, he reported the MDS coordinator has
been pulled away from completing MDSs and help out on the floor. There are administrative nurses that can help.
c. The MDS coordinator is responsible for entering data into the MDS.

A review of the facility policy titled: Resident Assessments and dated as last revised March 2022 had documentation of the following:
1. A comprehensive assessment of every resident's needs is made at intervals designated by ONRA and PPS requirements.
2. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements:
a. OBRA required assessments - conducted for all residents in the facility:
1. Admission Assessment (Comprehensive);
2. Quarterly Assessment;
3. Annual Assessment (Comprehensive);
4. Significant Change in Status Assessment (SCSA) (Comprehensive);
5. Significant Correction to Prior Comprehensive Assessment (SCPA) (Comprehensive);
6. Significant Correction to Prior Quarterly Assessment (SCQA); and
7. Discharge Assessment (return anticipated and return not anticipated).

3. "comprehensive assessment" includes:
Completion of the Minimum Data Set (MDS);
Completion of the care area assessment (CAA) process; and
Development of the comprehensive care plan

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F 655 SS=D	Continued From page 50 Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		

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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 655	Continued From page 51 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This Requirement is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to address the problem of an open wound on the initial care plan of one of one residents admitted within the last 30 days. (Resident #103). The facility reported a census of 48 residents. Findings included: 1. At the time of the survey, the admission MDS had not been completed for Resident #103. A review of the electronic medical record (EMR) list of medical diagnoses included: cerebral infarction due to embolism, muscle weakness and multiple fractures of ribs on the left side. In an observation and interview with the resident on 11/27/23 at 10:03 AM, as he sat up in the recliner in his room with feet elevated, he reported he came in with an open area to left shin which has kerlix dressing dated 11/25/23. He wore tubigrips to both legs which had with 2+ edema. A review of the progress notes dated 11/22/23 at 5:10 PM revealed Resident #103 as alert and oriented to person, time and place. On 11/27/23, a review of the EMR revealed the only problem addressed on the baseline care plan on 11/23/23 was urinary tract infection. It did not address the open area to his left lower leg. A review of the progress notes revealed the following:	F 655		

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	165220	A. BUILDING _____ B. WING _____	12/06/2023

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F 655	Continued From page 52 11/22/23 at 5:10 PM Resident arrived at facility at 12:45PM and had a wound to the left lower extremity shin which measured 2 centimeters (cm) by 1.5 cm with treatment that had already been implemented from the hospital. Resident #103 was identified as alert and oriented to person, time and place. In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported when a resident is newly admitted with an open area with orders for treatments, she would expect this to be addressed on the care plan and that the MDS coordinator is responsible for developing the baseline care plan. In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported when a resident is newly admitted with an open area with orders for treatments, she would expect this to be addressed on the care plan and she did not know who was responsible for developing the baseline care plan. In an interview on 11/30/23 at 12:15 PM, the MDS Coordinator reported Resident #103 had an open area to his left leg when he was admitted and this should have been addressed on the baseline care plan. She also reported any of the nurses can update the care plans. In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported when a resident is newly admitted with an open area with orders for treatments, he would expect that to be addressed on the care plan. He also reported the MDS coordinator was responsible for developing the baseline care plan. A review of the facility care plan titled: Comprehensive Person Centered Care Plans dated as last revised December 2016 had	F 655		

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F 655	Continued From page 53 documentation of the following: 1. The comprehensive person -entered care plan will: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d. Describe any specialized services to be provided as a result of PASARR recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of	F 655		

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F 655	Continued From page 54 practice for problem areas and conditions. 2. The comprehensive person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS) 3. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.	F 655		
F 656 SS=E	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 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	F 656		

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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 observation, interview, and record review, the facility failed to ensure bed rails, use of foot pedals during transport, and documentation of behaviors, anxiety, and major depressive disorder were addressed on the Care Plan for four of fifteen residents reviewed for Care Plans (Resident #7, Resident #11, Resident #22, Resident #30). The facility reported a census of 48 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment for Resident #11 dated 11/9/23 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam which indicated severely impaired cognition. Per the assessment, a bed rail was not used in bed for the resident.

The Care Plan did not address use of bed rails for the resident.

The Physician Order dated 6/11/21 documented, Halo/grab barsx2 for bed mobility and positioning.

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F 656	Continued From page 56 No directions specified for order. On 11/29/23 at 8:35 AM, observation of Resident #11 revealed the resident in her wheelchair in her room. Resident #11's bed observed to have partial rails bilaterally on the resident's bed, with one rail up and one rail down. On 11/30/23 at 8:19 AM, the Director of Nursing (DON) acnowledged he had seen issues with care planning the facility was trying to address. On 11/30/23 at 12:09 PM the Minimum Data Set (MDS) Coordinator queried about care planning of bed rails, the MDS Coordinator explained she believed a care plan added for Resident #11 yesterday or today. 2. The MDS (Minimum Data Set) assessment dated 9/21/23 revealed Resident #22 scored a 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam, which indicated cognition intact. The MDS revealed medical diagnosis for anxiety disorder and depression. The EMR (Electronic Medical Record) revealed the following medical diagnosis dated 11/28/22: a. major depressive disorder, single episode, unspecified b. anxiety disorder, unspecified The Physician Orders dated 11/28/22 revealed the following medications ordered: a. sertraline HCL (hydrochloride) tablet 100 mg (milligram)- give one tablet by mouth one time a day for anxiety b. buspirone HCL tablet 15 mg- give 1 tablet two times a day for depression The Social Work Progress Note dated 3/9/2023	F 656		

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at 2:22 PM, documented Social Services reported to DON (Director of Nursing) Resident #22 stated during his PHQ-9 (Resident Mood Interview) that he had thoughts of hurting himself and stated he had a plan. When asked to share the plan he put his finger to his lips and made shh sound. Social Services explained to Resident #22 that the facility used a protocol that they had to follow when someone stated thoughts and a plan to hurt themselves. Social Services phoned Resident #22 wife and informed her of what Resident #22 stated and that he was sent to the hospital for evaluation. The wife stated that she understood and wanted to make an appointment and come in and speak to Social Services next week about Resident #22 and her inability to care for him at home.

The Care Plan lacked documentation of a focus area for the above medical diagnosis and psychiatric medications upon admission.

The Care Plan revealed a focus area for antidepressant medication (venlafazine, mirtazapine) use for diagnosis of depression,; during interview Resident #22 stated he had suicidal ideation initated on 5/4/23. The interventions dated 6/13/23 revealed resident currently took antidepressant medications. Target behaviors to monitor include behavior #1 agitation; behavior #2 sad/crying; behavior #3 making statements and/or non-verbal actions of suicidal ideations.

The Care Plan revealed a focus area for alteration in mood and behaviors as evidenced by occasional verbal outbursts and cursing at staff dated 10/3/23. The interventions dated 10/3/23 documented anticipated and meeting the resident's needs and assisted the resident to

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F 656	Continued From page 58 develop the most appropriate methods of coping and interacting. During an interview on 11/30/23 at 12:09 PM, Staff L, MDS Coordinator queried on who does the care plans and she stated she did them and the DON started helping her and regional does them but only when they were in the building. Staff L asked if Resident #22 took major depressive disorder and anxiety disorder and admitted on psychiatric medications, should the care plan address the diagnosis and medications and she stated yes, the care plan needed a focus area. During an interview on 12/04/23 at 9:43 AM, the DON (Director of Nursing) queried on the expectation of the care plan addressing Resident #22 psychiatric medications and psychiatric diagnoses on admission and the DON stated yes, if they received the medications for the medical diagnoses at that time. 3. The Minimum Data Set (MDS) dated 11/9/23 identified Resident #7 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Diabetes Disorder, Gastrostomy and Anxiety Disorder. It also identified Resident #7 required substantial assistance with showers/baths, dressing, putting on footwear and turning from side to side. It did not identify the resident with a feeding tube and identified she was on a therapeutic diet. Observations of the resident during the survey from 11/27/23 through 11/30/23 revealed the resident's bed with two ¼ side rails up.	F 656		

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In an interview on 11/29/23 at 10:19 AM, Resident #7 reported she purchased her own bed as it had an air mattress and the side rails came with it, but none of the staff had provided any kind of education on safety issues on it.

In an interview on 11/29/23 at 10:45 AM, the Director of Nursing reviewed the resident's Electronic Medical Record and verified there was no documentation of side rail evaluation, education, etc in Resident #7's record.

A review of the care plan with the last revision date of 11/6/23 revealed the care plan did not address the use of side rails, the need for evaluation and education.

4. The Minimum Data Set (MDS) dated 10/26/23 identified Resident #30 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency (Kidney Failure) and Diabetes Mellitus. The MDS also identified Resident #30 required substantial staff assistance with lower body dressing, putting on footwear.

In an observation on 11/27/23 at 12:00 PM, Staff D, RN pushed Resident #30 in the wheelchair without foot pedals.

In an observation on 11/28/23 at 11:19 AM, Staff E, Restorative CNA pulled Resident #30 in her wheelchair out of the bathroom without foot pedals on with Resident #30's feet skimming the floor from the bathroom to outside in the hallway. Resident #30 then was able to self-propel to the main dining room.

On 9/14/20, the care plan identified Resident #30

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with the problem of being at risk for falls, however, failed to address the need to place foot pedals on the wheelchair prior to transporting the resident in the wheelchair.

In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported before pushing a resident in the wheelchair, should make sure the foot pedals are on the wheelchair and put their feet on the foot pedals. This should be addressed on the care plan which any nurse can update.

In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported before pushing a resident in the wheelchair, should make sure the foot pedals are on the wheelchair and put their feet on the foot pedals. This should be addressed on the care plan

In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported before pushing a resident in the wheelchair, should make sure the foot pedals are on the wheelchair and put their feet on the foot pedals. Resident #30 has a bag on the back of her wheelchair where the foot pedals are stored. He did not feel this should be addressed on the care plan as it is common sense. He also reported the facility did utilize many CNAs from different agencies. The DON also reported it was a team effort and that all nurses could update the care plan.

A review of the facility care plan titled: Comprehensive Person Centered Care Plans dated as last revised December 2016 had documentation of the following:
1. The comprehensive person -entered care plan will:
a. Include measurable objectives and time frames;

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F 656	Continued From page 61 b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d. Describe any specialized services to be provided as a result of PASARR recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions. 2. The comprehensive person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS)	F 656		

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F 656	Continued From page 62 3. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' 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 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, resident and staff interview, the facility failed to update the care plans for two of fifteen residents reviewed after returning from the hospital (Residents #7 and #22). The facility reported a census of 48 residents.	F 657		

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F 657	Continued From page 63 Findings include: 1. The Minimum Data Set (MDS) dated 11/9/23 identified Resident #7 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Diabetes Disorder, Gastrostomy and Anxiety Disorder. It also identified Resident #7 required substantial assistance with showers/baths, dressing, putting on footwear and turning from side to side. It did not identify the resident with a feeding tube and identified she was on a therapeutic diet. A review of the progress notes revealed the following: 7/22/23 at 1:50 AM Resident #7 complained of pain in her right upper quadrant rating it a 9 and states it feels like someone is punching her there. Also states she has been having this pain intermittently for about a week now. Bowels active X4 quadrants. Drainage tube is patent and flowing within normal limits. The physician on call was notified and new orders received to send to ER (Emergency Room) for evaluation. 7/22/23 at 2:31 AM Ambulance notified at 2:00 AM, arrived to facility at 2:20 AM. Out of facility at 2:27 AM. Report given to the hospital nurse. 7/22/23 12:35 PM Resident admitted to the hospital for acute cholecystitis (infection of the gall bladder) and will be having cholecystectomy (surgical removal of the gall bladder). The progress notes did not include documentation of complete assessment prior to transport to the hospital or notification of family. In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported any nurse or the MDS coordinator can update the care plan which should have been updated after Resident #7 was hospitalized.	F 657		

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In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported the MDS Coordinator, DON or ADON had the responsibility to update care plans. Care plans should be updated after a resident has been hospitalized.

In an interview on 11/30/23 at 12:15 PM, the MDS Coordinator reported the care plan had not been updated as she had been pulled to work the floor to give medications or work as being a CNA. She also reported any nurse could have updated the care plan.

In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported any nurse can update the care plan which should have been updated after Resident #7's hospitalization.

A review of the facility care plan titled: Comprehensive Person Centered Care Plans dated as last revised December 2016 had documentation of the following:
1. The comprehensive person -entered care plan will:
a. Include measurable objectives and time frames;
b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being;
c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;
d. Describe any specialized services to be provided as a result of PASARR recommendations;
e. Include the resident's stated goals upon admission and desired outcomes;
f. Include the resident's stated preference and

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potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire;
g. Incorporate identified problem areas;
h. Incorporate risk factors associated with identified problems;
i. Build on the resident's strengths;
j. Reflect the resident's expressed wishes regarding care and treatment goals;
k. Reflect treatment goals, timetables and objectives in measurable outcomes;
l. Identify the professional services that are responsible for each element of care;
m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels;
n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and
o. Reflect currently recognized standards of practice for problem areas and conditions.
2. The comprehensive person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS)
3. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.

2. The MDS (Minimum Data Set) assessment dated 9/21/23 revealed Resident #22 scored a 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam, which indicated cognition intact. The MDS revealed medical diagnosis for anxiety disorder and depression.

The EMR (Electronic Medical Record) revealed the following medical diagnoses dated 11/28/22:
a. major depressive disorder, single episode,

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F 657	Continued From page 66 unspecified b. anxiety disorder, unspecified The Social Work Progress Note dated 3/9/2023 at 2:22 PM, documented Social Services reported to DON (Director of Nursing) Resident #22 stated during his PHQ-9 (Resident Mood Interview) that he had thoughts of hurting himself and stated he had a plan. When asked to share the plan he put his finger to his lips and made shh sound. Social Services explained to Resident #22 that the facility used a protocol that they had to follow when someone stated thoughts and a plan to hurt themselves. Social Services phoned Resident #22 wife and informed her of what Resident #22 stated and that he was sent to the hospital for evaluation. The wife stated that she understood and wanted to make an appointment and come in and speak to Social Services next week about Resident #22 and her inability to care for him at home. The Social Work Progress Note dated 4/3/23 at 1:21 PM revealed the staff reported Resident #22 make gestures with a gait belt, gestures of wrapping it around his neck and hanging himself. The DON (put one on one in place immediately. Social Services had a conversation with Resident #22 about his gesture of hanging himself and he denied it. However with further conversation he stated that he cried all of the time and felt sad all the time. Social Services expressed to Resident #22 that they would need to send him to the hospital for evaluation, when comments like that were made the facility take them very serious. Resident #22 stated that he understood and he was willing to go to the hospital. The Care Plan revealed a focus area for antidepressant medication (venlafazine,	F 657		

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F 657	Continued From page 67 mirtazapine) use for diagnosis of depression,; during interview Resident #22 stated he had suicidal ideation initated on 5/4/23. The interventions dated 6/13/23 revealed resident currently took antidepressant medications. Target behaviors to monitor include behavior #1 agitation; behavior #2 sad/crying; behavior #3 making statements and/or non-verbal actions of suicidal ideations. The Care Plan revealed a focus area for alteration in mood and behaviors as evidenced by occasional verbal outbursts and cursing at staff dated 10/3/23. The interventions dated 10/3/23 documented anticipated and meeting the resident's needs and assisted the resident to develop the most appropriate methods of coping and interacting. During an interview on 11/30/23 at 12:09 PM, Staff L, MDS Coordinator queried if the care plan should of been updated after the resident sent to the hospital for suicidal ideation in March and April of this year prior to May and she stated yes, it should of been sooner. Staff L asked what time frame should the care plan be updated and she stated right away, when the resident came back from the hospital was always the goal. During an interview on 12/4/23 at 9:43 AM, the DON (Director of Nursing) queried on the expectation of the care plan being updated after a resident sent out for suicidal ideation and he stated as sooner as possible. The DON asked if the resident sent out in March and April and the care plan not updated until May, what would he expected and he stated it needed to be done sooner.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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§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, record review, resident and staff interview, the facility failed to follow physician orders and administer blood pressure medications per accepted standard of practice for 3 of 15 residents reviewed (Residents #7, #11, and #30) The facility reported a census of 48 residents.

Findings include:
1. The Minimum Data Set (MDS) dated 11/9/23 identified Resident #7 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Diabetes Disorder, Gastrostomy and Anxiety Disorder. It also identified Resident #7 required substantial assistance with showers/baths, dressing, putting on footwear and turning from side to side. It did not identify the resident with a feeding tube and identified she was on a therapeutic diet.

A review of the physician orders revealed the following:
5/12/23 G-Tube is to be clamped during meals and Med Pass and for 30 minutes after otherwise to vent at all times every shift for Gastric Outlet Obstruction.
5/17/23 Drain Gastric Drainage bag and record output every shift for Drain Gastric Drainage bag and record output

A review of the Medication Administration Records revealed an order to drain the Gastric Drainage bag and record output every shift and

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F 658	Continued From page 69 the order had not been followed on these dates: AUGUST No documentation on first shift on August 2, 7, 12, 17,22, 27, 28, on second shift on Aug 4 SEPTEMBER No documentation on first shift on Sept 3, 4, 18, 19, 28, 30, on second shift on Sept 21 & 29, on third shift September 19, 29, 30 OCTOBER No documentation on first shift on October 12 & 31, on third shift on Oct 1 NOVEMBER No documentation of outputs on the first shift on November 4 & 10, none on second shift on Nov 1 & 6 On 5/23/23, the care plan identified Resident #7 with the problem of actual/potential alteration in elimination pattern due to history of constipation and failed to address the order to drain the Gastric Drainage bag and record the output every shift. In an interview on 12/4/23 at 8:28 AM, the Director of Nursing reported the following: a. The nurse is responsible for draining the GT drainage bag and recording the output once a shift. b. The nurse should record it on the EMAR (Electronic Medication Administration Record) c. When the treatment is not signed out as completed, the EMAR will mark the item as red which should alert the nurse to complete. d. The only reasons why there wouldn't be documentation on the EMAR would be if the resident was out of the facility, the resident refused, or the resident was sleeping. And if that's the case, it should still be signed off when it was done	F 658		

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2. The Minimum Data Set (MDS) dated 10/26/23 identified Resident #30 as cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency (Kidney Failure) and Diabetes Mellitus. The MDS also identified Resident #30 required substantial staff assistance with lower body dressing, putting on footwear.

During an observation of a medication pass on 11/28/23 at 6:25 AM, Staff A, LPN administered Aspart insulin 2 units to Resident #30.

A review of an incident report dated 11/28/23 revealed documentation of the following: Resident #30 was administered Aspart insulin instead of Lispro as ordered.

A review of the physician orders revealed an order dated 7/25/23 for: Lispro Inject as per sliding scale: if 150 - 200 = 2 units

On 9/14/20, the care plan identified Resident #30 with the problem of being at risk for alteration in her blood sugar levels, hypoglycemia (low blood sugar) and/or hyperglycemia (high blood sugar) related to diabetes mellitus. Interventions included: Provide medication, blood sugar checks/labs as ordered.

In an interview on 11/28/23 at 12:30 PM, the DON (Director of Nursing) reported there was a medication error with Resident #30. The order was for Lispro sliding scale. The nurse pulled the wrong medication from the Emergency Kit and the nurse this morning went to give it didn't read it.

In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported before she administers insulin, she

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should check the manufacturer's name. When asked about the medication error which occurred 11/28/23 she reported, she pulled the pen that said it was short acting and she gave Resident #30 Aspart when she had orders for Lispro. The nurse who worked the night before pulled the wrong insulin pen from the Emergency kit. Staff A reported she should have checked the pen against the order.

In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported before she administers insulin, she would check the pen against the MAR (Medication Administration Record) and the medication error could have been prevented if the nurse checked the pen against the MAR.

In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported the medication error could have been prevented if the nurse followed the protocol for medication administration and followed the rights. The night shift nurse had pulled a pen out of the Emergency Kit and pulled out the wrong pen and put it in Resident #30's medication drawer. Staff A had pulled out the wrong insulin pen from the refrigerator.

3. The Minimum Data Set (MDS) assessment for Resident #11 dated 11/9/23 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition.

The Care Plan dated 7/13/21 documented, I have coronary artery disease (CAD) and prior NSTEMI. The Intervention dated 7/13/21 documented, Monitor blood pressure. Notify physician of any abnormal readings.

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The Physician Order dated 6/12/21 documented, AmLODIPine Besylate Tablet 5 MG (milligrams) with instructions to give 1 tablet by mouth one time a day for HTN (hypertension).

The Physician Order dated 9/10/21 documented, Carvedilol Tablet 6.25 MG with instructions to give 1 tablet by mouth two times a day for BP (blood pressure).

The Physician Order dated 6/16/21 documented, Isosorbide Mononitrate ER (extended release) Tablet Extended Release 24 Hour 30 MG with instructions to give 1 tablet by mouth one time a day for blood pressure DO NOT CRUSH.

Physician Orders for blood pressure medication lacked parameters for when to hold the above medications.

Review of the resident's Medication Administration Record (MAR) for October 2023 revealed the resident received all three medications every day in October 2023.

Review of documented blood pressures per the Blood Pressure Summary in the resident's electronic health record revealed, in part, the following documented blood pressures:

a. 10/2/2023 12:28 AM: 96/50
b. 10/3/23 2:25 PM: 91/50
c. 10/4/23 at 11:02 AM: 82/53
d. 10/9/23 at 10:26 AM: 98/46
e. 10/30/23 at 4:08 PM: 92/49

On 11/30/23 at 10:48 AM when queried if she noticed parameters for blood pressure medications, Staff A, Licensed Practical Nurse

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F 658	Continued From page 73 (LPN) said no. Staff A explained she went by nursing judgement, and if all over the place, she would contact the doctor and see what they wanted. Staff A explained she would send a list of blood pressures the resident had and would ask for parameters. Per Staff A, everybody was different. Staff A explained she would look at the history and resident's baseline, and would make a decision off of that. Per Staff A, the med aide would tell her if high or low and she would look at the norm. When queried if she had been notified by the med aide, Staff A explained she had not been notified about low blood pressures. On 11/30/23 at 11:47 AM when queried about parameters for blood pressure medications, Staff B, Registered Nurse (RN), explained she saw parameters on occasion and not always. Staff B explained if low blood pressure, she would call the Physician if there were not parameters in place. On 12/4/23 at 10:06 AM, the Director of Nursing explained he personally did not give blood pressure medications to people without parameters with a systolic below 100. The DON acknowledged if the medication aide gave blood pressure medications and took the blood pressure below the normal level, the nurse would be notified prior to giving medications.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		

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practice, the comprehensive person-centered care plan, and the residents' choices.
This Requirement is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure through assessment prior to a resident's hospitalization, failed to ensure thorough assessment post a documented episode of choking, and failed to ensure the dressing to a non-pressure skin wound changed as ordered for three of four residents reviewed for assessment/intervention (Resident #7, Resident #14, Resident #103). The facility reported a census of 48 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment for Resident #14 dated 8/25/23 revealed the resident scored 3 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment.

The Health Status Note dated 10/17/23 at 8:59 AM documented, Resident AM blood glucose (BG) very low (57). He was assisted OOB (out of bed) and into dining room and given honey thickened chocolate milk and orange juice. Recheck 1 hour later was 135. While eating breakfast, resident choked on biscuits and gravy. Resident cyanotic but coughing. Resident coughed up pieces of breakfast and was verbal. PRN (as needed) Hyosyne given per MAR (Medication Administration Record). Message left for hospice nurse requesting a lookback at morning BGM's (blood glucose monitor) as well as a possible texture change to pureed for resident's diet.

The Health Status Note lacked documentation of oxygen saturation or assessment of lung sounds

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following the resident's documented episode of choking.

Review of oxygen saturation documentation per the weights/vitals tab in the resident's electronic health record lacked documentation of oxygen saturation on 10/17/23.

The Health Status Note dated 10/17/23 at 10:01 AM documented, PRN (as needed) breathing treatment administered following coughing episode and res is now currently sitting up in wc (wheelchair) in room to prevent further coughing episodes. No coughing noted at this time with SpO2 (oxygen saturation) at 96% on room air Lungs are diminished but clear at this time Hospice has been notified and aware of this episode Hospice nurse to be in today to assess resident.

On 11/30/23 at 10:50 AM when queried as to what would be charted and what assessment would entail, Staff A, Licensed Practical Nurse (LPN) explained if the resident had an episode at a meal or what have you, lung sounds assessed, doctor notified, family notified. Staff A acknowledged vitals would be taken, and would be put in the vitals tab and in the progress note. Per Staff A, the lung sound assessment would be in the progress note.

On 11/30/23 at 11:48, Staff B, Registered Nurse (RN) explained the following would be charted for a choking episode: What led up to it, causative factors, the outcome of the episode and if able to clear the airway, measures taken, notification to family, physician, and administration, measures in place to prevent a reoccurrence. When queried if vital signs would be charted, Staff B acknowledged yes, under the vitals section and

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possibly in the note. When queried if an assessment of lung sounds would be completed, Staff B responded yes, and further explained they would typically be done for a few days after as well so make sure no residual effect. Staff B acknowledged the documentation would be in the progress notes.

On 12/4/23 at 10:08 AM when queried about assessment for a documented choking episode, the Director of Nursing (DON) responded a swallow study, determination why the resident choking, clearing the airway, full set of vitals, and to send the resident out. The DON acknowledged a respiratory assessment would be done, acknowledged it would be charted in evaluations, and in the progress note as well. The DON acknowledged need for notification to the family and doctor.

Review of the evaluations tab in the resident's electronic health record revealed the only assessment per the evaluations tab dated 10/17/23 was a skin assessment.

2. The Minimum Data Set (MDS) dated 11/9/23 identified Resident #7 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Diabetes Disorder, Gastrostomy and Anxiety Disorder. It also identified Resident #7 required substantial assistance with showers/baths, dressing, putting on footwear and turning from side to side. It did not identify the resident with a feeding tube and identified she was on a therapeutic diet.

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F 684	Continued From page 77 A review of the progress notes revealed the following: a. 7/22/23 at 1:50 AM Resident #7 complained of pain in her right upper quadrant rating it a 9 and states it feels like someone is punching her there. Also states she has been having this pain intermittently for about a week now. Bowels active X 4 quadrants. Drainage tube is patent and flowing within normal limits. The physician on call was notified and new orders received to send to ER (Emergency Room) for evaluation. b. 7/22/23 at 2:31 AM Ambulance notified at 2:00 AM, arrived to facility at 2:20 AM. Out of facility at 2:27 AM. Report given to the hospital nurse. c. 7/22/23 12:35 PM Resident admitted to the hospital for acute cholecystitis (infection of the gall bladder) and will be having cholecystectomy (surgical removal of the gall bladder). The progress notes did not include documentation of complete assessment prior to transport to the hospital or notification of family. d. 7/28/2023 5:24 PM Resident returned to facility by ambulance at 4:00 PM in wheelchair. Diet order: soft foods. Gastrostomy tube with a drainage bag intact and draining. Diagnosis: Emergency cholecystectomy (removal of gall bladder). Multiple bruising to left upper extremity. Edema noted in Left hand with large bruise on anterior surface. 2 areas bandaged on abdomen. Do not remove for 3 days, may get wet. Incision across abdomen with 27 staples. Complained of pain rated a 7. Scheduled medication for pain to be administered. Care plans in EMR revised. A review of the electronic medical record revealed no documentation to show transfer form had been completed for 7/22/23	F 684		

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F 684	Continued From page 78 A review of the physician orders revealed the following: a. 5/12/23 G-Tube is to be clamped during meals and Med Pass and for 30 minutes after otherwise to vent at all times every shift for Gastric Outlet Obstruction. b. 5/17/23 Drain Gastric Drainage bag and record output every shift for Drain Gastric Drainage bag and record output The Care Plan dated as reviewed 8/14/23 identified Resident #7 with the problem of an actual/potential alteration in elimination pattern due to history of constipation and failed to address the physician's order to leave the dressing in place for 3 days and the need to evaluate the surgical incision and evaluate for postoperative complications. On 11/29/23 at 10:18 AM, Staff A, Licensed Practical Nurse (LPN) reported before sending a resident to the hospital, she would need to document in the nurse's notes the change of condition assessment, vital signs, full assessment from lung sounds, bowel sounds, edema, anything pertinent to the change. She would also need to document she called the doctor and how the resident was transported. The nurse who sends the resident out is responsible for documentation of the assessment, sometimes the DON or Assisted Director of Nursing (ADON) will assist. In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported before sending a resident to the hospital, she would need to complete the change of condition report and transfer form under the evaluation tab, otherwise a progress note should detail actions taken and assessment of the	F 684		

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situation, who was notified, how they were transported, vital signs.

In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported before sending a resident to the hospital he would expect the nurse to document in the nurse's notes the reason why, the condition the resident is in, report to the hospital, and that the doctor and family were notified.

A review of the facility policy titled: Facility-Initiated Transfer or Discharge dated as last reviewed October 2022 had documentation of the following:
Orientation for Transfer or Discharge (Emergent or Therapeutic Leave)
1. For an emergency transfer or discharge to a hospital or other acute care institution, implement the following procedures:
aa. Call 911 if the resident meets clinical/behavioral criteria per facility policy, or assist in obtaining transportation;
bb. Notify the resident's attending physician
cc. Orient/prepare the resident for transfer and
dd. Prepare for medical record transfer.
2. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.

Documentation of a Facility-Initiated Transfer or Discharge
1. When a resident is transferred or discharged from the facility, the following information is documented in the medical record:
aa. The basis for the transfer or discharge; if the resident is being transferred or discharged because his
or her needs cannot be met at the facility, documentation will include:

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F 684	Continued From page 80 aaa. The specific resident needs that cannot be met; bbb. This facility's attempt to meet those needs; and ccc. The receiving facility's service(s) that are available to meet those needs 2. That an appropriate notice was provided to the resident and/or legal representative; 3. The date and time of the transfer or discharge; 4. The new location of the resident; 5. The mode of transportation; 6. A summary of the resident's overall medical, physical, and mental condition 3. At the time of the survey, the admission MDS for Resident #103 had not been completed. A review of the Electronic Medical Record (EMR) list of medical diagnoses included: cerebral infarction due to embolism, muscle weakness and multiple fractures of ribs on the left side. Observations of the resident revealed the following: a. In an observation and interview with the resident on 11/27/23 at 10:03 AM, as he sat up in the recliner in his room with feet elevated, he reported he came in with an open area to left shin which has kerlix dressing dated 11/25/23. He wore tubigrips to both legs which had with 2+ edema. b. On 11/28/23 at 7:04 AM Resident #103 reported he was supposed to get his dressing to his left leg and the staff didn't change it yesterday. The dressing to his left leg was dated 11/25/23 and appeared to be the same dressing he had yesterday. c. On 11/29/23 11:33 AM, during an observation of wound care, the ADON pulled up pant leg to left leg and removed Resident #103's sock. The	F 684		

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F 684	Continued From page 81 ADON verified the date on dressing as 11/25 and should have been changed 11/27. The dressings should be changed every other day. The progress notes dated 11/22/23 at 5:10 PM documented that Resident #103 as alert and oriented to person, time and place. A review of the physician orders revealed the following: 11/22/23 Mix equal parts of Clotrimazole, Triamcinilone and Silvasorb. Apply to left lower leg including wound bed. Cover any open ulcerations with Telfa, secure with rolled gauze and tape cover with tubigrip Size F every day shift every other day for wound treatment. A review of the November 2023 Treatment Administration Record revealed documentation that the treatment was signed out as completed on 11/27/23. The only problem addressed on the Care Plan on 11/23/23 was urinary tract infection. It did not address the open area to his left lower leg. On 11/29/23 at 10:18 AM, Staff A, Licensed Practical Nurse (LPN) reported she was not sure of a process for ensuring all treatment orders were being carried out daily. On 11/30/23 at 11:03 AM, the ADON reported nurses are supposed to sign off treatments on the Medication Administration Records (MAR) after the treatments have been completed. When asked why the dressings still had 11/25 dated on 11/29, the DON reported the dressings should have been done on 11/27. She could not explain why the treatment would be signed out on 11/27 when it had not been completed.	F 684		

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F 684	Continued From page 82 On 11/29/23 at 11:33 AM, Staff B, Registered Nurse (RN), reported Resident #103 should have had his dressings changed every other day. She was not sure if there was someone to double check MARs to ensure all treatments had been completed at the end of the day. In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported the nurse who signed off the MAR on 11/27 reported after she put the new dressing on, she dated it 11/25. There were no initials on the dressing and he had instructed staff they need to start writing their initials on the dressing.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was able to access appropriate and timely vision care by an outside provider, for 1 of 1 residents reviewed for vision care . The resident's vision had declined over the last nine months. (Resident #23) The facility reported a census of 48 residents.	F 685		

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F 685	Continued From page 83 Findings include: The Quarterly Minimum Data Set (MDS) assessment for Resident # 23 dated 10/05/23 documented the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam which indicated the resident was cognitively intact. Care Plan for Resident #23 dated 04/06/2020 and revised on 07/19/2020 with a Target date of 01/10/2024 documented the following focus area, goals and interventions: Focus area: My visual ability needs and preferences are: I wear eyeglasses. Date Initiated: 04/06/2020 Revision on: 04/06/2020 Goal: I will use appropriate visual devices to promote participation in ADLs and other activities. Date Initiated: 4/06/2020 Revision on: 07/19/2022 Target Date: 01/10/2024 Interventions: a. I am able to manage my own donning and caring of my eye glasses. If I need help I will ask for assist. Date Initiated: 04/06/2020 b. I have eye drops that will need staff to administer per my Healthcare Practitioner's order. Date Initiated: 04/06/2020 Revision on: 04/06/2020 c. I will need assistance to arrange consultation with my eye care practitioner as needed. Date Initiated: 04/06/2020 Revision on: 04/06/2020 d. Monitor/document/report as needed (PRN) if I have any signs or symptoms of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, complaints of halos around lights, double vision, tunnel vision, blurred or hazy	F 685		

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vision. Date Initiated: 04/06/2020

On 11/29/23 01:31 PM Resident # 23 reported she has missed six eye doctor appointments in the last 9 months due to the facility canceling or not getting her to her appointments. Resident #23 reported she has difficulty seeing out of both of her eyes but her right eye is worse than her left eye. The resident advised Staff member M, Licensed Practical Nurse (LPN) does all of the scheduling and she had canceled several of her vision appointments.

On 11/30/23 09:50 AM Staff M, LPN was queried about Resident #23 and canceled appointments. Staff M advised the resident was being seen for cataracts. She is not aware of the resident having a change or decline in her vision. Staff M indicated she was not aware that the resident needs or has ever gotten shots in her eyes. Staff M reported the resident had missed vision appointments for several reasons:
1. Resident #23 missed one appointment due to an issue with the van and the facility did not have alternate transportation available. That appointment had been rescheduled.
2. On 08/04/2023 the resident missed an appointment due to not being able to transfer to the chair in the exam room and staff had not been available to attend the appointment.
3. The family made an appointment the facility was not notified about and the appointment was missed.
4. The facility took Resident # 23 to her vision appointment on 10/06/2023 and the resident did not like that doctor. Another appointment had been made for the resident on 12/20/2023.

Staff M shared if a resident needed vision care they are seen by an outside Optometrist. Staff M

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was not aware of a facility contract with an Optometrist.

On 11/30/23 10:15 AM The facility Administrator was queried and indicated she would find out if the facility had a contract with an Optometrist.

On 11/30/23 10:24 AM Staff A, LPN, reported Resident #23 had not expressed concern with her vision. Staff A reported there had been an issue with the facility van and the resident could not attend her appointment. Staff A advised there had been a couple times the resident's appointment were rescheduled. Staff A shared she would not have documented information about any appointment changes or cancellations in progress notes.

On 11/30/23 11:03 AM The Director of Nursing (DON), advised the facility does not have a contract with an optometrist and an optometrist does not come to the facility. A resident would have to use their previous eye doctor. If not, they would try to find a local provider that would accept the resident's insurance.

On 11/30/23 11:15 AM Staff member C, Registered Nurse (RN) reported Resident #23 has not expressed concerns with her vision. Staff C advised the resident missed one appointment as the family had planned to take her but they were not able to drive her. On occasion, the facility has used the van to take another resident to the hospital or other unexpected situation and other facility transportation would not be available so the facility would have to cancel the scheduled appointment.

The Progress Notes dated 03/01/2023 at 3:48 PM revealed the Optometrist office called to ask

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F 685	Continued From page 86 which doctor the resident wanted to see for eye treatment. Discussed this with resident and she advised which doctor she requested to see and staff made resident aware that this doctor was not be able to do pre op testing on that date so appointment would need to be rescheduled. Resident voiced understanding. Called office to notify - left voicemail requesting to return call and speak with scheduler to reschedule appt. The Progress Notes dated 08/04/2023 at 8:45 AM documented this nurse attempted to notify family on 8-3-23 to see if they could meet resident at an appointment on 8-4-23 for a cataract referral and was unable to contact any family This nurse called the doctor's office stating that res will need assist to transfer into their chair for appointment and the office doesn't offer transfer help, and Dr Zimmers office asked for this nurse to reschedule the appointment. I spoke with resident this am and she is upset regarding this. I attempted to explain to resident that I have to have someone to go with her and resident didn't feel that she would need that help and I again told her that the office would not help her. I will continue to attempt to contact family to meet at next appointment. On 12/04/2023 The facility advised they do not have a policy regarding vision appointments or outside medical appointments.	F 685		
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	F 689		

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supervision and assistance devices to prevent accidents.
This Requirement is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to thoroughly investigate falls, determine root cause analysis, and ensure pre-existing interventions were implemented for fall prevention, and failed to ensure foot pedals utilized when a resident pushed in their wheelchair for two of five residents reviewed for accidents (Resident #11, Resident #30). The facility reported a census of 48 residents.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment for Resident #11 dated 8/19/23 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. The MDS documented that the resident had diagnoses including muscle weakness, chronic pain,, and non-Alzheimer's dementia. Per the assessment, Resident #11 did not have any falls since admission, entry, reentry, or the prior assessment.

The Care Plan dated 7/8/21, revised 7/13/21, documented, the resident is at risk for falls related to generalized weakness, impaired cognition, and impulsivity.

The Intervention dated 3/2/23 directed staff as follows: Resident to have gripper socks on at bedtime. The Intervention dated 10/1/23 documented, Gripper socks at bedtime. The Intervention also dated 10/1/23 documented, scoop mattress to bed.

The Health Status Note dated 10/1/23 at 9:19 PM

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documented, Resident had unwitnessed fall at 2100 (9:00 PM). Resident observed on floor of her room sitting on her bottom with both legs out in front of her. Resident crying out Help Me Help me. Daughter [Name Redacted] notified of unwitnessed fall and protocol of neuros started. Resident takes Eliquis (blood thinner). Resident states she did not hit her head. States her knees are hurting her. Resident unable to describe how she ended up on the floor. Not sure if she was asleep and fell out or what. Daughter states she is a wiggle worm in bed. Resident did not have gripper socks on at time of incident. Replaced her soft slipper socks with gripper socks at this time. Notified PCP (Primary Care Physician) [Name Redacted] of incident by Fax.

Review of the Incident Report dated 10/1/23 at 9:28 PM for an unwitnessed event documented, Certified Nurses Aide (CNA) notified this nurse at 2100 that resident was on the floor in her room. When this nurse entered resident's room resident was sitting on the floor upright on her buttocks with both legs in front of her next to her bed. No injuries noted after assessment. Resident was asked if she hit her head and she stated "no". The Resident Description section documented, Resident was not sure how she fell.

The Incident Report and Progress Notes did not reveal a root cause analysis for the resident's fall.

The Health Status Note dated 10/7/23 at 11:35 PM documented, in part, This nurse was called into residents' room by CNA, found on floor sitting up against bed, bp (blood pressure) 154/72, p (pulse) 71, o2 (oxygen) 95%, r (respiration)16, (temperature) 97.2, no s/s (signs/symptoms) of injury, denies pain, states she was trying to go to the bathroom, this nurse reminded her to use call

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light, resident transferred with assist x2 et gaitbelt off floor et onto bed, CNA assisted resident to bathroom.

The Intervention dated 10/26/21, revised 12/1/21, documented, Offer toileting after meals. The Intervention dated 11/25/21 documented, Offer toileting at shift change. The Intervention dated 10/11/23 documented, Frequently offer to help me to the restroom.

The Incident Report dated 10/8/23 at 12:47 AM for the resident's fall did not address the last time the resident was assisted to the restroom prior to the fall, when the resident was last seen/by whom, and whether or not the resident had gripper socks applied at the time of the fall.

On 11/30/23 at 10:52 AM, Staff A, LPN explained the following about the initial intervention: Per Staff A, she input it following discussion with nurse and the Director of Nursing (DON), and if she saw the intervention already present she may go to the DON and ask other people.

The Facility Policy titled [Facility] Falls-Clinical Protocol revised 3/18 documented, in part, the following: 1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. The Policy also documented, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling...If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is

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AZRIA HEALTH PRAIRIE RIDGE	608 PRAIRIE STREET MEDIAPOLIS, IA 52637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 90 identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). 2. The Minimum Data Set (MDS) dated 10/26/23 identified Resident #30 as cognitively intact with a Brief Interview for Mental Status of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency (Kidney Failure) and Diabetes Mellitus. The MDS also identified Resident #30 required substantial staff assistance with lower body dressing, putting on footwear. In an observation on 11/27/23 at 12:00 PM, Staff D, RN pushed Resident #30 in the wheelchair without foot pedals. In an observation on 11/28/23 at 11:19 AM, Staff E, Restorative Certified Nurses Aide (CNA) pulled Resident #30 in her wheelchair out of the bathroom without foot pedals on with Resident #30's feet skimming the floor from the bathroom to outside in the hallway. Resident #30 then was able to self-propel to the main dining room. On 9/14/20, the Care Plan identified Resident #30 with the problem of being at risk for falls, however, failed to address the need to place foot pedals on the wheelchair prior to transporting the resident in the wheelchair. In an interview on 11/29/23 at 10:18 AM, Staff A, Licensed Practical Nurse (LPN) reported before pushing a resident in the wheelchair, should	F 689		

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F 689	Continued From page 91 make sure the foot pedals are on the wheelchair and put their feet on the foot pedals. This should be addressed on the care plan which any nurse can update. In an interview on 11/29/23 at 11:33 AM, Staff B, Registered Nurse (RN), reported before pushing a resident in the wheelchair, should make sure the foot pedals are on the wheelchair and put their feet on the foot pedals. This should be addressed on the care plan In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported before pushing a resident in the wheelchair, should make sure the foot pedals are on the wheelchair and put their feet on the foot pedals. Resident #30 has a bag on the back of her wheelchair where the foot pedals are stored. He did not feel this should be addressed on the care plan as it is common sense. He also reported the facility did utilize many CNAs from different agencies. The DON also reported it was a team effort and that all nurses could update the care plan.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure consistent completion of assessments prior to dialysis for one of one resident reviewed for dialysis (Resident #37). The facility reported a census of 48 residents.	F 698		

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F 698	Continued From page 92	F 698		

Findings include:

Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/7/23 for Resident #37 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per the assessment, the resident received dialysis while a resident.

The Care Plan dated 8/3/22 documented, I have alteration of my renal function and require Dialysis d/t (due to) End Stage Renal Disease. I refuse to be weighed at the facility.

The Intervention dated 8/3/22 documented, The facility will assist me, as needed, to coordinate services and care with my dialysis clinic. Communication with the dialysis center will be done pre/post each visit using a communication sheet or via phone and documented.

Review of the resident's COMS-Pre/Post Dialysis Evaluation revealed only one evaluation had been completed for the resident on the following dates: 11/6/23, 11/8/23, and 11/20/23.

On 11/29/23 at 10:59 AM when queried about dialysis assessments pre and post, the Director of Nursing (DON) acknowledged staff were supposed to do pre and post dialysis assessments. The above dates were provided to the DON related to lack of pre dialysis assessments.

On 11/30/23 at 8:18 AM when queried about the pre-dialysis assessments, the DON acknowledged they were not completed, and explained the facility had set up triggers to pop up

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F 698	Continued From page 93 on the Medication Administration Record (MAR) for the need to do it every dialysis day. On 11/30/23 at 10:54 AM, Staff A, Licensed Practical Nurse (LPN) acknowledged an evaluation for pre and post dialysis in the evaluation tab. On 11/30/23 at 11:50 AM, Staff B, Registered Nurse (RN) acknowledged if a resident on dialysis pre and post assessment supposed to be done. Per Staff B, Resident #37 refused it should be charted in the nurses note, explained the resident refused weight on occasion, and refused a full set of vitals at times. The Facility Policy titled [Facility] Hemodialysis Access Care dated September 2010 did not address the area of concern.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		

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F 700	Continued From page 94	F 700		

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This Requirement is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure informed consent completed for use of side rails and ensure assessments completed for use of side rails for two of two residents reviewed for side rails (Resident #7, Resident #11). The facility reported a census of 48 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment for Resident #11 dated 11/9/23 revealed the resident scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam which indicated severely impaired cognition. Per the assessment, a bed rail was not used in bed for the resident.

The Care Plan did not address use of bed rails for the resident.

The Physician Order dated 6/11/21 documented, Halo/grab barsx2 for bed mobility and positioning. No directions specified for order.

On 11/29/23 at 8:35 AM, observation of Resident #11 revealed the resident in her wheelchair in her room. Resident #11's bed observed to have partial rails bilaterally on the resident's bed, with one rail up and one rail down.

On 11/30/23 at 8:34 AM, the Administrator and Director of Nursing (DON) explained they had done a sweep about bedrails, contacted Power of Attorney and family, and care planned them. Per the Administrator, the residents had admission

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education and there had been a paper form of consent on admission. During the conversation with the DON and Administrator, it was acknowledged side rail evaluations had not occurred.

The facility provided an evaluation for bed rails as well as consent dated 11/29/23 for Resident #11.

2. The Minimum Data Set (MDS) dated 11/9/23 identified Resident #7 as cognitively intact with a Brief Interview for Mental Status score of 15 and had the following diagnoses: Diabetes Disorder, Gastrostomy and Anxiety Disorder. The MDS also documented that the Resident #7 required substantial assistance with showers/baths, dressing, putting on footwear and turning from side to side. It did not identify the resident with a feeding tube and identified she was on a therapeutic diet.

Observations of the resident during the survey from 11/27/23 through 11/30/23 revealed the resident's bed with two ¼ side rails up.

In an interview on 11/29/23 at 10:19 AM, Resident #7 reported she purchased her own bed as it had an air mattress and the side rails came with it, but none of the staff had provided any kind of education on safety issues on it.

In an interview on 11/29/23 at 10:45 AM, the Director of Nursing reviewed the resident's Electronic Medical Record and verified there was

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no documentation of side rail evaluation, education, etc in Resident #7's record.

A review of the Care Plan with the last revision date of 11/6/23 revealed the care plan did not address the use of side rails, the need for evaluation and education.

A review of the facility policy titled: Bed Safety dated as last revised August 2022 had documentation of the following:

1. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.
2. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include:
   a. roll guards;
   b. foam bumpers;
   c. lowering the bed; and/or
   d. use of concave mattresses to reduce rolling off the bed.
   e. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails.

This interdisciplinary evaluation includes:

a. an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs;

b. the resident's risk associated with the use of bed rails;

c. input from the resident and/or representative; and

d. consultation with the attending physician.

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F 700	Continued From page 97 3. The resident assessment to determine risk of entrapment includes, but is not limited to: a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms; b. size and weight; c. sleep habits; d. medication(s); e. acute medical or surgical interventions; f. underlying medical conditions; g. existence of delirium; h. ability to toilet self safely; i. cognition; j. communication; k. mobility (in and out of bed); and l. risk of falling. 2. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following: a. Accident hazards: 1. The resident could attempt to climb over, around, between, or through the rails, or over the foot board; and/or 2. A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress. b. Restricted mobility: 1. Hinders residents from independently getting out of bed thereby confining them to their beds; 2. Creates a barrier to performing routine activities such as going to the bathroom or retrieving items in his/her room, eating, hydration and/or walking; 3. Decline in resident function, such as muscle functioning/balance; and/or 4. Skin integrity issues. c. Psychosocial outcomes: 1. Creates an undignified self-image and alters the resident's self-esteem;	F 700		

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F 700	Continued From page 98 2. Contributes to feelings of isolation; and/or 3. Induces agitation or anxiety. 3. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons. 4. The staff shall report to the director of nursing and administrator any accidents or incidents associated with a bed or related equipment including the bed frame, side or bed rails, and mattresses. The administrator shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act.	F 700		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This Requirement is not met as evidenced by:	F 804		

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F 804	Continued From page 99	F 804		

Based on observation, record review, resident and staff interviews, the facility failed to serve food that was warm and palatable for three of twenty four residents reviewed (Resident #23, Resident #30, Resident #103). The facility reported a census of 48 residents.

Findings included:

1. The Minimum Data Set (MDS) dated 10/26/23 identified Resident #30 as cognitively intact with a Brief Interview for Mental Status of 15 and had the following diagnoses: Heart Failure, Renal Insufficiency (Kidney Failure) and Diabetes Mellitus. The MDS also identified Resident #30 required substantial staff assistance with lower body dressing, putting on footwear.

In an interview on 11/29/23 at 8:30 AM sitting up in wheelchair in her room, Resident #30 complained that the food is horrible. The pasta is always overcooked and food has no taste. Breakfast is always cold, especially the eggs. She reported she had spoken to many people about it, even the dietitian.

On 8/31/20, the Care Plan identified Resident #30 with the problem of being at nutritional risk and directed staff to offer an alternate if she dislikes food or fluids given.

A review of the dietitian progress notes revealed the following:
a. 12/7/22 10:00 PM Some weight variation likely due to fluid fluctuations. Resident does have many food preferences and staff accommodates, if feasible. Would continue current care plan.
b. 2/28/23 7:58 PM Resident does have many food preferences and staff accommodates, if

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F 804	Continued From page 100	F 804		

feasible. Would continue current care plan. Intake meets estimated needs.
c. 10/6/23 12:05 PM RD (Registered Dietitian) talked to resident on Tuesday and decision made was to 'start with' small portions of potatoes when on the menu and No dessert except pie as resident stated 'do not take my pie away from me'.

2. At the time of the survey, the admission MDS for Resident #103 had not been completed. A review of the electronic medical record (EMR) list of medical diagnoses included: cerebral infarction due to embolism, muscle weakness and multiple fractures of ribs on the left side.

The Progress Note dated 11/22/23 at 5:10 PM documented Resident #103 as alert and oriented to person, time and place.

In an interview on 11/27/23 at 10:03 AM, Resident #103 reported the food does not always taste so good.

On 11/28/23, the Care Plan identified the resident to be at nutritional risk due to recent stroke and history of mild dementia and directed staff to offer an alternate if he dislikes food/fluids given on the menu.

On 11/28/23 at 12:47 PM, the dietary manager delivered a test tray and took the temperatures of the food that was delivered on a plate warmer with a hard plastic dome cover. She took the temperatures as follows:
Goulash at 178 degrees Fahrenheit
Green beans at 120 degrees Fahrenheit
Lettuce salad - 53.8 degrees Fahrenheit
The Surveyor tasted goulash which was very bland, the green beans were lukewarm. The

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F 804	Continued From page 101 lettuce salad tasted slightly warm. A review of the facility policy titled: Food Prep and dated as last revised April 2019 had documentation of the following: Food Preparation, Cooking and Holding Time/Temperatures 1. The "danger zone" for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. 2. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. 3. The longer foods remain in the "danger zone" the greater the risk for growth of harmful pathogens. Therefore PHF (Potentially Hazardous Food) must be maintained below 41 degrees Fahrenheit or above 135 degrees Fahrenheit. 3. During an interview on 11/28/23 at 11:48 AM, Staff N, Cook stated the tossed salads are never temperature tested. She stated they always make them prior to the service and put them on ice but they still don't temp well. On 11/28/23 at 11:55 AM, temperature checks done prior to the lunch service completed with Staff N, Cook revealed the following temperatures: a. tossed salad- 49.3 degrees- Staff N took the temperature of the toss salads in the refrigerator and stated they weren't much different. b. green beans 211.1 degrees	F 804		

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F 804	Continued From page 102 On 11/28/23 at 12:45 PM, the post temperatures completed at the end of the lunch meal completed and revealed the following temperatures: a. tossed salad 51.3 degrees b. green beans 174.9 degrees During an interview on 11/28/23 at 1:52 PM, Staff O, RDN (Registered Dietician Nutritionist) queried if she got a test tray and she stated yes she requested a test tray at the end of the month and completed a kitchen check. Staff O asked if she checked the temperatures and she stated the temperatures were low and the green beans tempted at 120 degrees. During an interview on 11/28/23 at 2:10 PM, Staff O stated the strawberries on her test tray tempted at 50.5 degrees. She stated she spoke to the residents after the meal and asked them about the temperatures of the food. Staff O stated she didn't temp the tossed salad. During an interview on 11/28/23 at 2:12 PM, Staff N, Cook stated they did the strawberries right after breakfast and then kept in the refrigerator until they started service. Staff N stated she felt they did everything they could do, they kept everything in the refrigerator and didn't take out until before service. Staff N stated she agreed the lettuce didn't temp at the appropriate temperature before or after the meal. Staff N asked if the green beans and strawberries tempted at the appropriate temperature on the test tray and she stated no, they didn't. Staff N asked about the goulash and how they add flavoring or if able to and she stated they follow the recipe and don't add anything. Staff N asked if resident can add their own flavoring and she stated yes, the	F 804		

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F 804	Continued From page 103	F 804		

residents had salt and pepper on the tables and the family could provide seasonings for them.

During an interview on 11/28/23 at 2:26 PM, Staff O queried if she tried the goulash and she stated yes and she ate it all. She stated she felt it could of had a little more flavoring. She stated she thought it needed a little more sodium and she didn't use a lot of salt in her cooking. Staff O asked if she thought the temperatures were appropriate and she stated the green beans could of been hotter but had good flavor and the strawberries were cold to her and the lettuce was fine.

During an interview on 12/4/23 at 12:54 PM, the Administrator queried on the expectation of the food temperature and she stated she expected them to be up to the regulations and up to a safe temperature. The Administrator asked about her expectations for the taste of the food and she stated they follow the recipes and make sure the tables had salt and pepper on them.

4. The Quarterly MDS dated 10/5/23 for Resident#23 documented that the BIMS score of 15 out of 15 which indicated intact cognitive skills.

On 11/28/2023 at 10:40 AM Resident # 23 was interviewed regarding any concerns she had. Resident advised the food here is terrible. It is nasty. I'm done eating it. Resident # 23 goes to the dining room but leaves most of the food on plate. It has no taste or flavor. Everything is starch or sugar.

On 11/28/23 1:47 PM Resident #23 The food

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F 804	Continued From page 104 today was fairly good. The State should be here all the time. The lettuce was good and it wasn't just wilted lettuce. It had tomatoes and onions in it. It usually doesn't. She liked the goulash and thought it had good flavor. It was hot enough for her. On 11/30/2023 at 11:45 AM Staff member B, Registered Nurse (RN) was queried and reported she had a lot of complaints about the taste of the food. Residents are given an alternative choice. On 12/04/2023 at approximately 2:30 PM Resident #23 advised the food had been bad again recently especially over the weekend. I didn't eat it. The meals served today had nothing but starch and sugar. That's all we get here starch and sugar.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		

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F 842	Continued From page 105 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842		

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F 842	Continued From page 106 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to accurately document receipt of hospice services and completion of a wound treatment for two of two residents reviewed for records (Resident #18, Resident #103). The facility reported a census of 48 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #18 dated 9/16/23, completed 9/22/23, revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam. Per the assessment, Resident #18 did not receive hospice care while a resident. The Care Plan revised 11/16/23 documented, I am at nutritional risk due to h/o (history of) ETOH (alcohol) dependence, cardiomyopathy, cirrhosis and weight loss hx (history). I have been admitted to Hospice in October 2022 and Decertified in Jan 2023. Resident to be certified for Hospice Care end of June/Early July 2023. As of October 2023 resident remains decertified from Hospice. The Health Status Note dated 9/18/23 at 8:22 AM documented, Resident discharged from hospice on 9/17/2023. No change in condition. Resident and POA (Power of Attorney) aware. The Health Status Note dated 9/24/23 at 9:39 PM documented, Hospice cares continue-No change in condition.	F 842		

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The Health Status Note 9/25/23 at 11:42 AM documented, Night nurse passed along to please have hospice fill resident's morphine sulfate order. Resident has not been on hospice services for awhile now per [Name Redacted], RN (Registered Nurse). Resident low on morphine sulfate, Back up/ partial bottle located in medication room at this time. Nurse on duty to call primary [Name Redacted], NP (Nurse Practitioner) office for request of medication refill when resident is running low at a later time to a lot time for processing of medication request.

The Health Status Note dated 9/26/23 at 3:51 AM documented, Resident continues on Hospice level of care. No changes noted this shift.

The Restorative Weekly Note dated 9/29/23 at 2:28 PM documented, Resident has recently been discharged from Hospice care All RT program activities at this time are being re-evaluated by in house PT (physical therapy).

On 11/30/23 at 8:16 AM when queried about hospice documentation, the Director of Nursing (DON) explained he was told the resident went back and forth on whether or not the resident wanted to be on hospice or did not. Per the DON, the nurses documented based on the resident's preference, and explained the nurse was not going to call to restart and stop which was why the documentation went back and forth.

On 11/30/23 at 10:54 AM, Staff A, Licensed Practical Nurse (LPN) explained the resident would say he did not want to be on hospice, the doctor would be contacted and it would be discontinued. Staff A explained usually when the resident had upper respiratory concerns or did not want to go to the the hospital, the resident

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F 842	Continued From page 108 wanted to go back on hospice. On 12/4/23 at 2:04 PM, the facility explained there was not a policy to address complete and accurate records. 2. At the time of the survey, the admission MDS for Resident #103 had not been completed. A review of the Electronic Medical Record (EMR) list of medical diagnoses included: cerebral infarction due to embolism, muscle weakness and multiple fractures of ribs on the left side. A review of the progress notes dated 11/22/23 at 5:10 PM revealed Resident #103 as alert and oriented to person, time and place. Observations of the resident revealed the following: a. On 11/27/23 at 10:03 AM, the resident sat up in the recliner in his room with feet elevated, he reported he came in with an open area to left shin which has kerlix dressing dated 11/25/23. He wore tubigrips to both legs which had with 2+ edema. b. On 11/28/23 at 7:04 AM Resident #103 reported he was supposed to get his dressing to his left leg and the staff didn't change it yesterday. The dressing to his left leg was dated 11/25/23 and appeared to be the same dressing he had yesterday. c. On 11/29/23 11:33 AM, during an observation of wound care, the Assistant Director of Nursing (ADON) pulled up pant leg to left leg and removed Resident #103's sock. The ADON verified the date on dressing as 11/25 and should	F 842		

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have been changed 11/27. The dressings should be changed every other day.

A review of the physician orders revealed the following:
11/22/23 Mix equal parts of Clotrimazole, Triamcinilone and Silvasorb. Apply to left lower leg including wound bed. Cover any open ulcerations with Telfa, secure with rolled gauze and tape cover with tubigrip Size F every day shift every other day for wound treatment.

A review of the November 2023 Treatment Administration Record revealed documentation the treatment signed out as completed on 11/27/23.

The only problem addressed on the Care Plan on 11/23/23 was urinary tract infection. It did not address the open area to his left lower leg.

In an interview on 11/29/23 at 10:18 AM, Staff A, Licensed Practical Nurse (LPN) reported she was not sure of a process for ensuring all treatment orders were being carried out daily.

In an interview on 11/30/23 at 11:03 AM, the ADON reported nurses are supposed to sign off treatments on the Medication Administration Records after the treatments have been completed. When asked why the dressings still had 11/25 dated on 11/29, she reported the dressings should have been done on 11/27. She could not explain why the treatment would be signed out on 11/27 when it had not been completed.

In an interview on 11/29/23 at 11:33 AM, Staff B, Registered Nurse (RN), reported Resident #103 should have had his dressings changed every

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F 842	Continued From page 110 other day. She was not sure if there was someone to double check MARs to ensure all treatments had been completed at the end of the day. In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported the nurse who signed off the MAR on 11/27 reported after she put the new dressing on, she dated it 11/25. There were no initials on the dressing and he had instructed staff they need to start writing their initials on the dressing.	F 842		
F 880 SS=D	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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		

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F 880	Continued From page 111 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: (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 observation, record review, resident	F 880		

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and staff interview, the facility failed to ensure proper infection control techniques for one of three residents observed during medication pass (Resident #6), during the drainage of a GT (gastric tube) drainage bag for one of one residents observed with a GT drainage bag (Resident #7) and during wound care for one of one residents observed for wound care (Resident #103). The facility reported a census of 48 residents.

Findings included:

1. The Minimum Data Set (MDS) dated 10/12/23 identified Resident #6 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and had the following diagnoses: Atrial Fibrillation (an abnormal heart rhythm), Coronary Artery Disease, Parkinson's Disease and Anxiety Disorder. The MDS also identified Resident #6 as independent with most activities of daily living.

During observation of med pass for Resident #6 on 11/28/23 at 6:35 AM, Staff B, Registered Nurse (RN) removed one tablet of Alprazolam 1 mg from blisterpack, the pill fell out on top of the med cart. Staff B picked up the pill with her bare hand, placed it in the medication cup and administered it to the resident.

A review of the Physician Orders and November 2023 Medication Administration Record (MAR) revealed an order dated 11/30/18 Alprazolam 1 milligram one tablet give by mouth two times a day for anxiety disorder.

In an interview on 11/29/23 at 10:18 AM, Staff A, Licensed Practical Nurse (LPN) reported if she removed pills from a blisterpack and it fell out on

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top of the medication cart, she would have to dispose of it.

In an interview on 11/29/23 at 11:33 AM, Staff B, Registered Nurse (RN), reported if she removed pills from a blisterpack and it fell out on top of the medication cart, she would have to waste it. She admitted she got flustered as the surveyor was observing her.

In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported if a nurse removed pills from a blisterpack and it fell out on top of the medication cart, she would expect the nurse to waste the pill.

2. The Minimum Data Set (MDS) dated 11/9/23 identified Resident #7 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Diabetes Disorder, Gastrostomy and Anxiety Disorder. It also identified Resident #7 required substantial assistance with showers/baths, dressing, putting on footwear and turning from side to side. It did not identify the resident with a feeding tube and identified she was on a therapeutic diet.

In an observation on 11/28/23 at 11:17 AM, Staff B, RN entered room and washed hands, donned gloves, a placed paper towel on the floor and placed graduate on top of paper towel. Staff B used the correct technique to drain the GT drainage bag. The GT drainage bag was not placed in a dignity bag. Staff B placed both the tubing and bag on the floor underneath the resident's wheelchair.

On 5/18/23, the Care Plan identified Resident #7 with a gastric drainage bag and did not direct staff to place the bag in a dignity bag and keep both

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bag and tubing off the floor.

In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported when emptying out Resident #7's GT drainage bag she would keep both bag and tubing off the floor.

In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported when emptying out Resident #7's GT drainage bag she would make sure it's secure and covered and off the floor.

In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported when emptying out Resident #7's GT drainage bag, he would expect the nurse to make sure both bag and tubing are kept off the floor.

3. At the time of the survey, the admission MDS for Resident #103 had not been completed. A review of the electronic medical record (EMR) list of medical diagnoses included: cerebral infarction due to embolism, muscle weakness and multiple fractures of ribs on the left side.

The progress notes dated 11/22/23 at 5:10 PM documented Resident #103 as alert and oriented to person, time and place.

During an observation of wound care which began on 11/29/23 at 11:17 AM, Staff C, RN did not use alcohol hand sanitizer to sanitize hands before she pulled out the 3 tubes of ointment out of the treatment cart. She squirted a small amount of Triamcinalone 0.025%, Clotrimazole 1% cream and Silvasorb and mixed together into a medication coup. She did not wear gloves to handle the tubes of ointment then returned to ziplock bag which she then returned to treatment cart. Staff C then found a bottle mixed by

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pharmacy with all 3 ointments and did not wear gloves when she used a cotton tipped applicator to remove from the bottle and added to med cup which she had mixed.

On 11/29/23 at 11:22 AM When asked what type of wound Resident #103 had, Staff C could not recall if the wound was arterial or venous. She stated she needed more supplies and took the medication cup of ointment with her and locked up treatment cart.

On 11/29/23 at 11:24 AM Staff C returned to unlock treatment cart and removed telfa dressings then said "I need rolled gauze" locked treatment (tx) cart and left to get rolled gauze.

On 11/29/23 at 11:30 AM Staff C returned to Resident #103's room with supplies and placed on paper towels on top of resident's bed.

On 11/29/23 at 11:33 AM Staff C washed her hands and donned gloves, removed Resident #103's sock. She verified the date on dressing was written as 11/25 and the dressing should have been changed 11/27/23.

On 11/29/23 at 11:35 AM Staff C removed a pair of scissors from her pocket and did not disinfect them prior to cutting the dressings from Resident #103's left leg.

On 11/29/23 at 11:37 AM Staff C washed her hands and donned new gloves. She squirted skin wound cleanser onto 4x4 gauze dressings and dabbed the wound from the top to the bottom, rather than inward out. She used same dressings to cleanse all areas (using a washboard motion) of the leg without changing surface.

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F 880	Continued From page 116 On 11/29/23 at 11:39 AM Staff C removed her gloves, did not use sanitize her hands and donned new gloves. She used a cotton tipped applicator to apply the ointment mixture onto telfa dressing and used same dressing to spread ointment mixture all over shin area and back of leg using washboard motion back and forth. On 11/29/23 at 11:41 AM Staff C removed her gloves, used Alcohol Hand Sanitizer and donned new gloves. Staff C applied dressings to the wound, did not disinfect the scissors before she cut the new dressing. In an interview on 11/29/23 at 10:18 AM, Staff A, LPN reported when cleansing a wound, she would clean from the middle of the wound and outward and should disinfect the scissors before and after each use. In an interview on 11/29/23 at 11:33 AM, Staff B,RN, reported when cleansing a wound, she would clean from the from the least dirty part of the wound which would be the outside of the wound before she would clean the actual wound. She would disinfect her scissors before and after each use. In an interview on 11/30/23 at 1:01 PM, the Director of Nursing (DON) reported when cleansing a wound, he would expect the nurse to clean from the high part of the wound to the lowest. He would also expect the nurse to disinfect the scissors before and after each use.	F 880		
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	F 883		

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	165220	A. BUILDING _____ B. WING _____	12/06/2023

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F 883	Continued From page 117 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- (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	F 883		

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F 883	Continued From page 118 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 Immunization Registry Information System (IRIS) review, staff interview, and facility policy review, the facility failed to ensure pneumococcal vaccines offered timely for two of five residents reviewed for immunizations (Resident #4, Resident #11). The facility reported a census of 48 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #4 dated 10/5/23 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Review of Resident #4's electronic health record revealed the resident was born in 1932. Review of IRIS documentation for the resident revealed the resident received PCV-13 (Pneumococcal Polysacharide) on 11/17/16. IRIS documentation of immunizations lacked additional pneumococcal vaccination administration. Review of a paper Vaccination History document provided by the facility revealed the resident last had PPSV-23 (Pneumococcal Polysaccharide) on 10/24/02.	F 883		

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F 883	Continued From page 119 The webpage https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html#adults-19-64 revealed the following per the Received PCV13 at Any Age and PPSV23 After Age 65 Years heading: "Use shared clinical decision-making to decide whether to administer PCV20. f so, the dose of PCV20 should be administered at least 5 years after the last pneumococcal vaccine." Review of the resident's Immunization Consent/Declination Form dated 10/16/23 lacked acceptance or declination about PCV-20. 2. The Minimum Data Set (MDS) assessment dated 11/9/23 revealed the Resident #11 scored 6 out of 15 on a Brief Interview for Mental Status (BIMS) exam which indicated severely impaired cognition. Review of Resident #4's electronic health record revealed the resident was born in 1934. Review of IRIS documentation for Resident #11 revealed the resident received PCV-23 on 10/25/13. Per the resident's electronic health record, the resident received PCV-13 on 11/1/17. On 12/4/23 at 4:38 PM, the Administrator explained via email the facility did not have any further information about PVC-20 for the above residents. The Facility Policy titled [Facility] Pneumococcal Vaccine revised 9/22 documented, Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission	F 883		

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F 883	Continued From page 120 to the facility unless medically contraindicated or the resident has 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 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	F 887		

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F 887	Continued From page 121 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 (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 Information Registry Information System (IRIS) review, staff interview, and facility policy review, the facility failed to ensure a resident was offered COVID-19 vaccination(s) timely for one of five residents reviewed for immunizations (Resident #18). The facility reported a census of 48 residents. Findings include: Review of census information for Resident #18 revealed the resident admitted to the facility 8/17/22. Review of IRIS documentation for the resident revealed the resident received one dose of a two dose series for COVID-19 vaccination on 8/17/22. The resident had another COVID-19 vaccine which could be given 9/7/22 per the earliest date per IRIS, 9/7/22 per the recommended IRIS information, and considered past due 9/28/22 per IRIS.	F 887		

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F 887	Continued From page 122 Review of the resident's Vaccination History per a paper form provided by the facility revealed dose 1 of a 2 dose series given 8/17/22. Review of the Immunization Consent/Declination Form revealed consent for COVID-19 dated 11/15/23. On 12/4/23 at 4:38 PM, the Administrator explained via email the facility did not have further information about the resident's second COVID vaccination. The Facility Policy titled [Facility] Coronavirus Disease (COVID-19) -Vaccination of Residents, revised 12/21, documented, Each resident is offered the COVID-19 vaccine unless is medically contraindicated, or the resident has already been immunized.	F 887		