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	165217	A. BUILDING _____ B. WING _____	C 11/26/2024

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F 000	INITIAL COMMENTS	F 000		
Ok ✓ Lg	Correction date: 12-20-24 The following deficiencies resulted from investigation of complaint #123477-C, conducted November 25, 2024 to November 26, 2024. Complaints #123477-C was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not 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	F 656	✓	

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

12/20/24

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

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recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to develop a care plan for 1 of 4 residents reviewed. Resident #1 was admitted to the facility on 10/29/24, as of 11/26/24 the clinical record lacked a care plan. The facility reported a census 24 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 10/29/24, Resident #1 was admitted to the facility on 10/29/24 from the hospital. A Brief Interview for Mental Status (BIMS) assessment, dated 10/30/24 at 8:41 AM, showed that Resident #1 had a score of 15 (cognitively intact).

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A document titled: Functional Abilities and Goals, dated 11/5/24 at 8:31 AM, showed that Resident #1 had lower extremity impairment on both sides. He was totally dependent on staff for toileting hygiene, lower body dressing, and showering. He required substantial assistance with rolling over and sit to lying. Sit to stand, bed to chair transfers, toilet transfers and walking were not attempted in the 3 day look back period due to medical conditions and safety concerns.

On 11/25/24 at 9:52 AM, Resident #1 was lying in a bariatric bed and there was a bariatric chair, wheel chair, commode and walker in the room. Resident #1 expressed that he was upset about the lack of planning related to his admission to the facility. He had been transferred to the facility for rehabilitation, with a goal of going back home. When he arrived, the bed was too small for him, they didn't have a large enough commode, walker or chair, and he was delayed in getting Physical Therapy (PT) so he had lost ground on the progress he had made in the hospital. He said that from October 29th through November 13th, he was mostly bed-ridden and the staff were giving him bed baths and using a bed pan that was too small for him.

According to a Care Plan Conference Summary, date 11/7/24 at 1:17 PM, staff had discussed the resident's nursing needs and the Care Plan was updated.

As of 11/26/24, the electronic record for Resident #1 did not include a Care Plan.

On 11/26/24 at 1:00 PM, the Director of Nursing (DON) said that they did not have policy on care

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F 656	Continued From page 3 planning and that the facility follows the regulations. She said that Resident #1 had a care conference where they discussed his goals but she was surprised to hear there was no care plan in the electronic record.	F 656		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident	F 725		

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interviews, clinical record review and facility document review the facility failed to ensure that they provided adequate nurse staffing to meet the needs for 3 of 4 residents reviewed. Residents #1, #3 and #4 indicated that many times there were only 2 staff on duty and they waiting a long time to get a response to their call lights. When the facility didn't have anyone else to work, Staff D, Licensed Practical Nurse (LPN) worked 23 consecutive hours and 49 hours in a three-day period. The facility reported a census of 24 residents.

Findings include:

1) According to the Minimum Data Set (MDS) assessment, dated 10/29/24, Resident #1 was admitted to the facility on 10/29/24. A Brief Interview for Mental Status (BIMS) assessment, dated 10/30/24 at 8:41 AM, showed that Resident #1 had a score of 15 (cognitively intact).

A document titled: Functional Abilities and Goals, dated 11/5/24 at 8:31 AM, showed that Resident #1 had lower extremity impairment on both sides. He was totally dependent on staff for toileting hygiene, lower body dressing, and showering. He required substantial assistance with rolling over and sit to lying. Sit to stand, bed to chair transfers, toilet transfers and walking activities were not attempted in the 3 day look back period due to medical conditions and safety concerns.

On 11/25/24 at 9:52 AM, Resident #1 was lying in bed and indicated that he was unhappy about his admission to the facility. He said that he was transferred to the facility for rehabilitation with a goal of going back home and there was a delay in starting Physical Therapy (PT) because they did

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not have the proper bariatric equipment. Resident #1 said that the call light response had been really long many times, with 45 to 90 minute waits before staff responded. Once they got to his room, the staff would tell him that they only had one Certified Nurse Aide (CNA) on the floor and they were trying to get to the residents as soon as they could.

2) According to the MDS dated 9/30/24, Resident #4 was admitted to the facility on 12/10/19. She had a BIMS score of 12 (moderate cognitive deficit) and was totally dependent on staff for toileting, dressing and sit to stand transfers. Her diagnosis included heart disease, renal insufficiency and diabetes mellitus.

The Care Plan for Resident #4, updated on 6/12/24, showed that she was at risk for skin breakdown and staff were to provide peri-care and barrier cream with incontinent episodes. Staff were to encourage the resident to use her call light for assistance.

On 11/26/24 at 11:00 AM Resident #4 was in her wheel chair in her room. She said that the call lights take forever. She said that she was incontinent and needed frequent changes because she's a heavy a wetter. Resident #4 said that she'd had skin breakdown in the past and the staff would come in and tell her she needed to get off her bottom, but "what can I do, I'm in a wheel chair." Resident #4 said that the staff would often come in and shut off the call light, she would turn the light back on when they didn't return in a timely manner. They often said they didn't have enough staff.

3) According to the MDS dated 10/5/24, Resident

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#3 had a BIMS score of 15 (intact cognitive ability). She was admitted to the facility on 10/17/12 and was totally dependent on staff for dressing, hygiene, toileting and transfers. Her diagnosis included; Cerebrovascular Accident (CVA) hemiplegia or hemiparesis, chronic pain and constipation.

The Care Plan updated on 6/5/24 showed that Resident #3 was at risk for skin breakdown, staff were to provide peri care as needed after incontinence episode. She was in an electric wheelchair and able to relieve pressure by tilting or adjusting wheelchair. The resident likes to go to her room after meals and lie down. Staff were to anticipate here needs and reassure her that they would assist as soon as possible.

On 11/26/24 at 8:42 AM, Resident #3 was in a motorized wheel chair, her body leaned to the left and her speech was slow and soft. Resident #3 stated the call lights take forever. She was not able to say how long she had to wait to get help, but the staff would usually tell her that they didn't have enough help to get there any sooner.

4) On 11/25/24 at 3:45 PM, Staff D, Licensed Practical Nurse (LPN) said that there were many times when they had just one CNA working. She said that, at times, the office staff would say they were going to help out but, that didn't happen very often. She said that some CNA's were better than others at getting to the residents when they were working alone. Staff D said that there was a weekend in August where she was the only nurse available so she worked over 40 hours straight, and then a 12-hour shift after that. She said that they provided an extra aide during that time so she could take naps.

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According to the timesheets for Staff D, on 8/2/24 she worked 23.25 hours straight with just two, 30-minute breaks and on 8/3/24 she worked 14.25 hours with one, 30-minute break. Over a three-day period (8/2 - 8/4) Staff D worked 49.25 hours.

On 11/25/24 at 2:05 PM, Staff B, CNA said that at least once a month, she is expected to work without another CNA, and she admitted that she had transferred residents that required 2 staff, without another staff person. She acknowledged that it did take a long time to respond to the call lights during these times.

On 11/26/24 at 8:40 AM, the Administrator said that the only time they would operate with just one CNA was on the night shift. During the day they need 2 CNA's or the office staff would come out and help with residents that required 2 staff assistance.

On 11/26/24 at 1:00 PM, the Director of Nursing (DON) said that they did not have a policy on call light response time and they follow the regulations.

The Facility Assessment dated 2/29/24, documented the facility would have resources needed to provide competent support and care for resident population every day and during emergencies. They would provide a Registered Nurse (RN) or LPN one for each shift. Staffing plan for direct care staff (CNA); based on resident need with a goal of 3.00 PPD (Hours Per Patient Day, using the number of residents, 24 x 3.0 = number of hours used in a 24 hour period. Equaling 72 CNA hours per day.)

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F 725	Continued From page 8 On 11/26/24 at 11:30 AM, the Regional Nurse Consultant said that the Facility Assessment needed to be updated and the PPD for direct care staff calculated out to be 3 CNA's on for 24 hours a day and that was not a realistic goal.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility document review, and staff interviews the facility failed to ensure that a Registered Nurse (RN) was at the facility for 8 consecutive hours every day. In a 30-day timeframe, 4 days with no RN coverage. The facility reported a census of 24 residents. Findings include: In a review of the nursing schedule for the month of November 2024, it was discovered that there were no RN's scheduled on the 9th, 10th, 17th and 23rd.	F 727		

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F 727	Continued From page 9 On 11/26/24 at 11:38 AM, the Director of Nursing (DON) said that she was a Registered Nurse and at the facility through the week and occasionally, on the weekends. She acknowledged that there was no RN coverage on November 9, 10, 17, or 23rd. She said that she would be talking to the Administrator on how they would handle RN coverage going forward. On 11/26/24 at 12:55 PM, Staff F, Nurse Scheduler, said that it had been very difficult to ensure they had RN coverage when they didn't have any on call staff and needed to rely on agency nurses. On 11/26/24 at 1:00 PM, the DON said that they did not have policy on RN coverage. According to the Facility Assessment dated 2/29/24, the facility would have resources needed to provide competent support and care for resident population every day and during emergencies with RN or LPN one for each shift.	F 727		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and clinical record review the facility failed to ensure they had the proper equipment	F 835		

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and services to meet the needs of residents before admission for 1 of 1 residents reviewed. Resident #1 sustained a knee injury that required therapy services and the facility agreed to accept the resident before considering his bariatric equipment needs. The facility reported a census of 24 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 10/29/24, Resident #1 was admitted to the facility on 10/29/24 from the hospital. A Brief Interview for Mental Status (BIMS) assessment, dated 10/30/24 at 8:41 AM, showed that Resident #1 had a score of 15 (cognitively intact).

The following documentation was found in the Progress Notes:
1) On 10/29/24 at 3:29 PM, the resident arrived via ambulance with a knee injury. He had bilateral lower extremity swelling and he was able to stand with a walker and transfer to bed.
2) On 10/30/24 at 4:45 PM, the resident required 2 staff assist with pivot transfers.
3) On 10/31/24 at 8:57 PM, Resident #1 was in bed, on the computer and had asked about equipment. The staff was unable to answer his questions.

A document titled: Functional Abilities and Goals, dated 11/5/24 at 8:31 AM, showed that Resident #1 had lower extremity impairment on both sides. He was totally dependent on staff for toileting hygiene, lower body dressing, and showering. He required substantial assistance with rolling over and sit to lying. Sit to stand, bed to chair transfers, toilet transfers and walking were not

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attempted in the 3 day look back period due to medical conditions and safety concerns.

On 11/25/24 at 9:52 AM, Resident #1 was lying in a bariatric bed. There was a bariatric chair, wheel chair, commode and walker in the room. Resident #1 expressed that he was upset about the lack of planning related to his admission to the facility. He said that he came from the hospital after his knee gave out and he was transferred to the facility for rehabilitation, with a goal of going back home. When he arrived, the staff were unaware of his equipment needs. The bed was too small for him, they didn't have a large enough commode, walker or chair, and he was delayed in getting Physical Therapy (PT) so he had lost ground on the progress he had made in the hospital. The resident looked through his phone and referenced detailed notes that he had taken. He said that on November 7th the Director of Nursing (DON) talked to him about the lack of equipment, and said they had a payment issue with suppliers and needed credit approval. On November 13th he finally got the 4 items, but From October 29th through November 13th, he was mostly bed-ridden. Staff were giving him bed baths and he was using a bed pan that was too small for him and would often spill over into the bed. The hospital had a difficult time finding him a skilled nursing facility because of his size, but this facility said that they could meet his needs, but when he got there, he found that they weren't prepared for him. Resident #1 said that when he didn't have a walker to use for therapy, his family went and bought one for him. Before that time, PT "made due" with a sit to stand that they "rigged" so he could do some exercising. The clinical record for the resident lacked a comprehensive care plan.

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A PT Evaluation and Plan of Treatment note dated 11/3/24, showed that the resident was unable to complete any ambulation or transfer as bariatric equipment had not been delivered. A note on 11/4/24 showed that the walker in the resident's room was rated for 500 pounds and he was over that weight. PT put a hold on functional transfers and ambulation until a walker arrived that can support his weight. On 11/5/24, the bariatric equipment had not arrived so they tried a Sara Steady walker device rated for 900 pounds for standing and he was able to transfer sit to stand. PT then used the Forward Wheeled Walker (FWW) rated for 500 pounds because the resident did not bear a lot of weight through the walker and he wanted to walk across the room and back. A PT note dated 11/8/24, showed that the equipment was still not at the facility, the family got upset and ordered him a walker that met size and weight requirements. A PT note dated 11/14/24 showed that the bariatric equipment had arrived on 11/13/24.

The History and Physical (H&P) report from the referring hospital's Emergency Room (ER), dated 10/9/24 at 5:54 PM, showed that Resident #1 presented to the ER with right knee pain. He was getting into his truck when his leg became weak and he dislocated his knee. The X-ray was negative for fractures. The ER contacted multiple skilled nursing facilities for which the patient exceeded the maximum weight limit. Due to his weight, he required bariatric bed and lift system.

A dietitian recommendation report dated 10/21/24 at 1:19 PM, (included with the hospital referral documents) showed that his admitting weight to the hospital on 10/8/24 was 770 lbs. On 10/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165217	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING ACRES NURSING AND REHAB CENTER	1000 HILLCREST DRIVE ANITA, IA 50020

(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 835	Continued From page 13	F 835		

it was 688.9 pounds, with a height of 70 inches. Some of the weight shifts likely related to fluid.

A daily hospital report dated 10/22/24 at 10:46 AM, showed that Resident #1 had a height of 177.8 centimeters (cm) (70 inches) and his weight was 313.4 kilograms (690 pounds).

On 11/25/24 at 1:43 PM, a Social Worker (SW) from the referring hospital said that the accepting facility would have gotten the hospital reports and therapy notes before they decided on accepting the patient. The SW said that the facility called to accept on 10/24/24. On the 28th they confirmed that the resident would transfer on the 29th.

On 11/25/24 at 2:38 PM, the Maintenance Manager (MM) said that he knew before Resident #1 arrived that he was over 600 pounds and would need a special commode but he wasn't aware that the resident didn't have a wheel chair or walker. The MM talked about the many supply companies that he contacted trying to find the equipment. He stated that there were many barriers to getting approval from the facilities corporate office and eventually they decided on rentals and found a company that could provide those needs.

On 11/26/24 at 8:40 AM, the Administrator said that she was involved in the decision to admit Resident #1 and she knew the hospital was having issues finding placement. She said that they were told that he could walk and once he got to the facility there were challenges with trying to get the equipment. Before accepting Resident #1 for admission, the Administrator, Assistant Director of Nursing (ADON), Director of Nursing (DON) brainstormed together if they could serve

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F 835	Continued From page 14	F 835		

his needs and no one on the team had concerns about his size. They all knew that he was 700 pounds and very tall. The Administrator acknowledged that they did not start calling for the specialized equipment until 11/3/24. She said that should would have liked to have more more information from hospital about his equipment needs before they had accepted him.

On 11/25/24 at 2:20 PM, Staff F, Assistance Director of Nursing (ADON) said that she was the first go-to for resident referrals. The decisions to accept were usually made between her and the DON. She said that she looked at insurance questions, medications and needs for skilled care. She said that she had been told the equipment for Resident #1 would have been delivered before his admission and that the Administrator and MM were taking care of those needs.

11/25/24 at 4:10 PM, the DON said that she became aware of the challenge with equipment needs for Resident #1 when he formally submitted a grievance. She said that before he was admitted, she wondered if they could meet his needs related to his large size.

According to the Facility Assessment last updated on 2/29/24, the Administrator, DON and governing body would ensure appropriate care and services could be provided to the resident prior to granting admission into the facility. All potential residents were screened for appropriate placement prior to admission. In the case of bariatric's patients over 425 pounds, the staff would obtain more information before making the decision to admit to the facility.

Caring Acres Nursing and Rehab

1000 Hillcrest Drive

Anita, Iowa 50020

712-762-3219

November 25, 2024-November 26, 2024

F656 481-58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:

58.20(4) Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:

a) The written health care plan, based on the assessment and reassessment of the resident's health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)

b) The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III)

F725 481-58.11(135C) Personnel.

58.11(2) Nursing supervision and staffing.

b) A qualified nurse RN shall be employed to relieve the supervising nurses, including charge nurses, on holidays, vacation, sick leave, days off, absences, or emergencies. Pertinent information for contacting such relief person shall be readily available to nurses (III)

481-58.18(135C) Nursing Care.

58.18(4) The facility shall provide prompt response from qualified staff for the resident's use of the nurse call system. (II,III) (Prompt response being considered as no longer than 15 minutes.)

F727 481-58.11(135C) Personnel.

58.11(1) The licensee shall:

a) Asume the responsibility for the overall operation of the nursing facility; (III)

b) Be responsible for compliance with all applicable laws and with the rules of the department; (III)

Steps To POC

F656

SS=D

1) Immediate Action

a) Resident Number #1 care plan was completed by the MDS Coordinator and Care Plan team on December 12, 2024.

b) The MDS Coordinator shall schedule each resident for a 7-day assessment period in which data will be gathered about the resident; this will be at least every 92 days with the frequency and type of assessment being determined according to the guidelines in the RAI Manual beginning on December 15, 2024 and ongoing.

c) Each person completing a section of the MDS attests to its accuracy and completeness.

d) Completion of the MDS is attested to by the MDS Coordinator who signs and dates item Z0500 on the MDS.

2) Identification of others at risk

a) MDS Coordinator will review all the residents to ensure that each resident has an up-to-date care plan completed by the care plan team by December 18, 2024.

b) By December 18, all the members of the care plan will review each care plan to ensure that each resident care plan is correct according to that individual resident.

3) Education and Monitoring

a) Within 48 hours after each resident's new admission to the facility, the care plan team will meet after admissions to complete the care plan for the new resident.

b) A post admission tool will be created to ensure all care plans are developed timely.

c) All other care plans will be completed at their regular time according to the MDS rules and regulations for each resident.

d) The care plan team was educated by the Administrator on 12-16-24 on the regulation regarding care plans.

4) Quality Assurance

a. Random audits will be conducted by the DON/Designee to ensure compliance weekly for 4 weeks. The Quality Assurance and Performance Improvement Committee will review audits to ensure compliance and make recommendations.

Steps To POC

F725

SS=E

1) Immediate Action

a) There will be sufficient staff members on each hall to provide nursing and related services to the resident's as planned by the interdisciplinary team based on the resident's assessment(s) to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident.
b) Facility leadership will provide for a sufficient number and mix of staff to support safe quality care, treatment, and services including licensed nurses, and other nursing personnel, including but not limited to nurse aides.
c) The facility leadership will designate a licensed nurse to serve as a charge nurse on each shift.
d) When the Director of Nursing is absent, responsibility for continuity of care and supervision of nursing care is delegated to a designated Licensed Nurse and/or Charge Nurse.
e) The staffing pattern will reflect the assessed and identified needs and preferences of the residents residing on the unit.
f) A registered nurse will be available in the facility for at least eight hours each day for seven day a week.
g) During any hours that a registered nurse is not available in the facility, the Director of Nursing will assign a Registered Nurse to be "on call" for immediate access to consultation.
h) Licensed nurses will be available in the facility 24 hours a day, seven days a week.
i) The Facility Assessment was updated on 12-16-24

2) Identification of others at risk.

a) All residents may be affected.

3) Education and Monitoring

a) The "Direct Care Staff Daily Report will be completed by the Director of Nursing to ensure that we have the appropriate staffing each shift to meet the needs of the residents on each shift.
b) The direct care staff will receive additional training/in-service/and competency and skill sets to take appropriate care of the residents. **** You need to educate staff on answering call lights, not using the lifts alone, the admission team on having equipment for residents in house prior to admission, DON and ADON on staffing and having RN coverage 7 days a week,

and the Facility Assessment needs to be updated. And we MUST assure NO staff members work long hours as it was reflected in the 2567. If agency cannot cover a shift, it is the expectation that we pull first from Social Services, next ADON, and at the very last resort, the DON.

4) Quality Assurance
5) Random audits will be conducted by the Administrator/Designee to ensure compliance weekly for 4 weeks. The Quality Assurance and Performance Improvement Committee will review audits to ensure compliance and make recommendations.

F727

SS=E

1) Immediate Action

a) The facility will have a Registered Nurse in the building seven days a week for seven days per week.

b) If the registered nurse is not present in the facility, a registered nurse will be available by phone to provide advice and guidance to the licensed practical nurses and other nursing team members.

2) Identification of others at risk

a) The Director of Nursing, Assistant Director of Nursing, and Administrator will ensure that we have RN coverage on a daily basis for 8 consecutive hours a day for seven days a week.

b) The facility will use agency RNs to cover the weekend RN coverage for the 8 hours.

3) Education and Monitoring

a) The Administrator will review the Staffing Policy with the Director of Nursing and the Assistant Director of Nursing to ensure that we have RN coverage for seven days per week.

F835

SS=D

1) Immediate Action

a) All specialized equipment will be ordered before the resident arrives in the building.

2) Identification of others at risk

a) If a resident needs specialized equipment, the equipment must be in the building before the resident enters the building.

b) On November 13th, resident received the bariatric equipment.

c) Ensure that more information is received from the hospital before the resident arrives.

3) Education and Monitoring

a) Director of Nursing and Assistant Director of Nursing to monitor all referrals coming into the facility to ensure that the patient has all medical equipment necessary before the arrival of of the patient.

4) Quality Assurance

Random audits will be conducted by the Administrator/Designee to ensure compliance weekly for 4 weeks. The Quality Assurance and Performance Improvement Committee will review audits to ensure compliance and make recommendations.