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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 04/24/2023.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 43 residents with 14 residents sampled including three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide safe ambulation with planned interventions for one Resident (R)34, while ambulating to the bathroom, to prevent accidents. Findings included: - The "Physician Order Sheet" (POS), dated 03/21/23, documented Resident (R)34 had diagnoses which included: Cerebrovascular accident (CVA) (stroke) - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and weakness.	F 689		

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

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The admission "Minimum Data Set" (MDS), dated 03/15/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She required limited assistance of one staff for ambulation in her room and extensive assistance of one staff for toileting. Her balance was not steady, and she was only able to stabilize with staff assistance.

The "Care Area Assessment" (CAA) for falls, dated 03/15/23, documented the resident had one non-injury fall since admission. The resident was at risk for falls due to a history of falls before admission.

The "Activities of Daily Living" (ADL) care plan, dated 03/09/23, instructed staff to assist the resident with ambulation with one staff and the use of a walker with a wheelchair behind the resident and the use of a gait belt.

The falls care plan, dated 03/09/23, instructed staff the resident had an unsteady gait due to a history of a CVA. The resident had difficulty walking, weakness, and poor balance. Staff were to use a gait belt and walker at all times when ambulating with the resident.

Review of the resident's electronic medical record (EMR) revealed fall assessments dated, 03/13/23 and 03/28/23, which placed the resident at a moderate risk for falls.

Review of the facility's fall investigation, dated 03/28/23, revealed the resident had a fall in her room on that date. Staff was ambulating with the resident to the toilet when the resident lost her balance and fell back against her walker and down to the floor. The staff member failed to put

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a gait belt on the resident before ambulating and the resident did not have her walker, which was behind her near the bed. The resident received a quarter sized red/purple bruise to her back from the fall. No other injuries were noted.

On 04/18/23 at 07:36 AM, Certified Nurse Aide (CNA) J assisted the resident to the dining room for breakfast. Staff ambulated with the resident with the use of a gait belt and the wheelchair pulled behind the resident. The resident wore appropriate footwear and had her walker in front of her while she ambulated down the hall.

On 04/17/23 at 10:18 AM, the resident stated she had fallen backwards onto her walker when staff assisted her to the bathroom on 03/28/23. The resident stated she did not have her walker at the time of the fall and the staff failed to put a gait belt on her to ambulate.

On 04/18/23 at 07:36 AM, CNA J stated the resident required staff to use a gait belt and a walker when ambulating with her so that she did not fall.

On 04/18/23 at 03:30 PM, CNA M stated staff should always use a gait belt while ambulating any resident.

On 04/17/23 at 07:44 AM, Licensed Nurse (LN) G stated staff should use a gait belt when ambulating with the resident. The resident also needed to use her walker to help with balance.

On 04/19/23 at 10:45 AM, LN H stated gait belts should be used by staff while ambulating with residents.

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F 689	Continued From page 3 On 04/19/23 at 11:51 AM, Administrative Nurse D stated the expectation was for staff to utilize gait belts when ambulating with residents. The facility policy for "Falls and Falls Risk", revised March 2018, included: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The facility failed to use planned interventions to prevent falls while ambulating this resident when she fell and received a bruise to the back.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		

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provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 43 residents with 14 residents sampled, including one resident reviewed for hydration. Based on observation, interview, and record review, the facility failed to provide adequate hydration for dependent resident R99, who was observed with dry lips and mouth, deep grooves in her tongue, an empty water cup, water out of reach of the resident, several staff provided cares but did not offer water, R99 cried and moaned asking for water, and her EMR recorded she received only two to four cups of water daily from 04/12/23-04/18/23.

Findings included:

- Review of Resident (R)99's electronic medical record (EMR), included a diagnosis of rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems).

The resident admitted to the facility on 04/12/23, which revealed no "Minimum Data Sheet" (MDS) was available for review.

The "Care Plan" for "Activities of Daily Living" (ADL), dated 04/12/23, instructed staff the resident required setup assistance with her meals.

The "Care Plan" for a diuretic (medication to promote the formation and excretion of urine), dated 04/12/23, instructed staff to encourage appropriate fluid intake for R99.

Review of the "Dietary Profile," dated 04/18/23, documented the resident was to have regular

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fluids. The record lacked evidence the resident was on a fluid restriction for any reason.

Review of the resident's EMR revealed from 04/12/23 through 04/18/23, the resident received 500 to 960 cubic centimeters (cc) of fluids, daily. The staff documented no other fluid intake.

One cup of fluid is equivalent to 236.5 cc of fluid, meaning R99 received about two to four cups of fluid daily from 04/12/23-04/18/23 [per mayoclinic.com women need 11.5 cups of water daily].

On 04/17/23 at 10:04 AM, the resident sat in her recliner in her room. The resident moaned and cried and stated she was very thirsty. An empty water cup sat on the bedside table in front of the resident, while the resident was observed with dried lips and mouth, and her tongue was observed with deep grooves present.

On 04/18/23 at 08:48 AM, Licensed Nurse (LN) H entered the resident's room to visit with her briefly and failed to offer the resident a drink of water, at that time.

On 04/18/23 at 11:30 AM, the resident rested in bed. The resident stated "I want some water, please, please." The water cup sat out of reach on the resident's bedside table. The resident had dry lips and mouth with visible grooves in her tongue. The resident continued to call out for water at 11:40 AM. At 11:44 AM, Administrative Nurse D entered the room at the request of Consultant Staff GG. The resident stated to Administrative Nurse D that she was "dying of thirst." Administrative Nurse D held the cup of ice water and the resident consumed approximately

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six ounces of water.

On 04/18/23 at 11:49 AM, Certified Nurse Aide (CNA) J stated the resident was able to get drinks from her water cup on her own. CNA J said the ice water was filled at least once a shift and the staff should offer residents a drink of water, with all cares.

On 04/18/23 at 03:30 PM, CNA M stated staff were to offer water to residents when cares were done.

On 04/19/23 at 09:38 AM, CNA L stated staff would fill ice water cups around 10:00 AM every morning. Staff were to offer water to the residents when giving cares, but sometimes staff would forget.

On 04/19/23 at 09:38 AM, CNA K stated staff should offer water to residents every time cares were given.

On 04/19/23 at 10:45 AM, LN H stated the resident could hold her cup and drink fluids on her own. Her ice water should be kept within reach of her while she was in her room and kept full of ice water.

On 04/19/23 at 11:51 AM, Administrative Nurse D stated if a resident had dry lips and mouth and grooves in their tongue, they would need a drink of water. Water should be kept within reach of all residents and staff should always offer resident a drink of water with all cares.

The facility policy for "Resident Hydration and Prevention of Dehydration," revised October 2022, included: Nurses will assess for signs and

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F 692	Continued From page 7 symptoms of dehydration during daily care. CNAs will provide and encourage intake of a bedside snack and meal fluids, on a daily and routine basis as part of daily care. The facility failed to provide adequate hydration for dependent resident R99, who was observed with a dry lips and mouth, deep grooves in her tongue, an empty water cup, water out of reach of the resident, several staff provided cares but did not offer water, she cried and moaned asking for water, and her EMR recorded she received only two to four cups of water daily from 04/12/23-04/18/23.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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: The facility reported a census of 43 residents with 14 residents sampled, including one resident reviewed for pain. Based on observation, interview, and record review, the facility failed to ensure appropriate pain control for the one Resident (R)99, by not ensuring the resident swallowed the pain medication. Findings included: - Review of Resident (R)99's electronic medical record (EMR), revealed a diagnosis of rheumatoid arthritis (chronic inflammatory	F 697		

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disease that affected joints and other organ systems).

The resident admitted to the facility on 04/12/23, so no "Minimum Data Sheet" (MDS) was available for review.

The care plan for pain, dated 04/12/23, instructed staff to administer pain medications as ordered.

Review of the resident's EMR, revealed the following physician's orders:

Tylenol 325 milligrams (mg) two tablets, by mouth (po), every (Q) six hours, for pain, dated 04/12/23.

May crush all appropriate medications, Q shift, dated 4/17/23.

On 04/18/23 at 08:48 AM, the resident rested in bed moaning with facial grimacing present. The resident stated she had pain. Observation revealed two half-dissolved pills rested on the resident's chest, below her chin. The resident stated, "Help me, help me, I hurt". Licensed Nurse (LN) H informed the resident she had been given Tylenol for pain at 08:20 AM and could not have more Tylenol yet. LN H then noticed the halfway dissolved medication on the resident's chest and determined it was that mornings administered Tylenol. LN H asked Certified Medication Aide (CMA) R to give the resident another dose of Tylenol as the resident did not swallow the medication earlier. At 09:01 AM, CMA R entered the room and administered Tylenol 650 mg, po, to the resident, crushed in pudding. The resident swallowed the medication without difficulty.

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F 697	Continued From page 9 On 04/18/23 at 09:04 AM, CMA R stated the resident would pocket her medications in her mouth at times. CMA R stated she thought the resident swallowed her pills earlier, but she had not. CMA R stated the resident could have crushed medications due to her pocketing her medications. On 04/18/23 at 08:51 AM, Licensed Nurse H stated the resident was to have her medications crushed so they were easier to swallow. The resident's pain was probably worse that morning due to having not swallowed the Tylenol. On 04/19/23 at 11:51 AM, Administrative Nurse D stated she would expect staff to ensure that residents were swallowing their medications when staff administered the medication. The facility policy for "Pain Management", revised March 2020, included: Administer pain medications as ordered. The facility failed to provide adequate pain control for this dependent resident.	F 697		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 43 residents. Based on observation, interview, and record review, the facility failed to provide sanitary food preparation and storage of food to prevent the spread of food borne illness to the residents of the facility.

Findings included:

- The initial environmental tour of the kitchen, on 04/17/23 at 09:10 AM, with Dietary Staff CC, revealed the following items/areas of concerns:

1. The snack refrigerator contained a pitcher of pre-made lemonade with prep date of 4/1/23 and lacked an expiration date.

2. Two foil covered pans labeled "mix berry cobbler" sitting on cart in the kitchen area. Dietary Staff CC identified them as being at "room temperature".

The side-by-side double door refrigerator contained the following concerns:

1. A large container of tartar sauce with an open date of 01/10/23, lacked an expiration date.

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2. A large container of thousand island salad dressing with an open date of 02/06/23, lacked an expiration date.

A large container of Cesar salad dressing with an open date of 02/06/23, lacked an expiration date.

On 04/17/23 at 09:10 AM, Dietary Staff CC stated the premade lemonade should be used within two to three days then discarded. Additionally, Staff C stated that the pans of cobbler were cooked on the previous day and were set out to cool overnight and then would be warmed back up for dinner service later that day. She further, stated that the salad dressings and tartar sauce should be discarded 30 days after opening.

On 04/19/23 at 10:10 AM, Dietary Staff BB stated that the foods should be discarded when the expired date has been reached or if the quality of the foods was compromised.

The 2020 "Food Storage (Dry, Refrigerated, and Frozen" policy states that all food items will be labeled with the date by which it should be used or discarded and to see "Date Marking Guidelines" for examples.

The undated, untitled document of foods list, identified by Dietary Staff BB as the "Date Marking Guidelines" documented that salad dressings, bottled and opened should be refrigerated after opening and placed in storage for 1-3 months.

The recipe for mixed berry cobbler, provided by Dietary Staff BB, documented that for service it should be maintained at 135 degrees Fahrenheit

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F 812	Continued From page 12 or above. If cooling/holding at room temp, it should be discarded after 4 hours. The facility failed to store and prepare food under sanitary conditions for the residents in the facility. This created the potential for the spread of food borne illnesses to the residents of the facility.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		

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F 883	Continued From page 13 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 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: The facility reported a census of 43 residents. The sample included 14 residents, with five reviewed for immunizations. The facility failed to provide proof of vaccination or declination of vaccines for the 2022-2023 influenza or pneumococcal (vaccines designed to prevent pneumonia [inflammation of the lungs which can be debilitating or lethal in the elderly]) for three of the five residents reviewed. Findings included: - Review of the Electronic Health Record (EHR)	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 14	F 883		

for Resident (R)30 lacked documentation of 2022 to 2023 influenza vaccine or declination of the vaccine. It further lacked documentation of any pneumococcal vaccine or declination of the vaccine(s).

Review of the EHR for R11 lacked documentation of 2022 to 2023 influenza vaccine or declination of the vaccine. It further lacked documentation of any pneumococcal vaccine or declination of vaccine(s).

Review of the EHR for R27 lacked documentation of 2022 to 2023 influenza vaccine or declination of the vaccine.

On 04/19/23 at 12:52 PM, Administrative Nurse D stated that the requested proof of vaccines or declinations could not be found for these three residents.

The 10/2019 facility policy "Vaccination of Residents" documented that all residents would be offered vaccines unless medically contraindicated or resident has already been vaccinated. Further documents that if vaccines are refused, it shall be documented in the medical record. Additionally, if the resident receives the vaccine, it shall be documented in the medical record.

The facility failed to provide proof of vaccination or declination of vaccines for the 2022-2023 influenza or pneumococcal for these three residents reviewed.