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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00182602, KS00182237, KS00183629, KS00183636, and KS00185596. The 2567 was sent electronically on 11/02/23.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		

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

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(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 34 residents. The sample include 14 with one reviewed for privacy. Based on observation, record review, and interviews, the facility failed to ensure privacy for Resident (R)108 when staff audio recorded medical treatment without consent. This deficient practice placed R108 at risk for decreased psychosocial wellbeing and impaired rights.

Findings Included-

- The "Medical Diagnosis" section within R108's Electronic Medical Records (EMR) included diagnoses of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), hypoxia (inadequate supply of oxygen), acute respiratory failure, and acute kidney failure.

R108's EMR indicated she admitted the facility on 10/12/23 and expired (passed away) on 10/21/23 at the facility.

A "Minimum Data Set (MDS)" assessment was not yet completed or due.

R108's "Care Plan" initiated 10/16/23 indicated she was a full code (term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest) and had altered respiratory status related to acute respiratory failure. The plan instructed staff to monitor her for respiratory distress, changes in orientation,

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increased restlessness, and air hunger (form of respiratory distress characterized by gasping and labored breathing).

R108's EMR revealed a "Health Status" note dated 10/21/23 indicating she was found unresponsive by staff at 03:52AM. The note indicated staff initiated cardiopulmonary resuscitation (CPR- emergency lifesaving procedure performed when the heart stops beating) on R108 and contacted emergency services (EMS). The note indicated EMS continued CPR upon arrival but R108 passed away during resuscitation attempts.

A review of a "Facility Reported Incident (FRI)" dated 10/24/23 revealed the facility was notified that a medical emergency on 10/21/23 was videotaped and updated to a social media video platform belonging to Licensed Nurse (LN) H.

On 10/24/23 at 15:33PM, LN H reported that he responded to the medical emergency related to R108 but did not record the event. He stated he would never record a resident or allow others to do so due to ethical concerns. He stated he did not even have his phone on him or in the room at the time of the event.

On 10/25/23 at 11:10AM, LN I stated he responded to the medical emergency. He stated he did not witness LN H recording the event or have his phone with him. He stated staff were expected not use their phones around the residents and he would not allow any employees to record the resident's treatment or care. He stated the facility held annual in-service training related resident rights, privacy, and protected health information (PHI).

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F 583	Continued From page 3 On 10/25/23 at 13:05PM, Administrative Staff B reported she reviewed the footage. She reported that LN H was on his lunch break filming a food review in the breakroom. She reported LN H was called to assist with the code and walked down the hall to R108's room. She stated R108 turned the video feed off, but the live audio recording remained on. She stated the audio recording contained the EMS response and commotion of the event but never revealed the identity of R108. She stated she ensured the sound recording was taken down from social media. On 10/24/23 at 02:33PM, Administrative Staff A reported staff were expected to not use their cell phones or record the residents in the facility at any time. She stated LN H had been removed from the facility's schedule and will not be allowed to return to the facility. She stated all staff will be re-educated on resident rights and usage of personal communication devices while at work. A review of the facility's "Resident's Rights" policy revised 10/2022 indicated the facility would ensure the privacy and confidentiality for each resident's related to treatment, personal cares, decision making, grievances, and medical records. The facility failed ensure privacy for R108 when staff audiotaped medical treatment as it occurred, without the resident's permission. This deficient practice placed R108 at risk for decreased psychosocial wellbeing.	F 583		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		

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§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 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

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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:
The facility identified a census of 34 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to develop a person-centered comprehensive care plan for Resident (R) 53 related to his limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). This deficient practice placed R53 at risk of loss of ability to perform activities of daily living (ADLs) and development or worsening contractures (abnormal permanent fixation of a joint or muscle) due to uncommunicated care needs.

Findings included:

- R53's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anoxic (lack of oxygen) brain damage, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS) dated 06/19/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The staff interview was not completed. The MDS documented that R53 was dependent on two staff member

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assistance for ADLs. The MDS documented R53 had not received physical therapy, occupational therapy, speech therapy or a restorative program during the observation period.

The "Quarterly MDS" dated 09/19/23 documented a BIMS score of zero which indicated severely impaired cognition. A staff interview was not completed. The MDS documented that R53 was dependent on two staff members assistance for ADLs. The MDS documented R53 had received speech therapy and occupational therapy from during the observation period.

R53's "Pressure Ulcer Care Area Assessment" (CAA) dated 06/20/23 documented he was totally dependent on staff for ADLs.

R53's "Care Plan" lacked direction for care and prevention of worsening contractures.

Review of R53's the EMR under "Documentation Survey Report" from 06/01/23 to 10/22/23 (144 days) lacked clinical evidence a consistent program or exercises aimed to maintain abilities and prevent loss of function.

The "Physical Therapy Evaluation and Plan of Treatment" dated 10/19/23 documented functional limitations were present due to contractures. Physical therapy would not treat, or address contractures and nursing was managing R53's contracture impairment.

Review of R53's the EMR under "Documentation Survey Report" from 06/01/23 to 10/22/23 (144 days) lacked clinical evidence a consistent program or exercises aimed to maintain abilities and prevent loss of function.

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Observation on 10/23/23 at 10:55 AM R53 laid on his left side with his bilateral lower extremities bent and his knees rested at waist level. R53 was unable to straighten out his lower extremities when asked.

On 10/25/23 at 03:13 PM Certified Nurse Aide (CNA) M stated she was not sure if R53 had a restorative program. CNA M stated she would be able to find that information on the Kardex (nursing tool that gives a brief overview of the care needs of each resident).

On 10/25/23 at 04:24 PM Administrative Nurse D stated the CNAs provided ROM during ADLs and should be documented under tasks in the EMR. Administrative Nurse D stated a resident at the time of discharge from therapy, therapy would educate and train the nursing staff about a resident's restorative program and that would be added to the plan of care and found on the Kardex. Administrative Nurse D stated the MDS coordinator developed the plan of care from the MDS and every department was able to make change and update as needed.

The facility's "Care Planning-Interdisciplinary Team" policy dated 01/2017 documented every resident would be assessed using the MDS according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual. While the CAAs identify common areas of concern in nursing home residents, the plan of care was not to be limited to the triggered areas. The comprehensive plan of care must address all care issues that would be relevant to the individual, whether they are specifically covered in the CAA process.

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F 656	Continued From page 8 The facility failed to develop a person-centered comprehensive care plan for R53 related to his limited ROM. This deficient practice placed R53 at risk of loss of ability to perform ADL and development or worsening contractures due to uncommunicated care needs.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 14 residents with five residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interviews, the facility failed to provide consistent bathing opportunities for Resident (R)104 and R53. This deficient practice placed the residents at risk for skin complications and impaired dignity. Findings Included: - The "Medical Diagnosis" section within R104's Electronic Medical Records (EMR) included diagnoses of acute kidney failure, morbid obesity (severely overweight), dysphagia (difficulty swallowing), cerebral infarction (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 history of brain hemorrhages (bleeding of the brain).	F 677		

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R104"s "Admission Minimum Data Set (MDS)" completed 08/28/23 indicated a Brief Interview for Mental Status assessment was not completed due to severe cognitive impairment. The MDS indicated she required total assistance from one to two staff for all ADL.

R104's "Cognitive Impairment Care Area Assessment (CAA)" dated 08/28/23 indicated she was triggered for severe cognitive impairment related to her medical diagnoses.

R104's "ADL CAA" was not triggered

R104's "Care Plan" initiated 09/11/23 indicated she was totally dependent on one staff for bathing, dressing, grooming, toileting, mobility, ad meals. The plan noted she preferred to have bed baths twice weekly on Monday and Thursday evenings.

A review of R104's EMR for bathing indicated she had only four baths (08/31/23, 09/25/23, 09/28/23, 10/02/23). The EMR indicated she was not available for bathing on 09/07/23 and not applicable was marked on 09/27/23.

On 10/23/23 at 07:45AM R104 rested in her bed. Her hair and face were greasy. R104's hair was uncombed. R104 had a low-air loss mattress and a cushion in her wheelchair. Her bed was in the low position with a fall mat next to her bed.

On 10/25/23 at 03:02 PM Certified Nurse Aide (CNA) M stated she looked in the EMR to know who required a bath for each shift. She stated if a resident refused a bath, she would ask three times and then report it to the nurse. CNA M stated that refusals, and alternative bathing

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options, would be documented in the resident's chart. CNA M stated R104 was to receive two bed baths a week. She stated the bed baths were documented in the EMR.

On 10/25/23 at 03:30 PM Licensed Nurse (LN) G stated nurses told the aides which resident required a bath for each shift and then it was to be charted in the EMR whether it was done or refused. He further stated if a resident refused a bath, then the nurses would attempt to find out why and address the issue, if they continued to refuse then it would be documented in the resident's chart as to why.

On 10/25/23 at 04:26 PM Administrative Nurse D stated R104's bed baths should have been documented in the EMR. She stated staff should have documented if a resident missed a bathing opportunity or missed a bath. She stated staff should have offered an alternative time or date for the missed occurrence.

The facility did not provide a policy related to bathing as requested on 10/25/23.

The facility failed to provide consistent bathing opportunities for R104. This deficient practice placed R104 at risk for infections and skin breakdown due to poor hygiene.

- R53's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anoxic (lack of oxygen) brain damage, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), and dementia (progressive mental disorder characterized by failing memory, confusion).

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The "Admission Minimum Data Set" (MDS) dated 06/19/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The staff interview was not completed. The MDS documented that R53 was dependent on two staff member assistance for ADLs. The MDS documented R53 had not received physical therapy, occupational therapy, speech therapy or a restorative program during the observation period. The MDS documented R53 was dependent on one staff member for bathing activity during the observation period. The MDS documented R53 did not exhibit refusal of care behavior during the observation period.

The "Quarterly MDS" dated 09/19/23 documented a BIMS score of zero which indicated severely impaired cognition. A staff interview was not completed. The MDS documented that R53 was dependent on two staff members assistance for ADLs. The MDS documented R53 had received speech therapy and occupational therapy from during the observation period. The MDS documented R53 was dependent on one staff member for bathing activity during the observation period. The MDS documented R53 did not exhibit refusal care behavior during the observation period.

R53's "Pressure Ulcer Care Area Assessment" (CAA) dated 06/20/23 documented he was dependent on staff for ADLs and was at risk for skin breakdown related to bowel incontinence.

R53's "Care Plan" dated 07/12/23 documented he was dependent on two staff for his bath.

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Review of the EMR under "Documentation Survey Reports" tab for bathing reviewed for the dates R53 was in the facility from 07/01/23 to 07/03/23 (3 days was discharged to hospital) no documentation of bath/shower was provided. Reviewed 07/06/23 (returned to facility) to 07/17/23 (12 days was discharged to the hospital) revealed no documentation a bath/shower was provided. Reviewed from 07/22/23 (returned to the facility) to 08/08/23 (18 days was discharged to the hospital) R53 received a bath/shower on 07/30/23. Reviewed from 08/10/23 (returned to the facility) to 10/10/23 (62 days was discharged to the hospital) R53 received two bath/shower on 08/02/23 and 09/29/23. Reviewed from 10/18/23 (returned to the facility) to 10/23/23 (5 days) no documentation of bath/shower was provided. R53's clinical record lacked documentation of R53's refusal for bathing.

Observation on 10/23/23 at 10:55 AM R53 laid on his left side with his bilateral lower extremities bent and his knees rested at waist level. R53 was unable to straighten out his lower extremities when asked. The room smelled of urine.

On 10/25/23 at 03:13 PM Certified Nurse Aide (CNA) M stated staff check the point of care (POC-charting terminal) at the beginning of the shift to find out which residents are scheduled for a bath/shower. CNA M stated if a resident refused their bath/shower after three attempts, staff report the refusal to the nurse. CNA M stated she had never given R53 a bath/shower. CNA M stated staff would document the bath if given or the refusal in POC.

On 10/25/23 at 03:30 PM Licensed Nurse (LN) G stated the charge nurse at the beginning of the

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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 677	Continued From page 13 shift lists the shower/baths due during that shift. LN G stated if a resident was to refuse their bath/shower, the CNA would report it to the nurse. LN G stated the nurse would ask the resident why they refused. LN G stated the nurse would make a note under the "Progress Note" tab and the CNA would document in the POC. On 10/25/23 at 04:24 PM Administrative Nurse D stated the resident was given a choice of day shift or evening for their bath/shower. Administrative Nurse D stated each resident should receive at least two baths/showers weekly. Administrative Nurse D stated if the resident refused their bath/shower after several attempts the staff would report the refusal to the nurse who then should ask the resident why they had refused and document the reason under the progress note tab. The facility was unable to provide a policy related to bathing. The facility failed to ensure a shower/bath was provided for R53, who was dependent on staff assistance with ADLs, which had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing.	F 677		
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	F 684		

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accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 34 residents. The sample included 14 residents with one reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to complete physician ordered daily weights for Residents (R)106 and R51. This deficient practice placed both residents at risk for complications related to edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

Findings Included:

- The "Medical Diagnosis" section within R106's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), acute respiratory failure, morbid obesity (severely overweight), post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and insomnia (difficulty sleeping).

R106's "Quarterly Minimum Data Set (MDS)" completed 07/25/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted she was independent for transfers, bed mobility, toileting, locomotion, meals, and dressing. The MDS noted she took diuretics (medication to promote the formation

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and excretion of urine). The MDS indicated she weighed 300 pounds (lbs.).

R106's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 11/21/22 indicated she required assistance with ADLs and transfers. The CAA noted her care plan will be completed to reflect her needs.

R106's "Urinary Incontinence CAA" completed 11/21/22 noted she was at risk for incontinent episodes related to her diuretic medication.

R106's "Care Plan" initiated 11/09/22 indicated she had congestive heart failure. The plan instructed staff to weigh her daily and report weight changes per her ordered parameters. The plan noted she was on a low sodium diet and fluid restriction of 1500 milliliters (ml) daily.

A review of R106's "Physician Orders" revealed an order dated 03/22/23 for staff to complete daily weights and notify the provider if R106 gained more than (>) five pounds in three days related to her CHF.

R106's "Physician's Order" revealed she took Bumex (diuretic medication) related to swelling and edema.

A review of R108's EMR for weights between 08/01/23 through 10/25/23 (116 days reviewed) indicated she missed 22 daily weights (10/23, 10/18, 10/8, 10/6, 10/5, 10/4, 9/29, 9/28, 9/25, 9/21, 9/17, 9/15, 9/13, 9/11, 9/8, 8/27, 8/24, 8/20, 8/13, 8/10, 8/7, and 8/4) The EMR indicated no weights were refused on the identified dates.

On 10/23/23 at 12:46PM R106 wheeled herself

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back to her room from the dining hall. R106 reported she wasn't happy but understood why she needed a low sodium diet. She reported that facility controlled her fluid intake, but she was not weighed everyday by staff.

On 10/25/23 at 03:28PM Certified Nurse's Aide (CNA) M stated the resident should be weighed and monitored for significant changes. She stated some residents were weighed daily and the nurse provided the list every day. She stated the direct care staff would enter the weights in the EMR after obtaining them. She stated the nurse would be notified of the weights and any refusals. She stated refusals would be noted in the EMR. She stated she would make three attempts before notifying the nurse of the refusal.

On 10/25/23 at 0340PM Licensed Nurse (LN) G stated the direct care staff would notify him of the weights obtained and report any missed or refused weights. He stated the nurse would talk with the resident and reschedule the weight time if the resident could not be weighed. He stated the weights should be documented in the EMR.

On 10/25/23 at 04:27PM Administrative Nurse D stated staff were expected to follow the residents weight schedules listed in the EMR. She stated the nurse should be notified of refusals and attempt to weigh the resident before documenting the refusal.

The facility did not provide a policy related to monitoring physician's orders for weights as requested on 10/26/23.

The facility failed to complete daily weights for R106. This deficient practice placed R106 at risk

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for complications related to edema.

- R51's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), repeated falls, muscle weakness, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Annual Minimum Data Set" (MDS) dated 06/21/23 documented a Brief Interview of Mental Status (BIMS) score of six which indicated severely impaired cognition. The MDS documented that R51 required extensive assistance of one staff member for activities of daily living (ADLs).

The "Quarterly MDS" dated 08/23/23 documented a BIMS score of five which indicated severely impaired cognition. The MDS documented that R51 required extensive assistance of one staff member for ADLs.

R51's "Dehydration/Fluid maintenance Care Area Assessment" (CAA) dated 07/05/23 documented staff would encourage fluids and monitor for signs/symptoms of dehydration.

R51's "Care Plan" dated 05/06/23 documented staff would weigh R51 daily related to fluid overload. Staff would weigh R51 every morning before breakfast and document the weight to monitor for fluid overload.

Review of the EMR under "Orders" tab revealed the following active physician orders:
Weight: Daily weight related to fluid overload. Weigh patient every morning before breakfast

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document results dated 05/05/23.

Review of the "Medication Administration Record" (MAR) and the "Treatment Administration Record" (TAR) from 05/06/23 thru 10/23/23 (171 days) lacked clinical evidence of a daily weight for R51.

The "Vitals" tab of R51's EMR revealed R51 was weighed on 05/01/23, 06/01/23, 06/02/23, 06/16/23, 07/10/23, 08/01/23, 08/21/23, 09/01/23, and 10/01/23. The tab documented seven other dates where weights were recorded but struck out due to data entry error or duplicate entry per staff documentation.

Observation on 10/24/23 at 11:57 AM Certified Nurse Aide (CNA) N pushed R51 from the nursing desk into the dining room with the resident's bilateral feet sliding on the floor.

On 10/25/23 at 03:13 PM CNA M stated dayshift staff obtain the daily weights.

On 10/25/23 at 03:30 PM Licensed Nurse (LN) G stated the staff obtain the daily weights before breakfast and the weights are documented under the "Vitals" tab in the residents' EMR. LN G stated the physician was notified of any weight gain concerns.

On 10/25/23 at 04:24 PM Administrative Nurse D stated the CNAs obtain the daily weight and report the weight to the charge nurse who then records the weight into the resident's EMR. Administrative Nurse D stated R51 was not supposed to be a daily weight, the order had been changed by the physician and was not updated.

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F 684	Continued From page 19 The facility was unable to provide a policy related to physician orders. The facility failed to follow a physician order for daily weights to monitor weight gain for fluid overload for R51. This deficient practice placed R51 at risk of adverse side effects for unnecessary complications related to fluid overload and edema.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 14 residents with two residents reviewed for limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension). Based	F 688		

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on observation, record review, and interviews, the facility failed to implement a ROM program to help maintain and prevent a decrease in ROM/mobility for Resident (R) 53. This deficient practice placed R53 at risk of loss of ability to perform activities of daily living (ADLs) and development of worsening contractures (abnormal permanent fixation of a joint or muscle).

Findings included:

- R53's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anoxic (lack of oxygen) brain damage, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS) dated 06/19/23 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The staff interview was not completed. The MDS documented that R53 was dependent on two member assistance for ADLs. The MDS documented R53 had not received physical therapy, occupational therapy, speech therapy or a restorative program during the observation period.

The "Quarterly MDS" dated 09/19/23 documented a BIMS score of zero which indicated severely impaired cognition. A staff interview was not completed. The MDS documented that R53 was dependent on two staff members assistance for ADLs. The MDS documented R53 had received speech therapy and occupational therapy from

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during the observation period.

R53's "Pressure Ulcer Care Area Assessment" (CAA) dated 06/20/23 documented he was totally dependent on staff for ADLs.

R53's "Care Plan" lacked direction for care and prevention of worsening contractures.

Review of R53's the EMR under "Documentation Survey Report" from 06/01/23 to 10/22/23 (144 days) lacked clinical evidence a consistent program or exercises aimed to maintain abilities and prevent loss of function.

The "Physical Therapy Evaluation and Plan of Treatment" dated 10/19/23 documented functional limitations were present due to contractures. Physical therapy would not treat or address contractures and nursing was managing R53's contracture impairment.

Review of R53's the EMR under "Documentation Survey Report" from 06/01/23 to 10/22/23 (144 days) lacked clinical evidence a consistent program or exercises aimed to maintain abilities and prevent loss of function.

Observation on 10/23/23 at 10:55 AM R53 laid on his left side with his bilateral lower extremities bent and his knees rested at waist level. R53 was unable to straighten out his lower extremities when asked.

On 10/25/23 at 03:13 PM Certified Nurse Aide (CNA) M stated she was not sure if R53 had a restorative program. CNA M stated she would be able to find that information on the Kardex (nursing tool that gives a brief overview of the

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F 688	Continued From page 22 care needs of each resident). On 10/25/23 at 03:30 PM Licensed Nurse (LN) G stated R53 did not have a restorative/exercise program in place to prevent his contractures for worsening. On 10/25/23 at 04:24 PM Administrative Nurse D stated the CNAs provided ROM during ADLs and should be documented under tasks in the EMR. Administrative Nurse D stated a resident at the time of discharge from therapy, therapy would educate and train the nursing staff about a resident's restorative program and that would be added to the plan of care and found on the Kardex. The facility's "Restorative Nursing policy and Procedure" undated policy documented it was the policy of the facility to provide restorative nursing which promoted the resident's ability to adapt and adjust to living as independently and safely as possible. Restorative nursing focused on achieving and/or maintaining optimal physical, mental, and psychological function of the resident. The restorative nurse, restorative nursing assistant, along with the interdisciplinary team would determine what programs would be initiated for the residents. The facility failed to implement a ROM/restorative program to help maintain and prevent a potential decrease in ROM/mobility for R53. This deficient practice placed him at risk of loss of ability to perform or participate with ADLs.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§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 had a census of 34 residents. The sample included 14 residents with five reviewed for accidents. Based on observation, record review and interview, the facility failed to secure 33 pressurized medical oxygen tanks in a safe, locked area, and out of reach of the two cognitively impaired independently mobile residents. The facility failed to ensure a safe environment free from accident hazards when staff failed to use foot pedals on Resident(R)52's wheelchair when staff pushed the wheelchair. The facility further failed to assist R151 while walking without his walker. These deficient practices placed the residents at risk for preventable accidents and injuries.

Findings Included-

- On 10/23/23 at 07:15AM, an inspection of the facility's oxygen storage room revealed the door unlocked. The room contained 33 pressurized supplemental oxygen cylinders stored on the racks. At 07:17AM, Certified Nurse Aid (CNA) N stated the door should be locked and always secured. The door locked upon closing.

On 10/23/23 at Licensed Nurse (LN) G stated the oxygen room should be locked at all times and impaired residents should not be allowed access

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to the pressurized cylinders.

On 10/25/23 at 04:30PM Administrative Nurse D stated oxygen tanks should be stored in a locked room and staff were expected to ensure the door secured properly upon opening the door.

A review of the facility's "Administration of Oxygen" policy revised 10/2010 noted that all oxygen cylinders will be stored in dry, secure, and well-ventilated areas away from sources of combustion.

The facility failed to secure 33 pressurized medical oxygen tanks in a safe, locked area, and out of reach of the two cognitively impaired independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries.
- R52's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of altered mental status, cognitive communication deficit, history transient ischemic attack (TIA-temporary episode of inadequate blood supply to the brain), seizure (violent involuntary series of contractions of a group of muscles), and cerebral infarction (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).

The "Admission Minimum Data Set" (MDS) was in progress.

R52's "Care Area Assessment" (CAA) had not been completed and was in progress.

R52's "Care Plan" dated 10/16/23 documented staff would encourage R52 to participate in

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activities that promoted exercise, physical activity for strengthening and improved mobility.

Observation on 10/23/23 at 09:30 AM an unidentified staff member pushed R52 down the hallway to her room with her bilateral lower extremities slightly raised off the floor. R52 had foot boot on her left foot.

On 10/25/23 at 03:13 PM Certified Nurse Aide (CNA) M stated staff should not push some resident without foot pedals. CNA M stated she was not sure if R52 should have foot pedals on her wheelchair, she would have to check the Kardex (nursing tool that gives a brief overview of the care needs of each resident).

On 10/25/23 at 03:30 PM Licensed Nurse (LN) G stated every resident should have foot pedals on their wheelchair if staff was going to push them to prevent injury from falls. LN G stated he was not sure if R52 was to have foot pedals on her wheelchair.

On 10/25/23 at 04:24 PM Administrative Nurse D stated staff should not be pushing resident in their wheelchair without foot pedals.

The facility's "Fall" policy dated 09/17/19 documented the purpose of the Fall Management Program was to develop, implement, monitor, and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that fostered resident independence and quality of life. The Fall Management Program promoted safety, prevention, and education of both Staff and residents.

The facility failed to ensure a safe environment

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free from accident hazards when staff failed to use foot pedals on R52's wheelchair when staff pushed the wheelchair. This deficient practice placed R52 at risk of accident and related injuries.
- R151's Electronic Medical Record (EMR) documented R151 had a diagnosis of generalized muscle weakness, difficulty in walking and other abnormalities of gait and mobility.

The "Admission Minimum Data Set" (MDS) dated 04/11/23, documented R151 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition . The MDS documented R151 used a walker and ambulated independently.

The "Quarterly MDS" dated 10/11/23, documented R151 had two or more falls since previous assessment.

The "Cognitive Loss / Dementia Care Area Assessment" (CAA), dated 04/11/23, documented R151 had altered mental status (term used to describe various disorders of mental functioning) and disorganized thinking.

The "Falls CAA" dated 04/11/23, documented R151 was at risk for falls due to not always using his walker when he ambulated.

R151's "Care Plan" with an initiated date of 03/31/23, documented R151 was at risk for falls. An intervention initiated 04/13/23, directed staff to encourage R151 to use his walker when ambulating and documented that sometimes R151 would get up and leave his walker behind.

The "Fall Risk" assessment dated 10/10/23

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documented R151 used an assistive device/walker to aid in ambulation and was in the high-risk category for falls.

The "Occurrence Report" dated 09/04/23 documented Licensed Nurse (LN) I heard a bang after R151 passed them in the hallway. The report documented R151 was ambulating in the hallway with his walker at the time. The report documented LN I then saw R151 on the floor in a seated position and his walker was turned upside down. The report further documented R151 stated that his legs gave up and he sat on the floor. The report, under the "Follow up Report" section, documented R151 ambulated throughout the halls and had a hard time knowing when he was fatigued.

The "Occurrence Report" dated 10/17/23 documented R151 walked past the nurses' station and down the hallway and shortly after LN I heard someone call out for help. The report documented LN I found R151 on the floor in a seated position with his legs stretched out straight and his walker in reach. The report further documented R151 stated that he was walking and both legs gave up and he decided to sit. The report, under the "Follow up Report" section, documented R151 ambulated in the hallway and got tired and weak. The report further documented R151 did not recognize when he got tired.

On 10/23/23 at 09:15 AM R151 walked out of his room and down the hallway. He did not have his walker with him. R151 walked past two staff members as he walked down the hallway, passed the nurses station, and into the physical therapy room. He was met by a staff member in the

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physical therapy room and R151 turned around and walked back down the hallway to his room to get his walker. He then took his walker and walked back down to the therapy room. No staff assisted or intervened while R151 walked in the hallway without his walker.

On 10/25/23 at 03:02 PM Certified Nurse Aide (CNA) M stated R151 often forgot to use his walker while walking in the hallway and that staff reminded him to use it or must get it for him. She stated that she would not tell R151 to go get his walker if he was not using it during ambulation but would either assist him while going back to get it or have him sit in a safe place while she got it for him. She further stated that she would not send him to get his walker on his own without assistance.

On 10/25/23 at 03:30 PM Licensed Nurse (LN) G stated he would redirect R151 if he saw him attempting to walk without using his walker. LN G further stated he would have R151 sit somewhere safe and then bring the walker to him as it would not be safe for R151 to walk alone to get his walker by himself.

10/25/23 at 04:26 PM Administrative Nurse D stated if R151 was walking in the hallway without his walker, she expected staff to contact guard him and ask someone to get his walker for him. She further stated it was not appropriate for R151 to walk in the hallway without the walker.

The facility provided "Fall Policy" revised 09/17/19, documented the facility shall ensure that a Fall Management Program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote

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F 689	Continued From page 29 independence and safety. The policy further documented residents found to be high risk for falls are placed on the Fall Program and interventions are implemented to meet individual needs. The facility failed to assist/intervene while R151 ambulated in the hallway without his walker. This placed R151 at risk for further falls and potential injury.	F 689		
F 692 SS=D	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 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 14 residents with two	F 692		

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reviewed for nutrition. Based on observation, interviews, and record review, the facility failed to provide consistent weekly weight monitoring as required by Resident (R)105's physician's orders. This deficient practice placed R105 at risk for complication related to weight loss and malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients).

Findings Included:

- The "Medical Diagnosis" section within R105's Electronic Medical Records (EMR) included diagnoses of COVID-19 (highly contagious respiratory virus), dysphagia (swallowing difficulty), and aphasia (condition with disordered or absent language function).

R105's "Significant Change Minimum Data Base (MDS)" completed 09/20/23 noted a Brief Interview for Mental Status (BIMS) assessment was not completed due to severe cognitive impairment. The MDS indicated he required total assistance from one staff for meals. The MDS noted he weighed 133 pounds (lbs.) and had weight loss. The MDS noted he was not on a weight-loss regimen.

R105's "Nutritional Care Area Assessment" completed 03/25/23 indicated he was at risk for weight loss. The CAA noted he had supplemental tube feedings in the evenings for weight loss.

R105's "Care Plan" initiated 03/10/23 indicated he had a potential nutritional problem. The plan noted he was at risk for malnutrition. The plan instructed staff to weigh him per his orders and monitor for significant loss. The plan instructed

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staff to notify the medical provider and dietician immediately related to weight changes.

R105's EMR under "Orders" revealed an order started 10/02/23 instructing staff to weigh him weekly due to his supplemental tube feeding. The order indicated R105 was to be weighed every Monday.

R105's EMR revealed his last documented weight of 139lbs. occurred on 10/02/23. The EMR revealed missing weights for the weeks of 10/09/23, 10/16/23, and 10/23/23. R105's EMR revealed no refusals were reported.

R105's EMR indicated he tested positive for COVID-19 and was placed on isolation from 10/11/23 through 10/24/23.

On 10/23/23 at 07:45AM R105 sat upward in his bed. R105 was assisted eating his breakfast by staff. R105 ate his full breakfast without concerns. R105 was assisted with personal hygiene and rested in bed after breakfast.

On 10/25/23 at 03:28PM Certified Nurses Aide (CNA) M stated weights were completed based on each resident's orders in the EMR. She stated residents at risk for weight loss would have been weighed weekly. She was not sure if R105 was a monthly or weekly weight. She was not sure if a resident in isolation would continue being weighed or how to weigh them.

On 10/25/23 at 03:40PM Licensed Nurse (LN) G stated R105 was on monthly weights. He stated R105's weight monitoring should have been continued while he was on isolation due to the increased risk of weight loss.

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F 692	Continued From page 32 On 10/25/23 at 04:27PM Administrative Nurse D stated she was not sure how residents on isolation would be weighed due to the scale being too large to enter the rooms, but staff should encourage the resident to wear a mask and take them to the weight room. She stated all weights should be entered into the EMR and reviewed by the nurse. She stated refusals should be noted in progress notes or on the tasks section of the EMR. A review of the facility's "Nutrition and Weight Loss" policy revised 09/2012 noted the facility will closely monitor residents at risk for weight loss. The policy indicated staff will ensure the individualized dietary requirements and weigh scheduled was followed to ensure high risk residents with acute illness or symptoms are closely monitored preventative care needs. The facility failed to provide consistent weekly weight monitoring as required by R105's physician's orders. This deficient practice placed R105 at risk for complication related to weight loss and malnutrition.	F 692		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced	F 699		

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by:
The facility identified a census of 34 residents. The sample included 14 residents with one reviewed for trauma informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R)106's childhood sexual abuse and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R106 at risk for decreased psychosocial well-being and ineffective treatment.

Findings Included:

- The "Medical Diagnosis" section within R106's Electronic Medical Records (EMR) included diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), acute respiratory failure, morbid obesity (severely overweight), post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and insomnia (difficulty sleeping).

R106's "Quarterly Minimum Data Set (MDS)" completed 07/25/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS noted she was independent for transfers, bed mobility, toileting, locomotion, meals, and dressing. The MDS noted she required physical assistance from one staff for bathing. The MDS noted she had PTSD.

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R106's "Psychosocial Well-Being Care Area Assessment (CAA)" completed 11/21/22 indicated she was at risk for problems related to issues related decreased interest and pleasure in activities. The CAA noted a social service assessment and care plan would be completed to address her needs. The CAA lacked documentation related to her PTSD.

R106's "Mood State CAA" completed 11/21/22 indicated she was at risk for a decline in social involvement. The CAA noted a social service assessment and care plan would be completed to address her needs. The CAA lacked documentation related to her PTSD.

R106's "Behaviors CAA" was not triggered.

R106's "Care Plan" initiated 11/09/22 indicated she had potential psychosocial wellbeing problem related to her depression, and PTSD. The plan indicted staff were to assist, encourage, and support realistic goals and identify problems that can be controlled. The plan noted she would be consulted with pastoral, social, and psychiatric services. The plan instructed staff to monitor and document R106's feelings relative to depression, isolation, unhappiness, anger, and loss. The plan instructed staff to encourage referrals for social relationships. The plan lacked documentation identifying trauma-based triggers and individualized interventions to prevent reoccurring episodes related to her PTSD.

R106's "Admission Nursing Assessment" completed 11/08/22 identified she verbalized anxiety and PTSD from abuse in her childhood. The EMR lacked further assessment for R106

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related to her identified PTSD.

On 10/23/23 at 12:46PM R106 wheeled herself back to her room from the dining hall. R106 reported she suffered from PTSD related to early sexualized trauma in her childhood. She reported she had fears related to males. She stated she felt comfortable with some of the males at the facility, but the facility used agency staff and new people were brought in. She stated the facility was aware of her PTSD.

On 10/25/23 at 03:28PM Certified Nurses Aide (CNA) M stated staff should be aware if a resident had specific care need or requirement. She stated the care plans should reflect if a resident had fears or a history of abuse. She stated was not sure if R106 had specific PTSD related needs, but staff should take the time to meet with the resident and aid them.

On 10/25/23 at 04:09PM, Social Service X stated all residents were screened upon admission for trauma informed care. She stated the information should be reflected on the care plan and specific triggers should have been identified. She stated the resident were screened for preferences and care needs. She stated she was not aware of R106's childhood abuse or fear of male staff.

On 10/25/23 at 04:27PM Administrative Nurse D stated staff were assigned to care for each resident based on the needs and preferences of the residents. She stated if a resident had a specific known concern or need, the facility would accommodate them. She was not aware of R106's history of abuse from males.

The facility's "Trauma Informed Care" policy

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F 699	Continued From page 36 10/2022 indicated the facility will screen and provide residents with identified past traumatic experiences with person centered care plans designed to avoid re-traumatization through the application of trauma informed care. The facility failed to identify trauma-based triggers related to R106's childhood abuse and implement individualized interventions to prevent re-traumatization. These deficient practices placed R106 at risk for decreased psychosocial well-being and ineffective treatment.	F 699		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

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§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents. The sample included 14 residents with six reviewed for pharmacy services. Based on observation, record review, and interviews, The facility failed to establish a system to enable accurate medication reconciliation and maintenance of Resident (R)106's controlled hypnotic medication (a class of medications used to induce sleep) records. This deficient practice placed the affected residents at risk for medication diversion and/or misappropriation.

Findings Included:

- The "Medical Diagnosis" section within R106's Electronic Medical Records (EMR) included diagnoses of congestive heart failure, acute respiratory failure, morbid obesity (severely overweight), post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and insomnia (difficulty sleeping).

R106's "Quarterly Minimum Data Set (MDS)" completed 07/25/23 noted a Brief Interview for Mental Status (BIMS) score of 15 indicating intact

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cognition. The MDS noted she was independent for transfers, bed mobility, toileting, locomotion, meals, and dressing. The MDS noted she took hypnotic medication.

R106's "Psychotropic Medication Care Area Assessment (CAA)" completed 11/21/22 indicated she was at risk for adverse reactions. The CAA indicated she was monitored by nursing staff every shift and evaluated by the pharmacist on a routine basis. The CAA noted care planned interventions were implemented alongside mental health monitoring.

R106's "Care Plan" initiated 11/09/22 indicated she had insomnia and took eszopiclone (Lunesta-hypnotic medication used to induce sleep). The plan instructed staff to encourage her preferred bedtime routine and evaluate factors that contribute to her sleep difficulties including noise, light, temperature, and diet.

A review of R106's "Physician Orders" revealed an order started 02/03/23 to administer one milligram (one tablet) of eszopiclone by mouth at bedtime for insomnia.

A review of R106's "Controlled Drug Record" for her eszopiclone from June 2023 to October 2023 revealed August and September's records were missing. The facility was unable to provide the missing documentation as requested on 10/25/23.

On 10/25/23 at 02:43PM, Licensed Nurse G stated staff were required to maintain accurate records for all controlled medications. He stated each time a medication was needed to be pulled, the nurse would verify the order and sign out the

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F 755	Continued From page 39 medication. He stated he would administer the medication and immediately sign-off on the EMR that it was given. He stated if a medication was not administered two nurses would destroy the medication and sign-off on the count sheet that it was destroyed. He stated each shift was required to complete a count of the controlled medications. He stated after the month was completed the count sheet were turned into Administrative Nurse D. On 10/25/23 at 04:30PM, Administrative Nurse D stated the facility had no record keeping process to track and maintain the controlled medication sheet until she took over and put one in place. She stated she was not able to find the missing medication sheets for August and September of 2023. A review of the "Pharmacy Services" policy revised 01/2022 indicated the facility will follow applicable laws regarding the administering, handling, and destruction of medications to ensure the safety of the residents. The policy indicated the facility was to ensure controlled medications were closely monitor and maintain necessary documentation for each medication. The facility failed to establish a system to enable accurate medication reconciliation and to maintain records of R106's controlled hypnotic medication. This deficient practice placed R106 at risk for unnecessary medication and misappropriation.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		

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Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

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

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents. Based of observations, record review, and interviews, the facility failed to ensure safe storage and handling of the resident's medications. This deficient practice placed the residents at risk for unnecessary medication and administration errors.

Findings Included:

- On 10/26/23 at 07:10AM a walkthrough of the facility was completed with the following observations:

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An unsecured treatment cart located across from the dining room was inspected. The top drawer contained Bactroban (topical ointment used to treat bacterial infections) and Nystatin (topical ointment used to treat fungal infections) cream for Resident (R)106; and Nystatin cream for R105. The drawer also contained Voltaren cream (topical cream used to treat inflammation) and betamethasone (medication used to treat inflammation) for R151. All medications contained the "Keep out of reach from children" warning due to the risk of poisoning." The cart was secured by an unidentified staff member after the inspection.

On 10/25/23 at 03:30PM Licensed Nurse (LN) G stated the treatment carts and medications inside should be secured at all times to prevent tampering with the medications. He stated the treatment carts only contained creams and treatment products.

On 10/25/23 at 04:30PM Administrative Nurse D stated staff were to ensure that all treatment and medication carts remained locked when not in use and supervised when used. She stated staff were given frequent reminders and educated on the importance of securing medications. She stated medications should never be left unsecured due to safety concerns.

A review of the "Pharmacy Services" policy revised 01/2022 indicated all medications provided to the facility will stored in a safe manner. The policy indicated all medication rooms and carts containing medications will be secured and always supervised.

The facility failed to ensure safe storage and handling of the resident's medications. This

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F 761	Continued From page 42 deficient practice placed the residents at risk for unnecessary medication and administration errors.	F 761		
F 779 SS=D	X-Ray Diagnostic Report in Record Sign/Dated CFR(s): 483.50(b)(2)(iv) §483.50(b)(2)(iv) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic services. This REQUIREMENT is not met as evidenced by: The facility identified a census of 34 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to ensure physician ordered chest x-ray results for Resident (R) 53 were signed and scanned into the clinical record. This deficient practice could result in unnecessary tests and delayed treatment. Findings included: - R53's Electronic Medical Record (EMR) under the "Medication Administration Record" (revealed the following physician orders: Chest X-ray two views to rule out pneumonia (inflammation of the lungs) dated 07/21/23. Chest X-ray two views due to congestion and cough 09/15/23. R53's EMR, including the "Misc." tab, lacked the chest x-ray results. The facility obtained and provided a copy of R53's unsigned x-ray results upon request. On 10/25/23 at 04:22 PM Administrative Nurse D stated she expected lab and x-ray results to reviewed and scanned into the residents EMR	F 779		

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F 779	Continued From page 43 within 24 hours but no later than 72 hours. The facility was unable to provide a policy related to medical records. The facility failed to ensure physician ordered chest x-ray results for R53 were signed and scanned into the clinical record. This deficient practice could result in unnecessary tests and delayed treatment.	F 779		
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. (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 identified a census of 34 residents. Based on observations, record review, and interviews, the facility failed to ensure refrigerated food items were covered, labeled, and dated, and	F 812		

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failed to ensure consistent temperature monitoring for walk-in refrigerator and walk-in freezer in the kitchen. This deficient practice had the risk to spread foodborne illness to the residents.

Findings included:

- On 10/23/23 at 07:19 AM a tour of the kitchen revealed the following:

Uncovered fruit cocktail; eight opened, pre-thickened containers of juice which were undated; uncovered cake, and undated and uncovered dipping sauces in the cooler/refrigerator.

Temperature logs for the walk-in refrigerator and walk-in freezer lacked evidence staff assessed and recorded temperatures from 10/17/23 through 10/22/23.

On 10/25/23 at 12:29 PM Dietary BB stated the food items in the refrigerator should be labeled, dated, and covered. Dietary BB further stated the temperature for the walk-in refrigerator and freezer should have been measured and documented for each day.

The undated facility provided "Food Storage (Dry, Refrigerated, and Frozen)" policy, documented food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. The policy further documented all food items will be labeled that includes name of the food and the date by which it should be sold, consumed, or discarded.

The facility failed to ensure refrigerated food

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F 812	Continued From page 45 items were covered, labeled, and dated, and failed to ensure consistent temperature monitoring for the walk-in refrigerator and walk-in freezer in the kitchen. This deficient practice had the risk to spread foodborne illness to the residents.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		

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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:
The facility identified a census of 34 residents. The sample included 14 residents. The facility identified three COVID-19 (highly contagious,

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potentially life-threatening respiratory virus) positive residents. Based on record review, observations, and interviews, the facility failed to ensure infection control standards were followed related to isolation precautions signage, water management for Legionella disease (Legionella is a bacterium which can cause pneumonia in vulnerable populations), and laundry services. This deficient practice placed the residents at risk for infectious diseases.

Findings Included:

- On 10/23/23 at 08:30AM an inspection was completed on the facility's laundry service room. An inspection of the facility's water temperature logs for the washing machine revealed no temperature testing was conducted after March 2023.

On 10/23/23 at 09:13AM a walkthrough of the facility revealed Residents (R)154 and R111 were in isolation for COVID-19. Isolation carts were placed outside the rooms, but no signs were posted indicating the required precautions to enter the rooms or to seek nurse prior to entering.

A review of the facilities water management program for Legionella indicated the facility was not actively monitoring the water after April 2023.

On 10/23/23 at 10:12AM Maintenance Staff U stated he had no record the washing machine temperatures were checked after March 2023. He was not able to locate the washing machine water temperature logs for April, May, June, July, August, September, and October of 2023. He stated he would start a new log immediately and ensure staff were checking the temperatures. He

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stated he had no record of the facility's water management treatment for Legionella and would immediately start monitoring it.

On 10/25/23 at 0430PM, Administrative Nurse D stated all resident in isolation should have visible signs posted outside their doors indicating that precautions were required before entering the rooms. She stated signs have been posted for the identified residents with missing signs.

The facility's "Infection Control and Program" policy (2010) indicated staff will be notified of all residents placed on special contact precautions. The policy noted signs with be placed outside of isolation rooms to direct staff and visitors of the required PPE. The policy indicated the facility will monitor and prevent the spread of pathogens by ensuring consistent infection control standards were followed to include hand hygiene, wearing of PPE, monitoring processes of dining/laundry services, and infection surveillance.

The facility did not provide a policy related to water management and legionella testing as requested on 10/23/23.

The facility failed to ensure infection control standards were followed related to isolation precaution signage, water management monitoring, and laundry services. This deficient practice placed the residents at risk for infectious diseases.