STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

(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 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00168251. The 2567 was sent electronically on 06/20/23.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: The facility identified a census of 30 residents. The sample included 12 residents with one resident reviewed for self-administration of medication. Based on observation, record review, and interviews, the facility failed to ensure safe and appropriate self-administration of medication for Resident (R) 85. This deficient practice placed R85 at risk for unnecessary medication side effects and self-administration errors. Findings included: - R85's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of muscle weakness, repeated falls, need for assistance for personal care, and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The "Admission Minimum Data Set" (MDS) dated 05/31/23 documented a Brief Interview of Mental	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/20/2023

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F 554	Continued From page 1	F 554		

Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R85 required extensive assistance of one staff member for activities of daily living (ADLs).

R85's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 06/05/23 documented R85 had impaired mobility related to recent fall with a fracture (broken bone).

R85's "Care Plan" dated 06/06/23 documented staff would praise R85 for all efforts at self-care.

Review of the EMR under "Orders" tab lacked any order for self-administration of medication.

Review of R85's EMR lacked an assessment related to self-administration of medication.

On 06/06/23 at 12:43 PM R85 sat in a recliner alone in a room. There was a medication cup with pills on R85's bedside table.

On 06/08/23 at 08:53 AM Administrative Nurse D stated R85 had requested to keep her anti-inflammatory (class of medication used to reduce inflammation) topical ointment at her bedside on 06/07/23. Administrative Nurse D stated the physician was notified and had declined to give a self-administration order, so a self-administration assessment was not completed.

On 06/08/23 at 12:16 PM Licensed Nurse (LN) H stated medications should not be left unattended in a resident room. LN H stated she was not aware if R85 had an order for self-administration.

On 06/08/23 at 12:56 PM Administrative Nurse D

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F 554	Continued From page 2 stated medication should never be left unattended in a resident's room. The facility's "Medication Administration Competency: Oral Medications" undated policy revision date documented staff would remain with resident until all medication are swallowed or dissolved. Medication should not be left at bedside or with resident. The facility failed to ensure safe and appropriate self-administration of medications for R85. This deficient practice had the risk for unnecessary medication side effects and self-administration errors for R85.	F 554		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 604		

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F 604	Continued From page 3	F 604		

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 22 was free of physical restraints when staff placed R22 in an electric recliner, raised the footrest, then unplugged the recliner despite R22 was unable to manually lower the footrest on her own. This positioning of the footrest and R22's inability to move the footrest created a physical restraint as the footrest impeded R22's freedom of movement and mobility. This deficient practice placed R22 at risk for impaired mobility, rights, and at increased risk for restraint related accidents.

Findings Included:

- R22's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of repeated falls, dementia (progressive mental disorder characterized by failing memory, confusion), 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), reduced mobility, and generalized muscle weakness.

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The "Significant Change in Status Minimum Data Set" (MDS) dated 01/20/23 documented a Brief Interview of Mental Status (BIMS) score of four which indicated severe cognitive impairment. The MDS documented R22 required extensive assistance of one staff member for many of her activities of daily living (ADLs) including bed mobility, toileting, and transfers.

The " Cognitive Loss / Dementia Care Area Assessment" (CAA), dated 01/20/23, documented R22 was triggered for cognitive loss due to recent BIMS of four and noted cognitive decline since admission. The CAA further documented R22 had poor safety awareness and voiced delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) thoughts to caregivers.

The "Falls CAA" dated 01/20/23, documented R22 had increased falls recently and a noted decline in cognition and safety awareness. The CAA further documented R22 was unstable with transfers, ambulation, and she was not able to remember to use her call light to ask for assistance and that caregivers were to anticipate her needs. The CAA documented that R22's family had been involved with putting appropriate interventions in place to try to decrease risk of injury and falls.

The "Care Plan" revised on 01/11/23, documented R22 was at risk for falls related to gait, balance problems, weakness, and history of falls. An intervention dated 02/04/23 directed staff to place a Dycem (thin, rubber-like material that helps prevent sliding) to R22's recliner. An intervention with an initiated date of 01/24/23 directed staff to unplug R22's electric recliner.

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F 604	Continued From page 5 On 06/06/23 at 12:18 PM R22 sat reclined in her recliner. Her legs were elevated using the recliner's built in leg rest and the chair was unplugged. A sign noted on the wall, behind the recliner, directed staff to unplug chair to prevent falls . On 06/07/23 at 10:00 AM R22 sat in her recliner with her legs elevated and watched TV. R22's call light was on the floor and out of reach. Her legs were elevated using the recliner's built in leg rest and the recliner was unplugged. The sign that documented to unplug chair after use to prevent falls was on the wall. On 06/08/23 at 10:03 AM R22 sat in her recliner with her legs elevated and watched TV. Her legs were elevated using the recliner's built in leg rest and the recliner was unplugged. The sign on thee wall diercted staff to unplug the chair after use to prevent falls. On 06/08/23 at 12:02 PM Certified Nurse Aide (CNA) N stated that the remote for the chair was not working anymore. She stated that R22's husband brought in an ottoman for R22 to elevate her legs with; however, she further stated that R22's husband wanted the ottoman to be placed under the recliner's footrest to prevent R22 from getting up and falling. CNA N stated that R22 had used the chair remote when she tried to stand up and had a couple of falls so staff were told to unplug the chair. She stated that staff have to manually lift the recliner's built-in footrest for R22 to elevate her legs. She stated that R22 did not have enough strength/force to push the footrest down on her own.	F 604		

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F 604	Continued From page 6 On 06/08/23 at 12:15 PM Licensed Nurse (LN) H stated that R22's family brought in a square footrest for her to use to elevate her legs. She stated the R22 had used the chair remote which resulted in her falling out of the chair. She stated that R22 could not lower the recliner's leg rest herself. LN H stated that she would not place the ottoman under the recliner's footrest as that would be a restraint. On 06/08/23 at 12:56 PM Administrative Nurse D stated that R22 was not safe to use the recliner and that she fell out of the recliner while using the remote. She stated that R22's family brought in an ottoman and staff unplugged the recliner. Administrative Nurse D stated that R22 was safer with the ottoman that her family brought in as she can move it out of the way on her own. She further stated that staff should not be using the built in footrest on the recliner anymore and should instead only use the ottoman. She stated that the ottoman should not be placed under the recliner's footrest. The facility did not provide a restraint policy. The facility failed to ensure R22 was free of physical restraints when staff placed R22 in an electric recliner, raised the footrest, then unplugged the recliner despite R22 was unable to manually lower the footrest on her own. This positioning of the footrest and R22's inability to move the footrest created a physical restraint as the footrest impeded R22's freedom of movement. This deficient practice placed R22 at risk for impaired mobility, rights, and at increased risk for restraint related accidents.	F 604		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		

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F 656	Continued From page 7 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and 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.	F 656		

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(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 30 residents. The sample included 12 residents with 12 residents reviewed for comprehensive care plans. Based on observation, record review, and interviews, the facility failed to develop person-centered comprehensive care plan for Resident (R) 20 related to his ability to transfer using a transfer bar. This deficient practice placed R20 at risk of injuries related to unmet or uncommunicated needs.

Findings included:

- R20's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of abnormal involuntary movements, muscle weakness, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit, and other reduced mobility.

The "Admission Minimum Data Set" (MDS) dated 08/31/22 lacked a cognitive assessment for R20. The MDS documented that R20 required limited assistance of one staff member for transfers and activities of daily living (ADLs).

The "Quarterly MDS" dated 05/12/23 documented a staff interview which documented moderately impaired cognition. The MDS documented that

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R20 required extensive assistance of one staff member for transfers and ADLs. The MDS documented R20 had one injury fall since admission.

R20's "Falls Care Area Assessment" (CAA) dated 11/06/22 documented R20 was at risk of injury/falls related his impaired mobility.

R20's "Care Plan" revised 03/30/23 documented R20 required extensive assistance of one staff member for bed mobility. The "Care Plan" lacked documentation of the usage for the transfer bar and the level of assistance R20 required for transfers.

On 06/06/23 at 11:20 AM R20 sat on the side of the bed with a walker in front of him. There was a transfer bar on the left side of his bed. R20 stood up from the bed and did not use the transfer bar.

On 06/08/23 at 12:02 PM Certified Nurse Aide (CNA) N stated everyone had access to review the care plans and or the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change). CNA N stated the Kardex would have the information for each resident's care.

On 06/08/23 at 12:16 PM Licensed Nurse (LN) H stated the Kardex was available for CNAs to review for the information of how much assistance each resident required.

On 06/08/23 at 12:56 PM Administrative Nurse D stated the care plans are reviewed weekly and updated by the interdisciplinary team (IDT).

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F 656	Continued From page 10 Administrative Nurse D stated everyone had access to review the Kardex. The facility's "Care plans, comprehensive Person Centered" policy dated 01/2023 documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Areas of concern that are identified during the resident's assessment would be evaluated before interventions are added to the care plan. Any identified problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. Assessments of residents would be ongoing and care plans would be revised as information about the residents and the residents' conditions changed. The facility failed to develop person-centered comprehensive care plan for R20 related to his ability to transfer safely using a transfer bar. This deficient practice placed R20 at risk of injuries related to unmet or uncommunicated needs.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		

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resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 30. The sample included 12 residents with 12 reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)27's plan of care was updated to include exercises to prevent a decline in his range of motion (ROM) and functional abilities for self-care. This deficient practice placed R27 at risk for decline in ROM and contractures (abnormal permanent fixation of a joint) due to uncommunicated care needs.

Findings included:

- The "Medical Diagnosis" section within R27's Electronic Medical Records (EMR) included diagnoses of spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), spondylosis (an

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age-related condition where the joints and cartilage lined discs of the neck are affected), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and cognitive communication deficit.

A review of R27's "Quarterly Minimum Data Set (MDS)" dated 02/23/23 indicated a Brief Interview for Mental Status (BIMS) of six indicating moderate intact cognitive impairment. The MDS indicated he required extensive assistance from two staff for bed mobility, transfers, locomotion, dressing, toileting, personal hygiene, and bathing. The MDS noted he could eat independently with setup assistance from staff. The MDS indicated had two no-injury falls since admission. The MDS indicated he received two days of restorative services during the assessment period for active range of motion (ROM).

A review of R27's "Annual Minimum Data Set (MDS)" dated 05/08/23 indicated he received no restorative services since the last assessment.

A review of R27's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 05/26/23 indicated he required extensive assistance from staff for transfers, bed mobility, toileting, personal hygiene dur to his medical diagnoses. The CAA noted he was able to propel himself in his wheelchair and eat meals with minimal assistance.

A review of R27's "Pressure Injury CAA" completed 05/26/23 indicated he was at risk for

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developing pressure injuries due to his impaired mobility and medical diagnoses.

R27's "Care Plan" created 12/08/22 indicated he had a self-care deficit and required extensive assistance from staff for bathing, bed mobility, dressing, personal hygiene and toileting. The plan instructed staff to encourage R27 to participate in his own cares and to use his call light (12/08/22). The plan lacked documentation related to a restorative nursing program (RNP) as instructed on his therapy discharge documentation.

A review of R27's "Physical Therapy" note dated 01/26/23 indicated he was discharged from physical therapy and was expected to continue working with the RNP.

A review of R27's EMR under "Tasks" for May 2023, revealed an entry for "Restorative Tasks" related to ambulation (exercises related to transfers using parallel bars and walking 15 feet), transfers (exercises related to transfers for toileting/showering), and active ROM (exercises related to functional tasks related to bathing). The review revealed these exercises were not completed in May 2023.

On 06/07/23 at 08:01AM R27 wheeled himself down the hall to his room. R27 reported he worked with therapy on strength training with physical therapy, but his nursing exercises stopped in May due to the aide leaving.

On 06/08/23 at 12:01PM Certified Nurse's Aide (CNA) M stated she recently took over the role of restorative aide (RA) on 06/05/23. She was not sure if 27's care plan included his restorative exercises and goals.

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F 657	Continued From page 14 On 06/08//23 at 12:27PM Administrative Nurse E stated R27's plan included ambulation, toileting, and strengths exercises related to ADLs. She stated the restorative activities should be listed and tracked in the EMR and listed on his care plan. A review of the facility's "Care Plan" policy revised 01/2023 indicated the facility would ensure a comprehensive, person-centered care plan with measurable goals be implemented for each resident. The policy indicated the plan needed to include revision and be updated as the treatment progressed. The facility failed to ensure R27's plan of care was updated to include implemented staff-led exercises to prevent a decline in his ROM and functional abilities for self-care. This deficient practice placed R27 at risk for decline in ROM and contractures due to uncommunicated care needs.	F 657		
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 30 residents. The sample included 12 residents with five residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide the care and services needed to residents who required	F 677		

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partial or complete assistance from staff for bathing when the facility failed to provide consistent bathing for Resident (R)15, R6, and R12. This deficient practice placed R15, R6, and R12 at risk for potential skin breakdown and/or skin complications from not maintaining good personal hygiene/bathing practices and impaired psychosocial well-being.

Findings included:

- The electronic medical record (EMR) for R15 documented diagnoses of Parkinson's disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement), spondylosis, (a condition in which there is abnormal wear on the cartilage and bones of the neck), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The "Significant Change Minimum Data Set" (MDS) dated 01/24/23 documented R15 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. R15 required extensive assistance of two or more staff for ADLs of bathing and personal hygiene. R15 had functional range of motion impairment to both lower extremities. R15 required the use of a wheelchair for mobility.

The "Quarterly MDS" dated 03/27/23 documented R15 had a BIMS score of eight which indicated moderately impaired cognition. R15 required extensive assistance of two or more staff for bathing and personal hygiene. R15 required the use of a wheelchair for mobility.

The "ADL Care Area Assessment" (CAA) dated

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01/27/23 documented R15 triggered for ADL function due to his decline in physical ability. R15 needed a sit to stand (a lift used to assist mobility patients when they are unable to transition from a sitting position to a standing position on their own) lift with two staff for transfers due to his increased bilateral lower extremity weakness. R15 was receiving therapy services to address his physical decline.

The "ADL Care Plan" revised on 11/14/22 directed staff for bathing for R15 was total assist of one for bathing tasks, with transfer to shower. Staff was to avoid scrubbing and pat dry sensitive skin. Staff was to check nail length and trim and clean on bath day and as necessary. Staff was to report any changes to the nurse.

The January 2023 "Documentation Survey Report" for R15 documented the ADL task of bathing scheduled Tuesday and Saturday evenings. The report documented R15 received a bath/shower on 01/21/22. R15 refused a bath/shower on 01/28/23, and 01/31/23. The report lacked documentation for scheduled bathing on 01/03/23, 01/07/23, 01/10/23, 01/14/23, and 01/17/23.

The February 2023 "Documentation Survey Report" for R15 documented the ADL task of bathing scheduled Tuesday and Saturday evenings. R15 refused a bath shower on two occasions (02/04/23, and 02/18/23). The report documented Not Applicable (NA on three occasions- 02/11/23, 02/14/23, and 02/21/22). The report documented R15 received a bath/shower on two dates 02/25/23 and 02/28/23).

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The March 2023 "Documentation Survey Report" for R15 documented the ADL task of bathing scheduled Tuesday and Saturday evenings. R15 received a bath/shower on 03/18/23 and 03/25/23. The report documented NA on 03/11/23 and 03/28/23. The report lacked documentation of bathing on 03/04/23, 03/07/23, 03/14/23, and 03/21/23.

The April 2023 "Documentation Survey Report" for R15 documented the ADL task of bathing scheduled Tuesday and Saturday evenings. The report documented R15 received a bath/shower on 04/01/23, 04/11/23, 04/18/23, and 04/25/23. The report documented R15 refused bathing/shower three dates (04/08/23, 04/15/23, and 04/22/23). The report lacked documentation for bathing on two occasions (04/04/23, and 04/29/23).

The May 2023 "Documentation Survey Report" for R15 documented the ADL task of bathing scheduled Tuesday and Saturday evenings. The report documented R15 received a bath/shower on five dates (05/02/23, 05/13/23, 05/23/23, 05/27/23 and 05/30/21. The report documented R15 refused a bath/shower on two occasions (04/09/23, and 04/16/23). The report lacked documentation of bathing for scheduled days of 05/06/23 and 05/20/23.

On 06/06/23 at 09:53 AM R15 sat in his wheelchair in his roo. His hair was messy and uncombed. He had food residue on the front of his shirt. R15 stated he did not always receive his showers as he should. R15 stated his shower days should be on Saturday and Wednesday he thought but said he did not always receive a shower on those days and sometimes not at all.

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On 06/07/23 09:29 AM R15 sat in his wheelchair in his room with his hair messy, and his sweatpants dirty from food.

On 06/08/23 at 12:02 PM Certified Nurse Aide (CNA) N stated the aide knew what day each resident was scheduled for a bath because it showed up on the "Point of Care" (POC) charting in the EMR for them. CNA N stated the nurse also would write who was to receive a shower each day on the position sheet each morning. CNA N stated bath/shower days showed up on the Kardex (a reporting system used to indicate the level of care a resident required). CNA N stated the aides also filled out a bath sheet each time a bath was completed, and the sheet was given to the nurses. CNA N stated R15 occasionally would refuse a bath and if a resident did refuse another staff member would go back later to ask the resident again.

On 06/08/23 at 12:15 PM Licensed Nurse (LN) H stated all staff had access to the care plan that should state bathing days as well as the tablets and POC let the aides know who was scheduled for a bath each day. LN H stated the aides gave that bath/shower and should complete a shower sheet as well as document in POC that the shower was given. LN H stated R15 rarely refused a shower; he might refuse initially when asked but would typically agree to one later if he had been asked.

On 06/08/23 at 01:05 PM Administrative Nurse D stated the expectation for bathing would be for the aide that completed the bath to document when a bath was completed. Administrative Nurse D stated she expected staff completing a

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shower sheet and turn the sheet into the charge nurse at the end of each day. Administrative Nurse D stated she had been working with staff to remember to document the bath in POC as well as completing the shower sheet to turn in.

The undated facility "Resident Bathing" policy documented: Bathing should be performed in accordance with any federal or state guidelines. Based upon resident preference, bathing should occur no less than twice per week, unless medically contraindicated. Based upon resident preference, bathing can be by shower or tub. Based upon resident preference, bathing should occur at a day and time selected by the resident to the extent practicable.

The facility failed to provide consistent bathing for R15. This deficient practice placed R15 at risk for potential skin breakdown and/or skin complications from not maintaining good personal hygiene/bathing practices and impaired psychosocial well-being.

- The "Medical Diagnosis" section within R6's Electronic Medical Records (EMR) included diagnoses of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), cerebral infarction (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), chronic kidney disease, major depressive disorder (major mood disorder), insomnia (difficulty sleeping), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dysphagia (swallowing difficulty), and dementia

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(progressive mental disorder characterized by failing memory, confusion).

A review of R6's "Annual Minimum Data Set (MDS)" dated 04/28/23 indicated a Brief Interview for Mental Status (BIMS) of five indicating severe cognitive impairment. The MDS indicated he required extensive assistance from two staff for transfers, bed mobility, toileting, personal hygiene, and bathing. The MDS indicated he was receiving hospice services.

A review of R6's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 04/24/23 indicated he required extensive assistance from two staff for bed mobility and transfers. The CAA noted he required assistance from one staff for dressing, toileting, hygiene, and meals. The CAA noted he used a wheelchair and Hoyer lift (total body mechanical lift) for transfers.

R6's "Urinary Incontinence CAA" completed 04/24/23 indicated he was incontinent but could, at times, voice his needs. The CAA instructed staff to complete incontinence cares when needed.

A review of R6's "Care Plan" created 06/03/21 indicated he required extensive assistance from two staff for transfers bed mobility, bathing, dressing, personal hygiene, toileting, and transfers. The plan indicated he received two showers weekly and as needed. The plan instructed staff to offer bathing if he refused. The plan indicated he received hospice services including nursing, social services, spiritual, and emotional support services. The plan lacked documentation which indicated R6 wished only to receive bathing from Hospice.

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A review of R6's EMR under "Tasks" revealed an entry labeled "bathing completed by hospice". The review indicated he regularly received baths on Sundays and Wednesday from hospice.

A review of R6's "Hospice Bathing Lookback" report between 12/01/22 to 06/01/23 (188 days reviewed) revealed he refused bathing on ten occasions (12/7, 12/14, 1/15, 2/5, 3/1, 3/5, 3/8, 5/14, 5/21, and 5/28). The report revealed nine occasions the bathing event was left unmarked (12/3, 12/11, 12/18, 12/25, 1/1, 1/4, 3/19, 4/16, and 4/23).

The EMR lacked documentation showing the missed bathing occurrences were addressed by the facility and lacked documentation that the facility was offering bathing opportunities to the resident other than the supplemental hospice services.

On 06/07/23 at 11:23AM R6 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline). R6's representative reported R6 had been found several times in the morning wet from incontinence episodes. R6's representative stated the facility no longer provided baths /showers to R6 due to staff said R6 repeatedly refused them. She stated hospice service provided R6 with all his baths.

On 06/08/23 at 12:03PM Certified Nurse's Aide (CNA) N reported R6 preferred having bed baths. She stated hospice was scheduled to give R6 his weekly baths, but staff may give him extras when needed. She stated the nurse puts out the shower list daily for other residents. She stated staff should check with hospice to see if he has

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received his daily baths. She was not sure if he received extra bathing outside of his scheduled hospice baths.

On 06/08//23 at 12:23PM Licensed Nurse (LN) H indicated hospice services provided R6 with all his bathing opportunities. She stated R6 liked to refuse his baths offered to him by the facility, so hospice took over bathing him. She stated the facility should give him baths when hospice was not at the facility.

On 06/08/23 at 12:57PM Administrative Nurse D reported R6 received his bathing from hospice but was not sure if his care plan included his bathing preferences. She stated staff should check with hospice and ensure his bathing was being completed.

A review of the facility's "Bathing" policy (undated) indicated all residents will be provide bathing with regards to hygiene, health, dignity, and general comfort. The policy indicted each resident right to preferences will be respected and listed in a plan of care.

The facility failed to ensure R6 received consistent bathing opportunities from the facility in addition to the supplemental services provided by hospice. This deficient practice placed R6 at risk for complications related to hygiene and infections.

- The "Medical Diagnosis" section within R12's Electronic Medical Records (EMR) included diagnoses of history of urinary tract infection (UTI), insomnia (difficulty sleeping), gastro esophageal reflux disorder (GERD- backflow of stomach contents to the esophagus), anxiety

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disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), abnormal gait, and dementia (progressive mental disorder characterized by failing memory, confusion).

A review of R12's "Admission Minimum Data Set (MDS)" dated 03/9/23 indicated a Brief Interview for Mental Status (BIMS) of eleven indicating mild cognitive impairment. The MDS indicated she required extensive assistance from two staff for transfers, bed mobility, toileting dressing, and bathing. The MDS indicated she was not steady moving on and off the toilet and required assistance to remain stable. The MDS indicated she was always continent of urine but always incontinent of bowel. The MDS indicated she was not on a toileting program.

A review of R12's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 03/24/23 indicated she required extensive assistance from two staff caregivers for her ADLs and self-care. The CAA noted she required encouragement to participate in bed mobility, transfers, dressing toileting, and showering. The CAA noted she used a wheelchair and required a Hoyer lift (full body mechanical lift) for transfers.

R12's "Urinary Incontinence CAA" completed 03/24/23 indicated she was incontinent of bowel and bladder. The CAA indicated she needed assistance from two caregivers for incontinence cares. The CAA noted she used incontinence pads at home instead of using the bathroom before her admission at home.

A review of R12's "Care Plan" initiated 03/22/23 indicated she was at risk for self-care deficits

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related to her ADLs.

The plan indicated she required extensive assistance from two staff for bathing, bed mobility, dressing, personal hygiene, toileting, and transfers. The plan noted she required a Hoyer lift for transfers. The plan indicated she was at risk for moisture associated skin disorders (MASD-skin breakdown and infections) related to her incontinence. The plan instructed staff to provide peri-care after incontinent episodes, change her clothing, and assess for infections (03/22/23).

A review of R12's "Bathing Look-Back" report from 03/03/23 to 04/01/2023 (30 days reviewed) revealed she only received a bath on two occasions. (3/22 and 3/29) The reported indicated she refused on two occasions. (3/8 and 3/26) The report noted "not applicable" was marked on three occasions. (3/5, 3/12, and 3/15).

On 06/06/23 at 09:35AM R12 reported bathing was "horrible" when she first admitted in March 2023. She stated she did not get a bath the first two weeks at the facility. She stated the facility kept stating she refused cares but she did not get offered other times or dates. She stated the bathing had improved some in April 2023 but still struggled with offering assistance.

On 06/08/23 at 12:37PM Certified Nurse Aide (CNA) N stated R12 would often call multiple times if she needed a bath or care assistance. She stated R12 would rarely refuse cares and would just ask for another time or date. She stated staff fill out a shower sheet to confirm and document skin concerns.

On 06/08//23 at 12:23PM Administrative Nurse D

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F 677	Continued From page 25 said staff were expected to ensure bathing was completed for each resident. She stated if a resident refused cares, the nurse should be notified for rescheduling. She stated all staff have access to the care plan and were expected to review it for each resident. A review of the facility's "Bathing" policy (undated) indicated all residents will be provide bathing with regards to hygiene, health, dignity, and general comfort. The policy indicted each resident right to preferences will be respected and listed in a plan of care. The facility failed to provide consistent bathing opportunities for R12. This deficient practice placed R12 at risk for complication related to hygiene and decreased psychosocial well-being.	F 677		
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	F 688		

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reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:

The facility identified a census of 30. The sample included 12 residents with one reviewed for decreased range of motion (ROM). Based on observation, record review, and interviews, the facility failed to ensure Resident (R)27 received services to prevent a decline in his ROM and functional abilities for self-care. This deficient practice placed R27 at risk for decline in ROM and contractures (abnormal permanent fixation of a joint).

Findings included:

- The "Medical Diagnosis" section within R27's Electronic Medical Records (EMR) included diagnoses of spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), spondylosis (an age-related condition where the joints and cartilage lined discs of the neck are affected), benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and cognitive communication deficit.

A review of R27's "Quarterly Minimum Data Set (MDS)" dated 02/23/23 indicated a Brief Interview for Mental Status (BIMS) of six indicating moderate intact cognitive impairment. The MDS indicated he required extensive assistance from two staff for bed mobility, transfers, locomotion, dressing, toileting, personal hygiene, and bathing. The MDS noted he could eat independently with

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setup assistance from staff. The MDS indicated had two no-injury falls since admission. The MDS indicated he received two days of restorative services during the assessment period for active range of motion (ROM).

A review of R27's "Annual Minimum Data Set (MDS)" dated 05/08/23 indicated he received no restorative services since the last assessment.

A review of R27's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 05/26/23 indicated he required extensive assistance from staff for transfers, bed mobility, toileting, personal hygiene dur to his medical diagnoses. The CAA noted he was able to propel himself in his wheelchair and eat meals with minimal assistance.

A review of R27's "Pressure Injury CAA" completed 05/26/23 indicated he was at risk for developing pressure injuries due to his impaired mobility and medical diagnoses.

R27's "Care Plan" created 12/08/22 indicated he had a self-care deficit and required extensive assistance from staff for bathing, bed mobility, dressing, personal hygiene and toileting. The plan instructed staff to encourage R27 to participate in his own cares and to use his call light (12/08/22). The plan lacked documentation related to a restorative nursing program (RNP) as instructed on his therapy discharge documentation.

A review of R27's "Physical Therapy" note dated 01/26/23 indicated he was discharged from physical therapy and was expected to continue working with the RNP.

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A review of R27's EMR under "Tasks" for May 2023, revealed an entry for "Restorative Tasks" related to ambulation (exercises related to transfers using parallel bars and walking 15 feet), transfers (exercises related to transfers for toileting/showering), and active ROM (exercises related to functional tasks related to bathing). The review revealed these exercises were not completed in May 2023.

On 06/07/23 at 08:01AM R27 wheeled himself down the hall to his room. R27 reported he worked with therapy on strength training with physical therapy, but his nursing exercises stopped in May due to the aide leaving.

On 06/08/23 at 12:01PM Certified Nurse's Aide (CNA) M stated she recently took over the role of restorative aide (RA) on 06/05/23. She stated the previous RA left about a month ago and the residents have not received the services due to no RA. She stated she started working with R27 this week on transfers, toileting, ambulation, and maintaining his strength during activities. She stated the restorative exercises should be documented in the EMR under "Tasks".

On 06/08//23 at 12:27PM Administrative Nurse E reported the previous RA left at the beginning of May for another position. She stated that CNA M just became certified to provide restorative care and the program was reactivated on 06/05/23. She stated the previous RA tried to provide the program but had issues and the program was not being fully completed for the residents. She stated R27's plan included ambulation, toileting, and strengths exercises related to ADLs. She stated the restorative activities should be listed and tracked in the EMR.

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F 688	Continued From page 29 A review of the facility's "Restorative Nursing Services" policy revised 07/2017 indicated the facility will provide services to help promote optimal safety and independence. The policy noted the facility will ensure services to maitain and/or improve functioning when possible. The facility failed to ensure R27 received services to prevent a decline in his ROM and functional abilities for self-care. This deficient practice placed R27 at risk for decline in ROM and contractures.	F 688		
F 689 SS=E	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 identified a census of 30. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to secure the main dining room kitchenette. This deficient practice placed five cognitively impaired independently mobile residents at risk for potential hazards or preventable accidents. The facility additionally failed to ensure Resident (R)22's Dycem (thin, rubber-like material that helps prevent sliding) was in her chair, as directed by the care plan, to prevent falls. This deficient practice placed R22 at risk for increased	F 689		

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falls and injury.

Findings Included:

-On 06/07/23 at 09:37PM an inspection of the kitchenette after breakfast service revealed no doors to secure kitchenette or potentially hazardous equipment. The kitchenette was left unsecured and unsupervised. An inspection of the counter revealed a coffee pot left on top of a double pot warmer. The heater element still on and the glass coffee pot still warm. The kitchenette contained a functioning oven, built-in steam table, conveyor style bread toaster, and crock-pot.

On 06/07/23 at 01:32PM the kitchenette was left unsecured and unsupervised. The oven and steam table were still warm and controllable with the gauges. The coffee pot burner remained hot. The glass coffee pot still warm.

On 06/08/23 at 11:48AM Dietary Staff BB reported a kitchen cart was often used as a barrier but not locking device or door has been used to secure the kitchenette. He reported a switch can shut off some of the equipment, but the facility has not had any issues yet. He stated staff keep supervision on the residents when the equipment is on.

On 06/08/23 at 01:30PM Administrator A reported staff were expected to provide supervision and activities to prevent resident wandering. He stated the facility had no previous concerns or issues with the equipment. He stated kitchen staff should be monitoring the equipment while in use and ensuring the equipment was shutdown after use.

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A review of the facility's "Accidents and Occurrences" policy (undated) indicated the facility will ensure that each resident receives adequate supervision to prevent occurrences. The policy indicated staff would inspect and identify potential accident and falls hazardous within the facility's environment and implement interventions to prevent occurrences.

The facility failed to secure the main dining room kitchenette. This deficient practice placed five cognitively impaired independently mobile residents at risk for accidents and hazards..

- R22's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of repeated falls, dementia (progressive mental disorder characterized by failing memory, confusion), 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), reduced mobility, and generalized muscle weakness.

The "Significant Change in Status Minimum Data Set" (MDS) dated 01/20/23 documented a Brief Interview of Mental Status (BIMS) score of four which indicated severe cognitive impairment. The MDS documented R22 required extensive assistance of one staff member for many of her activities of daily living (ADLs) including bed mobility, toileting, and transfers.

The "Cognitive Loss / Dementia Care Area Assessment" (CAA), dated 01/20/23, documented R22 was triggered for cognitive loss due to recent BIMS of four and noted cognitive decline since admission. The CAA further documented R22 had poor safety awareness and

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voiced delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) thoughts to caregivers.

The "Falls CAA" dated 01/20/23, documented R22 had increased falls recently and a noted decline in cognition and safety awareness. The CAA further documented R22 was unstable with transfers, ambulation, and she was not able to remember to use her call light to ask for assistance and that caregivers were to anticipate her needs. The CAA documented that R22's family had been involved with putting appropriate interventions in place to try to decrease risk of injury and falls.

The "Care Plan" revised on 01/11/23, documented R22 was at risk for falls related to gait, balance problems, weakness and history of falls. An intervention dated 02/04/23 directed staff to place a Dycem to R22's recliner. An intervention with an initiated date of 01/24/23 directed staff to unplug R22's electric recliner.

A "Nurse's Note" dated 01/02/23, documented that R22 was found seated on the floor in front of her recliner and documented R22 stated she attempted to transfer herself and slid. The "Nurse's Note" further documented that a small skin tear was noted to R22's left index finger.

An observation of R22's room on 06/08/23 at 08:50 AM revealed that there was no Dycem in R22's recliner. R22 was not in her room during observation.

An observation on 06/08/23 at 10:03 AM revealed R22 sat in her recliner with her legs elevated. On further inspection it was noted that there was no

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Dycem on her recliner. There was no Dycem noted to be on her wheelchair during inspection.

On 06/08/23 at 12:02 PM Certified Nurse Aide (CNA) N stated that R22 used the Dycem and that it was supposed to be in her wheelchair all the time. She stated that it should be placed under the cushion on her wheelchair.

On 06/08/23 at 12:15 PM Licensed Nurse (LN) H stated that if she received the order to get the Dycem for a resident that she would get it herself and put it in place. She further stated that she hoped that whoever got the order for it, would be the one to put the Dycem in place. She further stated that she was unsure if staff where checking to see if the Dycem was placed/being used and was not sure if there was a place for staff to document it.

On 06/08/23 at 12:56 PM Administrative Nurse D stated that the expectation is for the person that put in the intervention to get the Dycem and put it in place. She stated that if it's on the care plan, then it should be done. She further stated that she was unsure if it appeared on the Kardex for staff to check.

The facility's undated "Accidents and Occurrences" policy documented that it is the policy to ensure that each resident receives adequate supervision and assistive devices to prevent occurrences. The policy further documented that the licensed nurse would proceed in implementing immediate interventions to prevent further occurrences.

The facility failed to place Dycem in R22's chair, as directed by the care plan, to prevent falls. This

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F 689	Continued From page 34 deficient practice placed R22 at risk for increased falls and injury.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		

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possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 30 residents. The sample included 12 residents. Based on observation, record review and interview, the facility failed to monitor urine output (an indication of proper fluid intake or the presence of a problem and a common parameter of kidney function) and provide catheter (a tube placed in the bladder to drain urine into a collection bag) care to Resident (R) 8, who had a diagnosis of a neurogenic bladder (urinary condition where there is a lack bladder control due to a brain, spinal cord or nerve problems) and required the use of an indwelling catheter. This placed R8 at risk for infection and urinary catheter complications. The facility further failed to implement individualized toileting plans or attempt a toileting program related to bowel and bladder incontinence for R12. This deficient practice placed R12 at risk for complications related to incontinence.

Findings included:

- The electronic medical record (EMR) for R8 documented diagnoses of obstructive and reflux uropathy (when urine cannot flow due to some type of obstruction), quadriplegia (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), and neurogenic bladder.

The "Admission Minimum Data Set" (MDS) dated 04/23/23 documented R8 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R8 required total dependence of two or more staff for her activities of daily living (ADLs). R8 had functional limited range of motion

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to both upper and lower extremities on both sides of the body. R8 had an indwelling catheter.

The "Urinary Incontinence/Indwelling Catheter Care Area Assessment" (CAA) dated 05/05/23 documented R8 had a suprapubic catheter (a hollow flexible tube that is inserted through a cut in the abdomen into the bladder that is used to drain urine).

The "Catheter Care Plan" revised on 06/05/23 documented R8 had a suprapubic catheter. The care plan directed staff to check tubing for kinks when providing cares and frequently throughout the shift. Staff was directed to flush and/or clamp catheter with solution as per physician orders. Staff was directed to monitor and document output per facility policy. Staff was directed to provided catheter care minimally every shift and as needed.

Under the "Orders" tab, a physician's order dated 04/17/23 directed staff to change suprapubic catheter monthly using a #16 French (FR) with 30 cubic centimeters (cc) of water in balloon in the morning starting on the last day of the month every month for neurogenic bladder.

The "Orders" tab documented a physician's order dated 05/05/23 to change suprapubic catheter if clogged or dislodged as needed.

R8's clinical record for April 2023 and May 2023 lacked evidence the staff monitored and recorded R8's urine output.

R8's clinical record lacked evidence catheter care was provided in April and May 2023.

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On 06/07/23 at 03:39 PM R8 laid in her bed on her back had her supplemental oxygen (O2) via nasal cannula (a hollow tube with tabs that insert in the nostrils to on). The urine collection bags were hung on the right side of her bed.

On 06/08/23 at 12:02 PM Certified Nurse Aide (CNA) N stated that the aides documented resident's urine output and would also give the nurse a sheet with the output amount. CNA N stated R8 had a foley catheter and a suprapubic catheter and her output should be being monitored each shift.

On 06/08/23 at 12:15 PM Licensed Nurse (LN) H stated that R8 had returned from a hospital visit back in April 2023 and had the suprapubic catheter. LN H could not recall when R8's foley catheter was placed but she believed it was in May 2023. LN H stated when R8 was readmitted all the orders should have been entered into the EMR including catheter cares and monitoring urine output. LN H stated that the night shift nurse was responsible to check. orders input into the EMR, then the nurse managers would audit them also. LN H stated that R8's urine output should be monitored each shift daily by the CNA's and reported to the nurse.

On 06/08/23 at 12:58 PM Administrative Nurse D stated the urine output should be monitored each shift and documented into the EMR. Administrative Nurse D stated the admission nurse was responsible for inputting orders into the EMR, then the orders should be getting checked by the night shift nurse for accuracy. Administrative Nurse D stated catheter output and care should be input so they would flow over to the Medication Administration

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Report/Treatment Administration Report (MAR/TAR).

The facility "Combined Catheter Care Competency" policy/checklist lacked directed for staff on the frequency and/or documenting the urine output.

The facility failed to provide urine output monitoring and catheter care for R8 who had neurogenic bladder and required the use of indwelling catheters. This placed R8 at risk for infection and urinary catheter complications.

- The "Medical Diagnosis" section within R12's Electronic Medical Records (EMR) included diagnoses of history of urinary tract infection (UTI), insomnia (difficulty sleeping), gastro esophageal reflux disorder (GERD- backflow of stomach contents to the esophagus), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), abnormal gait, and dementia (progressive mental disorder characterized by failing memory, confusion).

A review of R12's "Admission Minimum Data Set (MDS)" dated 03/9/23 indicated a Brief Interview for Mental Status (BIMS) of eleven indicating mild cognitive impairment. The MDS indicated she required extensive assistance from two staff for transfers, bed mobility, toileting dressing, and bathing. The MDS indicated she was not steady moving on and off the toilet and required assistance to remain stable. The MDS indicated she was always continent of urine but always incontinent of bowel. The MDS indicated she was not on a toileting program.

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A review of R12's "Activities of Daily Living (ADLs) Care Area Assessment (CAA)" completed 03/24/23 indicated she required extensive assistance from two staff caregivers for her ADLs and self-care. The CAA noted she required encouragement to participate in bed mobility, transfers, dressing toileting, and showering. The CAA noted she used a wheelchair and required a Hoyer lift (full body mechanical lift) for transfers.

R12's "Urinary Incontinence CAA" completed 03/24/23 indicated she was incontinent of bowel and bladder. The CAA indicated she needed assistance from two caregivers for incontinence cares. The CAA noted she used incontinence pads at home instead of using the bathroom before her admission at home.

A review of R12's "Care Plan" initiated 03/22/23 indicated she was at risk for self-care deficits related to her ADLs. The plan indicated she required extensive assistance from two staff for bathing, bed mobility, dressing, personal hygiene, toileting, and transfers. The plan noted she required a Hoyer lift for transfers. The plan indicated she was at risk for moisture associated skin disorders (MASD- skin breakdown and infections) related to her incontinence. The plan instructed staff to provide peri-care after incontinent episodes, change her clothing, and assess for infections (03/22/23). The care plan lacked individualized interventions to prevent, maintain and promote R12's highest level of functioning related to incontinence.

A "Skilled Evaluation" completed on 03/15/23 indicated R12 was incontinent of both bowel and bladder. The evaluation noted she required

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	175560	A. BUILDING _____ B. WING _____	06/08/2023

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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 690	Continued From page 40	F 690		

incontinent products and instructed staff to complete peri-care.

A "Skilled Evaluation" completed on 05/31/23 indicated R12 was incontinent of both bowel and bladder. The evaluation noted she required incontinent products and instructed staff to complete peri-care.

On 06/06/23 at 09:35AM R12 reported she frequently worried about having incontinent episodes. She stated her incontinence episodes have increased since admitting and she can't take herself to the bathroom alone like she did at home. She stated she wore incontinence briefs but needed frequent reminders. She stated staff often forget in the evenings and nights to offer her bathroom breaks and bathing.

On 06/08/23 at 12:37PM Certified Nurse Aide (CNA) N stated staff frequently check on the residents and offer restroom breaks. She stated R12 was incontinent and did require frequent restroom breaks. She stated staff should ensure her call light is in reach during each encounter and provide peri-care when needed. She was not sure if R12 had specific toileting interventions to prevent incontinent episodes. She stated all staff had access to the Kardex (report pulled from care planned information) to show which residents required bathroom assistance.

On 06/08//23 at 12:23PM Administrative Nurse D stated all residents were offered restroom breaks upon waking up, before/after meals, and at bedtime. She stated staff were expected to frequently check on each resident and offer restroom breaks. She stated if a resident's status declined, the interdisciplinary team (IDT) would

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F 690	Continued From page 41 discuss the issues and provide interventions. A review of the facility's "Urinary Incontinence" policy revised 04/2023 indicated resident will be initially assessed for impaired urinary continence. The policy indicated appropriate interventions will be implemented to ensure treatable factors and environmental conditions are addressed. The facility failed to implement individualized toileting plans or attempt a toileting program related to bowel and bladder incontinence for R12. This deficient practice placed R12 at risk for complications related to incontinence.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 30 residents. The sample included 12 residents with one resident reviewed for respiratory services. Based on observation, record review, and interviews, the facility failed the facility failed to store oxygen tubing, nasal cannula (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) and nebulizer mask in a sanitary manner for Resident (R) 10. This deficient practice placed R10 at	F 695		

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F 695	Continued From page 42	F 695		

increased risk to develop a respiratory infection.

Findings included:

- R10's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of moderate persistent asthma (disorder of narrowed airways that caused wheezing and shortness of breath) and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Annual Minimum Data Set" (MDS) dated 12/02/22 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R10 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented R10 received oxygen therapy during the look back period.

The "Quarterly MDS" dated 05/15/23 documented a BIMS score of 12 which indicated moderately impaired cognition. The MDS documented that R10 was dependent on two staff members assistance for ADLs. The MDS documented R10 received oxygen therapy during the look back period.

R10's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 12/15/22 documented R10 was dependent on staff to assist with ADLs.

R10's "Care Plan" dated 11/04/22 documented staff would administer oxygen per nasal cannula per physician order, if R10 allowed.

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Review of the EMR under "Orders" tab revealed the following physician orders:
Change and label (date and name) oxygen tubing and humidified water (if used). Wash concentrator filter at bedtime every Sunday dated 10/04/19.
Oxygen at two liters(L) per minute via nasal cannula as needed to maintain oxygen saturation (measure of how much oxygen the blood carried as a percentage of the maximum it could carry) at 90% or greater and with all meals dated 08/15/22.
Ipratropium-albuterol solution (bronchodilator-a drug that causes widening of the bronchi, e.g., any of those taken by inhalation for the alleviation of asthma) 0.5-2.5 milligrams (mg)/three milliliters (ml) one vial inhale orally four times a day related to COPD dated 11/02/22.
Apply supplemental oxygen at two liters during all meals regardless of initial room air oxygen saturation per speech therapy recommendation. with meals 12/16/20.

On 06/06/23 at 10:58 AM R10's undated nebulizer mask hung unbagged from the call light cord attached to the wall. R10's nebulizer mask rested against the wall and was attached to the nebulizer machine which sat on the floor next to the bed.

On 06/07/23 at 08:51 AM R10 sat in her wheelchair next to the bed. The undated nebulizer mask was inside a clear trash bag which was inside a wash basin on the floor next the nebulizer machine, also on the floor, next R10's bed.

On 06/08/23 at 07:53 AM R10's undated nasal cannula and oxygen tubing was wrapped around

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F 695	Continued From page 44	F 695		

the oxygen cylinder, open to air, on the back of her wheelchair in the hallway outside her room.

On 06/08/23 at 12:02 PM Certified Nurse Aide (CNA) N stated the oxygen tubing should be stored in a bag which has a date on the outside of the bag. CNA N stated she was not sure how the nebulizer mask would be stored because the Certified Medication Aides and the nurse took care of those.

On 06/08/23 at 12:16 PM Licensed Nurse (LN) H stated oxygen tubing and nasal cannula was changed weekly and the nebulizer tubing and equipment should be changed weekly also. LN H stated the respiratory items should be stored on a clean surface or in a plastic bag. LN H stated respiratory items should be dated.

On 06/08/23 at 12:56 PM Administrative Nurse D stated respiratory equipment should be changed weekly on the night shift. Administrative Nurse D stated respiratory items should not be stored on the ground or wrapped around the oxygen cylinder.

The facility's "Oxygen Cylinder Safe Handling Training Policy" dated 10/2021 documented the facility would review the portable oxygen training with all employees. Periodically, the facility would perform audits and observe safe handling procedures. If the standards were not met, additional training would be scheduled at such time. Only those trained in maintenance and operation of oxygen related systems would be permitted to use such equipment.

The facility failed to store respiratory equipment in accordance with professional standards of

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F 695	Continued From page 45 practice for sanitary storage placing R10 at risk for developing a respiratory infection and/or illness.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		

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§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 30 resident. The sample included 12 residents with five reviewed for unnecessary medications. Based on record review, observations, and interviews, the facility failed to provide a stop-date for Residents(R)25's as needed (PRN) antidepressant medication (class of medications used to treat mood disorders and relieve symptoms of depression) used as a sleep aid. This deficient practice placed R25 at risk for unnecessary medications and side effects.

Findings Included:

- The "Medical Diagnosis" section within R25's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), insomnia (difficulty sleeping), restless leg syndrome (a condition that causes an uncontrollable urge to move the legs, usually because of an uncomfortable sensation), heart failure, and acute kidney disease.

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A review of R25's "Quarterly Minimum Data Set (MDS)" dated 04/28/23 indicated a Brief Interview for Mental Status (BIMS) of 12 indicating mild cognitive impairment. The MDS indicated she could perform her activities of daily living (ADLs) independently. The MDS noted she took antidepressant, diuretic (medication to promote the formation and excretion of urine), and anticoagulant medications (medications that decrease your blood's ability to clot).

A review of R25's "ADL Care Area Assessment (CAA)" completed 11/15/22 indicated she required limited assistance from one staff for her ADLs. The CAA noted she was admitted after her hospitalization for heart failure and shortness of breath. The CAA indicated she used a walker for mobility and could ambulate with minimal difficulty.

A review of R25's "Psychotropic Medication CAA" completed 11/15/22 noted she was taking antidepressant medication related to her depression and insomnia. The CAA indicated a care plan would be developed related to her psychotropic (altering mood or thought) medication usage.

A review of R25's "Care Plan" created 11/29/22 indicated she was taking trazodone (antidepressant) for her insomnia. The plan instructed staff to administer her medication as ordered and monitor for adverse reactions such as mood changes, social isolation, suicidal thoughts, diarrhea, changes in gait/mobility, and weight loss.

A review of R25's EMR under "Physician's Order" revealed an order dated 04/10/23 for staff to

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F 758	Continued From page 48	F 758		

administer 50 milligrams (mg) of trazodone by mouth PRN for insomnia. The order lacked a stop date.

A "Pharmacy Review" note completed 05/31/23 indicated the consulting pharmacist (CP) identified R25's PRN trazadone medication had no stop date and reported it to the facility. The note lacked a response from the physician.

On 06/07/23 at 11:32AM R6 reported no concerns with her medications or care at the facility.

On 06/08//23 at 12:23PM Licensed Nurse (LN) H reported the pharmacy reviews were faxed to the facility and placed in the medical providers box for review. She stated once recommendations were made the nurses would make the changes. She stated psychotropic medication given PRN should have a 14 day stop date.

On 06/08//23 at 12:57PM Administrative Nurse D stated psychotropic PRN medications should have a stop date of 14 days unless determined differently by the medical provider. She stated the pharmacy show review each resident's psychotropic medications and note on the review the changes needed to occur.

A review of the facility's "Psychotropic Drug Monitoring" revised 01/2021indicated the facility will monitor all residents that received psychoactive medications for appropriateness of treatment, effectiveness, and potential adverse effects. The policy indicated all supporting documentation for these medications will be maintained in the medical records. The policy noted that deviation from the recommended

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F 758	Continued From page 49 dosage and criteria will be shown in the clinical record with supportive justification for appropriateness. The facility failed to implement a 14-day stop date on R25's PRN trazodone order or provide documentation showing clinical necessity to continue the medication. This deficient practice placed R25 at risk for unnecessary medications and side effects.	F 758		
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 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.	F 761		

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F 761	Continued From page 50	F 761		

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 30 residents. The census included 12 residents. Based on observation and interview the facility failed to ensure safe and secure storage of medications when staff failed to securely lock one medication cart when the staff member was away from the cart. This deficient practice placed the facility's five independently mobile, cognitively impaired residents residents at risk accidental ingestion of medication and adverse reaction.

Findings included:

- During the initial tour of the facility on 06/06/23 at approximately 07:15 AM a medication cart was near the doorway of room 173. This medication cart was not securely locked and was left unattended by Certified Medication Aide (CMA) R. Upon the return of CMA R to the cart, inspection of the cart revealed the medication cart contained numerous over the counter stock medications (medications that can be used without a prescription), and narcotic medication (medications or substances that relieves pain and induces drowsiness) cards that were locked in a lock box.

On 06/06/23 at 07:20 AM CMA R stated that she normally did keep her medication cart locked when she was away from it. CNA M stated she had stepped briefly into a resident's room to assist the resident and had not realized she had left her cart unlocked.

On 06/07/23 Licensed Nurse (LN) H stated medication carts contain the stock medication and narcotics. LN H stated each room had a

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F 761	Continued From page 51 small closet door that locked that contained the scheduled medications for each resident. LN H stated the medication cart should be kept locked when not being used or when the staff member was not in the area of the cart. On 06/08/23 at 01:15 PM Administrative Nurse D stated she expected the medication cart to be locked at all times unless the staff member was in the resident room/doorway getting ready to administer a resident their medication or standing at the medication cart documenting in the electronic medical record. The 01/21 facility "Medication Storage-Storage of Medications and Biologicals (a variety of products made from a variety of natural sources used to treat, prevent, or diagnose diseases and medical conditions) documented: Only licensed nurses, authorized pharmacy personnel, and those lawfully authorized (such as medication techs) to administer medications are allowed access to medications. Medication rooms, medication carts, and medication supplies are locked or attended by persons with authorized access. The facility failed to ensure the safe and secure storage of medications when staff failed to securely lock a medication cart when the staff member was away from the cart. This deficient practice placed the affected residents at risk for accidental ingestion of medication and the potential for adverse reactions.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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§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 30 residents with one kitchen and one kitchenette. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to storage of food and kitchenware. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.

Findings included:

- On 06/06/23 at 07:39 AM observation in the kitchen's dry food storage room revealed two opened loaves of bread. The bags were not dated.

On 06/06/23 at 07:41 AM observation in the kitchen's dry food storage room revealed two bags of opened hamburger buns. The bags were not dated, and one bag was open to air.

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F 812	Continued From page 53 On 06/06/23 at 07:48 AM observation in the kitchen's dry food storage room revealed one opened package of beef gravy mix. The package was not dated. On 06/07/23 07:24 AM an observation of the kitchenette revealed bowls stored on a tray, at the end of the countertop. The bowls were uncovered and not inverted. On 06/08/23 at 11:55 AM Dietary BB stated opened food should be labeled and dated. He further stated that staff were expected to label and date everything that they opened, and discard opened food, stored in the refrigerator, after three days. Dietary BB stated that soup bowls were stacked, and stayed out, next to the kettle, as they were often used. He stated that dishes that were not commonly used were often stored in a storage room upstairs. The facility's "Food Receiving and Storage" policy revised October 2018, documented food shall be received and stored in a manner that complies with safe food handling practices. The policy further documented all foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date). The facility failed to maintain sanitary dietary standards related to storage of food and kitchenware. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.	F 812		
F 851 SS=C	Payroll Based Journal CFR(s): 483.70(q)(1)-(5)	F 851		

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F 851	Continued From page 54 §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each	F 851		

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individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(q)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 30 residents. Based on interview, and record review the facility failed to submit complete and accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ), when the facility failed to submit staffing hour data for all nursing personnel by the required deadline.

Findings included:

- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2022 Quarter three documented the facility failed to have staff Registered Nurse (RN) hours on 04/16,22, 04/17/22, 05/28/22 and 06/11/22 for the quarter.

The "Time Detail Report" was reviewed from

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F 851	Continued From page 56 04/01/22 to 04/30/22 that revealed there was RN coverage on 04/16/22 for a total time of 13 hours. Review of the "Exempt Nursing Staff Schedule" for April 2022 revealed on 04/17/22 RN hours of 8.5 hours for Administrative Nurse LL. Review of the "Exempt Nursing Staff Schedule" for May 2022 revealed on 05/28/22 Administrative Nurse MM had eight hours RN clock time. Review of the "Exempt Nursing Staff Schedule" for June 2022 revealed a clock time of 11.5 hours for Administrative Nurse D on 06/11/22. On 06/08/23 09:48 AM Administrative Staff A stated during that time period (FY Quarter three) the facility had tried to re-submit the correct RN hours for that quarter, but were unable. Administrative Staff A stated that the facility corporate office was responsible for the submission of the nursing hours for the PBJ report. Administrative Staff A stated on 06/08/23 at 09:50 AM that the facility followed the guidelines set by CMS for nursing hour data submission for the PBJ report. The facility did not have a policy regarding submitting data to the PBJ. The facility failed to submit complete and accurate staffing information to the federal regulatory agency through PBJ by the required deadline.	F 851		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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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 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

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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 30 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to ensure staff practiced standard infection control practices regarding appropriate hand hygiene and the facility failed to store oxygen tubing, nasal cannula (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) and nebulizer mask in a sanitary manner. This placed the affected residents at risk for contagious illness.

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Findings included:

- On 06/06/23 at 10:58 AM R10's undated nebulizer mask hung unbagged from the call light cord attached to the wall. R10's undated nebulizer mask rested against the wall and was attached to the nebulizer machine on the floor next to the bed.

On 06/06/23 at11:53 AM Licensed Nurse (LN) G placed her hands in her jacket pocket after serving a plate of food to a resident. LN G then walked back to the dining serving area with hands in her pocket, removde her hands from her pcokets but did not perfomr hand hygiene. She grabbed a dessert bowl with food in the bowl from the counter and delivered the bowl to a resident no hand hygiene.

On 06/06/23 at 11:56 AM LN G returned to the dining room area, touched the back of resident's wheelchair, placed her hands back into her jacket pockets, then touched several dining rooms chairs, touched her phone, touched her face, and then touched other staff members hands, then hand sanitized and then placed her hands back into her pockets. LN G then removed her hands from her pockets and, without performing hand hygiene, delivered a plate of food to a resident.

On 06/07/23 at 08:51 AM R10 sat in her wheelchair next to the bed. The undated nebulizer mask was inside a clear trash bag which was inside a wash basin on the floor next the nebulizer machine on the floor next R10's bed.

On 06/08/23 at 07:53 AM R10's undated nasal cannula and oxygen tubing was wrapped around

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the oxygen cylinder, open to air, on the back of her wheelchair in the hallway outside her room.

On 06/08/23 at 12:02 PM Certified Nurse Aide (CNA) N stated the oxygen tubing should be stored in a bag which has a date on the outside of the bag. CNA N stated she was not sure how the nebulizer mask would be stored because the Certified Medication Aides and the nurse took care of those. CNA N stated hand hygiene should be preformed between serving each plate of food to the resident.

On 06/08/23 at 12:16 PM Licensed Nurse (LN) H stated oxygen tubing and nasal cannula was changed weekly and the nebulizer tubing and equipment should be changed weekly also. LN H stated the respiratory items should be stored on a clean surface or in a plastic bag. LN H stated respiratory items should be dated. LN H stated hand hygiene should be preformed when visibly dirty and between serving food.

On 06/08/23 at 12:56 PM Administrative Nurse D stated respiratory equipment should be changed weekly on the night shift. Administrative Nurse D stated respiratory items should not be stored on the ground or wrapped around the oxygen cylinder. Administrative Nurse D stated staff should wash hands with soap and water before serving food and between each resident, staff should hand sanitize.

The facility's "Handwashing/Hand Hygiene" policy dated 08/2019 documented staff could use an alcohol-based hand rub before and after eating or handling food. Before and after assisting a resident with meals.

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F 880	Continued From page 61 The facility failed to ensure staff practiced standard infection control precautions to prevent the spread of infection when staff failed to perform proper hand hygiene and the facility failed to store respiratory equipment in accordance with professional standards of practice for sanitary storage. This placed the affected residents at risk for contagious illness.	F 880		