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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey along with a Complaint Investigation (CI) MS #24972 at the facility from 9/9/24 through 9/11/24. During the survey, the SA determined that the facility was not in compliance with Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M610, M1020 and M1570. The SA determined the facility was not in compliance with CI MS# 24972 and cited M610 for failure to provide incontinent care and personal hygiene care.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Pattern Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide assistance with Activities of Daily Living (ADL's) for residents that were dependent on staff, as evidenced by not being shaved (Resident #43), missed bath	M 610	1.On 9/10/2024 Resident #43 was shaved by assigned CNA. On 9/10/2024 the Unit Manager cleaned and trimmed Resident #151 fingernails. On 9/10/2024 Resident# #59 received full bath from CNA #2. On 9/9/2024 the assigned CNA for Resident #68 on 9/7/2024 was terminated.	10/25/24

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M 610	Continued From page 1 (Resident #59), not performing timely incontinent care (Resident # 68, 351 & 352) and long dirty nails (Resident #151) for six (6) of seven (7) residents reviewed for ADL's. Resident #43, 59, 68, 151, 351 and 352. Cross Reference F725 Findings include: Record review of facility policy titled, "Shaving - Male and Female" dated 1/15, revealed, "Residents will be free of facial hairs - both male and female. If the resident is alert and oriented and requests not to be shaved, this will be noted in the Care Plan." Review of the facility policy titled "Bath/Shower-Dependent" with a revision date of 8/11 revealed, "Policy: A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident." Also revealed under, "Responsibility: Nursing Assistants or Licensed Nurses monitored by Charge Nurse." Review of the facility policy titled "Incontinent Care" with a review date of 1/15 revealed, "Policy: To provide routine, preventative skin, perineal care to residents after an incontinent episode." Also revealed under, "Responsibility: All Nursing Personnel." Record review of facility policy titled, "Fingernails/Toenails Care", dated 1/15, revealed, "The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections". Resident #43	M 610	On 9/9/2024 the assigned CNA for Resident #68 on 9/8/2024 received disciplinary action and in-service on providing ADL-Care, responding to call-lights, and customer service. On 9/9/2024 the assigned CNA provided incontinence care to Resident #351. On 9/9/2024 Resident # 352 received incontinent care by the assigned CNA. On 9/11/2024, the Unit Managers and Certified Nursing Assistant (CNA) made observation of all residents fingernails and completed 100% audit on all residents residing in the facility. Any issues identified was corrected upon observation. On 9/16/2024, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers made observation rounds and completed 100% audit on all residents residing in the facility to identify if any issues with Activities of Daily Living (ADL), any issues found was updated to residents plan of care and corrected. On 9/18/2024, the Unit Managers updated residents bath preference. 2. All residents who require staff assistance with Activities of Daily Living (ADL) have the potential to be affected. 3. On 9/9/2024, an educational in-service was initiated by Staff Development Coordinator (SDC) with all	

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M 610	Continued From page 2 On 9/9/24 at 10:50 AM, during an interview and observation , Resident #43 revealed her preference was to have her facial hair removed by shaving, and she had asked staff to assist her with this, but they had not. Facial hair was noted on resident's face. An interview and observation of Resident #43 on 9/10/24 at 11:50 AM, revealed facial hair on chin and lower jaw area. She stated she had a shower yesterday afternoon and she wanted her facial hair to be removed, but the staff did not do it. During an interview and observation in Resident #43's room on 9/10/24 at 12:05 PM, the resident informed the Director of Nursing (DON) that she wanted her facial hair shaved, but staff had not done this. The resident informed the DON she had a shower yesterday afternoon, but shaving was not done. The DON confirmed the resident, who required assistance with care, had facial hair present and did not receive the Activity of Daily Living (ADL) care for shaving, which was part of the grooming process, especially for a female resident. Record review of Task Record revealed Resident #43 had a bath on 9/9/24 at 8 PM. Record review of Resident #43's "Admission Record" revealed the facility admitted the resident on 12/18/2020. Diagnoses included Type 1 diabetes mellitus and arthritis. Record review of Resident #43's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/26/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had a mild	M 610	Licensed Nursing personnel regarding weekly skin assessments to include if nail care and facial hair shaving is needed. On 9/9/2024, an educational in-service was initiated by SDC with all Licensed Nursing personnel and Certified Nursing Assistants (CNA) on call lights, incontinent care, nail care and facial hair with residents bathing and grooming care. On 9/11/2024 the DON in-serviced and educated Unit Managers on making proper rounds and observation, and monitoring residents ADL-care, On 9/20/2024, the SDC in-serviced Physical Therapy Assistant (PTA) on reporting resident care issues and concerns to nursing supervisors and Director of Nursing (DON). On 9/20/2024, the SDC initiated in-service and educated all staff on answering call lights, and reporting residents needs to nursing supervisors when services can not be rendered. 4.Beginning week of 9/16/2024, the Unit Managers will make observation rounds on all residents on their unit, checking residents ADL Care for proper grooming, nail care, and baths weekly for eight weeks, then monthly for two months utilizing the ADL audit tool and bathing assessment tool. Beginning 9/23/2024, the audits will be given to the DON weekly for review, any issues and concerns will be	

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M 610	Continued From page 3 cognitive impairment. Resident #151 On 9/9/24 at 10:50 AM, an observation and interview with Resident #151 revealed fingernails were long (approximately one-half inch from nail bed) with a brown substance noted under nails. The resident stated she would love for her nails to be trimmed but no one had done it. On 9/10/24 at 4:15 PM, during an observation and interview with the DON and Resident #151 , the resident stated she wanted her nails to be trimmed. The DON confirmed the nails were long with a brown substance under each nail and nails were to be trimmed and cleaned to ensure skin was not scratched and to prevent infections and the facility failed to do this. Record review of Resident #151's "Admission Record" revealed the facility admitted the resident on 8/23/24. Diagnoses included Metabolic Encephalopathy, Type 2 Diabetes Mellitus, and Need for assistance with personal care. Record review of Resident #151's admission MDS with ARD of 8/30/24 revealed a BIMS score of 9 which indicated the resident was moderately impaired cognitively. Resident #59 An observation and interview on 9/9/2024 at 12:18 PM, with Resident #59 who stated, "I'm not going to lie on them or for them... I have not had a bath of any type since last Tuesday; They will wash my face, but that's it." He revealed he would love to be really cleaned up. This observation revealed the resident was a double above the	M 610	immediately addressed. The DON will forward weekly audits to the ED for further review. The ED will present the audit tools to the monthly Quality Assurance Committee beginning 10/23/2024 for four months for review and recommendation. The Quality assurance Committee (QA) will make recommendation for the continuation of audits or discontinuation based upon results achieved.	

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knee amputee and stated he needed assistance with his baths.

An interview on 9/10/2024 at 10:17 AM, with Certified Nurse Assistant (CNA) #1 confirmed that she was assigned to Resident #59, and he had told her he only gets a bath when she was on duty. She stated she knew that the resident complained to Licensed Practical Nurse (LPN) #1 last week about it, but was not sure what happened.

In an interview on 9/10/2024 at 12:10 PM, with LPN #1, confirmed that Resident #59 had complained to her about not receiving a bath on 8/31/24, but she did not report it to anyone, that she just discussed it with the resident.

Record review of documented baths for Resident #59 confirmed that the resident did not receive a bath on 8/31/2024. This documentation revealed the resident received a bed bath on 8/29/2024 with the next bath on 9/3/2024.

Record review of the "Admission Record" revealed the facility admitted Resident #59 on 11/14/2023 with a medical diagnosis of chronic venous insufficiency.

Record review of the Quarterly MDS with an ARD of 7/24/2024 revealed, under section C, a BIMS summary score of 13, which indicated Resident #59 was cognitively intact and in Section GG that the resident needs assistance with Activities of Daily Living (ADL's).

Resident #68

An observation and interview on 9/9/2024 at 10:20 AM, with Resident #68 revealed, she was

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sitting in her wheelchair in her room. The resident explained that both Saturday (9/7) and Sunday (9/8) she rang her call light and told the aide who came in that she was wet and needed to be changed. She revealed on both days the aide turned the call light off, said she would be back, and left the room without ever coming back. She revealed, last night, her sister called the facility and spoke with the nurse to report that the aide never came back. The resident explained that the nurse and another aide later came to change her. She revealed, "I sat in that urine for an hour."

On 9/10/2024 at 8:50 AM, in an interview with the DON revealed she was aware of both incidents that happened over the weekend with Resident #68. She explained that she met with the resident and her son yesterday. She revealed the aide who cared for the resident on Saturday (9/7) had been terminated. The DON revealed she spoke with the aide, and the aide stated that she changed the resident after breakfast and that every time she went back into the resident's room, the resident was asleep. The aide reported that she did not wake the resident to check her or provide incontinent care. The DON revealed that she terminated the aide because this was her second occurrence of not making rounds and leaving the residents soiled. She explained that the resident had a different aide on Sunday (9/8). The DON revealed that she met with the aide, and the aide stated that she answered the call light, cut it off, and told the resident she would be back, but never went back. She revealed the resident called her sister, who then called the facility and reported the issue. The DON revealed that during that time the aide had gone to break, and the aide stated that she had changed the resident before supper. The DON revealed the aide was written up and counseled on answering

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the call lights and rendering the care when needed, as this was her first offense. The DON confirmed her expectations were for the aides to make rounds on the residents every two (2) hours and as required, and render the necessary care needed.

An interview with Resident #68 on 9/10/2024 at 9:25 AM, revealed the aide assigned to her on Sunday (9/8) did not toilet or change her before supper. She explained that she waited until after supper and the trays were all picked up and pushed her call light to be changed. She stated the aide came in, turned the light off and said she would be back. The resident explained that after the aide did not return, she called her sister around 7:30 PM, who called the facility. She stated, "They don't come check on me every 2 hours; They say they do, but they don't." She stated, "They can't be lying on me because I have my mind."

An interview with the DON on 9/10/2024 at 1:21 PM, confirmed staff did not provide the necessary care for Resident #68. She revealed her expectations were for staff to answer the call lights and render the care that the resident needs in a timely manner. She explained that the aides were to make rounds every 2 hours and as needed to ensure the residents were clean and dry and to prevent skin breakdown.

An interview with Certified Nurse Aide (CNA) #4 on 9/10/2024 at 3:20 PM, revealed she had been employed at the facility for eight (8) months and worked 3-11 shift. She revealed on Sunday (9/8) she was assigned to Resident #68. She revealed she had the split section which included her working the top section of A and B hall. CNA #4 revealed she was in the middle of cleaning up

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another resident on another hall at the time Resident #68's light went off. She explained that she had stepped out of the other resident's room to get some clean linen when she answered Resident #68's light, turned it off, and told the resident she would be back. She stated she forgot to go back.

Record review of the "Admission Record" revealed the facility admitted Resident #68 on 8/19/2024 with a medical diagnosis of Chronic Combined Systolic and Diastolic Heart Failure.

Record review of the Admission MDS with an ARD of 8/26/2024 revealed, under section C, a BIMS score of 13, which indicated Resident #68 was cognitively intact.

Resident #351

On 9/9/2024 at 10:45 AM, observation of Resident #351 and interview with a family member revealed, he was sitting in a reclining wheelchair in his room. His eyes were open, and he was non-verbal. The resident was wearing a gray pair of jogger pants that were saturated through the groin area and in between the legs with urine. The family member revealed he was brought back from therapy like this, and nobody had been there since to check on him. The family member revealed the resident's bed was always wet with urine. She revealed the bed was soaked out this morning and had to be changed after they got him up. She stated, "They say they are changing him every 2 hours, but they are not because I am here, and they do not enter the room." She explained that the resident was wetting out his clothes and the bed with urine through a brief. The family member revealed when he was in bed, she positioned a pillow

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under his stroke affected arm, and it even got soaked with urine. She reiterated, "They are not changing him like they should be." She revealed she had been waiting on the resident's nurse to come back since 10:15 AM because she had some questions regarding the resident's fluid medication, but she had yet to come back.

On 9/9/2024 at 10:51 AM, an interview with CNA #5 revealed she got Resident #351 up this morning, but she was unsure what time. She stated the resident had been to therapy, and she did not realize he was back. She revealed therapy did not come and let her know he was back or that he was wet. CNA #5 revealed she makes rounds every 2 hours to see if the residents need changing. She confirmed the resident's bed linen had to be changed because it was wet this morning.

An interview with the DON on 9/10/2024 at 11:10 AM revealed, Resident #351 should be checked and changed every 2 hours and more if he needed it. She explained that he may be a heavy wetter and needed to be changed more frequently. The DON revealed if the resident was a heavy wetter, she could see that the resident could wet the bed. She revealed she was not aware of the family members' concerns regarding the resident's care, and stated those concerns were just brought to her attention yesterday.

Record review of the "Admission Record" revealed the facility admitted Resident #351 on 8/23/2024 with diagnoses including cerebral infarction.

Resident #352

On 9/9/2024 at 10:58 AM an observation and

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interview with Resident #352 revealed, he was lying in bed. There was a foul odor around the resident. The resident revealed, after he ate breakfast and took his morning medicine, it was 2 hours before someone could come to clean him up and change him. He stated, "They tell me they are working with somebody and will get to me when they can." He revealed the therapy man will even come to his room to take him to therapy, and he must tell him that he cannot go right now because he needs changing. The resident stated, "He (the therapy man) wouldn't want to sit like that, so he should understand." The resident stated he was still waiting to be changed today.

On 9/10/2024 at 11:50 AM, interview with the Physical Therapy Assistant (PTA) revealed, Resident #352 not being changed had been an issue since he had been working with him. He revealed he had only done about 4 sessions with the resident, and each time the resident would be dirty. The PTA revealed it took 2-3 hours before the resident got changed by the staff. He stated he usually goes down to the resident's room about 8:00-9:00 in the morning to start his session, but after the resident reports being soiled, he will push the resident's call light. He stated he also goes to hunt down someone to help change the resident, but nine times out of ten he cannot find anybody. The PTA stated yesterday he pushed the call light, and nobody ever came, so he went to the nurse and told her, and she went to change the resident.

An interview with the DON on 9/10/2024 at 2:52 PM, revealed she was not aware Resident #352 was not being changed in a timely manner. She stated that therapy had not reported anything to her. She revealed when an issue was brought to her attention, she would address it. The DON

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M 610	Continued From page 10 confirmed that the aides should be rounding on the residents every 2 hours and the residents should be changed in a timely manner. Record review of the "Admission Record" revealed the facility admitted Resident #352 on 9/3/2024 with diagnoses that included Osteomyelitis of vertebra, thoracic region. Record review of the Admission MDS with an ARD of 8/13/2024 revealed under section C, a BIMS score of 15, which indicated Resident #352 was cognitively intact.	M 610		