| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25A162 | A. BUILDING _____ B. WING _____ | 08/10/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHEARER-RICHARDSON MEMORIAL NURSING HOME | 512 ROCKWELL DRIVE OKOLONA, MS 38860 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual re-certification survey at the facility from 08/08/23 through 08/10/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies at F 600, F 636, F656, F677, F689, F699, and F791.<br><br>Census at the time of survey was 68 and the facility has beds for 73 residents. | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to prevent neglect by failing to provide goods and services to a resident to ensure that the resident received the necessary Activities of Daily Living (ADL) and oral care for one (1) of 17 residents sampled. | F 600 | Resident #34 was provided with Activity of Daily Living (ADL) that included oral care, nail care and the removal of facial hair during a "Teachable Moment" with NA#1 by the Quality Assurance Nurse (QA Nurse) on the day of discovery 8/8/23. On 8/10/23 a dental consult was scheduled | 9/2/23 |

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

Electronically Signed | 08/30/2023

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| F 600 | Continued From page 1<br>Resident #34.<br><br>Findings Include:<br><br>Record review of the facility policy titled Abuse, Neglect and Exploitation undated revealed, "Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation..."Policy Explanation and Compliance Guidelines: ... 2. ... Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being... 6. "Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress..."<br><br>An observation on 8/08/23 at 2:18 PM, of Resident # 34's room revealed the door was closed. The Survey Agent (SA) knocked and entered the resident's room, where he was observed lying in bed with his mouth open and eyes closed. An overpowering putrid (rotten) odor was present inside the room. The resident's tongue was observed with raised brown patches. The resident's teeth were observed to be in bad condition, with dark brown/black color to all teeth and red, inflamed gums. The resident's lower lip was raw, dry, and cracked with dried bloody patches. Long facial hair measured approximately 1/4 inch in length. The resident's nails were long, measuring approximately 3/8 inch in length from the tip of the fingers, with a brown substance underneath all the nails. The resident aroused to verbal stimuli and tried to communicate, but speech was low, unclear, and garbled. | F 600 | for 8/28/23 for Resident #34. The RN Charge Nurse completed an assessment on this resident dated 8/12/23, which included his current dental status of abnormal mouth tissue, cavities/broken teeth and an inflamed gum. As part of Resident #34's routine dental care Peridex has been added as of 8/23/23 in conjunction with the use of a Water Pick system 8/28/23 and that a licensed nurse will be required to perform his oral care daily as evident per documentation within the Medication Administration Record.<br><br>The dietary manager completed an observation round on 8/15/23 to identify residents with PEG tubes who could possibly be affected by the stated deficient practice. There were 3 of 25 residents identified that could have been been affected within this unit. The Director of Nurses completed a oral/dental evaluation on the three residents identified, with the findings of one resident already having a dental appointment, and the other two had no reason for a dental consult.<br><br>On 8/1/23 the facility has acquired a new nursing documentation module titled "Nursing Advantage" which should assist with licensed personnel in completing a more detailed comprehensive assessment related to dental/oral evaluation. With every required comprehensive assessment which includes the admission assessment, an annual comprehensive assessment and upon a significant change assessment, | |

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| F 600 | Continued From page 2<br><br>An observation and interview on 8/08/23 at 2:55 PM, with Nurse Assistant (NA) # 2 revealed she was working along with Certified Nurse Aide (CNA) # 1 to care for Resident #34. NA # 2 confirmed that she smelled an odor when she entered the resident's room and stated, "Mm-hmm, it smells like body odor." She revealed that she had washed the resident up today and had put on deodorant but did not give him a complete bath. She confirmed that she had not shaved him and stated, "I was scared to do that." She revealed that Resident # 34 had a bad odor coming from his mouth since he was admitted to the facility a couple of months ago. She revealed that when he came to the facility, he had old food (debris) that was caked on his teeth and stated, "His lips have been chapped like that since he came from the other place." She revealed that she had been applying baby oil to the resident's lips because his family had requested her to do that, but she had not applied anything on his lips today.<br><br>An observation and interview on 8/08/23 at 3:06 PM, with Certified Nurse Aide (CNA) # 1 revealed that the aides do not perform oral care for the residents with tube feedings and revealed that the nurses do it. She confirmed that they had not performed oral hygiene for Resident #34 today.<br><br>An observation and interview on 8/08/23 at 3:10 PM, with Registered Nurse (RN) #1 confirmed that there was a foul odor in Resident # 34's room and stated, "It's coming from his teeth." She revealed that they have worked on getting his teeth cleaner. She revealed that the resident came from another facility and had an excessive amount of buildup on his teeth. She revealed that | F 600 | beginning 8/23/23, the dental/oral section of any required comprehensive assessment will be reviewed by the will be reviewed by the Director of Nurses and/or the RN House Supervisor to ensure completion of dental evaluation, triggers are identified, interventions are appropriate and placed within the resident care-plan within 72 hours of admission. The DON will randomly observe 2 residents a day for at least 5 days a week to ensure adl assistance was provided as documented per care-plan. The RN Nursing Supervisor will be responsible to provide in-services to all nursing staff of the need and requirement to provide goods and/or services regarding ADL Care, with emphasis on oral care, fingernail care, and facial hair removal. As of 8/23/23, the RN Supervisor has in-serviced 46 of 54 nursing staff members, with the expectation of 100% compliance with the remaining nursing staff to be completed by 9/1/23. As of 8/22/23, systematic changes have been implemented regarding documentation of daily adl care by both the bath tech and the direct care giver for accountability of staff to attain, maintain services to a resident that are necessary. As of 8/23/23, the facility has developed a one-on-one mentor program that will be overseen by the Director of Nursing Services, which will assign a certified nursing assistant mentor to be assigned to all newly trained nursing assistants after completion of their certification program times 2 weeks to enhance their core knowledge, skills, comfort level, and | |

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| F 600 | Continued From page 3<br>the nurses and aides are both responsible for oral care on the resident and that oral care was part of the daily care that was supposed to be provided for the resident. RN #1 confirmed that the resident had raised brown patches on his tongue and a cracked lower lip with patchy areas of dried blood. She revealed that the aides should be using a lip moisturizer instead of baby oil to hydrate the lips. She confirmed that the resident's nails were long and dirty and stated, "The aides can cut and clean the nails as long as the resident is not a diabetic, and he is not." She confirmed that the resident had long facial hair and stated, "Yes, he is supposed to be shaved with his bath." The Survey Agent (SA) inquired who would be responsible for ensuring that all the needed care was provided for Resident #34, and she replied, "Well, I guess that would be me."<br><br>An observation and interview with the Director of Nursing (DON) on 8/08/23 at 3:20 PM, confirmed that Resident #34 had not been shaved, had long dirty fingers nails, and had a cracked lower lip with patchy areas of dried blood and raised brown patches to his tongue. She revealed that the aides and nurses are both responsible for the oral care and that the aides should be using a lip moisturizer on his lips, and he should be shaved daily. She revealed that the aides are responsible for cleaning the resident's nails and can cut them if the resident was not a diabetic. The DON revealed that the resident had come to the facility with his teeth and mouth in that condition and stated the odor was coming from his teeth. She confirmed that the resident had an excessive amount of "buildup" on his teeth.<br><br>An interview on 8/09/23 at 8:35 AM, with Registered Nurse (RN) # 1 revealed that the aide | F 600 | competency. At the end of the two weeks the new hire will be checked-off on performance/competency level by the QA Nurse and reviewed by the Director of Nurses to ensure compliance and continuation of employment. An in-service for all staff members on Resident Rights including the right to be free from Abuse & Neglect is scheduled for 8/29/23 by the local Ombudsman. Written material from the Attorney General's Office regarding Abuse and Neglect will be distributed to all staff as well with all staff members being in-serviced no later than 9/8/23. No staff member will be allowed to work after 9/8/23 till they receive the mandatory in-service regarding Abuse & Neglect. Social services was in-serviced by the Administrator on 8/16/23 on regarding her role as an advocate for the residents to ensure they receive necessary treatments as per resident rights, federal regulations, and dental services regarding benefits available to each resident.<br><br>A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, and Nursing Staff. The Focus Review will be to provide dental/oral services as needed and required as determined from a comprehensive assessment completed by licensed nurses, reviewed by the Director of Nurses, and referred to social services for scheduling of dental appointments as needed. Social services will be responsible to conduct interviews | |

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| F 600 | Continued From page 4<br>had tried to brush Resident # 34's teeth this morning and his gums began bleeding, and the resident became agitated and upset.<br><br>An interview with the Director of Nursing (DON) on 8/09/23 at 4:00 PM, revealed that the facility had not attempted to make Resident # 34 a dental appointment. She stated, "No, we have not." She revealed that the resident came to the facility with his teeth in bad condition and stated that the facility used to have a dentist who came out to the facility, but no longer does.<br><br>An interview with the Administrator (ADM) on 8/09/23 at 4:30 PM, revealed that it was the responsibility of the aides and the nurses to do oral care for Resident #34. She confirmed that the resident should be shaved, nails should be cleaned and trimmed, and the nurse should ensure that all the care was done. She stated, "It is a concern." She revealed that they have not made the resident a dental appointment and revealed she was made aware of the situation yesterday with his teeth and the odor.<br><br>An interview with Resident #34's Resident Representative (RR) on 8/09/23 at 8:30 PM, via telephone, revealed that she visited Resident #34 a couple of times a week. She revealed that she had witnessed a lack of oral hygiene and that she had discussed with the staff about getting some dental help for him. She stated, "I told them to get his teeth extracted, if that's what it took." She revealed that she had a conversation with the Social Worker (SW) on admission and was assured that he would get the dental care needed.<br><br>An observation of Resident #34's teeth with the | F 600 | with resident and/or family member (if resident is not interview-able) regarding resident/family Satisfaction with services provided regarding dental status and services beginning 9/1/23 and ending no later than 9/8/23 with all 6 individuals who was or could have been affected by deficient practice. Beginning 8/23/23 all new admissions with a Peg tube will have the same resident/family survey conducted within 14 days of admission by social services to ensure that deficient practice does not recur. Any negative remarks made by either party will be reported immediately to the administrator for further review and corrective measures if needed. The Quality Assurance Nurse, Director of Nurses and the RN House Supervisor will observe Residents for oral care being provided as evident of no mouth odor, no cracked/dry lips and no debris within mouth cavity on all Peg tube feeder at least weekly from 8/18/23-9/15/23, and then monthly for 2 months thru 11/10/23. The Quality Assurance Nurse will utilize the Dental Status and Services Critical Element Pathway to conduct staff interviews(nursing aides, nurse, DON, MDS Nurse and social services) with at least 35% of noted staff per month till 100% compliance is met beginning 8/15/23 and ending 11/15/23, with any negative findings to be reported immediately to the administrator and/or the DON for further corrective measures to be taken. The Quality Assurance Nurse will present at the weekly QAPI meeting times 4 weeks beginning 08/23/2023 thru | |

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| F 600 | Continued From page 5<br>Director of Nursing (DON) on 8/10/23 at 8:39 AM, confirmed the only actions taken by the facility since the resident was admitted was mouth care. She revealed that the facility was unable to look and determine what was going on with his teeth and revealed that the resident was a mouth breather and had an order for nothing by mouth (NPO) which caused his mouth to be drier. The DON described the resident's teeth as, "Dark with dark buildup at the base of all his teeth" but stated she was unable to state that his teeth were decaying. She revealed that she did not see any broken or missing teeth. The DON described the resident's lower gums as "Raw" and stated, "They probably just cleaned them, so they are irritated." She revealed that they have not made the physician aware of the oral/dental condition and stated, "No, we have not made him aware, but he had assessed him." The Survey Agent (SA) inquired if she could provide documentation to support the resident's dental status, and she replied, "It should be there." The DON did not provide any documentation to support the residents' oral/dental status to the SA.<br><br>An interview with the Social Worker (SW) on 8/10/23 at 8:50 AM, revealed that the resident was admitted from another facility and stated that during her admission assessment with the RR that dental care was never discussed. She revealed that the residents' Supplemental Security Income (SSI) does not pay for the dental company that the facility will be in contract with for dental care.<br><br>Record review of the Order Summary Report revealed an order dated 6/21/23, "NPO (nothing by mouth) diet tube feeding texture related to Cerebral Infarction, Dysphagia." Also revealed an | F 600 | 09/13/2023 then monthly for two months beginning 09/20/2023 endign on 11/15/2023. The QA Committee met on 8/23/23 with the Medical Director attending and discussed survey results and Performance improvement Plan with next QAPI meeting scheduled for 9/1/23 and 9/8/23 and reviewed with the QA Committee on 9/01/23. The Administrator will be responsible for reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded within the documented minutes. | |

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| F 600 | Continued From page 6 | F 600 | | |

order dated 6/21/23, "Enteral Feed Order every day and night shift Clean mouth with swabs."

Record review of Resident # 34's Nurse Progress Notes dated 6/21/23 through 8/10/23 revealed no documentation regarding the residents' oral/dental status.

Record review of Resident # 34's Nursing Admission Screening/History dated 6/21/23 revealed under, "6. MOUTH" none of the boxes were checked to describe the resident's oral condition or history.

Record review of the Physician's Progress Notes dated 6/29/23 and 7/06/23 revealed no documentation regarding the condition of Resident #34's oral/dental status.

Record review of the Admission Record revealed Resident # 34 was admitted to the facility on 06/21/23 with medical diagnoses that included Cerebral Infarction, Unspecified Dementia, Dysphagia, Hemiplegia and Hemiparesis Affecting Right Dominant Side and Gastrostomy Status.

Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/27/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident is severely cognitively impaired. Also revealed under Section G, the resident requires total dependence for personal hygiene and revealed under Section L, "None of the above were present" which indicated Resident # 34 did not have any oral/dental status concerns.

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| F 636 | Continued From page 7 | F 636 | | |
| F 636 SS=D | Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) | F 636 | | 9/2/23 |

§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in

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| F 636 | Continued From page 8<br>assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, record review and facility policy review, the facility failed to accurately complete the oral/dental section of the admission comprehensive assessment on a resident with dental concerns for one (1) of five (5) residents reviewed for activities of daily living (ADL) care. Resident # 34<br><br>Findings include:<br><br>Review of the facility policy titled Minimum Data Set (MDS) 3.0 Completion with a revision date of 3/10/23 revealed under, "Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to | F 636 | Resident #34 was reassessed by RN charge Nurse on 8/12/23 for current dental status, with indicators of abnormal mouth tissue, cavities and or broken teeth, inflamed or bleeding gums, oral cavity being clean, with a dental appointment scheduled for 8/28/23. Resident #34's care-plan has been updated to include his dental consult and the needs for his oral care. As part of Resident #34's routine dental care, he has been assessed for additional treatment of Peridex Solution and a Water Pick system beginning 8/23/23. Beginning 8/23/23 the assigned licensed nurse will be | |

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| F 636 | Continued From page 9<br>develop an interdisciplinary care plan." ...<br><br>Record review of the facility policy titled Conducting an Accurate Resident Assessment with a revision date of 3/29/23 revealed, "Policy: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas...Policy Explanation and Compliance Guidelines: ... 2. Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record .... 5. Information provided by the initial comprehensive assessment establishes baseline date for the ongoing assessment of resident progress." ...<br><br>Record review of the admission MDS with an Assessment Reference Date (ARD) of 6/27/23 revealed under section L, "None of the above were present" which indicated Resident # 34 did not have any oral/dental status concerns.<br><br>During an observation on 8/08/23 at 2:18 PM, of Resident # 34's room revealed the door was closed and as the room was entered it was observed that the resident was lying in bed with his mouth open and eyes closed. An overpowering putrid (rotten) odor was present inside the room. The resident's tongue was observed with raised brown patches and the residents' teeth were observed to be in bad condition, with dark brown/black color to all the teeth with red, inflamed gums.<br><br>During an observation and interview with the | F 636 | responsible for providing the mouth care to Resident #34, with documentation to be recorded on the Medication Administration Record.<br><br>The MDS Nurse on 8/15/23 audited 68 medical records and determined that 37 out of 68 residents, plus any new admission could possibly be affected by the stated deficient practice.<br><br>On 8/1/23 the facility has acquired a new nursing documentation module titled "Nursing Advantage" which should assist with licensed personnel in completing a more detailed comprehensive assessment related to dental/oral evaluation. With every new admission beginning 8/23/23, the dental/oral section of the Clinical Admission Assessment will be reviewed by the Director of Nurses and/or the RN House Supervisor to ensure completion of dental evaluation, triggers are identified, interventions are appropriate and placed within the resident care-plan. Beginning 8/16/23 and ending 9/1/23, the RN Nursing Supervisor will be responsible to provide in-services to all licensed nurses on the need to complete the dental/oral evaluation in its entirety on admission, annually, and with a significant change in condition as outlined per federal guidelines and the Resident Assessment Instrument guidelines. Beginning 8/23/23 the MDS Nurse will be responsible for completing Section "L" of the MDS for accuracy of the dental condition of a resident, utilizing the MDS schedule. The | |

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| F 636 | Continued From page 10<br>Director of Nursing (DON) on 8/08/23 at 3:20 PM, revealed that the resident had come to the facility with his teeth and mouth in that condition and stated the odor in the room was coming from his teeth and confirmed that the resident had an excessive amount of "buildup" on his teeth.<br><br>In an observation and interview with the Director of Nursing (DON) on 8/10/23 at 8:39 AM, of Resident # 34's teeth revealed she described the condition of resident's teeth as, "Dark with dark buildup at the base of all his teeth," with his lower gums as, "Raw" and she stated, "They probably just cleaned them, so they are irritated."<br><br>An interview with MDS Nurse on 8/10/23 at 9:45 AM, confirmed there was not any documentation in Resident #34's medical record that revealed he had poor oral/dental status. She revealed, although the floor staff were aware of his dental condition, they did not document it or report it to her, so therefore, the MDS was not captured accurately, nor was a care plan developed. She revealed she reviewed all the medical record documentation including the admission assessment to accurately complete the MDS and the assessment should accurately reflect the resident's status to provide the best quality of care and it does not.<br><br>Record review of Resident # 34's Progress Notes dated 6/21/23 through 8/10/23 revealed no documentation regarding the residents' oral/dental concerns.<br><br>Record review of Resident # 34's Nursing Admission Screening/History dated 6/21/23 revealed under, "6. MOUTH" none of the boxes were checked to describe the resident's oral | F 636 | completed dental evaluation will be reviewed by the Director of Nurses and/or the RN House Supervisor within 72 hours of admission to ensure completion, interventions are appropriate and entered within the medical record.<br><br>A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, Nursing Staff, and the Quality Assurance Nurse.<br>The Focus Review will be to provide dental services as needed and required as determined by a comprehensive assessment by licensed nurses, reviewed by the Director of Nurses, referral made to social services to ensure outside appointments for dental services are scheduled, documented and maintained within the medical record. The completed dental evaluation will be reviewed by the Director of Nurses and/or the RN House Supervisor within 72 hours of admission to ensure completion, interventions are appropriate and entered within the medical record beginning 8/18/23, weekly, for 3 months ending 11/15/23.<br>The Quality Assurance Nurse will review monthly beginning 8/18/23 and ending 11/15/23 at least 10% of completed admission dental assessments to ensure compliance is met regarding their dental assessment for any indicators of dental services being acted upon, and remains compliant as outlined on the Dental Service Critical Pathway. Findings from completion of the Dental Service Pathway | |

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| F 636 | Continued From page 11<br>condition or history.<br><br>Record review of the Admission Record revealed Resident #34 was admitted to the facility on 6/21/23 with medical diagnoses that included Cerebral Infarction, Unspecified Dementia, Dysphagia, Hemiplegia and Hemiparesis Affecting Right Dominant Side and Gastrostomy Status. | F 636 | will be reported during the Quality Assurance Performance Improvement Program weekly by the Quality Assurance Nurse beginning 8/25/23. The Quality Assurance Nurse will utilize the Dental Status and Services Critical Element Pathway for 3 months beginning 8/15/23 to measure compliance with oral care as outlined and report any negative findings to the Quality Assurance Committee during the facility's Quality Assurance meeting scheduled for 9/1/23, with the Medical Director in attendence. The stated deficiency was presented during the current month meeting on 8/23/23 with the Medical director in attendance. The Administrator will be responsible for reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded within the minutes. | |
| F 656 SS=G | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as | F 656 | | 9/2/23 |

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| F 656 | Continued From page 12<br>required under §483.24, §483.25 or §483.40; and<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review and facility policy review the facility failed to develop and implement a person-centered care plan for residents requiring assistance with Activities of Daily Living (ADL) (Residents #4, #6, #27, and #35), a resident requiring assistance with transfers using a lift (Resident #53), a resident | F 656 | On the day of discovery 8/8/23 Resident #6 had his ADL care addressed which included a shave, fingernails trimmed. Resident #6's care plan was updated on 8/9/23 to his preference of having his goatee and moustache but all other portions of his face to be clean-shaved, | |

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| F 656 | Continued From page 13 | F 656 | | |

with a diagnosis of Post-Traumatic Stress Disorder (Resident #47), and a resident requiring dental services and ADLs, (Resident #34) for seven (7) of 19 resident care plans reviewed.

Findings included:

Review of the facility policy titled, "Comprehensive Care Plans" with a revision date of 3/10/23, revealed, it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

Resident #6

Record review of Resident #6's care plan revealed the resident's need for assistance with ADL's related to Hemiplegia resulting from a car accident. Interventions related to the care plan included "fingernail care daily (if needed)" and to "check nail length and trim and clean as necessary". Record review of care plan revealed there were no interventions in place for shaving.

On 8/8/23 at 2:30 PM, an observation and interview with Resident #6 revealed long and bushy facial hair on his face, chin, mustache, under the chin and jaws, on lower cheeks, and neck. He stated he liked having a mustache and a goatee, but he prefers to be clean-shaven on the rest of his face and neck. His fingernails were noted to be long, approximately 1/3 inch from the nailbed and he stated he would like for his fingernails and toenails to be trimmed since fingernails trimmed at least weekly by the bath aide and cna's as necessary. Resident #53 had an updated lift assessment completed on 8/15/23 by the RN Restorative Nurse and compared to the resident current care-plan to ensure proper transferring device is utilized. Resident #4 facial hair was removed on the day of discovery 8/8/23, with her care plan updated on 8/9/23 to include her need to have her facial hair removed at least weekly during bath time and on alternate days by floor staff if needed. Resident #47's care-plan was updated on 8/9/23 by the MDS Nurse to include PTSD and potential triggers, with notification to be made with the psyche nurse practitioner. Resident #27's care plan was updated on 8/9/23 by the MDS Nurse to include her transferring needs and her ability to get out of bed when she is compliant and noncombative, fingernail care to be performed at least weekly during bath time and by hall staff on alternate days if needed, staff to observe for dirty nails and clean as necessary due to her eating snacks through out the day and is not able to identify the need for cleanliness. On 8/9/23 Resident #34 had ADL care provided for him on the day of discovery by the QA Nurse and nursing assistant which included shaving, mouth care, and cleaned and trimmed fingernails. Resident #35 was given a shower on the day of discovery 8/9/23 by a certified nursing assistant with his care plan updated on 8/9/23 to include his preference on bath time of three days a week and fingernail care to be given at

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| F 656 | Continued From page 14<br>they were too long. He stated he had mentioned these things to someone on staff, but he was unsure who that was and stated he needed the staff's assistance at this time, but hoped he could eventually do these things independently.<br><br>An interview with the Minimum Data Set (MDS) Registered Nurse (RN) on 8/9/23 at 4:10 PM, stated the care plan should reflect the needs of the residents and the care on the care plan is transferred to the Kardex so the staff will know what care is required. She confirmed the facility failed to follow the care plan for the fingernail care daily (as needed) and to check nail length and trim and clean nails as necessary. The facility also failed to develop a person-centered care plan for the resident's preference for mustache/goatee and otherwise a clean-shaven face.<br><br>An interview with the Director of Nursing (DON) on 8/10/23 at 9:40 AM, revealed the resident is cognitive and able to make his requests known. She stated his care plan should be reflective of his preferences and his preferences should be honored and confirmed the facility failed to do that when he was not groomed the way he preferred.<br><br>Record review of Resident #6's Admission Record revealed the resident was admitted to the facility on 5/18/23. His diagnoses included Hemiplegia, Personal History of Traumatic Brain Injury, Lesion of Ulnar Nerve, Left Upper Limb, Chronic Pain, Unilateral Primary Osteoarthritis of Left Knee.<br><br>Record review of MDS with Assessment Reference Date (ARD) of 5/25/23, revealed a | F 656 | least weekly during bath time and on alternate by staff as needed.<br><br>The MDS Nurse audited 68 of 68 charts on 8/15/23 to identify residents who need staff's assistance to perform ADL Care. 59 of 67 residents could have been affected by the stated deficient practice.<br><br>All residents care plans will be reviewed and updated as necessary with their next scheduled MDS by the interdisciplinary Team which includes the MDS Nurse, Social Worker, Dietary Manager, and the Activity Director beginning 8/14/23. Beginning 8/16/23 thru 9/1/23, the RN Supervisor will in-service nursing staff to the need and requirement to perform Adl's to a resident as outlined in their individual care-plan.<br><br>A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, Nursing Staff, and the Quality Assurance Nurse. The Focus Review will be to update the care plan to include personal preference and the level of assistance needed by staff to assist with their daily Adl's as evident by documentation of Adl's within the Point of Care program. The Quality Assurance Nurse, will audit Adl performance as outlined in the ADL Critical Element Pathway and presented weekly at the scheduled QAPI meeting beginning 8/23/23 times 4 weeks thru 9/13/23, and then monthly times two | |

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| F 656 | Continued From page 15<br>Brief Interview of Mental Status (BIMS) of 15 indicating resident was cognitively intact.<br><br>Resident #53<br><br>Record review of "Care Plan" with an onset date of 3/27/23, revealed the resident needed assistance with ADL care and for transfers she was listed as "Transfer: the resident is totally dependent on 2 (two) staff for transferring" and "the resident requires Mechanical Lift (Vander) with 2 staff assistance for transfers."<br><br>Record review of "Care Plan" with review start date of 6/30/23, revealed the resident needed assistance with ADL care and for transfers she was listed as "Transfer: the resident requires Mechanical Lift (Vander) with 2 staff assistance for transfers."<br><br>Record review of Physician's Order dated 6/16/23, revealed an order for x-ray of left shoulder related to acute pain. Record review of "Patient Results" of left shoulder x-ray from local hospital dated 6/16/23, revealed, "Findings: Bone - There is a nondisplaced fracture involving the neck of the left humerus. There is no definite dislocation identified. There is mild angulation of the humeral head laterally. Intact AC joint".<br><br>The MDS Registered Nurse (RN) revealed in an interview on 8/10/23 at 8:45 AM, the resident was care planned for a total lift for transfers and it was changed to a sit to stand lift, and after her shoulder incident, she was changed back to a total lift. She printed off the previous care plans and noted on the care plans, only the Vander Lift (full body lift) was listed for transfers. She stated that the Vera Lift (sit to stand lift) had to be on the | F 656 | months beginning 9/14/23 and ending on 11/15/23. The DON and/or RN Supervisor will monitor care plans weekly times 12 weeks beginning 08/18/2023 thru 11/17/2023 and will present results of audit at the weekly QAPI meeting beginning 08/25/2023 times 3 months ending 11/24/23. The Quality Assurance Nurse will report any negative findings to the Quality Assurance Committee during the facility's Quality Assurance meeting scheduled the third week of each month with the attendance of the Medical Director. The next scheduled Quality Assurance meeting will be conductd on 09/01/2023 with the Medical Director. The Administrator will be responsible for reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded in the documented minutes. | |

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care plan at some point since she could see a resolved date for the Vera Lift after the resident's incident. She stated she is unable to locate the care plan that listed the sit-to-stand lift in the system, but she can see that it was resolved.

An interview with the Director of Nursing (DON) on 8/10/23 at 9:10 AM, revealed the full body lift was currently being used, but for a period the sit-to-stand lift was being used. When asked about the care plan indicating the full body lift was to be used for transfers, she responded that she is uncertain why that one is listed since she had been using the sit-to-stand lift and was able to bear some weight and was doing well with transfers. She pulled the most recent lift assessment dated 12/21/22 and it revealed the resident required a Vander Lift or other full mechanical lift which is a full body lift and not a sit to stand lift. She stated the residents are assessed annually for the type of lift required. She confirmed the most recent assessment determined the need for the total lift, and at the time of the resident's injury, the wrong lift was used for her transfer. She confirmed the care plan was inaccurately developed for a brief time frame of the resident's stay and it was not being implemented properly since only a full body lift should have been used according to this resident's lift assessment.

During an interview with MDS RN and DON on 8/10/23 at 10:30 AM, the MDS RN revealed that after reviewing the "Care Plan" and "Kardex" for this resident, she had determined that at some point between 4/15/23 and 5/15/23, the Vera Lift (sit to stand lift) was added to the care plan since it shows up on the "Kardex." She stated the information on the Kardex comes from the "Care

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Plan", so it had to be added to the Care Plan for it to trigger on the Kardex. She stated from what can be determined on the Kardex/Care Plan, it appears that the sit-to-stand lift was added on 5/5/23 and removed on 6/16/23 (after the incident involving the fracture of the left humerus), and the full lift was put in on 1/5/22 and was never removed. The DON confirmed the most recent assessment was for a total lift, so, the total lift should have been the one used.

Record review of Resident #53's "Admission Record" revealed the resident was admitted to the facility on 12/21/21 with diagnoses included Wedge Compression Fracture of first and second Lumbar Vertebra, Hypertension, Cerebrovascular Disease, Muscle Weakness, Moderate Protein-Calorie Malnutrition, and Paroxysmal Atrial Fibrillation.

Record review of Resident #53's MDS with ARD of 6/20/23, revealed a BIMS of nine (9) indicating the resident is mildly cognitively impaired.

Resident #4

Record review of Resident #4's care plans revealed a care plan indicating the resident needed assistance with bathing.

An observation on 08/08/23 at 11:25 AM revealed that Resident #4 was sitting up in her wheelchair in the dining area with approximately 10 gray hairs in random areas of the chin and cheeks that were approximately 1 inch long.

In an observation and interview on 8/8/23 at 4:30 PM with Certified Nurse Assistant (CNA) #11 confirmed that Resident #4 had several long hairs

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on her chin and cheeks that needed to be removed. She revealed she is unsure if she is supposed to shave the resident or use a tweezer to remove the hairs. She revealed that facial hair removal should occur when the resident gets a bath and that she does not recall being told which way to remove facial hair on female residents and has not ask, but admitted it needed to be removed.

An interview on 8/9/23 at 4:20 PM with the DON confirmed that females should have facial hair removed during their bath unless they refuse, and that CNA's have been taught that. She confirmed that the residents care plan regarding ADL assistance had not been implemented properly.

Record review of Resident #4's "Admission Record" revealed the resident was admitted to the facility on 02/10/23 with medical diagnoses that included Dementia and Need for Assistance with Personal Care.

Record review of Resident #4's MDS with an ARD of 5/17/23 revealed in Section C a BIMS score of 04, which indicated the resident is severely cognitively impaired. This review revealed in Section G that the resident needed assistance from staff to complete "Personal Hygiene" and 'Bathing."

Resident #47

Record review of Resident #47's medical diagnoses revealed an admitting diagnosis of Post Traumatic Stress Disorder (PTSD).

Record review of Resident #47's care plans revealed the resident did not have a care plan

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regarding PTSD.

During an interview on 8/9/23 at 11:45 AM with the MDS RN revealed that she is responsible for doing most all the care plans. She revealed that she discovered a few weeks ago that the resident had a diagnosis of PTSD even though she had been the one to code that diagnosis on the resident's MDS. She confirmed that she realized it was on her admitting diagnoses and stated, but that was just a history. She confirmed that the resident did not have a care plan regarding PTSD but should have and that she did not actually do this resident's care plans but sees now that she should have gone back and checked the record. When asked if she knew what triggered the resident's PTSD, she stated "No." She confirmed that care plans direct care to make sure the resident gets all the care they need. When asked if a care plan would have helped the staff to know what triggers the resident she stated, "Yes."

On 8/9/23 at 1:36 PM, interview with the Licensed Social Worker (LSW) revealed that a care plan lays out the specific care provided for the residents. She confirmed that the resident needed a PTSD care plan.

On 8/9/23 at 2:18 PM, interview with the DON stated that she did not realize that the resident had a diagnosis of PTSD on admission to the facility and confirmed that the resident should have had a care plan to address this diagnosis.

Record review of Resident #47's "Admission Record" revealed the resident was admitted to the facility on 1/7/21 with medical diagnoses that included PTSD.

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Record review of Resident #47's MDS with an ARD of 5/4/23 revealed in Section I that the resident had a diagnosis of PTSD and in Section C a BIMS of 11, which indicated the resident is moderately cognitively impaired.

Resident #27

Record review of Resident #27's care plan revealed the "Resident needs assistance with ADL related to (r/t) Dementia and physical limitations. Fingernail Care Daily (if needed) and (Resident's name) is to be gotten out of bed daily and dressed and brought out of her room."

An observation on 08/08/23 at 10:50 AM, revealed Resident #27 was lying in bed with fingernails on bilateral hands were approximately one-half (1/2) inch long and jagged past the fingertips and a brown substance was under the nails.

An observation and interview on 08/08/23 at 3:10 PM the DON confirmed that the nails were long and jagged and had a brown substance under her nails and it appeared as if they hadn't been cleaned in a while.

In an interview on 08/09/23 at 4:00 PM with RN #1 revealed the resident has a special wheelchair for her, but we don't get her up every day, it's usually about two or three times a week. The SA inquired about Resident #27's ADL care plan and RN #1 confirmed after pulling the CNA Kardex that the resident is to be gotten out of bed daily and dressed and brought out of the room. RN #1 revealed I didn't know that was in her plan of care. RN #1 revealed the aides must click on it every day and document whether she was gotten

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up or not.

An interview on 08/09/23 at 4:15 PM, with CNA #3 confirmed the plan of care was not being followed regarding getting the resident up daily. She revealed I didn't know it was in there.

An interview on 08/09/23 at 4:35 PM, the DON confirmed Resident #27's care plan regarding nail care and getting the resident out of bed daily was not followed and it should have been. She revealed she wasn't aware of Resident #27 being out of bed daily but confirmed it was on the CNA's Kardex.

An interview on 08/10/23 at 10:30 AM, with CNA #4 revealed she did document that she got Resident #27 up yesterday, but I documented in error and did not get her up. She revealed she wasn't aware that the resident needed to be up every day but confirmed that it did show up on the Kardex to be signed off daily.

An interview on 08/10/23 at 10:40 AM, with CNA #5 revealed I think the last time she got up was sometime last week we haven't been getting her up every day.

A record review of Resident #27's "Admission Record" revealed the resident was admitted to the facility on 03/17/22 with diagnoses that include Metabolic Encephalopathy, Unspecified Dementia, Peripheral Vascular Disease, and Generalized Anxiety Disorder.

Record review of the MDS with an ARD of 07/20/23, revealed the resident is rarely/never understood which indicated the resident has severe cognitive impairment.

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Resident #34

A record review of the care plan for Resident #34, date initiated 7/10/23, revealed "Focus: The resident needs assistance with ADL r/t (related to ) stroke ...Interventions: BATHING/SHOWERING: The resident is totally dependent on 1 staff for bathing. Check nail length and trim and clean as necessary ...PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assistance of 1 staff with personal hygiene and oral care ..."

An observation on 8/08/23 at 2:18 PM, of Resident # 34 revealed long nails that measured approximately 3/8 inch in length from the tip of the fingers, with a brown substance underneath and raised brown patches on his tongue. An overpowering putrid (rotten) odor was present inside the room. The residents' teeth were observed to be in bad condition, with dark brown/black color to all the teeth and red, inflamed gums.

An observation and interview with the DON on 8/08/23 at 3:20 PM, confirmed that Resident #34 had long dirty fingers nails, and raised brown patches on his tongue and it appeared that he had not received oral or nail care lately.

An interview on 8/10/23 at 9:45 AM, with the MDS nurse confirmed that there was not a care plan developed for the resident's dental condition and that the staff was not aware of the problem with his teeth. She confirmed that the staff did not follow the care plan for cleaning and trimming the residents' nails and stated, "If it's on there to be done, they are supposed to do it." She

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acknowledged nail care was part of the standard care the aides should provide.

Record review of the "Order Summary Report" revealed an order dated 6/21/23, "NPO (nothing by mouth) diet tube feeding texture related to Cerebral Infarction, Dysphagia." Also revealed an order dated 6/21/23, "Enteral Feed Order every day and night shift Clean mouth with swabs."

Record review of the "Admission Record" revealed Resident # 34 was admitted to the facility on 06/21/23 with medical diagnoses that included Cerebral Infarction, Unspecified Dementia, Dysphagia, Hemiplegia and Hemiparesis Affecting Right Dominant Side and Gastrostomy Status. Review of the MDS with an ARD date of 6/27/23 revealed under section G, Resident #34 required total dependence for personal hygiene.

Resident #35

Record review of Resident #35's care plans revealed, under, "BATHING/SHOWERING: The resident requires extensive assist from 1 staff with bathing. Check nail length and trim and clean as necessary. HE HAS REQUESTED TO HAVE A SHOWER DAILY."

An observation and interview on 08/08/23 at 11:07 AM, revealed Resident #35 stated that the facility was not bathing him but once a week. The resident revealed his bath day was yesterday, but he did not get one. The resident stated, "I want my nails cut too." Observed long nails on both hands that measured approximately 3/8 inch in length.

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An observation and interview on 8/8/23 at 3:25 PM, with RN #2 confirmed that Resident #35 had long nails and it could cause skin injury. RN # 2 asked Resident #35 if he got a shower yesterday, and the resident replied, "No, I didn't." She revealed that the resident was a diabetic, so she would have to cut his nails.

An interview with the DON on 8/09/23 at 11:30 AM, revealed she had spoken with the aide assigned to the resident to give him a shower on Monday. She confirmed that the aide did not give the resident a shower.

An interview with the DON on 8/9/23 at 11:32 AM, revealed she was not aware that Resident #35 was care planned for a daily shower. She stated, "I didn't know." She confirmed that the resident had not been receiving daily showers routinely and agreed that the care plan was not followed.

An interview with the MDS Nurse on 8/10/23 at 9:45 AM, revealed that the staff did not follow the care plan by not giving the resident a daily shower or provide needed nail care. She confirmed that the ADL had not applicable (N/A) documented, which revealed a daily shower had not been done.

Record review of the August ADL bathing task for Resident #35 revealed under 8/01/23, 8/03/23, 8/04/23, 8/06/27, 8/07/23, and 8/08/23, "Not Applicable (N/A)" was checked indicating the resident did not receive a daily shower.

Record review of the "Admission Record" revealed that Resident #35 was admitted to the facility on 6/26/23 with medical diagnoses that included Type 2 Diabetes Mellitus, Major

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| F 656 | Continued From page 25<br>Depressive Disorder, Gastro-Esophageal Reflux Disease, Acquired Absence of Left Leg Below Knee and Acquired Absence of Right Leg Above Knee.<br><br>Record review of the MDS with an ARD of 7/12/23 revealed under section C a BIMS score of 10, indicating Resident # 35 is moderately cognitively impaired. Also revealed under section G, the resident requires one-person physical assist with personal hygiene and is totally dependent for bathing. | F 656 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff and resident interviews, record review, and facility policy review the facility failed to remove facial hair, bathe, shave, and perform nail and oral care for residents requiring assistance with their Activities of Daily Living (ADL) for five (5) of 19 sampled residents reviewed for ADLs. Resident #4, Resident #6, Resident #27, Resident #34, and Resident #35<br><br>Findings Include:<br><br>Record review of the facility policy titled Activities of Daily Living (ADLs) with a revision date of 3/10/23 revealed under, "Policy: ... Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, | F 677 | On the day of discovery 8/8/23 Resident #6 had his ADL care addressed which included a shave, fingernails trimmed. Resident #6's care plan was updated on 8/9/23 to his preference of having his goatee and moustache but all other portions of his face to be clean-shaved, fingernails trimmed at least weekly by the bath aide and cna's as necessary. Care-plan revised on 8/23/23 regarding dental care by a licensed nurse with additional treatment plan. Resident #4 facial hair was removed on the day of discovery 8/8/23, with her care plan updated on 8/9/23 to include her need to have her facial hair removed at least weekly during bath time and on alternate | 9/2/23 |

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grooming and oral care." Also revealed under, "Policy Explanation and Compliance Guidelines: ... 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." ...

Record review of the facility policy titled NAILS, CARE OF (FINGER AND TOE) undated revealed, "BASIC RESPONSIBILITY: LICENSED NURSE PERFORMS THE PROCEDURE ON HIGH-RISK RESIDENTS. NURSING ASSISTANTS MAY PERFORM THE PROCEDURE IF THE RESIDENT IS NOT AT RISK FOR COMPLICATIONS OF INFECTION...PURPOSE 1. To provide cleanliness 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems..."

Resident #6

An observation and interview with Resident #6 on 8/8/23 at 2:30 PM, revealed long and bushy facial hair on his face, chin, mustache area, under chin and jaws, on lower cheeks, and neck. He stated he liked having a mustache and a goatee, but he prefers to be clean-shaven on the rest of his face and neck. His fingernails were noted to be long, approximately 1/3 inch from nailbed and he stated he would like for his fingernails and toenails to be trimmed since they were too long.

During an interview on 8/8/23 at 3:00 PM, Certified Nursing Assistant (CNA) #10 revealed the resident had excess facial hair on his lower jawbone, under his chin, and on his neck. She stated this resident had been in the hospital and had moved from another hall of the facility and has been back from the hospital for a few days.

days by floor staff if needed. Resident #27's care plan was updated on 8/9/23 by the MDS Nurse to include her transferring needs and her ability to get out of bed when she is compliant and noncombative, fingernail care to be performed at least weekly during bath time and by hall staff on alternate days if needed, staff to observe for dirty nails and clean as necessary due to her eating snacks through out the day and is not able to identify the need for cleanliness. On 8/9/23 Resident #34 had ADL care provided for him on the day of discovery by the QA Nurse and nursing assistant which included shaving, mouth care, and cleaned and trimmed fingernails. Resident #35 was given a shower on the day of discovery 8/9/23 by a certified nursing assistant with his care plan updated on 8/9/23 to include his preference on bath time of three days a week and fingernail care to be given at least weekly during bath time and on alternate by staff as needed.

The MDS Nurse audited 68 of 68 charts on 8/15/23 to identify residents who are dependent on staff for Adl assisstance. Upon review of the Resident Matrix by the MDS Nurse it was determined that 58 of 68 residents were dependent on staff for assistance with Adl care.

An in-service is scheduled for 8/29/23 by the Director of Nurses for all licensed nurses, certified nurse aids and nurse aides regarding the need and requirement for staff to provide care and assistance to

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| F 677 | Continued From page 27<br>She stated it was the CNA's responsibility to ask what the resident prefers and to shave the residents and to trim the fingernails as the resident desired and she had failed to ask this resident.<br><br>During an interview and observation on 8/8/23 at 3:15 PM, Registered Nurse (RN) #2 revealed that it is the nurses' responsibility to trim the toenails, unless a podiatrist is needed. She removed the resident's socks and revealed the toenails on the left foot are slightly long (less than 1/4 inch from nailbed to tip of nail). The toenails on the right foot were noted to be long with the big toenail being approximately 1/4 - 1/3 inch long and very jagged with part of nail being close to 1/3 inch long, then the other half of the big toenail about 1/4 inch long. Rough and jagged area between these two lengths of the big toenail were observed. She confirmed that the toenails should be kept smooth and short to maintain good nail care and prevent damage to skin and that his nails were too long and jagged to be safe or comfortable. She confirmed the resident prefers to be clean shaven and that he currently is not. She also confirmed that the resident's fingernails needed to be trimmed since the resident prefers them to be short. She stated that from his appearance, it had been several days since he had these things done.<br><br>Record review of Resident #6's "Admission Record" revealed the resident was admitted to the facility on 5/18/23 with diagnoses included Hemiplegia, Personal History of Traumatic Brain Injury, Lesion of Ulnar Nerve Left Upper Limb, Chronic Pain, Unilateral Primary Osteoarthritis of Left Knee. | F 677 | residents who are unable to carry out Activity of Daily Living, any updated facility practices regarding nail care, removal of facial hair, lift program, and required documentation.<br><br>A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, Nursing Staff, and the Quality Assurance Nurse. The Focus Review will be to ensure assistance is provided per the individual resident care plan as evident by documentation and general rounds made by the Director of Nurses, RN House Supervisor and the Quality assurance Nurse at least 2 times a week for 12 weeks beginning 8/18/23 to observe at least 12 residents per round.<br><br>The Quality Assurance Nurse, will audit Adl performance as outlined in the ADL Critical Element Pathway and presented weekly at the scheduled QAPI meeting beginning 8/23/23 times 4 weeks thru 9/13/23, and then monthly times two months beginning 9/20/23 and ending on 11/15/23.The Quality Assurance Nurse will audit weekly observation rounds and present weekly at the scheduled QAPI meeting beginning 08/23/23 times 4 weeks thru 09/13/23 and then monthly times two months beginning 09/20/23 and ending 11/15/223. The Quality Assurance Nurse will report any negative findings to the Quality Assurance Committee during the facility's Quality Assurance meeting | |

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| F 677 | Continued From page 28<br>Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/25/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating resident was cognitively intact.<br><br>Resident #4<br><br>An observation on 08/08/23 at 11:25 AM revealed that Resident #4 was sitting up in her wheelchair in the dining area with approximately 10 gray hairs in random areas of the chin and cheeks that were approximately 1 inch long. An attempted interview with the resident revealed she was confused.<br><br>An observation and interview on 8/8/23 at 4:30 PM with CNA #11 confirmed that Resident #4 had several long hairs on her chin and cheeks that needed to be removed. She revealed she is unsure if she is supposed to shave the resident or use a tweezer to remove the hairs.<br><br>An interview on 8/8/23 at 4:38 PM, with CNA #12 confirmed that shaving is a part of bathing and stated, "But I am not sure about female shaving, because I don't want to embarrass them by asking." CNA #12 was asked if a resident cannot determine if they need facial hair removed then how would she know if they need shaved, she revealed she is not sure about females but admitted that she would not want facial hair.<br><br>An interview on 8/8/23 at 4:40 PM, with Registered Nurse (RN) #2 and RN #3 confirmed that female facial hair removal should occur when the resident is bathed unless they refuse. Record review of Resident #4's ADL care at this time with | F 677 | scheduled the third week of each month with the attendance of the Medical Director. The next scheduled Quality Assurance meeting is scheduled for 09/01/2023 with the Medical Director. The Administrator will be responsible for reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded in the documented minutes. | |

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RN #3 revealed there was no documentation that the resident had refused any care.

An interview on 8/9/23 at 4:20 PM, with the Director of Nurses (DON) confirmed that females should have facial hair removed during their bath time.

Record review of Resident #4's "Admission Record" revealed the resident was admitted to the facility on 02/10/23 with medical diagnoses that included Dementia and Need for Assistance with Personal Care.

Record review of Resident #4's MDS with an ARD of 5/17/23 revealed in Section C a BIMS score of 04, which indicated the resident is severely cognitively impaired. This review revealed in Section G that the resident needed assistance from staff to complete "Personal Hygiene" and 'Bathing."

Resident #27

An observation on 08/08/23 at 10:50 AM of Resident #27 lying in bed with fingernails on bilateral hands approximately one-half (1/2) inch long and jagged past the fingertips and a brown substance was under the nails.

An observation and interview on 08/08/23 at 2:55 PM with CNA #1 revealed, Resident #27 gets a bed bath daily and we do her nail care but today she was combative, and I didn't do her nails. She revealed we try and go back when she is calmer and see if she will let us do her nails. If she doesn't then we get the nurse to do them. CNA #1 confirmed her nails were long, jagged, and had a

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brown substance underneath them.

An observation and interview on 08/08/23 at 3:10 PM with the DON revealed the aides are responsible for fingernail care which included trimming and keeping them washed and cleaned out. She revealed Resident #27 eats with her fingers and that her nails would require cleaning more frequently because of that. The DON confirmed that the nails were long and jagged and had a brown substance under her nails.

A record review of Resident #27's "Admission Record" revealed the resident was admitted to the facility on 03/17/2022 with diagnoses that include Metabolic Encephalopathy, Unspecified Dementia, Peripheral Vascular Disease, and Generalized Anxiety Disorder.

A record review of the MDS with an ARD of 07/20/23, revealed the resident is rarely/never understood which indicated Resident #27 has severe cognitive impairment.

Resident #34

An observation on 8/08/23 at 2:18 PM, of Resident # 34 revealed his tongue was observed with raised brown patches, lips were dry with dried bloody spots on the bottom lip and his teeth were observed to be in bad condition, with dark brown/black color to all teeth. Long facial hair measured approximately 1/4 inch in length and his nails were long, measuring approximately 3/8 inch in length from the tip of the fingers, with a

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brown substance underneath all nails.

An observation and interview on 8/08/23 at 2:55 PM, with Nurse Assistant (NA) # 2 confirmed that she smelled an odor when she entered the resident's room and stated, "Mm-hmm, it smells like body odor," and that she had washed the resident up today and had put on deodorant but did not give him a complete bath. She confirmed that she had not shaved him and stated, "I was scared to do that." She revealed that when he came to the facility, he had old food (debris) that was caked on his teeth. She stated, "His lips have been chapped like that since he came from the other place." She revealed that she had been applying baby oil to the resident's lips because his family had requested her to do that, but she had not applied anything on his lips today.

An observation and interview on 8/08/23 at 3:10 PM, with Registered Nurse (RN) #1 confirmed that the nurses and aides are both responsible for oral care on the resident. She stated that this was part of the daily care that was supposed to be provided for the resident. She confirmed that the resident's nails were long and dirty and stated, "The aides can cut and clean the nails as long as the resident is not a diabetic, and he is not."

An observation and interview with the Director of Nursing (DON) on 8/08/23 at 3:20 PM, confirmed that Resident #34 had not been shaved, had long dirty fingers nails, and had an extremely dry, cracked lower lip with patchy areas of dried blood and raised brown patches to his tongue. She revealed that the aides and nurses are both responsible for the oral care, nail care and hygiene.

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An interview with the Administrator (ADM) on 8/09/23 at 4:30 PM, revealed that it was the responsibility of the aides and the nurses to do oral care for Resident #34 and stated, "It is a concern."

Record review of the "Admission Record" revealed Resident # 34 was admitted to the facility on 06/21/23 with medical diagnoses that included Cerebral Infarction, Unspecified Dementia, Dysphagia, Hemiplegia and Hemiparesis Affecting Right Dominant Side and Gastrostomy Status.

Record review of the MDS with an ARD date of 6/27/23 revealed under section C a BIMS score of 7, indicating Resident #34 is severely cognitively impaired. Also revealed under section G, Resident #34 requires total dependence for personal hygiene.

Resident #35

An observation and interview on 08/08/23 at 11:07 AM, revealed Resident #35 revealed that the facility is only bathing him one time a week. lying in bed. The resident stated, "I want to be shaved, and have my nails cut." An observation revealed long nails on both hands that measured approximately 3/8 inch in length, and facial hair approximately 1/4 inch.

An observation and interview on 8/8/23 at 3:25 PM, with RN #2 confirmed that Resident #35 had long nails and facial hair and she asked him if he received a shower yesterday and the resident replied, "No, I didn't."

An interview with CNA # 6 on 8/09/23 at 11:10

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| F 677 | Continued From page 33<br>AM, revealed the aides have a shower list that they keep at the nurse's station and that the resident was on the list for Monday, Wednesday, and Friday showers.<br><br>An interview with RN #2 on 8/09/23 at 11:20 AM, confirmed that Resident # 35 did not get a shower on Monday and stated, "I'm not sure why he didn't; I wasn't here."<br><br>An interview with the Director of Nursing (DON) on 8/09/23 at 11:30 AM, revealed she had spoken with the aide assigned to Resident #35 and she confirmed that she did not give him a shower on Monday because every time she went in his room he was asleep so she didn't wake him up.<br><br>Record review of the ADL bathing task for Resident #35 revealed under Monday 8/07/23, "Not Applicable" was checked.<br><br>Record review of the "Admission Record" revealed that Resident #35 was admitted to the facility on 6/26/23 with medical diagnoses that included Type 2 Diabetes Mellitus, Major Depressive Disorder, Acquired Absence of Left Leg Below Knee and Acquired Absence of Right Leg Above Knee.<br><br>Record review of the MDS with an ARD of 7/12/23 revealed under section C a BIMS score of 10, indicating Resident # 35 is moderately cognitively impaired. Record review revealed under section G, the resident requires one-person physical assist with personal hygiene and is totally dependent for bathing. | F 677 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) | F 689 | | 9/2/23 |

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| F 689 | Continued From page 34<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident was free from accidents during a lift transfer by using the inappropriate lift for one (1) of 19 residents reviewed for investigations. Resident #53<br><br>Findings include:<br><br>Record review of facility policy titled "Modified Lifting Policy" undated, revealed, "(Proper name of nursing home) will provide a safe work environment for patient care areas by providing and requiring the use of safety materials, equipment and training designed to prevent personnel and patient injury." The policy also revealed, "1. Staff will follow the documented lifting protocol deemed appropriate for each resident. ... 2. Staff will utilize proper transfer/lifting/assistance procedures for each resident to include use of mechanical transfer devices or other lifting equipment or devices and by applying proper body mechanics."<br><br>Record review of Physician's Order dated 6/16/23, revealed an order for x-ray of left shoulder related to acute pain. Record review of "Patient Results" of left shoulder x-ray from local | F 689 | An updated lift assessment was completed for Resident #53 by the RN Restorative Nurse on 8/15/23 in which it was reiterated that a full body sling was appropriate for this resident. Resident #53 care-plan was reviewed and found to be accurate as deemed with the current assessment.<br><br>An audit was completed by the MDS Nurse on 8/14/23, on 68 of 68 electronic health records to identify how many residents are in need of a mechanical lift, in which it was identified that there were 19 of 68 residents identified to have the need of a mechanical lift for transfers to assist in prevention of accidents occurring.<br><br>Between the dates of 8/16/23-9/1/23, the restorative nurse will in-service all licensed personnel on the need and requirement for lift assessments to be accurate and completed on admission, annually with a comprehensive assessment and with a significant change in condition and as needed per professional judgement. It will also be | |

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hospital dated 6/16/23, revealed, "Findings: Bone - There is a nondisplaced fracture involving the neck of the left humerus. There is no definite dislocation identified. There is mild angulation of the humeral head laterally. Intact AC joint".

Record review of hospital records dated 6/16/23, revealed, "77-year-old female who presents from local nursing facility due to a humeral fracture. Patient says she was being helped to bed and she may have slipped somewhat but there is no significant fall or trauma. She has pain to her left shoulder with any attempts at movement. Denies any other complaints." Hospital records also revealed the aftercare instructions as "Humerus Fracture, treated with immobilization."

An interview on 8/8/23 at 11:55 AM, with Resident #53 revealed the staff was assisting her from her chair to her bed and their feet got twisted and she fell. Stated she was taken to the hospital due to a broken left arm but did not have to have surgery. She stated she wore a sling while it healed.

An interview on 8/9/23 at 3:00 PM, with Resident #53 revealed she did not fall to the floor with this incident, but when she was on the stand-up lift, she "stumbled" when transferring to the bed. She stated she had pain in her arm, and she was given Tylenol.

An interview with the Minimum Data Set (MDS) Registered Nurse (RN) on 8/10/23 at 8:45 AM, revealed the resident was care planned for a full body total lift for transfers and it was changed to a sit to stand lift, and after her shoulder incident, she was changed back to a total lift. She printed off the previous care plans and noted on the care plans, only the Vander Lift (full body lift) was listed

discussed that the care-plan must coordinate and reflect the results of the lift assessment upon completion. On 8/15/23 the Director of Nursing reviewed 68 of 68 charts to make a comparison of the current lift assessment and compared it to the individuals care-plan, with no negative findings. On 8/22/23 the Quality Assurance Nurse and the MDS Nurses completed a comparison report for all 19 residents to ensure that the care-plan had an appropriate coordinating lift assessment to ensure completion of both an assessment and a coordinating care-plan.

A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, Nursing Staff, and the Quality Assurance Nurse. The Focus Review will be to review lift assessment for existing resident in need of a transferring device for appropriateness and that the appropriate interventions are included within the resident's care plan as deemed by the comprehensive assessment. Beginning 8/18/23, the Restorative Nurse is responsible for completion of the lift assessment within 48 hours of admission, annually with a comprehensive assessment or upon a significant change in a residents condition. An audit will be completed by the Quality Assurance Nurse weekly times 90 days beginning 8/23/23 to ensure compliance with the need and requirement that both the lift

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| F 689 | Continued From page 36<br>for transfers. She stated that the Vera Lift (sit to stand lift) had to be on the care plan at some point since she could see a resolved date for the Vera Lift after the resident's incident. She stated she is unable to locate the care plan that listed the sit-to-stand lift in the system.<br><br>An interview with the Director of Nursing (DON) on 8/10/23 at 9:10 AM, revealed the resident was being transferred from her chair to the bed in a sit-to-stand lift by two (2) staff members and when the resident was placed in bed, she complained of her left arm and stated she had pain. She confirmed she investigated the incident and sent the information into the State Agency (SA) and from what she was able to determine the resident had a diagnosis of osteoporosis and it could have been a spontaneous type fracture. She was unable to determine any other cause of the injury. She stated the full body lift was now being used, but at that time she had been assessed for a sit-to-stand lift. When asked about that the care plan indicated that the full body lift was to be used for transfers, she responded that she is uncertain why that one is listed since she had been using the sit-to-stand lift and was able to bear some weight and was doing well with transfers. She pulled the assessment dated 12/21/22 and it revealed the resident required a full body lift/Vander Lift or other full mechanical lift and not a sit to stand lift. She stated she looked for another assessment or documentation for the change in lift type, but she was unable to find where another assessment was done. She stated the residents are assessed annually for the type of lift required. She confirmed the most recent assessment determined the need for the total lift, and at the time of the resident's injury, the wrong lift was | F 689 | assessment and the resident's care-plan are one and the same. DON will observe at least 2 residents per week that require mechanical lift to ensure lift is appropriate per lift assessment, care-plan and observation of demonstration by assigned staff. The Quality assurance Nurse will report any negative findings to the Quality Assurance Committee during the facility's Quality Assurance meeting scheduled the third week of each month with the attendance of the Medical Director beginning 8/23/23 times 3 months. The next Quality Assurance meeting is scheduled for 09/01/2023. The Administrator will be responsible for reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded in the documented minutes. | |

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used for her transfer.

An interview with Minimum Data Set (MDS) Registered Nurse (RN) and the DON on 8/10/23 at 10:30 AM, revealed that after reviewing the "Care Plan" and "Kardex" for this resident, she had determined that at some point between 4/15/23 and 5/15/23, the Vera Lift (sit to stand lift) was added to the care plan since it shows up on the Kardex. She stated the information on the Kardex comes from the Care Plan, so it had to be added to the Care Plan for it to trigger on the Kardex. She stated from what can be determined on the Kardex/Care Plan, it appears that the sit-to-stand lift was added on 5/5/23 and removed on 6/16/23 (after the incident), and the full lift was put in on 1/5/22 and was never removed. The MDS RN stated she does not know why she added this lift, and it could have been a system error or improperly entered information. The DON stated she is not sure how far back the use of the sit/stand lift was being used, but she knew it was being used for a while before the injury occurred. The DON confirmed the most recent assessment was for a total lift, so, the total lift should have been the one used. She stated when the lift was changed from the full lift to the sit-to-stand lift, no assessment was done to ensure safety for the resident. She confirmed that prior to changing a resident to a more independent type of transfer device, an assessment should have been done to ensure the resident would be safe using this for transfers and the facility failed to do this assessment.

An interview with Certified Nursing Assistant (CNA) #9 on 8/10/23 at 10:40 AM, revealed she had worked at the facility for about one and a half years and has worked with this resident often.

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She stated the staff use the Kardex to determine what lift to use, and this resident had the sit to stand lift listed. She stated that the resident was now using the full body lift for transfers.

A phone interview with CNA #8 on 8/10/23 at 10:45 AM, revealed she was working with the resident when this incident occurred. She stated this was the first time she had worked with this resident. She stated she and another CNA used the sit-to-stand lift to transfer the resident from the chair to the bed that evening. She stated she "wondered why the stand-up lift was being used since her left arm was weak." She stated they placed the resident in her bed and after she was lying down, the resident stated her left arm was hurting and would like some Tylenol. The nurse gave Tylenol, and her pain was eased. She stated she was unaware of anything that occurred during the transfer that would have caused an injury, but the next day an x-ray was done and showed a fracture. She stated the facility had trained her on lift use and she had done this job for 15 years. She confirmed that the resident's Kardex showed to use a sit-to-stand lift.

During an interview on 8/10/23 at 10:40 AM, the Administrator confirmed the facility failed to use the lift the resident was assessed for. She confirmed the resident had an injury but could not confirm it was from the lift.

Record review of "Transfer/Lift Assessment" dated 12/21/22, for Resident #53 revealed, "Instructions - An assessment should be made prior to each task if the resident has a varying level of ability due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist in the transfer/repositioning."

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Section A of assessment revealed, "Ability to assist with transfer/positioning - The resident's level of assistance can best be described as - Dependent: resident requires more than 50% assistance by staff or is unpredictable in the amount of assistance offered." Section B of assessment revealed, "Weight Bearing - Can the resident bear weight? No." Section C of the assessment revealed, "Upper Extremity Strength - Does the resident have upper extremity strength to support his/her weight during transfer? No." Section G of the assessment revealed, "Care Plan - After completing assessment, indicate transfer/repositioning needs below: How does the patient transfer to and from bed-chair, chair toilet, chair-chair, etc. - Vander Lift or other full mechanical lift - one or two person assist."

Record review of "Care Plan History" revealed on 1/5/22, the Vander (full body) lift was listed. On 5/5/23, the Vera (sit-to-stand lift) was listed. On 6/16/20, the Vera Lift was resolved.

Record review of "Care Plan" with review start date of 3/27/23, revealed the resident needed assistance with Activities of Daily Living (ADL) care and for transfers she was listed as "Transfer: the resident is totally dependent on 2 staff for transferring" and, "the resident requires Mechanical Lift (Vander) with 2 staff assistance for transfers."

Record review of "Kardex Report" for each month from 12/15/23 - 4/15/23, revealed, "Transfer: the resident is totally dependent on 2 staff for transferring" and "Transferring: the resident requires Mechanical Lift (Vander) with 2 staff assistance for transfers."

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Record review of "Kardex Report" dated 5/15/23 and 6/15/23 revealed, "Transfer: the resident is totally dependent on 2 staff for transferring" and "Transferring: the resident requires Mechanical Lift (Vera) with 1 or 2 staff assistance for transfers."

Record review of "Care Plan" with review start date of 6/30/23, revealed the resident needed assistance with Activities of Daily Living (ADL) care and for transfers she was listed as "Transfer: the resident requires Mechanical Lift (Vander) with 2 staff assistance for transfers."

Record review of Electronic Medication Administration Record for June 2023 revealed the resident received the nightly dose of Tylenol on 6/15/23. The resident received the as needed dose of Tylenol on 6/16/23 at 5:11 AM and on 6/17/23 at 2:36 AM. The resident received her night dose of Tylenol each night but did not receive the as needed Tylenol any other time during the month of June.

Record review of Resident #53's "Admission Record" revealed the resident was admitted to the facility on 12/21/21. Diagnoses included Wedge Compression Fracture of first and second Lumbar Vertebra, Hypertension, Cerebrovascular Disease, Muscle Weakness, Moderate Protein-Calorie Malnutrition, and Paroxysmal Atrial Fibrillation.

Record review of Resident #53's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/20/23, revealed a Brief Interview for Mental Status (BIMS) score of nine (9) which indicated the resident is moderately cognitively impaired.

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| F 699 SS=D | Trauma Informed Care<br>CFR(s): 483.25(m)<br><br>§483.25(m) Trauma-informed care<br>The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews, record review, and facility policy review the facility failed to deliver care and services for a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD) for one (1) of 66 residents reviewed. Resident #47.<br><br>Findings include:<br><br>Review of the facility policy titled, "Trauma Informed Care" with an implementation date of 03/01/23 revealed, "Policy ...It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization".<br><br>Record review of Resident #47's medical diagnoses revealed an admitting diagnosis of Post Traumatic Stress Disorder.<br><br>An observation on 8/8/23 at 10:50 AM, revealed the resident lying in bed with the covers over her head and would not respond to the State Agent | F 699 | A care-plan was developed for Resident #47 that included a history of PTSD by the MDS Nurse on 8/10/23. The MDS Nurse was unable to garner information from the Resident regarding PTSD to assist with identifying, type of event that may have caused PTSD. When interviewed by the MDS Nurse on 8/8/23, she stated she did not have PTSD that she knew of. The Psyche Nurse Practitioner visited With Resident #47 on 8/11/23 and 8/28/23, with resident being noncooperative with her request to discuss her diagnosis of PTSD or possible triggers. Psyche Nurse Practitioner made no new recommendations or changes in medications, with a written note that Resident #47 nor nursing staff have reported any nightmare activity or flashbacks or any other indicator that she may possibly be reacting to a PTSD symptom. Resident will continue to be monitored by psyche nurse and the social director monthly to allow the resident to express any anger, sad or anxious feeling for implementation of other interventions as deemed necessary in addressing | 9/2/23 |

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| F 699 | Continued From page 42<br>(SA) verbally.<br><br>An interview on 8/9/23 at 8:15 AM with the Administrator stated, "Where did you find PTSD on this resident (Resident #47)?" SA informed her that it was listed on the resident's diagnosis, the Administrator stated, "Oh, I missed that." She then stated that Resident #47 had a serious car accident where she was driving, and her daughter was killed.<br><br>An interview on 8/9/23 at 1:25 PM, with Resident #47 revealed that she sees the nurse practitioner about some of her medicines, but she does not think they have ever talked about PTSD. Asked the resident if she recalled receiving a diagnosis of PTSD in the past the resident replied I'm not sure, I have so many.<br><br>An interview on 8/9/23 at 11:45 AM with the Minimum Data Set (MDS) Registered Nurse (RN) revealed that she discovered a few weeks ago that the resident had a diagnosis of PTSD even though she had been the one to code that diagnosis on the resident's MDS. She revealed that she realized it was on her admitting diagnoses and stated, but that was just a history. When asked if she knew what triggered the resident's PTSD, she stated "No."<br><br>An interview on 8/9/23 at 11:45 AM, with the Behavioral Nurse Practitioner (NP) and MDS RN revealed that she discovered a few weeks ago that the resident had a diagnosis of PTSD even though she had been the one to code that diagnosis on the resident's initial MDS. When asked if she thinks the resident may have missed services since the diagnosis of PTSD was not addressed, she stated, "I see what you mean | F 699 | triggers related to PTSD.<br><br>An audit was completed by the MDS Nurse on 8/10/23, for 68 of 68 residents which did not reveal that any other resident had a diagnosis of PTSD. Any new admission could be affected by the deficient practice.<br><br>The MDS Nurse and the Social Worker were counseled by the Administrator on 8/18/23 of the need and requirement for identification of PTSD upon admission or a change in condition, prevention or minimizing triggers for PTSD situations, with a care-plan being developed addressing PTSD. All departments heads which consist of nursing, dietary, housekeeping, maintenance, activity and administration will view a video on 8/29/23 regarding Trauma Care presented by national Institute of Mental Health and National Library of Medicine. All staff will be in-serviced on Trauma Care and how their department can assist in managing Trauma Informed Care as of 9/13/23. Any resident identified with PTSD will be referred to a mental health professional within 72 hours. Nursing managers, which include the DON, QA Nurse, MDS Nurse and the RN Supervisor will review daily at least 5 days a week, beginning 8/18/23 with all newly admitted residents diagnosis list to identify any diagnosis of PTSD, with potential triggers identified, identifiable goals and interventions are appropriate to assist in developing a person-centered care plan. | |

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| F 699 | Continued From page 43<br>about missing services, but I don't know her so I just can't say." MDS RN stated that the resident sees the Behavioral Nurse Practitioner monthly due to the residents past behaviors. She revealed that the resident has had angry outburst in the past and had to be sent to behavioral health facilities, but anger is normal in residents with Huntington's Disease. When the SA ask if the NP was aware of the PTSD diagnosis, she stated, "I do not know, let's call her". A phone call interview at this time with the NP revealed that she was not aware that the resident had a diagnosis of PTSD. She admitted that she has access to the medical records and should have seen that diagnosis. She stated that she would have covered that with the resident when she came monthly, but since she wasn't aware, therefore it was never addressed. She revealed that she plans to return to the facility on Friday now that she knows about the PTSD diagnosis and address it with the resident to see if she needs a referral.<br><br>An interview on 8/9/23 at 1:36 PM, with the Licensed Social Worker (LSW) revealed that she was not aware until recently that Resident #47 had a diagnosis of PTSD and therefore no trauma assessment had been completed. She stated that she was aware of the regulation regarding trauma informed care and now the facility covers it on admission, but since she did not realize the resident had that diagnosis then an assessment was not completed. She revealed that the resident had never talked about it and admitted that she had never asked the resident about it.<br><br>An interview on 8/9/23 at 2:18 PM, with the DON stated that she did not realize that the resident | F 699 | A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, Nursing Staff, and the Quality Assurance Nurse. The Focus Review will be to educate staff on the need and requirement on how to manage Trauma Informed Care. The Quality Assurance Nurse will provide a post test to all staff after individual training to ensure knowledge of Informed Trauma Care in which should be completed by 9/13/23. The Director of Nurses will review the resident diagnosis list and an 802 Resident Matrix form weekly beginning 8/18/23, times 3 months ending 11/15/23 to ensure that any resident diagnosed with PTSD is identified, triggers noted, interventions are appropriate with a referral made to a psyche professional. The DON will be responsible to bring the outcome of her audit as evident by the number of residents identified with PTSD, what criteria is found to be compliant or not to the QAPI meeting weekly, beginning 8/23/23 times 3 months, ending 11/15/23 if compliance is met as outlined through the Critical Element Pathway for Trauma Informed Care. The Quality Assurance Nurse reported at the Quality Assurance meeting on 8/23/23 that there were no other residents as of that date who possessed a diagnosis of PTSD. The QA Nurse will present at the next Quality Assurance committee meeting with the Medical Director in attendance, which is scheduled for 9/1/23 any updates | |

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| F 699 | Continued From page 44<br>had a diagnosis of PTSD on admission to the facility. She confirmed that no one had assessed the resident regarding what triggers her PTSD and that the facility failed to do that.<br><br>An interview on 8/9/23 at 2:49 PM, with the Administrator confirmed that she did not know that Resident #47 had a diagnosis of PTSD on admission but does not think she missed any services while she has been at the facility. She confirmed that she does think they missed in planning her care and knowing her triggers. She stated that she was aware of the new regulation that came out in the Fall of 2022 that required the facility to do a trauma assessment on anyone with PTSD and admitted they should have assessed Resident #47, but no one realized she had that diagnosis.<br><br>Record review of Resident #47's "Admission Nursing Assessment" dated 1/7/21 revealed the resident had a diagnosis of PTSD.<br><br>Record review of Resident #47's progress note dated 01/24/21 revealed the resident had an angry aggressive outburst with staff that required the resident to be sent out to a behavioral health facility and returned to the long-term care (LTC) facility on 2/5/21. Review of progress note dated 3/10/22 revealed the resident had to be sent to the Emergency Room for a psych evaluation following an angry aggressive outburst with facility staff and returned to the LTC facility on 3/15/22.<br><br>Record review of Resident #47's "Behavioral Medicine/Psychiatric Assessment" dated 3/15/21 revealed she was assessed by the NP on 3/15/21 following a return from a stay to a behavioral health facility regarding aggressive behaviors and | F 699 | regarding PTSD. The QA Nurse will continue to report any negative findings to the Quality Assurance Committee with the attendance of the Medical Director at the monthly meeting times 3 months, ending 11/15/23. The Administrator will be responsible to report any concerns to the Board of Trustees at their monthly meeting scheduled for the third Monday of the month, with concerns noted in the minutes. | |

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| F 699 | Continued From page 45<br>a "Behavioral Medicine Evaluation & Management Note" dated 6/19/23 as the last assessment by the NP regarding psychiatric medication review that indicated the resident has periods of agitation that require redirection by staff.<br><br>Record review of Resident #47's "Admission Record" revealed the resident was admitted to the facility on 1/7/21 with medical diagnoses that included Post Traumatic Stress Disorder (PTSD).<br><br>Record review of Resident #47's MDS with an Assessment Reference Date (ARD) of 5/4/23 revealed in Section I that the resident had a diagnosis of PTSD and in Section C a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident is moderately cognitively impaired. | F 699 | | |
| F 791 SS=D | Routine/Emergency Dental Srvcs in NFs<br>CFR(s): 483.55(b)(1)-(5)<br><br>§483.55 Dental Services<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(b) Nursing Facilities.<br>The facility-<br><br>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:<br>(i) Routine dental services (to the extent covered under the State plan); and<br>(ii) Emergency dental services;<br><br>§483.55(b)(2) Must, if necessary or if requested, | F 791 | | 9/2/23 |

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| F 791 | Continued From page 46<br>assist the resident-<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services locations;<br><br>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;<br><br>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and<br><br>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review and facility policy review the facility failed to provide necessary dental services to meet a residents dental needs for one (1) of 19 residents reviewed. Resident #34<br><br>Findings Include:<br><br>Record review of the facility policy titled "Dental Services" with a revision date of 3/14/23 revealed, "Policy: It is the policy of this facility to assist residents in obtaining routine (to the extent | F 791 | Resident #34 was provided with Activity of Daily Living (ADL) that included oral care, nail care and the removal of facial hair during a "Teachable Moment" with NA#1 by the Quality Assurance Nurse (QA Nurse)on the day of discovery 8/9/23. A dental consult has been scheduled for 8/28/23, at 2pm. As part of Resident #34's routine dental care, we have added a Water Pick System and Peridex Solution as of 8/28/23, With a licensed nurse to be responsible in providing the | |

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| F 791 | Continued From page 47<br>covered under the State plan) and emergency dental care.... Policy Explanation and Compliance Guidelines: 1. The dental needs of each resident are identified through the physical assessment and MDS assessment processes and are addressed in each resident's plan pf care. a. Oral/dental status shall be documented according to assessment findings. ... c. Referrals to dietician, speech therapist, physician, or dental provider shall be made as appropriate..."<br><br>On 8/08/23 at 2:18 PM, an observation of Resident # 34's room revealed he was observed lying in bed with his mouth open and eyes closed. An overpowering putrid (rotten) odor was present inside the room. The resident's tongue was observed with raised brown patches. The residents' teeth were observed to be in bad condition, with dark brown/black color to all the visible teeth and red, inflamed gums were observed.<br><br>On 8/08/23 at 2:55 PM, an observation and interview with Nurse Assistant (NA) #2 confirmed that she smelled an odor upon entering the Resident's room and that there had been bad odor coming from his mouth since he was admitted to the facility a couple of months ago. She revealed that when he came to the facility, he had old food (debris) that was caked on his teeth. She stated, "His lips have been chapped like that since he came from the other place."<br><br>On 8/08/23 at 3:10 PM, an observation and interview with Registered Nurse (RN) # 1 confirmed that there was a foul odor in Resident # 34's room and stated, "It's coming from his teeth." She revealed that the resident came from another facility and had an excessive amount of buildup | F 791 | mouth care to Resident #34, with documentation of care provided recorded the Medication Administration Record.<br><br>The dietary manager completed an observation round on 8/15/23 to identify residents with PEG tubes who could possibly be affected by the stated deficient practice. There was only one resident who could have been affected by the deficient practice who was in need of a referral for an outside dental services.<br><br>On 8/1/23 the facility has acquired a new nursing documentation module labeled "Nursing Advantage" which should assist with licensed personnel in completion of a more comprehensive assessment related to potential dental needs. With every new admission beginning 8/23/23, the Clinical Admission Assessment will be reviewed by the Director of Nurses and/or the RN House Supervisor to ensure completion, interventions are appropriate and care plan addresses oral care. Beginning 8/16/23, the RN Nursing Supervisor will be responsible to provide in-services to all nursing staff of the need and requirement to provide goods and/or services regarding ADL Care, with emphasis on oral care, fingernail care, and facial hair removal. As of 8/23/23, the RN Supervisor has in-serviced 46 of 54 nursing staff members, with the expectation of 100% compliance with the remaining nursing staff to be completed by 9/1/23. As of 8/22/23, systematic changes have been implemented regarding documentation to be completed by both the bath tech and | |

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| F 791 | Continued From page 48 | F 791 | | |

on his teeth. RN #1 confirmed that the facility has not had the resident assessed for dental services that she knows of and she confirmed that she has not informed the physician of the odor or the condition of the resident's teeth.

On 8/08/23 at 3:20 PM, during an observation and interview with the Director of Nursing (DON) , confirmed that the resident had come to the facility with his teeth and mouth in that condition and stated the odor was coming from his teeth.

Registered Nurse (RN) # 1 revealed during an interview on 8/09/23 at 8:35 AM, that the aide had tried to brush Resident #34's teeth this morning and his gums began bleeding, and the resident became agitated and upset.

On 8/09/23 at 4:00 PM, an interview with the DON confirmed after record review that the facility had not attempted to make Resident # 34 a dental appointment. She stated, "No, we have not." She revealed that the resident came to the facility with his teeth in bad condition. She revealed that the facility used to have a dentist who came out to the facility, but no longer does.

An interview with the Administrator (ADM) on 8/09/23 at 4:30 PM, revealed they have not tried to get Resident #34 a dental appointment. She revealed she was just made aware of the situation yesterday and stated, "Naturally, we'll get that done for him."

On 8/09/23 at 8:30 PM, an interview with Resident #34's Resident Representative (RR) via telephone, revealed she had discussed with the staff at the facility several times about getting some dental help for him. She stated, "I told them

the daily care giver regarding ADL's performed, which include nail care/facial hair removal and oral care to ensure responsibility and accountability are maintained. As of 8/23/23, the facility has developed a one-on-one mentor program that will be overseen by the Director of Nursing Services, which will assign a certified nursing assistant mentor to be assigned to all newly trained nursing assistants after completion of their certification program times 2 weeks while enhancing their individual skills, comfort level of the profession chosen, and competency. At the end of the two weeks the new hire will be checked-off on performance/competency level by the mentor. On 8/24/23 the 4 residents identified to have had a Peg tube were assessed by a licensed nurse to possibly identify any they may need additional services from a dental consult. It was found that 1 had good fitting dentures and the remaining 3 residents mouth/teeth were not in need of an outside dental consult.

A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, Nursing Staff, and the Quality Assurance Nurse. The focus review will be to provide outside dental services as needed and required as determined by a comprehensive assessment by licensed nurses, reviewed by the Director of Nurses, referred to social services to ensure outside

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| F 791 | Continued From page 49<br>to get his teeth extracted, if that's what it took." She revealed she had a conversation with the Social Worker (SW) on admission and was assured that he would get the dental care he needed.<br><br>In an observation of Resident #34's teeth with the DON on 8/10/23 at 8:39 AM, confirmed the only actions taken by the facility since the resident was admitted was mouth care. She revealed that the facility was unable to look and determine what was going on with his teeth and revealed that the resident was a mouth breather and had an order for nothing by mouth (NPO) which causes his mouth to be drier. The DON described the resident's teeth as, "dark buildup at the base of all teeth" but stated she was unable to state that his teeth were decaying. She revealed that the resident's teeth were worse than that when he arrived at the facility. She confirmed that she did not see any broken or missing teeth. The DON described the resident's lower gums as "Raw" and stated, "They probably just cleaned them, so they are irritated." She revealed that they have not made the physician aware of the oral/dental condition, and she stated, "No, we have not made him aware, but he had assessed him." She revealed that the resident had not expressed pain associated with his teeth. The DON did not provide any documentation to support the residents' oral/dental status to the SA.<br><br>On 8/10/23 at 8:50 AM, an interview with the Social Worker (SW) revealed that the resident was admitted from another facility and during her admission assessment with the RR dental care was never discussed. She revealed that the residents' Supplemental Security Income (SSI) does not pay for the dental company that the | F 791 | appointments for dental services are scheduled, documented and maintained. The Director of Nurses will report weekly at the QAPI meeting beginning 8/18/23, the number of residents who had a dental assessment completed and required outside dental services, with confirmation of visit and treatment provided by dentist, times 3 months beginning 8/18/23 and ending 11/15/23 to ensure compliance being met. The Quality Assurance Nurse, Director of Nurses and the RN House Supervisor will observe at least 10 nursing staff perform oral care at least weekly beginning 8/18/23 and ending 9/15/23, and then monthly times 2 months beginning 9/16/23 and ending 11/10/23. The Director of Nursing, RN House Supervisor and the Quality Assurance Nurse will continue to observe for oral care being conducted by assigned staff with a record maintained for the day of observation. The Director of Nurses will report weekly at the QAPI meeting beginning 8/18/23 the number of observations, with noted results times 3 months, beginning 8/18/23, ending 11/15/23. The Quality Assurance Nurse will utilize the Dental Status and Services Critical Element Pathway for 3 months beginning 8/15/23 to measure compliance with oral care as outlined and reported to the Quality Assurance Committee on 8/23/23 with the Medical Director in attendance, with the next meeting being scheduled for 9/1/23 with the Medical Director and will continue to be discussed times 3 months or compliance is met. The Administrator will be responsible for | |

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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 |
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| F 791 | Continued From page 50<br>facility will be in contract with for dental care.<br><br>Record review of Resident # 34's "Progress Notes: dated 6/21/23 through 8/10/23 revealed no documentation regarding the residents' oral/dental concerns.<br><br>Record review of Resident # 34's "Nursing Admission Screening/History" dated 6/21/23 revealed under, "6. MOUTH" none of the boxes were checked to describe the resident's oral condition or history.<br><br>Record review of the "Admission Record" revealed Resident #34 was admitted to the facility on 6/21/23 with medical diagnoses that included Cerebral Infarction, Unspecified Dementia, Dysphagia, Hemiplegia and Hemiparesis Affecting Right Dominant Side and Gastrostomy Status.<br><br>Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/27/23 revealed under section L, "None of the above were present" which indicated Resident # 34 did not have any oral/dental status concerns. Also revealed under section C a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident is severely cognitively impaired. | F 791 | reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded in the with documented minutes. | |