STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 02/01/2024

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GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 58251

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 01/29/24 and concluded 02/01/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		3/15/24

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

Electronically Signed | 02/23/2024

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, the facility failed to provide care in a manner that maintained or enhanced resident dignity for 2 of 17 sampled residents (Resident #9 and #11). Failure to provide privacy during toileting does not enhance the residents' quality of life. Findings include: Review of the facility policy titled "Resident Dignity" occurred on 02/01/24. This policy, dated 11/16/23, stated, ". . . The location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect . . . Ideas for maintaining a resident's dignity may include, but not be limited to: . . . Respecting resident's private space and property. . . . Treating residents with respect . . ." - Observation on 01/29/24 at 1:38 p.m. showed an unidentified certified nurse aide (CNA) exited Resident #9's room, leaving the door open. Observation showed the bathroom door also open, and Resident #9 seated on the toilet. - Observation on 01/29/24 at 4:27 p.m. showed	F 550	1) Upon discovery, CNAs were re-educated on dignity specific to resident privacy when toileting. 2) All residents have the potential to be affected by this deficient practice. 3) All staff will be re-educated by DNS or designee on 03/01/24 or prior to next scheduled shift on Residents Rights specific to dignity and the importance of providing privacy during cares. 4) The Director of Nursing or designee will perform observations audits on three random resident cares to ensure their dignity is maintained. Audits will be completed 2 X / week for 4 weeks, then 1 X / week for 4 weeks, then 1 X / month for 2 month. Any deficient practice identified will be immediately addressed. Audit results will be submitted to monthly QAPI Committee for review and recommendations. 5) This corrective action will be completed by March 15, 2024	

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F 550	Continued From page 2 Resident #11's room and bathroom doors open, and Resident #11 seated on the toilet. The resident stated, "She [the CNA] was in here but she had someone else in the bathroom." When asked if the surveyor should close the bathroom door, Resident #11 replied, "Yeah, that would be good." The CNAs failed to close Resident #9 and #11's doors to provide privacy and maintain dignity while toileting.	F 550		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		3/15/24

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F 640	Continued From page 3 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Centers for Medicare and Medicaid Services (CMS) internet Quality Improvement Evaluation System (iQIES), and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), the facility failed to electronically transmit completed Minimum Data Sets (MDSs) to iQIES for 1 of 17 sampled residents (Resident #230) and 2 supplemental residents (Resident #82 and #181). The facility also failed to transmit entry tracking within 14 days of admission for 3 of 17 sampled residents (Resident #81, #230, and #231) and 2	F 640	1) The admission and quarterly assessments not transmitted for Resident #82 (4/23/23 and 10/16/23), for Resident #181 (10/9/23) and for Resident #230 (10/17/23) were transmitted on 02/22/2024. 2) All residents have the potential to be affected by this deficient practice. 3) MDS coordinator re-educated by GSS Senior Clinical Reimbursement RN on 02/27/24 on GSS MDS Policy and Procedure, specific to transmission of MDS and processing validation reports.	

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F 640	Continued From page 4 supplemental residents (Resident #82 and #181). Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.18.11), page 5-1, stated, "Transmitting MDS Data. All Medicare and/or Medicaid-certified nursing homes . . . must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). Required MDS records are those assessments and tracking records that are mandated under OBRA [Omnibus Budget Reconciliation Act] . . ." Review of the medical records and iQIES for Residents #82, #181, and #230 showed the facility failed to submit the following MDSs: *Resident #82: admission MDS with an Assessment Reference Date (ARD) of 04/23/23 and a quarterly MDS with an ARD of 10/16/23 *Resident #181: quarterly MDS with an ARD of 10/09/23 *Resident #230: admission MDS with an ARD of 10/17/23 The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.18.11), page 2-38, states, ". . . Assessment Management Requirements and Tips for Entry Tracking Records: . . . Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days) . . ." Review of the medical records and iQIES for	F 640	MDS Coordinator, Social Services Designee (SSD) and Business Office Manager (BOM) re-educated on 02/27/24 by GSS Senior Clinical Reimbursement RN on facility process: MDS Coordinator will transmit MDS□ with SS Designee as back-up. The initial feedback report and state / CMS final validation reports will be reviewed / signed, by MDS Coordinator, SSD and BOM to ensure the assessments transmitted, accepted by CMS and the state, and note any errors that need to be corrected. 4). DNS or designee will audit Final Transmission Reports for MDS acceptance, any noted errors with correction of applicable and MDS, SSD, and BOM signature. Audit will be completed on 100% final validation reports 1 time every 2 weeks X 2, then 1 time a Month X 2 months and quarterly X 1. Any deficient practice will be immediately addressed. All audit results will be submitted to the monthly QAPI committee for review and recommendations. The DNS or designee will perform audits on the timely MDS coding, transmission and submittal at the following frequency: weekly for 3 months. Audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5)This corrective action will be completed by March 15, 2024.	

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F 640	Continued From page 5 Resident #81, #82, #181, #230, and #231 showed the following entry tracking records submitted more than 14 calendar days from admission to the facility: *Resident #81: entry date 10/19/23, submitted 11/03/23 (1 day late) *Resident #82: entry date 04/17/23, submitted 05/04/23 (4 days late) *Resident #181: entry date 07/11/23, submitted 07/26/23 (1 day late) *Resident #230: entry date 10/17/23, submitted 11/03/23 (3 days late) *Resident #231: entry date 10/05/23, submitted 11/03/23 (15 days late)	F 640		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		3/15/24

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F 657	Continued From page 6 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans for 5 of 17 sampled residents (Resident #9, #15, #80, #81, and #231). Failure to update care plans with residents' current care needs may negatively impact the care provided to residents. Findings include: Review of the facility policy titled "Care Plan" occurred on 02/01/24. This policy, dated 11/01/23, stated, ". . . This plan of care will be modified to reflect the care currently required/provided for the resident. . . . The interdisciplinary team will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition. . . ." - Review of Resident #9's medical record occurred on all days of survey. The care plan identified, ". . . TRANSFER: Total assist of 2 with total lift [full body mechanical lift] . . . Revision on: 01/15/2024 . . ." Observations during the survey showed staff transferred Resident #9 with a sit to stand mechanical lift and not the total lift.	F 657	1) Sit to Stand data collection tool was completed on Resident #9 on 1/24/24 and care plan updated on 2/1/24 to include transfer: sit to stand lift, 2 assist, medium sling. Resident #15□s care plan was updated on 2/19/24 to include heel protect boots to B/L feet at all time for off load. Wound data collection tool was completed for Resident #80□s Lt heel with pressure ulcer resolved. Resident #80□s care plan was updated on 2/22/24 to include healed pressure ulcer with prevention/protective interventions. Resident #81□s care plan was updated on 2/1/24 to include a indwelling foley catheter and catheter care. Resident #81□s care plan was updated on 2/22/24 to include weight loss interventions: Prosource and Boost. Resident #231□s is hospitalized, care plan will be updated on return to facility. 2) All residents have the potential to be affected by this deficient practice. 3) All staff responsible for updating care plans will be re-educated on GSS Comprehensive Care Plan policy and procedure specific to accurate / timely updating of the care plan by DNS or designee on 3/1/24 or prior to next scheduled shift.	

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F 657	Continued From page 7 - Review of Resident #15's medical record occurred on all days of survey. The care plan stated, ". . . The resident has potential for pressure ulcer development R/T [related to] Immobility . . ." Physician's orders included bilateral heel boots worn at all times to off load pressure. The care plan failed to include the use of heel boots for pressure ulcer prevention. - Review of Resident #80's medical record occurred on all days of survey and identified an unstageable pressure ulcer to the left heel. The care plan stated, ". . . The resident has potential for further pressure ulcer development R/T stays in bed majority of day . . ." The care plan failed to identify the left heel pressure ulcer and interventions to promote healing. - Review of Resident #81's medical record occurred on all days of survey. The care plan stated, ". . . TOILET USE: Resident requires extensive assist of 2. Q [every] 2 hours. Catheter removed 10/25/2023 . . . The resident has unplanned/unexpected weight loss R/T nausea and poor intakes. . . . Resident loves drinking juices and boosts [nutritional supplement]. offer food first then fluids if less than 50% intake at meals. . . ." Observations on all days of survey showed Resident #81 with a catheter in place. A nurse's note, dated 11/26/23 at 2:47 p.m., stated, ". . . Communication/Visit with Physician . . . Catheter placed. . . ." A dietary note, dated 12/18/23 at 12:09 p.m. stated, ". . . Wt: [weight] 161# [pounds], significant weight loss of 10% in 3 weeks. . . . Will	F 657	4) Social Services, Dietary, Nursing or designee will audit three care plans 3 x week for accuracy weekly for 4 weeks, then monthly for 2 months. Updates will be made if inaccuracy is identified. Audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5) This corrective action will be completed by March 15, 2024.	

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F 657	Continued From page 8 add 240 ml [milliliters] Boost BID [twice a day] between meals. . . ." Resident #81's care plan failed to include the reinsertion of the catheter and the Boost added for weight loss. During an interview on the morning of 02/01/24, an administrative nurse (#4) agreed staff failed to update Resident #9, #15, #80, and #81's care plans. - Review of Resident #231's medical record occurred on all days of survey. A physician's order, dated 01/22/24, included aspiration precautions. The care plan failed to include a concern of aspiration or interventions to prevent aspiration. During an interview on 02/01/24 at 12:24 p.m., an administrative staff member (#1) confirmed the facility staff failed to update Resident #231's care plan.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and resident interview, the facility failed to ensure residents received the necessary service to maintain personal hygiene for 1 of 16 sampled residents (Resident #12) who required staff assistance for bathing. Failure to provide	F 677	1) Resident #12 will have baths twice weekly as per resident choice and care plan. 2) All residents have the potential to be affected. 3) All nursing staff will be re-educated by	3/15/24

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F 677	Continued From page 9 assistance to residents who cannot perform the bathing task independently may result in poor hygiene, skin issues and decreased self-esteem. Findings include: Review of the facility policy titled "Bathing" occurred on 01/31/24. This policy, revised 08/29/23, stated ". . . To promote cleanliness and general hygiene . . . to stimulate circulation of the skin. . . ." Review of Resident #12's medical record occurred on all days of survey. Diagnoses included Psoriasis (condition of the skin). The care plan stated, ". . . Resident requires extensive assist of 1 for bathing . . . Psoriasis needs: monitor skin rashes for infection . . . notify nurse immediately of any new areas of skin breakdown noted during bath. . . ." Resident #12's bathing record identified baths scheduled twice per week on Mondays and Thursdays. Review of the December 1-31, 2023 bathing record identified the resident received five of eight scheduled baths. Review of the January 1-25, 2024 bathing record showed Resident #12 received three of eight scheduled baths. During an interview on 01/30/24 at 2:00 p.m., Resident #12 stated there is not enough staff, and sometimes they are not getting a bath because staff are too busy. He stated the lack of bathing increases the itching from his psoriasis.	F 677	DNS or designee on 02/28/2024 or prior to next schedule shift on the responsibility of following each resident□s individualized bathing schedule / care plan to include benefits of bathing. 4) The Director of Nursing or designee will audit that all residents are receiving baths at their individualized bathing schedules at the following frequency: once per week for two months, once every two weeks for two months and once per month for two months. Audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5) This corrective action will be completed by March 15, 2024.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/15/24

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F 686	Continued From page 10 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to provide care and services to promote the healing or prevent the development of pressure ulcers for 3 of 17 sampled residents (Resident #15, #80, and #81). Failure to provide pressure relief interventions may result in the deterioration of existing pressure ulcers and/or the development of new pressure ulcers. Findings include: Review of the facility policy titled "Skin Assessment Pressure Ulcer Prevention and Documentation" occurred on 02/01/24. This policy, dated 04/26/23, stated, ". . . Developing an individualized repositioning schedule is required for those residents unable to position themselves . . . The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation	F 686	1) Resident #15 skin observation was completed on 2/22/24 and care plan was updated on 02/22/24 to include pressure ulcer preventative interventions for repositioning and heel boots. Resident #80□s skin observation was completed on 2/21/24 and wound data collection completed on 2/22/24. Resident #80□s care plan was updated on 2/19/24 to include pressure-relieving heel boots at all times. Resident #81□s skin observation was completed on 2/22/24 and wound data collection completed on 2/19/24. Resident #81□s care plan was updated on 2/19/24 to include pressure-relieving heel boots at all times and repositioning plan. 2) All residents at risk for pressure ulcers have the potential to be affected by this deficient practice. 3) All nursing staff will be re-educated on GSS Skin Assessment Pressure Ulcer	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 11 UDA [user defined assessment] . . ." - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included diabetes mellitus type II. The care plan stated, ". . . The resident has potential for pressure ulcer development R/T [related to] Immobility, Incontinence, Diabetes . . . Assist to turn/reposition at least every 2 hours. Tilt and space wheelchair used to aid in repositioning . . ." Physician's orders included: "Cleanse area to (R) [right] buttock with normal saline and apply mepilex [a foam dressing] every 72 hours . . ." and "Heels [sic] protect boots to B/L [bilateral] feet at all time [sic] for off load . . ." A "Braden Scale for Predicting Pressure Sore Risk," dated 01/25/24, identified a score of 11 (high risk). Review of Resident #15's "Skin Observation" assessments identified the following: *12/07/23: ". . . R) buttock skin shear 1 x [by] 0.2 cm [centimeter] and Mepilex applied. . . ." *12/14/23: ". . . Left [sic, right] buttock skin shear 1 cm x 0.2 cm and Mepilex Sacral dressing applied. . . . R) buttock skin shear 1 x 0.2 cm and Mepilex applied. . . ." *12/21/23: ". . . redness noted to coccyx- sacral mepilex applied per orders . . ." *01/18/24: ". . . Coccyx slight redness/intact scab remained to coccyx area . . . Mepilex to coccyx for protection and change every 72 hrs [hours] and PRN [as needed] . . ." Resident #15's medical record lacked weekly assessments of the right buttock/coccyx area between 12/21/23 and 01/18/24 and after 01/18/24.	F 686	Prevention and Documentation Policy and Procedure specific to skin observation, wound data collection and wound assessment with documentation, care plan interventions and providing care as per care plan by DNS or Designee on 02/28/2024 or prior to next scheduled shift. 4) The Director of Nursing or designee will audit that all resident wound interventions are being carried out as per order/care plan at the following frequency: 1 X / week for 4 weeks, then 1 time X month for 2 months. Audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5) This corrective action will be completed by March 15, 2024.	

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	355097	A. BUILDING _____ B. WING _____	C 02/01/2024

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F 686	Continued From page 12	F 686		

Observation on 01/30/24 from 8:10 a.m. until 12:35 p.m. (approximately 4.5 hours), and on 01/31/24 from 8:15 a.m. until 2:11 p.m. (approximately 6 hours) showed Resident #15 seated in her wheelchair without repositioning by staff. Observations throughout the day on 01/30/24 showed Resident #15 in her wheelchair without bilateral heel boots in place.

Staff failed to reposition Resident #15 every two hours and failed to ensure the resident wore bilateral heel boots at all times.

- Review of Resident #80's medical record occurred on all days of survey. Diagnoses included peripheral vascular disease and a pressure ulcer to the left heel. The care plan stated, ". . . potential for further pressure ulcer development R/T stays in bed majority of day and cath [catheter] in place . . . Interventions . . . Inform resident/family of any new area of skin breakdown . . . Provide pressure relieving device on bed and chair . . . Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. . . ." The care plan lacked interventions specific to Resident #80's left heel ulcer.

Resident #80's nurses' notes identified the following:
*01/02/24 at 8:16 p.m.: ". . . Resident is a new admission from [hospital name] . . . Has a wound to left heel with a Mepilex in place. Must wear a Prevalon boot [a pressure relieving foam boot] @ [at] all times. . . ."
*01/05/24 at 3:09 p.m.: ". . . Has P/U [pressure ulcer] to L) [left] heel and xeroform [petroleum

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F 686	Continued From page 13 gauze] and Mepilex applied per order. . . ." *01/07/24 at 2:43 p.m.: ". . . P/U to L) heel present upon admission and mepilex intact and heel protective boot on at all times. . . ." *01/11/24 at 8:30 p.m.: ". . . Has a 0.6 x 0.6 [centimeter] o/a [open area] to left heel. . . . Applied a new Mepilex to pressure area left heel. . . ." *01/15/24 at 11:57 p.m.: ". . . Resident does not keep heel boot on left foot. Is restless et [and] moves about in bed. . . ." *01/16/24 at 3:14 p.m.: ". . . Resident left with ambulance staff to be evaluated in ER [emergency room] for altered mental status . . ." *01/24/24 at 10:41 p.m.: ". . . Resident re-admitted to Center from hospital . . . Unstageable pressure ulcer left heel has a Mepilex in place. . . ." *A wound assessment, dated 01/26/24, stated, ". . . In healing process unstageable P/U . . . Left heel intact slight peeled skin 2x 1.4 cm . . . Mepilex applied . . ." Observations throughout the day on 01/30/24 showed Resident #80 remained in bed without a pressure relieving device/mattress, her heel resting directly on a regular mattress, and a blue heel boot (for pressure relief) on the floor or on top of a box in the resident's room. During an interview on 01/30/24 at 9:29 a.m., Resident #80 stated, "It's ok [her heel]. I need to get them [the staff] to put my boot on, though." The resident stated she wears her boot most of time, and "sometimes I kick it off if it gets too hot." Observations showed staff entered the resident's room throughout the day but failed to assist Resident #80 with the pressure relief boot.	F 686		

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F 686	Continued From page 14	F 686		

Observations throughout the day on 01/31/24 showed Resident #80 remained in bed without a pressure relieving device/mattress, her heel resting directly on a regular mattress, and a blue heel boot on the floor. At 11:47 a.m., Resident #80 stated, "I should have them [the staff] put it on. Maybe it will stop me from sliding down in bed."

Observations on the morning of 02/01/24 showed Resident #80 remained in bed without a pressure relief device and her heel resting directly on the mattress.

The facility failed to implement interventions for pressure relief of Resident #80's left heel.

- Review of Resident #81's medical record occurred on all days of survey. The care plan stated, ". . . has potential for pressure ulcer development R/T Immobility, Incontinence . . . Assist to turn/reposition every 2 hours . . . Provide pressure reducing device on bed and chair. 12-25-23 Foam boot to left heel at all times for protection. . . ." A "Braden Scale for Predicting Pressure Sore Risk," dated 01/19/24, identified a score of 9 (very high risk).

Observations on 01/30/24 from 9:00 a.m. until 4:06 p.m. showed Resident #81 seated in her wheelchair in the TV area or dining room. Staff failed to reposition the resident for approximately seven hours.

Observations on 01/31/24 from 8:53 a.m. until 3:00 p.m. showed Resident #81 seated in her wheelchair in the TV area or dining room. Staff failed to reposition the resident for approximately

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F 686	Continued From page 15 six hours. During an interview on the morning of 02/01/24, an administrative nurse (#1) stated staff should assess the area to Resident #15's coccyx weekly. During an interview on the afternoon of 02/01/24, an administrative nurse (#1) confirmed staff should reposition Resident #15 and #81 and keep pressure off Resident #80's left heel.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to provide appropriate and sufficient supervision and/or assistive devices for 2 of 15 sampled residents (Resident #11 and #25) observed during transfers. Failure to provide appropriate assistance and assistive devices during transfers placed the residents at risk for accidents, falls, and/or injuries. Findings include: Review of the policy/procedure titled "Safe Resident Handling Program Resource Packet"	F 689	1) Charge nurse will be responsible for ensuring fall huddle investigation is completed after each fall / found on floor incident as soon as resident□s needs are met but no later than end of shift for staff working at time of fall. Resident #25 will be transferred as per care plan. 2) All residents have the potential to be affected by this deficient practice. 3) Facility investigative team (administrator, DNS and Social Services Designee) will be re-educated by GSS Regional Clinical Services Director on 2/27/24 on GSS Incident Reporting Policy	3/15/24

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F 689	Continued From page 16 occurred on 01/30/24. This policy, revised 08/01/23, stated, ". . .The Care Plan is part of the communication process to the caregiver. Interventions must include. . . the type and size of the sling, the size of the harness, and the number of employees required for safety . . ." - Review of Resident #11's medical record occurred on all days of survey. The current care plan stated, ". . . TRANSFER: Resident requires limited assist of 1 [staff member] pivot transfer . . . The resident is at risk for falls R/T [related to] balance problems and left sided weakness from cva [cerebrovascular accident, i.e., stroke]. Found on floor 09/12/2023 . . . Educate resident about safety reminders and to call for assist with transfers and toileting . . ." A fall investigation, dated 09/12/23, identified Resident #11 had a fall in the bathroom after getting up from the toilet and attempting to self-transfer. The investigation failed to identify if Resident #11 used her call light. Observation on 01/30/24 at 8:53 a.m. showed Resident #11 seated in her wheelchair by her bed with the call light on. At 9:09 a.m., a certified nurse aide (CNA) entered the room, shut off the call light, and left the room. Observation showed Resident #11 had already self-transferred to the toilet. During an interview on 01/30/24 at 10:40 a.m., Resident #11 stated, "If you put your light on, they'll [staff] come and help. But usually by the time they get here I'm already on the toilet." The resident stated sometimes she cannot wait that long for staff to assist her.	F 689	and Procedure specific to timely thorough investigation of all incidents. All nursing staff will be re-educated by DNS or designee on 02/28/2024, or prior to next scheduled shift, on the requirement of participating in / completing the fall huddle investigation for all falls and providing care as per care plan, specific to resident transfers. 4) The Director of Nursing or designee will conduct resident transfer observation audits and documentation review on three residents to ensure their most recent Sit-To-Stand-Walk Collection Tool matches the care plan intervention and care is provided as per care plan. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months. Audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5) This corrective action will be completed by March 15, 2024.	

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F 689	Continued From page 17 - Review of Resident #25's medical record occurred on all days of survey. The care plan stated, ". . . TRANSFER: Extensive assist of 2 with sit to stand lift medium size harness . . . Toilet use: Resident requires extensive assist of 2 . . ." Observation on 01/30/24 at 8:53 a.m. showed two CNAs (#5 and #6) transferred Resident #25 from the bed to the toilet with the sit-to-stand mechanical lift. At the end of the observation, Resident #25 reported to the CNAs (#5 and #6) the harness they used was too small, and he required the medium sized harness that hung on the bathroom door. The CNAs failed to use the appropriately sized harness for the resident while transferring. Observation on 01/30/24 at 1:47 p.m. showed a CNA (#6) assisted Resident #25 off the toilet with a mechanical sit-to-stand lift. The CNA failed to request assistance from another staff member for the transfer. During an interview on 02/01/24 at 12:24 p.m., an administrative staff member (#1) confirmed facility staff failed to follow Resident #25's care plan for transfers.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		3/15/24

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F 690	Continued From page 18 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide appropriate incontinence care for 1 of 15 sampled residents (Resident #15) who required staff assistance with toileting. Failure to provide incontinence care may result in a loss of dignity and placed residents at risk for skin breakdown and urinary tract infections (UTIs).	F 690	1) Bladder Evaluation and Bowel Evaluation completed on 2/23/24 for Resident #15□s and care plan reviewed / updated as indicated. 2) This deficient practice has the potential to affect all residents. 3) All nursing staff will be re-educated by DNS or Designee on 02/28/2024 or prior	

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F 690	Continued From page 19 Findings include: Review of Resident #15's medical record occurred on all days of survey. Diagnoses included dementia and a hospitalization in November 2023 for a UTI. The care plan identified, ". . . check and change q [every] 2-3 hours during the day and q 4 [hours] at night . . . TOILET USE: Resident is not toileted . . ." A skin assessment, dated 01/18/24, stated, ". . . Coccyx . . . slight redness/intact scab remained to coccyx area and Mepilex applied for protection. . . ." Observations on 01/30/24 from 8:10 a.m. until approximately 11:45 a.m. showed Resident #15 seated in her wheelchair in the living room area. At 11:45 a.m., staff took the resident to the dining for lunch, and at approximately 12:35 p.m., brought the resident to her room to lie down. Staff failed to check and change the resident during this time (approximately 4.5 hours). Observation on 01/31/24 from 8:15 a.m. until approximately 11:45 a.m. showed Resident #15 seated in her wheelchair in the living room area. At 11:45 a.m., staff took the resident to the dining room for lunch. After lunch, staff brought the resident to the living room where she remained in her wheelchair until 2:11 p.m. (approximately six hours). At 2:40 p.m., observation showed Resident #15 lying in bed. Bowel and bladder charting for the afternoon of 01/31/24 showed Resident #15 was incontinent of urine and a large bowel movement. The facility staff failed to provide incontinence cares for Resident #15 for periods of 4.5 to 6	F 690	to next scheduled shift, on providing care as per care plan specific to toileting and incontinent care. 4) The Director of Nursing or designee will conduct observation audits three residents per week to ensure each is being toileted per order or care plan at the following frequency: once per week for two months, every two weeks for two months, and monthly for two months. Audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations. 5) This corrective action will be completed by March 15	

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F 690	Continued From page 20 hours, placing the resident at risk for further skin breakdown and UTIs.	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to maintain acceptable parameters of nutritional status for 1 of 2 sampled residents (Resident #81) with weight loss. Failure to routinely monitor and evaluate weights, ensure timely weight loss interventions and consistently implement them, accurately document intakes, and periodically review existing interventions and evaluate the need for updated interventions resulted in	F 692	1) Consulting Dietitian and Physician are collaborating with facility staff to address Resident #81 weight loss, poor appetite and nausea, continuing to adjust orders / interventions. On 2/22/24 weight stable for last month, will continue to monitor. Facility now reviews all residents weights and dietary changes at clinical meeting each business day, reporting significant changes to dietitian and physician.	2/23/24

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F 692	Continued From page 21 continued weight loss for Resident #81. Findings include: Review of the facility policy titled "Weight and Height" occurred on 02/01/24. This policy, dated 09/18/23, stated, ". . . PURPOSE . . . To ensure that the resident maintains acceptable parameters of nutritional status regarding weight . . . To monitor weight loss or gain in a resident . . . All residents are weighed at a minimum of weekly for the first four weeks following admission . . . Residents at nutritional risk will be weighed weekly . . ." Review of the facility policy titled "Nutrition and Hydration - Food and Nutrition" occurred on 02/01/24. This policy, dated 04/12/23, stated, ". . . POLICY: The location ensures that each resident maintains acceptable parameters of nutritional status such as usual body weight or desirable body weight range and electrolyte balance unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. . . . Provide nutritional care and services to each resident, consistent with the resident's comprehensive assessments and periodic reassessments. a. Identify, implement, monitor and modify interventions (as appropriate) that are consistent with the resident's assessed needs, choices, preferences, goals and current professional standards of practice to maintain acceptable parameters of nutritional status. b. Monitor weight and intake of food and drinks. . . ." Review of Resident #81's medical record occurred on all days of survey. Diagnoses	F 692	2) All residents have the potential to be affected by this deficient practice. 3) All nurses and medication aides will be re-educated by DNS or designee on the importance of accurate documentation of food and nutritional supplement intake, and weights. GSS weight policy and procedure will be reviewed specific to re-weighs and frequency of weight monitoring. Documentation of nutritional supplements will include administration and amount consumed. The nutritional risk committee will meet monthly and follow the GSS Nutritional Risk Committee policy and procedure. 4) The Certified Dietary Manager or designee will conduct documentation audit to verify weights, food and nutritional supplement intake is present; physician and dietitian notification with at risk changes and verify that nutritional risk committee meets monthly. Audits will be completed 1 X / week for 4 weeks, then 1 X / month for 2 months, then quarterly X 1. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations. 5) The corrective action will be completed by February 23, 2024.	

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F 692	Continued From page 22	F 692		

included diabetes mellitus Type II, hypertension, and deafness. An admission Mini-Nutritional Assessment (MNA), completed by the dietician on 10/26/23, identified a score of 10, indicating at risk of malnutrition. The current care plan identified, ". . . The resident has unplanned/unexpected weight loss R/T [related to] nausea and poor intakes. Date Initiated: 01/15/2024 . . . Resident will maintain weight between # [pounds] 155-165 . . . Resident prefers fluids to help maintain/increase weight. Resident loves drinking juices and boosts. offer food first then fluids if less than 50% intake at meals. . . ." The record lacked evidence of implementation of a care plan related to weight loss prior to 01/15/24.

Weights obtained since admit included:
*10/19/23 194.4 pounds (Lbs) (admission weight)
*11/16/23 179.5 Lbs
*12/07/23 161.0 Lbs
*12/14/23 no weight recorded
*12/21/23 159.5 Lbs
*12/28/23 159.5 Lbs
*01/04/24 158.5 Lbs
*01/11/24 no weight recorded
*01/19/24 160.8 Lbs
*01/25/24 156.0 Lbs
*Staff failed to monitor Resident #81's weight for four weeks following admit. Staff failed to monitor the resident's weight weekly after the dietician determined the resident to be at nutritional risk. The weights obtained by staff showed a 14.9 lb weight loss (7.6%) in 30 days (October 19-November 16), and an additional 18.5 lb weight loss (10.3%) over the next three weeks (November 16-December 7).

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Dietary notes identified the following:
*11/20/23 at 12:45 p.m.: ". . . Wt: [weight] 179.5#, down 15# or 8% in the past month = significant loss. This is resident's 2nd weight since admission. Some of the weight loss may be r/t [related to] fluids as resident was started on bumex [a diuretic started on 11/08/23] d/t [due to] poor kidney function. . . . Intake averages 50%. Staff has been giving soup and pizza in place of other items that resident doesn't seem to like. She drinks apple juice at meals, and will eat Boost pudding when offered. Wrote down questions for resident re: [regarding] food. She pointed to "snacks" on the piece of paper and nodded her head when I mentioned "do you like cookies, pudding, yogurt?". Will add fortified to diet order and recommend a high kcal [kilocalorie] snack between meals. Will continue to monitor weekly weights. . . ."

The record identified staff failed to obtain weekly weights until ordered by the physician on 12/06/23. Review of nursing assessments during this time showed Resident #81 had 1+ edema (slight pitting that disappears rapidly) to 2+ (deeper than 1, disappears in 10-15 seconds) edema in her bilateral lower extremities.

*12/04/23 at 12:23 p.m., ". . . Notified of continued poor intake. Resident is only eating 25% meals this past week. No new weight available. Visited with resident's daughters about weight loss and poor appetite. They provided a list of food likes and dislikes. Posted list in kitchen. Resident was given preferred foods at noon meal today, and still refused to eat most of it. She would look at it and shake her head. She is being offered high kcal snack between meals

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and a high kcal shake at 2 pm. Continue to offer and encourage intake as resident will accept. . . ."

*12/18/23 at 12:09 p.m.: ". . . Wt: 161#, significant weight loss of 10% in 3 weeks. Resident's appetite remains very poor. She is eating 25% or less at most meals. She is refusing her favorite foods. Staff reports that she has been drinking well. Will add 240 ml [milliliters] Boost [a nutritional supplement] BID [twice a day] between meals. Continue to encourage intake as resident will accept. . . ."

*01/04/24 at 12:13 p.m.: ". . . Wt: 158#, down 3# in the past month. Weight has stabilized since starting 240 ml Boost BID. Meal intakes remain poor for the most part, eating 25% at meals with an occasional 75-100%. The kitchen offers preferred foods. Resident continues to c/o [complain of] abdominal pain. Unsure if any testing has been done to determine cause. Continue current plan. . . ."

Observations identified the following:
*01/29/24 12:06 p.m.: Resident #81's breakfast tray, containing one piece of toast and 240 ml of supplement, on top of a toaster in the living room area. The tray was untouched, and intake records for the meal identified 0-25% eaten.
*01/30/24 at 8:43 a.m.: Resident #81 eating breakfast in the living room area. The tray contained toast and 240 ml of supplement. Resident #81 drank the supplement but did not attempt to eat the toast. A certified nurse aide (CNA) removed the tray and failed to offer Resident #81 other foods/fluids.
*01/30/24 at 11:45 a.m.: An unidentified CNA

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took Resident #81 to the dining room. Observation showed no supplement given during the morning medication pass.
*01/30/24 at 11:58 a.m.: Resident #81 sat a table in the dining room. The resident drank 240 ml of supplement and 120 ml of water. At 12:10 p.m., staff brought the resident her meal tray, which consisted of 120 ml juice, pasta, a breadstick, and cheesecake. The resident drank her juice and ate two bites of cheesecake. Throughout the meal, Resident #81 repeatedly lifted her drink glasses to her mouth and tried to take additional drinks from the empty glasses. Observation showed a CNA sat with her at the table, assisting another resident to eat. At 12:35 p.m., the CNA asked the resident if she was ready to go and removed her from the dining room. The CNA and other staff failed to offer Resident #81 additional food/fluids. Intake records for this meal identified staff documented the resident ate 26-50%.
Failure of staff to accurately document intakes misrepresents actual intakes consumed by the resident and may result in a delay of additional nutritional interventions necessary to prevent further weight loss.
*01/30/24 at 2:08 p.m.: Resident #81 received 120 ml (not 240 ml as ordered) of supplement, of which she drank 100%. During an interview on 01/30/24 at 4:22 p.m., a medication aide (MA) (#3) identified the nurses sign off the supplement in the medication administration record (MAR). The MA identified the supplement comes from the dietary department (around 2:00 p.m.), and the CNAs pass it out. The MA stated the drink Resident #81 had was her afternoon supplement.
*01/31/24 at 9:10 a.m.: Resident #81 seated in the living room area with her breakfast tray, consisting of toast and 240 ml supplement. At

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9:29 a.m., a staff member attempted to feed the resident a bite of toast, which the resident did not want. The resident consumed 100% of her supplement. The staff member then removed the tray and failed to offer the resident additional food/fluids.
*01/31/24 at 11:45 a.m.: Staff brought Resident #81 to the dining room for lunch. Observation showed Resident #81 did not receive a supplement during the morning medication pass (between the breakfast meal and the lunch meal).

During an interview on 01/31/24 at 1:38 p.m., a MA (#8) stated she does not give residents supplements, and they come from the dietary department. The MA stated the supplement listed on the MAR for the a.m. medication pass is the one Resident #81 receives at lunch, and the supplement for the p.m. medication pass will be given at supper. The MA stated the dietary department gives the supplements, but the nurses or MAs sign them off in the MAR.

The MAR identified, "House Supplement two times a day Give 240 ML of Boost BID. Start Date 12/22/2023," scheduled for the a.m. and p.m. medication pass. The MAR identified staff recorded the supplement intakes as check marks (and not the actual amount in milliliters).

During an interview on the morning of 02/01/24, an administrative nurse (#4) stated the nurses or MAs should give the supplements as they are listed on the MAR.

The facility failed to routinely monitor and assess Resident #81's weight, which resulted in delayed

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F 692	Continued From page 27 interventions for weight loss and a 33.4 pound weight loss (17%) in less than two months. The facility also failed to accurately document intakes and consistently implement existing weight loss interventions which may have contributed to further weight loss.	F 692		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to identify a history of trauma, and/or trauma triggers for 1 of 2 sampled residents (Resident #3) reviewed for Post-Traumatic Stress Disorder (PTSD) and/or Trauma. Failure to identify a resident's history of trauma and/or trauma triggers may cause re-traumatization. Findings include: Review of the facility policy and procedure titled "Trauma Informed Care" occurred on 01/31/24. This policy/procedure dated 11/16/23, stated, ". . . Staff will ensure that residents who experience trauma receive culturally competent, trauma-informed care . . . accounting for residents' experiences and preferences in order	F 699	1) Resident #3 Trauma Assessment was completed on 2/2/24 Resident #3□s care plan was updated on 2/2, 2024 potential for well-being deficit from childhood trauma and 2/22/24 to include PTSD diagnosis. 2) All residents with traumatic life experiences and PTSD diagnosis have the potential to be affected by this deficient practice. 3) The Social Work Designee, MDS Coordinator and all nurses will be re-educated by DNS on 02/28/2024 or prior to next scheduled shift on GSS Trauma Informed Care Policy and Procedure, to include the importance of resident□s well-being, completion of trauma assessment, and integrating	3/15/24

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F 699	Continued From page 28 to eliminate or mitigate triggers that may cause re-traumatization . . ." Review of Resident #3's medical record occurred on all days of survey. The record showed a diagnosis of PTSD. A psychiatry provider note, dated 09/25/23, stated, ". . . patient endorses history meeting DSM [Diagnostic and Statistical Manual of Mental Disorders] criteria for PTSD. Symptoms include nightmares, flashbacks, startle response, and intrusive thoughts/memories. The patient will also have significant panic when these occur. Symptoms can occur in any setting . . ." The record lacked development of a plan of care that identified the resident's history of trauma, symptoms, and/or potential triggers which may cause re-traumatization. During an interview on 02/01/24 at 12:24 p.m., an administrative staff member (#1) confirmed the facility failed to identify/develop a care plan for Resident #3's PTSD and its potential triggers.	F 699	trauma-informed care interventions/diagnoses in the care plan for each resident, if applicable. 4) The Social Work Designee or designee will audit all residents who have PTSD or have the potential to have PTSD to ensure they have a current trauma assessment completed, with complete care plan with any pertinent diagnoses, triggers and interventions at the following frequency: weekly for two months, every two weeks for two months and monthly for two months. The audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5) The corrective action will be completed by March 15, 2024.	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		3/15/24

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F 725	Continued From page 29 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of resident council meeting minutes, and resident, staff and family interviews, the facility failed to ensure sufficient nursing staff and related services available at all times to meet the residents' needs for 5 of 16 sampled residents (Residents #9, #11, #12, #24, and #25) who required assistance. Failure to provide sufficient staffing may result in residents experiencing falls, poor hygiene, incontinence, and skin issues and may negatively affect the residents physical, mental, and psychosocial well-being Findings include: Review of the facility policy titled "Nursing Services Staff" occurred on 01/31/24. This policy, revised October 2023, stated, ". . . The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725	1) Residents #12, #24, #9, #25, and #11 were individually interviewed by managers to address their staffing concerns, share our interventions and to provide a time for the resident to express their feelings. 2) All residents have the potential to be affected by this deficient practice. 3) Nursing schedule will be adjusted to include a full time bath aide. Staffing and care concerns will be added to the monthly resident council meeting agenda to continue to receive resident input. System change to include facility leadership rounding / checking on and visiting with residents each business day with resident. All staff will be re-educated by DNS on 02/28/2024 or prior to next scheduled shift, on timely cares, answering call lights in a timely manner, customer service skills, as well as helping	

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F 725	Continued From page 30 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Review of the resident council meeting minutes, dated October 2023-January 2024, identified the following resident concerns: * "There are cutbacks on CNAs [certified nursing assistants] and it's affecting us." * "Nights are the worst for call light response time." * "They come in at 6:30 p.m. and ask if we're ready for bed! If we say no, we won't see them again until 10:30 -11:00 p.m." * "There is 1 CNA on for the whole facility." * "Snack cart not going around to the rooms." Observation on 01/29/24 at 4:27 p.m. showed Resident #11 in the bathroom with the call light on. At 4:49 p.m. (22 minutes later), staff entered the room to provide assistance. Resident interviews on 01/29/24 identified the following: *At 12:22 p.m., Resident #12 stated, "They [the facility] don't have nearly enough help." He also stated on Sunday morning (01/28/24) there was one CNA for the whole facility for awhile, and "That's not right." *At 1:43 p.m., Resident #24 reported the facility is short staffed in the nursing department with only one or two CNAs per shift, resulting in call lights not being answered timely. "I have waited an hour to an hour and a half for staff to answer my call light at times." *At 1:53 p.m., Resident #9 stated residents sometimes have to wait awhile to have their call	F 725	the resident reach their highest psychosocial well-being. 4) The Director of Nursing or designee will audit staffing levels (# residents / CNA) and care observations related to bathing, passing trays, call light times, missed therapies, cares provided, incontinence, skin integrity issues, falls, and psychosocial well-being on three residents weekly at the following frequency: weekly for two months, every other week for two months, and monthly for two months. Audit results will be submitted to the monthly QAPI Committee meeting for review and recommendations. 5) The corrective action will be completed by March 15, 2024.	

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light answered. Resident #9 stated, "They [the facility] could use more help. They're always looking [for staff]."
*At 1:57 p.m., Resident #25 reported he soiled his pants waiting an hour to an hour and a half for staff to answer his call light. The resident also stated he missed his morning physical therapy one day because staff did not assist him with getting dressed in time.
*At 2:43 p.m., Resident #11 stated, "Oh, yes, they are short staffed."
*At 4:45 p.m., Resident #25 stated, "Now they're [the staff] telling me they have to have two [staff] to get me up because you're [the surveyors] here. It's hard enough to get one person to help now you say they have to have two." Resident #25's care plan identified two staff members required for transfers.

Resident and family interviews on 01/30/24 identified the following:
*At 9:59 a.m., family member #1 stated on 01/28/24, their family member did not receive a lunch tray until 3:00 p.m. Family member #1 also stated the facility is short staffed and do not get their family member up in his chair because "they do not have enough staff."
*At 10:40 a.m., Resident #11 stated, "If you put your light on, they'll [staff] come and help. But usually by the time they get here I'm already on the toilet." The resident identified sometimes she cannot wait that long for staff to assist her.
*At 2:00 p.m., Resident #12 stated the facility is short staffed, residents wait a long time for staff assistance, and sometimes residents are not receiving a bath because staff are too busy.

During an interview on the afternoon of 01/31/24,

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F 725	Continued From page 32 an administrative nurse (#4) acknowledged the facility is short staff on many shifts. Refer to F677, F686, F689, F690, and F692.	F 725		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of the facility's nursing staff schedules, and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for 2 of 92 days reviewed (10/7/23 and 10/28/23). Failure to ensure sufficient, qualified nursing staff are available eight consecutive hours a day has the potential to affect the health and safety of all residents residing in the facility. Findings Include: Review of the facility policy titled "Nursing	F 727	1) Administrator, DNS and scheduler understand the requirement of 8 consecutive hour RN coverage seven days / week. 2) All residents have the potential to be affected by this deficient practice. 3) The facility□s nursing schedule will include 8 consecutive hour RN coverage 7 days / week. If RN is not available to meet this requirement, this will be immediately reported to DNS and Administrator so schedule adjustments can be made for compliance. 4) The Director of Nursing or designee	3/15/24

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F 727	Continued From page 33 Services Staff" occurred on 01/31/24. This policy, revised October 2023, stated, ". . . The location will use the services of a registered nurse for at least eight consecutive hours a day, seven days a week . . ." Review of the nursing schedule for the time period of 10/01/23 to 12/31/23 showed showed the facility lacked the required RN coverage on 10/07/23 and 10/28/23. During an interview on 01/31/24 at 10:38 a.m., an administrative nurse (#1) confirmed the facility lacked eight consecutive hours of RN coverage on 10/07/23 and 10/28/23.	F 727	will perform an audit to ensure there are eight consecutive hours of RN coverage seven days a week. These audits will be performed weekly for two months, every two weeks for two months and monthly for two months. Audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5) Corrective action will be completed by March 15, 2024.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure residents remained free from significant medication errors for 1 of 1 supplemental resident (Resident #17) reviewed who experienced a medication error. Failure to practice professional standards of medication administration resulted in Resident #17 receiving a double dose of Methadone (a narcotic analgesic), a missed dose of Lorazepam (an antianxiety medication), and an as needed (PRN) dose of Morphine Sulfate (narcotic analgesic) too early which have resulted in negative health outcomes.	F 760	1) Resident #17□s side effects from medication error are resolved. 2) All residents have the potential to be affected by this deficient practice. 3) All nurses and medication aides will be re-educated by DNS or designee on 03/01/24 on the GSS Medication Administration policy and procedure to include the requirement of following the six rights,: right medication, right dose, right resident, right route, right time and right documentation. 4) The Director of Nursing or designee will conduct medication administration observation audits to ensure the six rights	3/15/24

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F 760	Continued From page 34 Findings include: Review of the facility policy titled "Medication: Administration Including Scheduling and Medication Aides." This policy, revised 03/29/23, stated ". . . Follow the 'Six Rights': Right medication, right dose, right resident, right route, right time, and right documentation. . . Perform three checks: Read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication. . ." Review of Resident #17's medical record occurred on 01/30/24. Diagnoses included pain in unspecified joint and anxiety disorder. Physician's orders included the following: *Methadone HCl (hydrochloride) tablet 5 milligrams (mg), 1 tablet by mouth three times a day for chronic pain *Lorazepam tablet 0.5 mg, 1 tablet by mouth two times a day related to anxiety disorder *Morphine Sulfate, 6 mg by mouth every 4 hours as needed for pain, may give 2 hours after scheduled Methadone An Incident Report, dated 01/19/24 at 7:42 p.m., stated, "Med [medication] Aid gave a dose of Methadone (5mg) instead of her [Resident #17's] dose of Lorazepam (0.5mg) during the PM [evening] med pass at 1942 [7:42 p.m.]. He also gave her [Resident #17] a PRN dose of her Morphine (0.3ml) at the same time. I gave her scheduled Methadone dose at 2113 [9:15 p.m.]. We discovered the mistake during our count of the cart at 2230 [10:30 p.m.]."	F 760	are being followed for at least six random medication administrations at the following frequency: weekly for two months, every other week for two months, every month for two months. Any deficient practice identified will be immediately addressed. Audit findings will be submitted to the monthly QAPI Committee for review and recommendations. 5) Corrective action will be completed by March 15, 2024	

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F 760	Continued From page 35 During an interview on 02/01/23 at 12:24 p.m., an administrative staff member (#1) confirmed the above incident resulted in significant medication errors for Resident #17.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview the facility failed to ensure safe and secure storage of controlled	F 761	1) Upon discovery, Gabapentin is now stored in the controlled substances lock box on the medication cart, so it is double	3/15/24

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F 761	Continued From page 36 medications for 1 of 1 medication cart. Failure to store medications securely may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled "Medication Storage" occurred on 01/31/24. This policy, dated August 2021, stated, ". . . 1. General guidelines: a. All drugs and biologicals will be stored in locked compartments. . . during medication pass, medications must be. . . locked in the medication storage area/cart. . . ." Review of the facility policy titled "Medication Administration" occurred on 01/31/24. This policy, dated March 2023, stated, ". . . controlled drugs . . . and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments . . ." Review of the facility policy titled "Medications: Controlled" occurred on 1/31/24. This policy, dated June 2023, stated ". . . Controlled Medications: . . . schedules II-V, have a potential for abuse . . ." Observations during medication pass on 01/29/24 at 4:51 p.m. and 01/30/24 at 1:10 p.m. showed pregabalin and Gabapentin (schedule V controlled medications) stored throughout the medication cart and not double locked. During an interview on 01/31/24 at 10:45 a.m., an administrative staff member (#1) confirmed staff failed to double lock pregabalin and Gabapentin.	F 761	locked. 2) All residents on a scheduled / controlled medication have the potential to be affected by this deficient practice. 3) All nurses and medication aides will be re-educated by DNS on 02/28/2024, or prior to next scheduled shift, on the requirement of double locking all schedule II-V medications, including Gabapentin. 4) The Director of Nursing or designee will conduct audits on the double-locking of all schedule II-V medications at the following frequency: weekly for two months, every other week for two months, and monthly for two months. Audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5) Corrective action will be completed by March 15, 2024.	
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		3/15/24

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F 812 SS=F	Continued From page 37 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, review of product information, and staff interview, the facility failed to store, prepare, and serve food in a sanitary manner for 1 of 1 kitchen. Failure to label, date and discard food, monitor and record sanitizing levels of the dishwashing machine, and ensure the appropriate concentration levels of sanitizer solution has the potential to affect food quality and may result in the spread of foodborne illness to residents, staff, and visitors. Findings include:	F 812	1) The affected foods covered with ice were disposed of on February 1, 2024. All temperatures for the dishwasher and food served will be monitored / recorded in log per policy. The Oasis Multi-Quat sanitizer reading 100 ppm was replaced on February 1, 2024 so the concentration reached 300 ppm. 2) All residents have the potential to be affected by this deficient practice. 3) All dietary staff will be re-educated by the Certified Dietary Manager on 02/15/2024 or prior to next scheduled shift on proper storage and disposal of	

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F 812	Continued From page 38 FOOD STORAGE Review of the facility's policy titled "Food Storage" occurred on 01/31/24. This policy, revised November 2010, stated, ". . . foods opened will be placed in an enclosed container, dated and labeled . . . the date/time the original container is opened . . . expiration dates will be checked on a regular basis and foods/fluids which have expired will be discarded . . ." A tour of the kitchen occurred on 01/29/24 at 1:30 p.m. with a dietary manager (#7). Observation in the walk-in freezer showed the following opened and undated food items: * One box of chicken breasts covered with frost/ice * One box of pork rib patties covered with frost/ice * One container of ham covered with frost/ice During an interview on 01/29/24 at 1:30 p.m., a dietary manager (#7) stated she expected staff to cover and date food when opened and discard freezer damaged food. DISHWASHER Review of the facility's policy and procedure titled "Dishwashing" occurred on 01/29/24. This policy, revised March 2009, stated, ". . .Check temperatures for proper temperature for wash and rinse cycles each meal service . . . 150 F [Fahrenheit] wash . . . 180 F rinse . . . (160 F or greater at the rack and dish/utensil surfaces) . . . record temperature on dish machine temperature log . . . dish machine using hot water to sanitize . . . if temperatures are outside acceptable	F 812	frozen food, proper monitoring of dishwasher temperatures and proper monitoring of food temperatures. 4) The Certified Dietary Manager or designee will audit proper storage and disposal of frozen food, proper monitoring of dishwasher temperatures and proper monitoring of food temperatures at the following frequency: weekly for two months, every two weeks for two months, and every month for two months. Audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5) Corrective action will be completed by March 15, 2024.	

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F 812	Continued From page 39	F 812		

parameters, staff will notify the director of dietary services (DDS) or maintenance before proceeding with dishwashing . . ."

A tour of the kitchen occurred on 01/29/24 at 1:30 p.m. with a dietary manager (#7). Observation in the dishwashing room showed a dietary staff member (#9) washing the lunch meal dishes using a high temperature dishwashing machine. The staff member ran two loads of dishes through the dishwasher, with the dishwasher reaching a maximum temperature of 155 degrees F at the dish level. The dietary manager (#7) asked the dietary staff member (#9) to drain the dishwasher, refill with hot water, and run the machine again. The staff member rewashed the dishes, and the maximum temperature reached 161 degrees F the dish level.

Review of the dishwasher temperature logs from November 1, 2023 through January 28, 2024, showed staff failed to record dishwasher temperatures for 16 of 89 days, and 18 of 73 documented entries showed out of range temperatures. Staff failed to monitor and record temperatures at each meal service and report to the DDS or maintenance when temperatures were out of range.

During an interview in the afternoon on 01/29/24, a dietary manager (#7) verified staff failed to monitor and record dishwasher temperatures at each meal service.

SANITIZING SOLUTIONS

Review of the facility policy titled, "Sanitizing Solutions" occurred on 02/01/24. This policy,

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F 812	Continued From page 40 revised November 2012, stated, ". . . To promote the effective use of solutions on direct contact surfaces used for food areas . . .". Review of Oasis 146 Multi-Quat sanitizer product information occurred on 01/29/24 and stated, "Oasis 146 is an effective sanitizer against Escherichia coli and Staphylococcus aureus on food contact surfaces . . . 150 ppm [parts per million] to 400 ppm Quat Range . . ." The Food and Drug Administration (FDA) Food Code 2022, Page 453, stated, ". . . The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitization . . ." A tour of the kitchen occurred on 01/29/24 at 1:30 p.m. with a dietary manager (#7). Observation showed a dietary aide (#9) wiped counters and dining room tables with a cloth from a container of sanitizer solution. The dietary manager (#7) stated the container held a mixture of water and Oasis Multi-Quat sanitizer used for cleaning the kitchen. When asked to test the concentration of the sanitizer, the dietary manager obtained a result of 100 ppm. The dietary aide (#9) mixed a new container of sanitizer solution, and retested the solution at 300 ppm. During an interview in the afternoon on 01/29/24, a dietary manager (#7) verified staff failed to ensure appropriate sanitizer concentration.	F 812		