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	0016752	A. BUILDING: _____ B. WING _____	C 09/15/2023

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N 000	Initial Comments On 08/31/2023, Surverys conducted an unannounced facility visit to investigate 1 complaint. Additional information was received through 09/15/2023. The complaint was unsubstantiated and 4 deficiencies were identified. One of 4 deficiencies was a repeat violation. Census: 20	N 000		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview, Administrator J did not provide the supervision necessary to ensure all residents received proper care and treatment. Findings include: Prior to conducting the onsite visit, Surveyor reviewed the provider's compliance history. During a survey ending 01/03/2023, the	N 214		

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

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Department issued 8 deficiencies including the following:

Rights of Residents Free From Mistreatment - the provider did not ensure Resident 7 was free from neglect. The provider did not secure or maintain adequate care or services to meet Resident 7's needs for pressure injury prevention or care. Within 20 days of admission, Resident 7 developed 6 new pressure injuries including a stage IV (the most serious) injury. Resident 7 was hospitalized, developed other infections and eventually died.
Rights of Residents Adequate Treatment - Resident 2 had a medical condition that impacted his/her brain function and ability to recognize and respond to bowel incontinence. The provider did not ensure Resident 2 received prompt incontinence care or adequate assistance cleaning fecal matter from his/her room and bedding.

As a result of the deficiencies on 02/16/2023, the Department issued the following enforcement actions:

Order to comply with requirements.
Order not to admit new or additional residents (lifted 04/24/2023.)
Order to correct all deficiencies in consultation with a qualified professional not currently affiliated with the licensee.
Order for consultation to include development or revisions of procedures to address "Adequate Treatment, including how the facility will: (a) assess risk factors contributing to skin integrity concerns including pressure injuries, (b) implement pressure injury prevention and treatment, (c) monitor and document changes in a resident's health, (d) notify the physician, notify

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the resident's legal representative or family, notify the care manager (if any) when a resident experiences a change in health status or medical emergency, (e) ensure timely medical assessments and emergency medical care, (f) review and revise individualized service plans annually or when there is a change in a resident's needs, abilities or physical or mental condition, and (g) implement standards of practice for medical records to ensure each resident's record is accurate, current, and complete.

During the current survey, new concerns were identified with pressure injury prevention and treatment.

On 08/31/2023 Surveyor observed and interviewed Resident 1 and reviewed portions of his/her facility file. Resident 1 had diagnoses to include dementia and multiple sclerosis. S/he was incontinent of urine and dependent on staff for all needs related to toileting, transferring and repositioning. In addition to those risk factors, Resident 1 had a history of pressure injuries as recently as May 2023. Resident 1's individualized service plan current as of 08/31/2023, did not identify his/her risk for or history of pressure injuries, interventions to manage exiting pressure injuries or strategies to prevent the development of new pressure injuries.

On 09/05/2023, Surveyor reviewed hospice records (date range of 06/14 - 09/05/2023.) The records documented the recurrence or development of 6 pressure injuries, including a stage II pressure injury on his/her coccyx first identified 09/04/2023.

On 09/14/2023 at 12:30 p.m., Surveyor interviewed Registered Nurse (RN)/Administrator

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N 214	Continued From page 3 J. S/he confirmed Resident 1 was at risk for pressure injuries and had developed several since June 2023. However, s/he had not assessed Resident 1's wounds for about 1 month and was not aware of the stage II coccyx wound identified by hospice staff 10 days prior. RN Administrator J also stated s/he had not been reviewing Resident 1's charting closely to ensure caregivers were providing and charting necessary incontinence care or repositioning. Cross Reference: N0535 DHS 83.23(2)(i) Rights of Residents: Adequate Treatment	N 214		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 received prompt and adequate care. Resident 1 was at risk for the development of pressure injuries due to his/her age, diagnoses, incontinence and inability to independently ambulate or position him/herself. Between June 2023 and September 2023 Resident 1 did not receive prompt toileting and repositioning assistance for the prevention and management of pressure injuries. During this timeframe s/he developed 5 new pressure injuries and 2	N 353		

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previously identified pressure injuries worsened. In addition, Resident 1 did not receive adequate care with feeding assistance.

This is a repeat deficiency. See Statement of Deficiency (SOD) #5S2P14, dated 01/03/2023.

Findings include:

The facility is licensed to serve up to 20 residents from the following client groups: developmentally disabled, irreversible dementia/Alzheimer's and advanced age. At the time of the survey the census was 20 and at least 4 residents (Residents 1, 3, 5 and 6) were at risk for the development of skin breakdown and pressure injuries due to age, diagnoses, incontinence and limited ability to reposition or ambulate.

On 08/31/2023, Surveyor reviewed portions of Resident 1's facility record. S/he was admitted to the facility on 06/15/2022. Resident 1 was elderly, non-ambulatory and had diagnoses to include multiple sclerosis, dementia, and functional urinary incontinence. Resident 1's individual service plan (ISP) identified his/her complete dependence on staff for assistance with toileting every two hours, repositioning and all activities of daily living. Resident 1 required the use of a mechanical lift for transfers and a Broda wheelchair for ambulation. In August 2022 the medication administration record (MAR) identified the need for repositioning assistance and pressure relief with a goal to prevent pressure injuries. On 10/28/2022 Resident 1 established services with Hospice.

Resident 1's record documented the development of pressure injuries on the bilateral heels during March (right heel) and May (left heel) 2023. In

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response, some documentation in the record identified the need to wear pressure relieving boots on the heels. However, Resident 1's ISP current as of 09/07/2023, was silent to skin integrity concerns. The ISP did not identify the history of pressure injuries, interventions to manage existing pressure injuries or strategies to prevent the development of new ones.

According to Cleveland Clinic, "Bedsores (also called pressure injuries, pressure wounds or decubitus ulcers) are wounds that occur from prolonged pressure on your skin. People who are immobile for long periods, such as those who are bedridden or use a wheelchair, are most at risk for bedsores. These painful wounds, or pressure ulcers, can grow large and lead to infections. In some instances, bedsores can be life-threatening ... Bedsores are most likely to develop on the parts of your body where your bones sit closest to your skin, such as your ...buttocks ...heels, hips and tailbone...

What causes bedsores? Bedsores occur when pressure reduces or cuts off blood flow to your skin. This lack of blood flow can cause a pressure wound injury to develop in as little as two hours ... Bedsores are more likely to develop when there's pressure along with moisture from sweat, urine ... or stool ... traction (pulling or stretching of skin) from sliding down in an inclined bed or wheelchair.

Who is at risk for bedsores? People who have thinner skin and people who have limited (or no) ability to move are more likely to develop bedsores ... Adults with certain health conditions are more likely to develop bedsores. These conditions include ...dementia ... Many people who develop bedsores are malnourished.

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Malnutrition can occur due to advanced age or health conditions. A nutritious, high-protein diet can prevent bedsores or help them heal."

There are four stages that describe the severity of bedsores:

"Stage 1: Your skin looks red or pink, but there isn't an open wound. It may be hard for people with darker skin to see a color change ... Your skin may feel tender to the touch. Or your skin might feel warmer, cooler, softer or firmer.

Stage 2: A shallow wound with a pink or red base develops. You may see skin loss, abrasions and blisters.

Stage 3: A noticeable wound may go into the skin's fatty layer (the hypodermis).

Stage 4: The wound penetrates all three layers of skin, exposing muscles, tendons and bones ...

What are the complications? Bedsores increase your risk of potentially life-threatening bacterial infections ...You may develop sepsis or require an amputation. Worldwide, bedsores lead to the deaths of more than 24,000 people each year ... Fever and chills are often the first signs of an infection. The pressure ulcer may be extremely painful, foul smelling ...Other signs of infection include pain, a foul smell ... oozing puss ...

How can you prevent bedsores?
Change positions every 15 minutes if you are seated or every one to two hours if you're in a bed. A caregiver can help you do this if you're unable to reposition yourself.
Check your skin regularly (or have a caregiver do it) to look for changes in skin color and

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sensations (tenderness or pain, warmth or coolness).
Eat a nutritious diet and stay well hydrated. Keep your skin clean and dry. Apply moisture barrier creams to protect your skin from sweat, urine and stool ..."

Source: https://my.clevelandclinic.org/health/diseases/17823-pressure-injuries-bedsores; retrieval date 09/27/2023.

Some pressure injuries are unstageable. According to the NPUAP (National Pressure Injury Advisory Panel) 2019 publication, entitled "Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide)," an unstageable pressure injury occurs when "the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue either yellow or black in color.) If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed."

PRESSURE INJURIES

INTERVIEWS

---Hospice Caregiver A
During an interview on 08/31/2023 at 1:25 p.m., Hospice Caregiver A stated there were, "issues with bedbound residents." Hospice Caregiver A had concerns staff were not repositioning Resident 1 or ensuring s/he was wearing the heel protector boots. Hospice A stated, "[Resident 1]'s feet are getting worse." Hospice A suggested Surveyor talk to Hospice Registered Nurse (RN) C who may have more information.

---Hospice Patient Care Supervisor/RN B

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Surveyor interviewed Hospice Patient Care Supervisor/RN B on 09/06/2023 at 12:45 p.m. RN B confirmed their agency had concerns the provider was not consistently ensuring Resident 1's repositioning needs were being met. RN B said their agency had attempted to educate the provider multiple times without sustained improvement. RN B reviewed Resident 1's hospice records and provided Surveyor the following timeline of wound progression:
05/18/2023 - left heel pressure injury. Currently, the wound was "worsening (and) unstageable" with bloody discharge. The amount of slough and eschar at the beginning was 0 to 25%, but "now it is 76% to 100%...it's not healing. In fact it went from (having) no drainage, to now bloody drainage ...and strong odors."
07/07/2023 - right heel pressure injury (first identified March 2023.) Currently unstageable.
09/04/2023 - coccyx (base of the spine/tailbone) pressure injury, stage 2.

RN B said their agency requested meetings on 08/24/2023 and 08/28/2023 with the provider and the MCO (managed care organization/funding course) to discuss care concerns. RN B stated, "the biggest concern I have is that again, it wasn't felt that [Resident 1] was being repositioned as often as [s/he] should." In addition, RN B stated hospice staff would routinely arrive and find Resident 1 incontinent. S/he commented, " ...unless you're on them about basics of patient care, the perception is, it isn't being done."

---Hospice RN Case Manager C
Surveyor interviewed Hospice Case Manager/Registered Nurse (RN) C on 09/07/2023 at 10:00 a.m. RN C stated s/he had concerns with the care Resident 1 receives from facility staff. S/he said concerns include "skin integrity and

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repositioning, and I mean just [his/her] overall care..." RN C confirmed Resident 1 currently has 3 pressure injuries located on his/her left heel, right heel and coccyx. RN C provided the following examples of care concerns:

Resident 1 has heel protectors that must be worn at all times to relieve pressure on his/her heels. RN C stated that 50% of the time Resident 1 is not wearing heel protection and is found incontinent. S/he stated, "I couldn't educate enough and they still do not follow the education and instructions I give."
During July 2023, Resident 1's left heel wound was getting worse and s/he was admitted to the hospital due to a possible infection. Resident had a fever, the left heel wound was draining, with an odor and had "opened up."
During a visit on 09/04/2023, RN C smelled urine when s/he entered Resident 1's room. S/he found Resident 1 heavily incontinent, wearing a urine soaked brief and lying on a urine saturated incontinence pad. RC C stated facility staff claimed they recently changed Resident 1.
Hospice C stated, " ...it was just that odor of old urine that you knew [s/he] was not changed just prior to my arrival to the facility."
RC N recalled during the same visit on 09/04/2023, s/he identified a new pressure injury to Resident 1's coccyx.

---Caregiver L
Surveyor interviewed Caregiver L on 09/07/2023 at 4:12 p.m. Caregiver L recalled on 08/07/2023, s/he was in training with Caregiver E. They got Resident 1 up for the day at about 7:00 a.m. Resident 1 spent the entire morning in his/her Broda chair either in front of the TV or in the dining room for meals. Caregiver L said at 12:30 p.m., s/he noticed in Resident 1's record s/he was

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supposed to be repositioned back in bed after breakfast. Caregiver L said during the 5 ½ hours Resident 1 was in his/her Broda chair, Caregiver E did not inform Caregiver L of Resident 1's need to be repositioned.

RECORD REVIEW

On 09/05/2023, Surveyor reviewed hospice records for the date range of 06/14/2023 through 09/05/2023 and noted the following (each new wound location underlined for emphasis):

06/14- "Hospice physician order ...Left heel: Keep foam booties in place. Elevate heels off surfaces ... Facility staff to report any changes to left heel."
06/27- "Hospice physician order ...Left heel: cleanse site with wound wash. Pat dry with clean gauze. Apply moisten gauze. Apply dry gauze wrap with gauze wrapping. Cover with sock to keep in place. Foam booties in place. Elevate heels off of surfaces ...Hospice ...change once per week. Facility staff to change and cleanse as needed."
06/28- " ...wound in bilateral inner thighs. Cleanse with soap and water. Pat dry, keep open to air. Complete this wound care twice per day and as needed ..."
07/10- "Hospice Physician Order (order date 7/7, approved 7/10). Right heel: cleanse with wound wash. Pat dry with clean guaze [sic]. Apply non adherent dressing ...wrap to keep non adherent in place. Foam booties .... Change dressing weekly and prn (as needed) if loose or soiled ...New wound to right heel ..."
07/13- "Hospice physician order ...Bilateral heels: cleanse [sic] with wound wash. Apply calcium alginate, apply ABD pad, wrap with gauze wrap, secure with conhensive [sic] wrap. Foam booties in place. Elevate heels off surfaces. Hospice

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nurse ...change dressing weekly. Facility staff to change if loose or soiled."
07/17- "Hospice physician order ...Left buttocks: Cleanse site with soap and water. Pat dry with clean gauze, and apply barrier cream ...Facility staff to complete wound care twice per day and as needed with incontinence care."
07/24- "Pressure ulcer of left ankle stage 2 ... (and) Left buttock: Stage 1 cleanse with soap and water, pat dry to [sic] gauze, and barrier cream to area ...Writer placed foam booties on patient feet. Reminded staff to place on patient feet ...Writer provided education reminders on repositioning patient at least every 2 hours."
07/24- Hospital admission overnight due to worsening of left heel pressure injury. (Per aforementioned Hospice RN C interview and after visit summary found in facility file.)
08/01- "Patient sitting in Broda chair upon arrival (10:59 a.m.). Reeducated facility staff of repositioning patient every 2 hours. Encouraging patient to lay in bed after meals..."
08/09- "... Reeducation on repositioning every 2 hours and elevating heels off surfaces. Booties in place at all times."
08/11- "Coccyx remains intact."
08/14- "Patient sitting in Broda chair upon arrival (9:49 AM) in common area. Patient slouching and sliding down in broad chair. Writer requested that facility staff assist with transferring patient into bed. Hoyer Lift for transfers. Reeducation on getting patient in bed after meals. Focused on that eventually patient will slide out of Broda Chair and fall out of it..." [sic - all]
08/18- "Wounds to bilateral heels .... Odor to left heel present."
08/28- Facility staff reported to hospice "Patient will refuse cares due to pain and repositioning ...potential in not being repositioned."
09/04- Bloody drainage and strong odor to left

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heel. "Writer also provided complete bed bath due to being incontinent of bowel and bladder and chuck pad being saturated in urine and having strong urine order [sic]. Facility staff reported that had just checked and changed patient prior to writers' arrival. New wound on coccyx ...Stage 2 ..."
09/05- "Coccyx: cleanse with soap and water. Pat dry with clean washcloth. Apply thin layer of barrier cream. Facility staff to complete twice a day and as needed after bowel movements ..." Increased skilled nurse and home health aid visits to daily.

Between 09/07/2023 and 09/15/2023, Surveyor reviewed Resident 1's complete resident record for evidence s/he received the necessary care and treatment as identified and ordered by hospice. Surveyor noted the following:

The provider utilized different functions of an electronic software system (ECP) to prompt for and document care and treatment. These ECP functions included the task administration record (TAR) and medication administration record (MAR).

The aforementioned records were silent to the following:
Pressure injuries on the bilateral heels or the hospice orders dated 06/27/2023, 07/10/2023 and 07/13/2023 to change dressings if loose or soiled
Wounds on the bilateral inner thighs or the hospice orders beginning 06/28/2023 to complete wound care twice daily.
Stage I pressure injury on the left buttock and the hospice order dated 07/17/2023 to cleanse and apply barrier cream twice daily.
Stage II pressure injury on the left ankle identified

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N 353	Continued From page 13 on 07/24/2023. Stage II pressure injury on the coccyx and hospice order 09/05/2023 need to cleanse and apply barrier cream twice daily. Surveyor also noted barrier cream was not identified on the June, July or August MARs. Resident 1's record included a list of "active cares," task administration records and medication/treatment administration records. The aforementioned documentation did identify general needs related to toileting assistance, repositioning and pressure relief dating back to 2022. However the interventions were vague, repetitive and were not updated after each change in condition was identified. The documented general needs and interventions were: 2022: 07/05 - "Check and change resident every 2 hours, especially at NOC (nighttime.)" Scheduled every 2 hours. 08/08 - "Change of position w/pillow behind back when on sides. Pillow between legs at all times. Observe for pressure areas every 2 hours/prn (prn = as needed.) Reason ...prevent skins breakdown/pressure breakdown" [sic - all] Scheduled every 2 hours. 08/15 - "Per Therapy, Reposition resident every 2-3 hours on either side, pillow between knees and ankles, resident is a high risk for breakdown. Therapy will update case manager and request Broda chair." [sic - all] 2023: 03/22 - "Resident requires staff assistance with all positioning needs. Please make sure blue foam booties are on when in bed and heels are off the bed."	N 353		

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N 353	Continued From page 14 06/19 - "Per Therapy, Reposition resident every 2-3 hours on either side, pillow between knees and ankles, res. Is a high risk for breakdown. Resident must have [his/her] foam booties on when in bed ..." Scheduled for 1:00 a.m., 4:00 a.m. and 10:00 p.m. (not every 2-3 hours.) [sic - all] 07/03 - "resident needs to be put to bed after each meal and have [his/her] heel off bed and all surfaces at all times" Scheduled for 9:00 a.m., 1:00 p.m. and 6:00 p.m. 08/16 - "resident needs to be put to bed after each meal with heels off all surfaces at all times" Scheduled 12 times each day, every 2 hours. On 09/07/2023, Surveyors further reviewed the the task and medication/treatment administration records for evidence the aforementioned repositioning and toileting cares were provided as scheduled. Surveyor noted times when Resident 1 did not receive timely repositioning assistance. Examples include: 08/20/2023: No repositioning or toileting for 10 hours and 51 minutes (08/19 at 7:09 p.m. - 08/20 at 6:00 a.m.) No repositioning or toileting for 2 hours and 53 minutes (11:07 a.m. - 2:00 p.m.) No repositioning or toileting for 2 hours and 30 minutes (7:30 p.m. - 10:00 p.m.) The last evening toileting and repositioning was charted as completed at 10:00 p.m. 08/21/2023: The first morning toileting and repositioning was charted as completed at 6:00 a.m., 8 hours since the last time it was charted. No repositioning for 4 hours and 34 minutes (5:26 p.m. - 10:00 p.m.)	N 353		

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N 353	Continued From page 15 09/03/2023: No repositioning or toileting for 6 hours (12:00 a.m. - 6:00 a.m.) No repositioning or toileting for 2 hours and 48 minutes (7:12 p.m. until 10:00 p.m.) 09/03/2023: No repositioning or toileting for 6 hours (12:00 a.m. - 6:00 a.m.) No repositioning or toileting for 2 hours and 52 minutes (1:14 p.m. - 4:06 p.m.) No repositioning or toileting for 2 hours and 48 minutes (7:12 p.m. - 10:00 p.m.) 09/04/2023: No repositioning or toileting for 2 hours and 47 minutes (7:13 p.m. - 10:00 p.m.) No repositioning for 2 hours and 59 minutes (7:41 a.m. until 10:40 a.m. when hospice arrived.) Surveyor noted toileting was charted at 10:18 a.m.. however, at 10:40 a.m. hospice RN C found Resident heavily incontinent had the impression s/he had not been toileted for a long period of time. MANAGEMENT INTERVIEW On 09/14/2023 at 12:30 p.m., Surveyors interviewed Director H and RN/Administrator J. These managers stated or confirmed the following: The different prompts between the MAR and the TAR were repetitive, vague and were potentially confusing for caregivers. Director H said Manager K was probably adding cares in ECP when hospice provide education or revised orders and did not ensure previously entered cares were deleted or merged. RN/Administrator J said his/her process is to periodically review MARs and TARs to ensure	N 353		

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cares are being documented, but s/he had not noticed gaps in Resident 1's charting until pointed out by Surveyors.
Both managers stated they were unaware of the August meetings with hospice regarding care concerns. They speculated hospice staff were talking to Manager K and Manager K did not communicate with them.
Neither manager was aware of Resident 1's new stage II pressure injury on his/her coccyx, identified 10 days prior.
RN/Administrator J explained their process is to update ISPs based on direction from hospice but confirmed that did not occur for Resident 1.

FEEDING ASSISTANCE

INTERVIEWS

---Caregiver D
On 08/31/2023 at 10:54 a.m., Surveyor interviewed Caregiver D. S/he said, "Yesterday, [Caregiver E] lied to me and said [Resident 1] refused breakfast." Caregiver D went on to explain the following:

On 08/30/2023 at approximately 9:30 a.m. Caregiver E told Caregiver D Resident 1 refused breakfast. Shortly after, Dietary Aide F told Caregiver D s/he questioned whether Resident 1 had actually refused the meal and suggested Caregiver F look into it.
Caregiver F went into Resident 1's room and asked Resident 1 why s/he didn't have a breakfast tray. Resident 1 replied, "I haven't seen anybody besides you." Caregiver F asked for confirmation that Caregiver E did not offer breakfast and Resident 1 replied, "[Expletive] no. [S/he] wasn't in here."
Caregiver F said Resident 1 proceeded to eat a

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bowl of cereal, toast and orange juice, and asked for more. Resident 1 then consumed a banana and yogurt. Caregiver D said, "This was about 10:15 a.m.," and by lunch s/he was hungry again and ate the full meal.

---Dietary Aide F
On 09/05/2023 at 12:11 p.m., Surveyor interviewed Dietary Aide F. S/he stated, "I have had [Caregiver E] a couple times ...say a resident did refuse to come out to eat and before I took food cart back to kitchen I stopped by that resident and asked, 'Are you sure I can't get you something?' and then they are hungry we made them a plate and then they eat." Surveyor asked which resident this happened with and s/he replied, "[Resident 1]."

---Hospice RN Case Manager C
On 09/07/2023 at 10:00 a.m., Surveyor interviewed RN C who stated s/he had concerns Resident 1 was not receiving enough assistance with meal prep and feeding. S/he explained Resident 1 needs staff to bring meals to the room and set them up so s/he can feed him/herself.. RN C described visiting Resident 1 on 09/04/2023 (approximately 10:00 a.m.) and "[Resident 1]'s breakfast was still sitting on the bedside table untouched ...and it was not in his/her reach."

---Director H
On 09/07/2023 during an interview with Director H, Surveyor shared concerns received during interviews about Caregiver E not providing necessary feeding assistance to Resident 1. Director H stated s/he would conduct an investigation. On 09/08/2023, Director H provided Surveyor documentation of an investigation which resulted in Caregiver E's termination. The

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investigation corroborated concerns with Caregiver E's care and treatment of residents, including inaccurate documentation of care refusals.

---Resident 1
Surveyor interviewed Resident 1 on 08/31/2023 at 11:25 a.m., and asked about the care s/he received. Resident 1 replied, "Bring food better ....Bring meals in here." Resident 1 elaborated sometimes staff do not bring him/her food. Surveyor asked about the staff working at the time (Caregiver G and Caregiver E.) Resident 1 stated s/he could "count on" Caregiver G to bring food, but not Caregiver E. Surveyor asked if s/he reported the concern to management and Resident 1 said s/he did not because it would "cause trouble." S/he added, "I just don't eat."

RECORD REVIEW

Surveyor reviewed hospice records for the month of August 2023 and noted the following:
08/01/2023- "Facility staff report needing to assist with patient being fed. Eating only about 50% of meals independently. When assisted patient eats about 75% of meal."
08/09/2023- "Patient lying in bed with HOB (head of bed) elevated. Patient was staring at breakfast that was sitting on bedside table. Writer set up [his/her] meal. Patient fed self apples with fork. Took 2 bites of hashbrowns and ate nearly all of [his/her] scrambled eggs."

Surveyor reviewed Resident 1's TARs for July and August 2023. They both included prompts for caregivers to provide "partial assistance ...to complete eating tasks. [S/he] needs food cut up and sometimes needs assistance." The TAR also prompted caregivers to document the percentage

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of the meal that was consumed. Surveyor noted the following;

July - 76 of 89 entries were left blank (Resident 1 was out of the facility for 4 meals). During the 13 times feeding assistance was documented, Resident 1 consumed 75-100% of his/her meals, with the exception of once when s/he consumed 50%. No refusals were documented.
August - 40 of 90 entries were left blank. During the 50 times feeding assistance was documented, Resident 1 typically consumed 75-100% of his/her meals. There were 4 times 0% consumption was documented, but only 1 refusal was noted.

Surveyor also noted on 09/15/2023, the TAR was updated with prompts to bring the meal tray to the room and provide full assistance to complete eating tasks. This was 6 weeks after the hospice records identified increasing needs with feeding assistance.

IN SUMMARY

During March and May 2023, Resident 1 developed pressure injuries on both heels. As of 09/07/2023, the wounds on Resident 1's heels were unstageable and the left heel was worsening. Unstageable pressure injuries indicate the underlying wound is stage 3 or 4.

During June 2023, Resident 1 developed pressure injuries on both inner thighs. During July 2023, s/he developed pressure injuries on his/her left ankle and left buttock. Although those 3 areas healed, on 09/04/2023 Resident 1 developed a new stage 2 pressure injury on his/her coccyx. On the same day the coccyx wound was identified, Resident 1 was found lying in a urine

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N 353	Continued From page 20 soaked brief on a urine saturated incontinence pad. Resident 1's record identified the need to be repositioned and provided toileting assistance/incontinence care every 2 hours. According to the documentation, there were times Resident 1 went up to 6 or 10 hours between repositioning and incontinence care. In addition, Resident 1 did not consistently receive necessary assistance with meals, posing increased risks for the development and progression of pressure injuries. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 353		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not make reasonable attempts to keep all rooms clean and free from odors. Pervasive odors were present throughout the facility on 08/31/2023, including odors in Resident 2's room and on his/her person. Resident 2 needed assistance with incontinence checks and care every 2 hours. On 08/31/2023, Resident 2 was last checked at 10:00 a.m. At 12:05 p.m. Caregiver E acknowledged Resident 2 was due for a check and had an odor indicating possible	N 489		

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incontinence. Caregiver E did not provide the incontinence check until after 1:05 p.m. In addition, on 08/31/2023 Resident 1's floor was littered with crumbs and debris. Resident 1 was bedbound and dependent on staff assistance for all housekeeping needs.

Findings include:

On 08/31/2023, Surveyors were in the facility for 5.5 hours. Throughout the entire visit, Surveyors noted pervasive and permeating odors. Surveyors made the following observations and conducted the following interviews:
09:08 a.m. - immediately upon entering the facility Surveyors noted odors in the lobby
11:25 a.m. - 11:37 a.m. - while sitting bedside interviewing Resident 1, a foul odor was present. The carpet was dirty with food crumbs and debris littered on the floor up to 5 feet away from Resident 1's bed.
11:40 a.m. - Surveyors asked Caregiver E to check Resident 1 for incontinence. S/he returned momentarily and said Resident 1 was not incontinent.
11:44 a.m. - Surveyors and Caregiver E returned to Resident 1's room to observe the floor and odors. Caregiver E said housekeeping had just been there the previous day. Resident 1 interjected, "Supposedly." Caregiver E confirmed Resident 1 is bedbound and therefore could not have caused the mess on the carpet that extended away from his/her bed. After leaving the room Surveyor asked about the odors. Caregiver E replied, " ...there is always a little smell there."
11:50 a.m.- strong odor in Resident 2's room
12:00 p.m.- strong odor as Resident 2 walked past Surveyor in the lobby
12:05 p.m. - Caregiver E confirmed s/he could smell an odor coming from Resident 2 and said

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s/he checks him/her every 2 hours to "help with the smell. I last checked on [him/her] around 10:00 a.m. so [s/he] is due for a check. I am planning on checking [him/her] when [s/he] is done eating."
01:05 p.m.- Surveyor entered lobby from outside and smelled the same odor from earlier. Caregiver E approached surveyor and confirmed s/he could smell the odor. Caregiver E admitted s/he had not checked on Resident 2 yet. Caregiver E stated, "I am going there right now to change [Resident 2] honey."
02:30 p.m. - Surveyor interviewed Caregiver M and asked about the odors. S/he stated, "I know what you are talking about, how like bad it smells." [sic]

Surveyor reviewed Resident 1's record which indicated s/he was bedbound and completely dependent on staff for toileting and housekeeping needs. Surveyor reviewed Resident 2's record and noted s/he needed frequent checks for incontinence. Caregivers were prompted to document the checks on the medication administration record and no checks were documented between 10:00 a.m. and 1:00 p.m.

On 09/05/2023 at 12:11 p.m., Surveyor interviewed Dietary Aide F. S/he confirmed odors were present in the facility and attributed it to incontinent residents and odors in the fabric of the furniture. Dietary Aide F said s/he is also trained as a caregiver and knows Resident 2 needs to be checked every 2 hours for incontinence. S/he said caregivers get busy and "sometimes it does go longer, but for the most part we try."

On 9/07/2023 at 4:12 p.m., Surveyor interviewed Caregiver L who said, "It smells so bad...I just

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N 489	Continued From page 23 don't think the residents are getting washed up. I really don't." Surveyor requested Director H send the facility's housekeeping schedule. On 9/07/2023, Director H emailed the schedule which showed housekeeping was scheduled for Resident 1s room on Wednesdays. Surveyor noted the facility visit and observations of the dirty floor were on a Thursday. During an interview with Director H on 09/14/2023 at 12:30 p.m., s/he described efforts to mediate the odors in the facility which were implemented after Surveyors' visit. This included application of an odor eliminating powder on the floors and upholstery that is designed to pull moisture and then be vacuumed. Director H said s/he felt the treatments to the carpeting were having some effect but likely the furniture would need to be replaced. Director H also stated housekeeping staff should have been in Resident 1's room the day prior to the visit and s/he could not offer an explanation as to why the floor was so dirty during Surveyors' visit.	N 489		
N 500	83.45(4) Pest control. Pest control. The CBRF shall implement safe, effective procedures for control and extermination of insects, rodents and vermin. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not implement effective procedures for the control and elimination of flies. Findings include:	N 500		

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N 500	Continued From page 24 While at the facility on 8/31/2023, surveyor made the following observations and conducted the following interviews: 10:45 a.m.- During an interview with Surveyor, Resident 3 was swatting at a fly and apologized to Surveyor about the nuisance of the fly. At 10:50 a.m. facility staff entered the room and Caregiver E asked Resident 3, "Where is the fly swatter honey?" Caregiver E attempted once to hit the fly with fly swatter, missed, and left the room. 11:55 a.m.- Surveyor observed Resident 4 sitting in his/her wheelchair in the lobby, holding onto a fly swatter and waving it around. 01:05 p.m.- Surveyor asked Caregiver E about the flies. Caregiver E stated, "Residents do not complain. I go in their room and swat them." 01:17 p.m.- Surveyor walked past Resident 5's room and observed him/her sitting in recliner watching TV while waving around a fly swatter. 01:35 p.m.- While conducting an interview in Resident 4's room, there was a fly sitting on Resident 4's sweater during the entire 32 minute interview. On 09/07/2023 at 10:00 a.m., Surveyor interviewed Hospice Registered Nurse (RN) C who had at least 2 patients residing at the facility. S/he stated the flies were a nuisance to the residents. S/he also described an observation on 09/04/2023, "[Resident 1]'s breakfast was still sitting on [his/her] bedside table, untouched, with flies on it ..." RN C described how a different hospice patient has a hard time sleeping because the flies are "pestering" him/her during the night. RN C stated the fly problem had gotten worse over the past 2-3 weeks and said, "I've had it myself where I'll be sitting in the facility charting,	N 500		

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and there's like just these one or two flies that just won't go away and they're just in your face and flying into you the whole time."

On 09/07/2023 at 4:12 p.m., Surveyor interviewed Caregiver L. S/he acknowledged there was a problem with flies and said, "Yes there were some (flies) in [Resident 6]'s room and then a few like in the hallway and then some other residents' rooms."

On 09/07/2023, Surveyor requested Director H send the provider's pest control policy/procedure and documentation of all pest control efforts to eliminate the flies. On 09/07/2023, Director H replied via email with documentation of two treatments to Resident 2's bedroom and bathroom completed on 08/08/2023 and 09/01/2023. The email reply did not include a policy/procedure and did not identify any other areas of the facility that were treated.

During an interview with Director H on 09/14/2023 at 12:30 p.m., Surveyors asked if the provider had a pest control policy/procedure. S/he replied, "I don't think we have one. I didn't see one." Director H confirmed the only efforts to eliminate flies prior to Surveyors' visit on 08/31/2023 were the 2 times in August focused only in Resident 2's room. Director H said since Surveyors's visit, s/he ensured maintenance staff treated common areas of the facility and s/he felt like there had been some improvement.