DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: November 25, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference also cites the findings specified in the Federal Report. An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from November 12, 2024, through November 25, 2024. The deficiencies contained in this report are based on observation, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred and four (104). The survey sample size was forty-six (46) residents.		
3201 3201.1.0 3201.1.2	**Regulations for Skilled and Intermediate Care Nursing Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**	Please refer to F-tag 580 Please refer to F-tag 585 Please refer to F-tag 609 Please refer to F-tag 610 Please refer to F-tag 644 Please refer to F-tag 657 Please refer to F-tag 677 Please refer to F-tag 686 Please refer to F-tag 689 Please refer to F-tag 690 Please refer to F-tag 692 Please refer to F-tag 758 Please refer to F-tag 773 Please refer to F-tag 791 Please refer to F-tag 812 Please refer to F-tag 842	1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025 1/9/2025

Provider's Signature K. Nathan Block Title Administrator Date 12/20/24

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3201.9.0 3201.9.5	Cross Refer to the CMS 2567-L survey completed November 25, 2024: F580, F585, F609, F610, F644, F657, F677, F686, F689, F690, F692, F758, F773, F791, F812 and F842. **Records and Reports** **Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R89) out of two residents reviewed for falls, the facility lacked evidence of a thorough investigation of R89's falls to include statements from the staff. Findings included: Review of R89's clinical record revealed: 2/5/24 – R89 was admitted to the facility with dementia. 3/3/24 7:48 PM - An incident report documented that R89 was found sitting on floor next to her bed. The facility failed to obtain statements from staff working at the time of the fall to thoroughly investigate.	Please refer to F-tag 610	1/9/2025

Provider's Signature J. E. Hutchison-Cl Title Administrator Date 12/26/24

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	5/11/24 3:30 AM – An incident report documented that the nurse heard R89 yelling from her room, "help I am in the floor!" Upon entering resident's room, R89 was noted sitting on her buttocks on the floor beside her bed. The facility failed to obtain statements from staff working at the time of the fall to thoroughly investigate. 6/13/24 10:01 AM – An incident report documented that R89 was observed lying face down on the floor in the bathroom in her room. It was documented that R89 stated, "I was getting off the toilet and couldn't stand anymore." The facility failed to obtain statements from staff working at the time of the fall to thoroughly investigate. 7/5/24 7:40 PM – An incident report documented that R89 reported falling from her bed after attempting to get up. The facility failed to obtain statements from staff working at the time of the fall to thoroughly investigate. 11/19/24 8:52 AM – During an interview, E2 (DON) supplied the surveyor with an email that she had composed to staff for the lack of statements in R89's incident reports.		
3201.9.8 3201.9.8.4 3201.9.8.4.2	11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference. **Reportable incidents are as follows:** **Significant injuries.** **Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological**	Please refer to F-tag 609 Please refer to F-tag 610	1/9/2025 1/9/2025

Provider's Signature J.E. Hoskins-Lillo Title Administrator Date 12/20/24

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: November 25, 2024

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	reassessment of the resident's clinical status by professional staff for up to 24 hours. Based on interview and record review for one (R112) out of four residents reviewed for accidents the facility failed to report one fall and failed to report a second fall within the required time frame. 4/30/24 – Admitted to the facility. 7/5/24 1:05 AM – A change in condition evaluation in the EHR documented that R112 fell and required neurological checks. 7/14/24 3:30 AM – A Neurological check sheet was initiated on R112 due to a fall. 7/14/24 6:23 AM – A change in condition evaluation in the Electronic Health Record (EHR) documented that R112 was found lying on the floor in a prone position. "Assessed the resident, complaint of generalized pain, headache 10/10. Vital signs within normal limits. Notified the on call [doctor] obtained the order to transfer [R112] to the hospital for further evaluation, family notified by leaving a voicemail to call the facility back." R112 fell and required a transfer to the hospital and was not reported until 7/24/24, 10 days later. The facility was unable to provide any evidence that the fall on 7/4/24 was ever reported and the fall on 7/14/24 was not reported until 7/24/24. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.		

Provider's Signature J.E Heatherdale-d Title Administrator Date 12/20/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILFORD CENTER	700 MARVEL ROAD MILFORD, DE 19963

(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
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from November 12, 2024 through November 25, 2024. The facility census was 104 on the first day of the survey. In accordance with 42 CFR 483.73, an emergency preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interview, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from November 12, 2024 through November 25, 2024. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was one hundred and four (104). The survey sample size was forty-six (46) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CG - Caregiver; CNA - Certified Nursing Assistant; DON - Director of Nursing; LPN - Licensed practical nurse; MD - Doctor of medicine; NHA - Nursing Home Administrator; NP - Nurse practitioner;	F 000		

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

Electronically Signed | 12/20/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

RN - Registered nurse;
SW - Social worker;
UM - Unit Manager;

Activities of daily living (ADLs) - Tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;
ARD (Assessment Reference Date) - The specific end point of look-back periods in the MDS assessment process;
Assessment - An evaluation of a condition or resident;
Baseline - A minimum or starting point used for comparisons;
BIMS - (Brief Interview for Mental Status) - Assessment of the resident's mental status. The total possible BIMS Score ranges form 0 to 15 with 15 being the best.
0-7: Severe impairment (never/rarely made decisions
8-12: Moderately impaired (decisions poor; cues/supervision required
13-15: Cognitively intact (decisions consistent/reasonable);
Bipolar Disorder - Mood disorder;
CO2 - Carbon Dioxide;
Continence - Control of bladder and bowel function;
COPD - Chronic obstructive pulmonary disease;
Dementia - A severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation or loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
Dialysis - Cleansing of the blood by artificial means when the kidneys have failed;
DM - Diabetes;
Incontinence - Loss of control of bladder and/or

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F 000	Continued From page 2	F 000		

bowel function;
ETA - Estimated time of arrival;
GM - Gram;
L - Liter;
Laceration - A cut or tear in the skin caused by blunt trauma, such as stretching, shearing, or tearing forces;
MAR - Medication administration record;
Meds - Medications;
MG - Milligrams;
Min - Minute;
MRR - Monthly Regimen Review;
Medi-honey - Natural, non-toxic agent that has been used to treat wounds;
Minimum Data Set (MDS) assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs;
O2 - Oxygen;
OOB - Out of bed;
Optifoam - Brand of foam dressing that has a silicone adhesive border;
Pain level - Pain is identified between zero (0) to 10, with 10 being the worst pain imaginable and 0 being no pain;
PASARR - Preadmission Screening and Resident Review - Screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there;
PRN - As needed;
Q - Every;
Schizoaffective Disorder - Condition in which a person experiences a combination of schizophrenia symptoms such as hallucinations

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F 000	Continued From page 3 or delusions and mood disorder symptoms such as mania and depression; SQ - Subcutaneously; SSI - Sliding scale insulin; TID - Three times a a day; Treatment Administration Record (TAR) - List of daily/weekly/monthly treatments to be performed; Wanderguard - Bracelet worn by residents that are at risk for wandering; alerts staff with audible alarm when resident is near an alarmed door.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		1/9/25

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F 580	Continued From page 4 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R38) out of two residents reviewed for dialysis, the facility failed to ensure that the provider was consulted when R38 refused dialysis services. Findings include: Review of R38's clinical record revealed: 8/23/22 - R38 was admitted to the facility. 6/1/14 - A quarterly MDS documented R38 was receiving dialysis as a special treatment. 7/8/24 11:17 AM - A progress note documented that R38 refused dialysis today and the Unit	F 580	F580 Failure to notify provider of resident refusing dialysis services 1.Resident #38 refused dialysis services on 7/8/2024. Staff failed to document notification of the refusal. Immediate action was unable to be provided as the incident occurred 4 months prior. 2.All dialysis residents have the potential to be affected. Current residents receiving dialysis have been audited for attending dialysis in the last 30 days. 3.An education program will be conducted	

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F 580	Continued From page 5 Manager (UM) was made aware. 11/15/24 2:31 PM - In an interview, E11 (RN) stated that the expectation if a resident refused dialysis would be to notify the provider and notify the family. E11 stated she would provide education to the resident and encourage them to attend dialysis. 11/15/24 2:43 PM - In an interview, E12 (UM) stated that expectation of a resident missing dialysis would be that the nurse responsible for the resident would notify the provider. E12 stated she was aware of R38 missing dialysis on 7/8/24 and that the provider was already aware of R38's behavior of refusing dialysis. 11/18/24 9:18 AM - An interview with E15 (NP) stated that if a resident has a change in condition, specifically missing dialysis, the expectation would be to notify the provider. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 580	by the Nurse Practice Educator, Assistant Director of Nursing and/or designee with licensed staff addressing refusals of dialysis services that require notification of the resident's physician and documentation of notification. 3.The Director of Nursing Services, and or nursing leadership, will conduct a random audit of residents receiving dialysis services weekly for four consecutive weeks, then monthly for two months. These residents will be assessed to ensure that any refusals have been identified, properly evaluated and communicated to the appropriate people. 4.This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root Cause Analysis: Staff not properly educated on the documentation of provider notification. Compliance date 1-9-25	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other	F 585		1/9/25

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F 585	Continued From page 6 residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,	F 585		

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F 585	Continued From page 7 receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and	F 585		

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F 585	Continued From page 8 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for one (R50) out of one reviewed for grievances, the facility failed to ensure that resident concerns received by the facility included prompt efforts to resolve the resident's problems. Findings include: Review of R50's clinical record revealed: 12/19/23 - R50 was admitted to the facility. 5/2024 - A grievance/concern log revealed an entry for 5/17/24 for R50 stated a clinical concern and DON/UM were responsible to investigate. 5/17/24 - A grievance report documented that R50 had concerns that staff did not provide care during the 7:00 AM to 3:00 PM shift on 5/8/24. The report was initially accepted by E4 (SW). The follow up section of the grievance report was blank. 5/17/24 - A grievance report documented that R50 had concerns that staff did not address R50's immediate needs during the 7:00 AM to 3:00 PM shift on this date. This report was completed by E4 (SW). The follow up section was blank. 11/21/24 9:37 AM - An interview with E4 (SW) revealed that E4 was the grievance officer. E4 stated that the process starts when a resident	F 585	F585-Failure to complete grievance process 1. Resident #50 voiced a grievance with facility administration on 5/17/2024 with concerns that staff did not provide timely care. A grievance form was initiated, upon further investigation facility administration deemed the concern to be a reportable event. The event was reported on 5/17/2024 with 5 day follow up submitted timely with interventions in place. The facility failed to complete the follow up section of the grievance form. The facility is unable to post document in the grievance form despite interventions being in place. 2. All residents who offer grievances have the potential to be affected. Current residents or their responsible party will be audited to ensure the grievance is followed up in a timely manner. 3.The grievance process will be reviewed by the Administrator, Director of Nursing and/or designee with department heads and nursing leadership to ensure accurate documentation of completion of the grievance process. 4.The NHA or/ and DON will audit the grievance log for completion weekly for 4	

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F 585	Continued From page 9 makes a complaint and once the resident is interviewed, the results go to the DON and NHA. E4 stated that when a grievance was considered reportable the process stops. E4 confirmed the grievance forms are incomplete and unaware if the grievances were resolved. 11/21/24 10:35 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the grievances written on 5/17/24 were not resolved and lacked evidence that the grievance was addressed. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 585	consecutive weeks followed by monthly for 2 months. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root Call Analysis: Leadership staff not following grievance process, lack of proper education Compliance date 1-9-25	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		1/9/25

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F 609	Continued From page 10 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R261) out of four residents reviewed for allegation of neglect, the facility failed to immediately report an allegation of neglect within the required timeframe. A five day follow-up report wasn't submitted following the allegation until fifteen days later. Findings include Review of R261's clinical record revealed: 7/30/22 - R261 was admitted to the facility. 6/9/24 - A facility incident report documented, E9 (CNA) alleged E10 (LPN) was neglectful by not responding to the needs of R261 in a timely manner and reported the allegation to E2 (DON). 6/17/24 - An incident report was submitted to the state agency for an allegation of neglect for R261, eight days after the allegation. 7/2/24 - The five day follow up report for R261 was submitted to the state agency for the allegation of neglect on day fifteen. 11/22/24 9:37 AM - During an interview, E2 (DON) confirmed the allegation of neglect was reported late, eight days after the allegation.	F 609	F609- Failure to Report Alleged Violations Timely 1. Resident #261 was not provided appropriate care from his assigned nurse by a staff member on 6/9/2024. This was documented in a facility incident report. The incident was reported to the state agency on 6/17/2024, in an untimely manner. A thorough investigation was initiated by the Director of Nursing Services and the facility Administrator. The results of the investigation were submitted on 7/2/2024 in an untimely manner. This failure was unable to be rectified as it occurred 7 months prior. 2. The facility has determined that all residents involved in incidents that are reportable in nature have the potential to be affected. 3.An in-service education program was conducted by the LNHA and DON with department heads and nursing leadership addressing circumstances that require reporting including appropriate timeframes for submission.	

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F 609	Continued From page 11 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.	F 609	4. The Director of Nursing Services and/or nursing leadership, will conduct a random audit of up to five incident reports and reportable events for (4) consecutive weeks then monthly x2 for timely completion and reporting. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root Cause Analysis: Staff not properly trained on mandatory reporting processes including timely reporting and submission. Compliance date 1-9-25	
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		1/9/25

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F 610	Continued From page 12 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation as indicated, it was determined that for four (R12, R50, R6 and R413) out of ten residents reviewed for and allegation of abuse and neglect, the facility failed to have evidence of thorough investigation. 1. Review of R12's clinical record revealed: 9/25/20 - R12 was admitted to the facility. 6/6/24 - A quarterly MDS documented R12 was dependent for ADL's including toileting, dressing, and personal hygiene. 8/2024 - A review of the CNA task flow sheet for August 2024 lacked evidence that staff provided care on 8/25/24. 11/18/24 11:25 AM - A review of the facilities investigative documents for an allegation of neglect lacked evidence of direct care staff interviews for 8/25/24. The packet included the initial report to state agency, the five day follow up and a disciplinary report on alleged employee. 11/21/24 9:37 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence of interviews with direct care staff. E1 was unable to provide staff interviews from the facility investigation. 2. Review of R50's clinical record revealed: 12/19/23 - R50 was admitted to the facility.	F 610	F610- Failure to thoroughly investigate alleged violations 1. Residents #12, #50, #6 and #413 had reported allegations of abuse or neglect. The facility failed to provide documentation of a thorough investigation. The deficient practices are unable to be retrocorrected. 2. The facility has determined that all residents involved in incidents that are reportable in nature have the potential to be affected. 3. An in-service education program will be conducted by the Director of Nursing and LNHA with department heads and nursing leadership addressing the need to document and be able to provide evidence of the investigations initiated after a reportable event. 4. The Director of Nursing Services and or nursing leadership, will conduct a random audit of up to five incident reports and repotable events for (4) consecutive weeks then monthly x2 for evidence of the investigation. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root Cause Analysis: Staff not properly	

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F 610	Continued From page 13 3/20/24 - A quarterly MDS documented that R50 was dependent for all ADL's including toileting, dressing, and personal hygiene. 11/18/24 11:45 AM - A review of the facilities investigative documents for an allegation of neglect revealed that interviews were not included in the facilities investigation. The packet included a copy of a grievance form and incident reports. 11/21/24 9:37 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence of interviews with direct care staff. E1 was unable to provide staff interviews from the facility investigation. 3. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 7/16/24 - A facility reported incident was submitted for an allegation of neglect that documented that a wound dressing to R6's right heel was dated 7/8/24 and there was an order for a dressing change to be completed one time every other day. This revealed that eight days had passed without wound treatment. 7/2024 - A review of the treatment administration record (TAR) for July 2024 revealed that on 7/10/24, R6 was away from the facility and did not receive the wound treatment. On 7/12/24, R6 received the wound treatment to the right heel and on 7/14/24, R6 had refused the wound treatment to the right heel. 7/30/24 - The facility investigative follow-up packet included statements from E11 regarding the care from 7:00 AM to 3:00 PM on 7/10/24 and from E24 regarding the care from 7:00 AM to	F 610	trained on retaining documents recorded in a reportable event investigation. Compliance date 1-9-25	

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F 610	Continued From page 14 3:00 PM on 7/12/24. The facility was unable to provide any additional statements from staff from the other shifts for 7/10/24 and 7/14/24 to determine the missed wound treatment to R6's right heel. 4. Review of R413's clinical record revealed: 5/10/24 - R413 was admitted to the facility with diagnoses including major mood disorder and anxiety. 5/17/24 - R413's admission BIMS documented a score of 14, indicating a fully intact cognitive status. 5/23/24 - A facility reported incident for an allegation of verbal abuse to the State Agency documented, " ...Resident reports that staff member was "mad" last night ...." 11/22/24 10:15 AM - A review of the facility's investigative documents for this allegation revealed that the facility failed to obtain staff statements. 11/22/24 9:37 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence of interviews with direct care staff. 11/22/24 9:37 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility lacked evidence of interviews with direct care staff. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 610		
F 644 SS=D	Coordination of PASARR and Assessments	F 644		1/9/25

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F 644	Continued From page 15 CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R38 and R66) out of two residents reviewed for PASARR, the facility failed to ensure that a referral for PASARR screening was completed. Findings include: 1. Review of R38's clinical record revealed: 8/23/22 - R38 was admitted to the facility with diagnosis including bipolar disorder. 7/2/24 - A discharge summary [hospital] revealed that R38 was admitted related to dementia with behaviors. The summary revealed that R38 was having aggressive behaviors while at the dialysis center for treatment and transferred to the	F 644	F644- Coordination of PASRR and assessments 1. The facility failed to provide evidence of updated PASRR for residents R66 and R38. Social worker failed to complete the required PASRR timely. R66 had the PASRR completed 11/22/24 with a determination 12/2/24. R38 had the PASRR completed 12/12/24 with a determination for refer to Level 2 onsite on 12/18/24 2. All residents with behaviors and positive level 1 PASRR in the facility have a potential for harm due to this alleged	

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F 644	Continued From page 16 emergency department for treatment. 7/15/24 - A psychology progress note revealed that R38 had a new diagnosis of unspecified mood disorder and adjustment disorder with depressed mood. The facility lacked evidence that a referral was made to the State PASARR authority. 11/18/24 10:05 AM - An interview with E4 (SW) confirmed that R38 had not had an update sent to PASARR and confirmed she would send the update now. 2. Review of R66's clinical record revealed: 6/17/21 - R66 was admitted to the facility with the diagnosis including, but not limited to, bipolar disorder, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and major depressive disorder. 7/20/21 - A PASARR I screening was submitted for R66 to the PASARR authority and listed the following diagnoses of depression and major depressive disorder. 10/1/23 - A psychology progress note revealed that R66 had a new diagnosis of other persistent mood (affective) disorder. 11/18/24 10:05 AM - An interview with E4 (SW) confirmed that R66 had not had an update sent to PASARR and confirmed she would send the update now. The facility lacked evidence of an updated PASARR reflecting R66's accurate diagnoses.	F 644	deficient practice. 3. The LHNA or/and DON will inservice the admissions department and the social service team on the requirement of correct PASRR and the regulations requiring them to be accurate and timely. 4. MDS, DON or designess will complete an audit that all new admissions have a recently completed Level 1 PASRR and/ or level 2 PASRR as needed as well as resubmission to PASRR authority as indicated weekly x4 and monthly x2. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root Cause Analysis: Staff not ensuring proper documentation is available for residents prior to and on admission. Compliance date 1-9-25	

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F 644	Continued From page 17 11/18/24 - A resubmission of PASARR to the State PASARR authority revealed a result of "a PASARR Level II evaluation must be conducted and that evaluation will occur as an onsite/face-to-face evaluation." 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 644		
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 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	F 657		1/9/25

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F 657	Continued From page 18 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (R5, R61, R65, R83, R89, and R91) out of thirty-one sampled residents, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings and to ensure that care plan meetings occurred every three months. For R33, R34 and R38 the facility failed to revise the care plan to reflect resident's current needs. Findings include: 1. Review of R89's clinical record revealed: 2/12/24 - R89 was admitted to the facility with a BIM's of 13 which indicated that R89 was cognitively intact. 8/14/24 - R89's quarterly MDS assesment documented that her BIMs was not assessed, but R89 had disorganized thinking. 8/30/24 11:21 AM - A care plan evaluation progress note included that the social worker, medical staff and resident representative were aware of a room change. Review of the resident record revealed that the facility lacked evidence of a quarterly care plan meeting. 10/3/24 - R89's discharge MDS assessment documented that her BIMs was not assessed, but R89 had disorganized thinking. 11/4/24 10:27 AM - A care plan conference meeting progress note documented the following attendees were present: patient, social services,	F 657	F657- Care Plan Timing and Revision 1.The facility failed to show proof that all required members of the interdisciplinary team were involved in care plan meetings for 4 residents R5, R61, R65, R83, R89, R91. Social service failed to document the IDT members involved in care planning and ensure care plan meetings occur every 3 months. For residents R33, R34, and R38 the center failed to revise the care plans with current needs. The facility was unable to retrocorrect the documentation for care plan meeting attendance. The Care plans for R33, R34, and R38 were updated to reflect the current needs of the residents. 2.The facility has determined that all residents have the potential to be affected. Current residents have been audited to ensure that a care plan meeting has occurred in the last three months and that input from the IDT team is noted. Care plans will be updated to reflect the current needs of the residents. 3.An in-service education program will be conducted by the LNHA and DON with department heads and nursing leadership addressing necessary IDT member input which will include in person, via phone and/or in consultation, that is needed in care plan meetings. Education will also include care plan reviews and updates	

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F 657	Continued From page 19 nurse, and UM. The facility lacked evidence that a physician, a dietician and a CNA with the responsibility for the resident had input in R89's care plan conference. In addition, the facility lacked evidence of a family representative attending related to R89's impaired cognition. 11/15/24 8:31 AM - During an interview, E4 (SW) confirmed that the facility failed to ensure that R89's August quarterly care plan was conducted, and failed to ensure that the required IDT members participated in R89's 11/4/24 care plan conference meeting. 2. Review of R61's clinical record revealed: 4/18/23 - R61 was admitted to the facility. 5/9/24 - A quarterly care plan meeting note lacked evidence of input from the physician and the CNA. 5/10/24 - A quarterly MDS was completed. 8/7/24 - An annual MDS was completed. Review of facility records lacked evidence that a care plan meeting occurred to coincide with the MDS. 11/4/24 - A quarterly MDS was completed. 11/7/24 - A quarterly care plan meeting note lacked evidence of input from the physician, CNA and dietician. 3. Review of R65's clinical record revealed: 3/13/24 - R65 was admitted to the facility. 6/12/24 - A quarterly MDS was completed.	F 657	with clinical leadership. Education will also be completed with Social Services and MDS regarding timely completion of quarterly and annual care plan meetings by communicating via email, MDS calendar and/or monthly hand outs of all care plans that are due. 4. The Director of Nursing Services and or nursing leadership, will conduct a random audit of up to five care plan meetings for (4) consecutive weeks then monthly x2 for evidence of correct documentation. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root Cause Analysis: Staff not properly educated in documentation of care plan meeting notes and care plan revision. Compliance date 1-9-25	

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F 657	Continued From page 20 Review of facility records lacked evidence that a care plan meeting occurred to coincide with the MDS. 4. Review of R83's clinical record revealed: 7/17/23 - R83 was admitted to the facility. 1/23/24 - A quarterly MDS was completed. Review of facility records lacked evidence that a care plan meeting occurred to coincide with the MDS. 4/23/24 - A quarterly MDS was completed. Review of facility records lacked evidence that a care plan meeting occurred to coincide with the MDS. 7/23/24 - An annual MDS was completed. 7/25/24 - An annual care plan meeting note lacked evidence of input from the physician and CNA. 10/20/24 - A quarterly MDS was completed. 10/24/24 - A quarterly care plan meeting note lacked evidence of input from the physician, CNA and dietician. 5. Review of R91's clinical record revealed: 3/14/24 - R91 was admitted to the facility. 6/12/24 - A quarterly MDS was completed. Review of facility records lacked evidence that a care plan meeting occurred to coincide with the MDS.	F 657		

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F 657	Continued From page 21 9/10/24 - A quarterly MDS was completed. 9/12/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 11/14/24 11:48 AM - In an interview, E1 (NHA) confirmed that she is aware that care plan meetings have not been occurring every three months and also that not all required participants are providing input. E1 further stated she confirmed this with E4 (SW). 5. Review of R43's clinical record revealed: 4/8/24 - Resident was admitted to the facility. 7/15/24 - A care plan meeting progress note documented the following attendees were present social worker, unit manager, and son via telephone. 11/14/24 10:31 AM - An interview with E4 (SW) confirmed that the physician, dietary, a CNA were not present or provided input for R43's care plan meeting. 6. Cross refer F686 Review of R5's clinical record revealed: 4/23/14 - R5 was admitted to the facility with hemiplegia and hemiparesis following a stroke. 1/19/18 - A care plan was initiated for alterations in functional mobility related to contracture deformity. Interventions included passive range of motion (ROM) to left elbow, left and right ankle, and bilateral knees twice a day for fifteen minutes each time.	F 657		

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F 657	Continued From page 22 3/18/21 - An updated intervention was added to R5's care plan documented offloading heel to bilateral lower extremity (BLE) while in bed. 5/31/21 - A physician's order for R5 documented adaptive equipment: apply multi podus boot to left foot while in bed. 5/18/22 - A physician's order for R5 documented heel suspension device (prevalon boot): to be donned on bilateral feet while in bed and chair. 11/19/24 3:01 PM - An interview with E14 (COTA) confirmed that the soft podus boots (prevalon) were the current recommendation for R5. 11/19/21 3:33 PM - An interview with E12 (UM) confirmed the care plan for R5 was not revised to include the use of prevalon boots while in bed. 7. Cross refer to F677 Review of of R33's clinical record revealed: 8/4/22 - R33 was admitted to the facility with dementia. 8/5/22 - R33's care plan included: Resident requires assistance/dependent for ADL care. 6/4/24 - R33's care plan included: Resistive to care. Refuses medication. R34's care plan did not include refusal of nail care. Observations on 11/12/24 2:42 PM, 11/15/23 10:20 AM, 11/22/24 10:52 AM and 11/22/24 10:56 AM, R33 was noted to have black debris underneath all of her nails.	F 657		

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F 657	Continued From page 23 11/22/24 10:56 AM - During an observation and interview E30 (CNA) confirmed that R33 had black debris under her nails, that at times R33 refused care, and that her refusals for care were not in her care plan. The facility failed to have a comprehensive individualized care plan for R33's refusal nail care. 8. Cross refer F677 Review of R34's clinical record revealed: 8/28/23 - R34 was admitted to the facility with dementia. 8/29/23 - R34's care plan included R34 was dependent for care. 4/30/24 - R34's care plan included: Resident is resistive to care. Refuses to wear extremity protectors, refuses skin assessment, refuse to take medications, refuse wearing BIPAP r/t (related to) cognitive loss/dementia. R34's care plan did not include refusal of nail care or washing of hair. 9/3/24 - R34's annual MDS assessment documented that R34 was cognitively impaired, required extensive assistance for bathing and hygiene Observations on 11/12/24 10:00 AM, 11/15/24 10:28 AM, 11/15/23 1:349 PM and 11/21/24 2:27 PM, R34 was noted to have long nails with visible blackish brown debris beneath them and R34's hair appeared greasy and disheveled.	F 657		

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F 657	Continued From page 24 11/2/24 9:03 AM - During an interview, E2 (DON) confirmed that R34 did at times refuse care, and did not have a care plan for refusal of hair and nail care. The facility failed to have a comprehensive individualized care plan for R34's refusal of hair and nail care. 3. Review of R38's clinical record revealed: 7/3/24 - A care plan was initiated that R38 was at risk for impaired renal function and was at risk for complications related to hemodialysis. Interventions included to maintain smooth catheter clamps at bedside and monitor external hemodialysis catheter and site for complications. 7/8/24 - A progress note documented that R38 refused dialysis today. 11/15/24 2:31 PM - An interview with E11 (RN) revealed that R38 will refuse to go to dialysis and E11 stated she would educate the resident on the importance of dialysis. 11/15/24 02:43 PM - In an interview with E12 (UM) revealed that R38 refuses to go to dialysis frequently and the provider was aware of these behaviors. E12 confirmed that refusing dialysis is an ongoing behavior for R38 and confirmed it was not on the care plan. The facility failed to implement a care plan related to refusal of care. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 657		

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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 observation, interview and record review it was determined that for three (R6, R12, and R34) out of twelve residents reviewed for activities of daily living (ADL's), the facility failed to provide care and services for dependent residents. Findings include: 1. Cross refer to F656 Review of R33's clinical record revealed: 8/5/22 - R33 was admitted to the facility with dementia. 8/5/22 - R33's care plan included that the resident requires assistance/dependent for ADL care. 6/4/24 - R33's care plan included being resistive to care and refusing medication. The care plan did not include refusal of nail care. 7/5/24 - A significant change MDS documented that R33 required partial/moderate assist for hygeine and bathing and had no rejection of care. Observations on 11/12/24 at 2:42 PM; 11/15/24 at 10:20 AM; 11/22/24 at 10:52 AM; and 11/22/24 at 10:56 AM revealed R33 had black debris underneath all of her nails. 11/22/24 - During an observation and interview,	F 677	F758- Free from Unnec Psychotropic Meds/PRN Use 1. The facility lacked evidence of side effect monitoring for psychotropic medications for R89. Side effect monitoring has been added to R89 electronic medical record. 2. The facility has determined that all residents prescribed psychotropic medication have the potential to be affected by this alleged deficient practice.Current residents prescribed psychotropic medication have been reviewed to ensure side effect monitoring is in place. 3. Inservice education will be done with clinical management staff on monitoring side effects for psychotropic medication. 4. The director of nursing or designee will conduct a random audit of at least five residents receiving psychotropic medication to ensure side effects are monitored. The audit will be conducted once a week for 4 weeks then monthly for 2 months until substantial compliance is achieved or as otherwise determined by the Risk Management/Quality Assurance	1/9/25

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F 677	Continued From page 26 E30 (CNA) stated that it was the responsibility of the CNA's to provide nail care. E30 confirmed that R33 had black debris under her nails. 2. Cross refer to F656 Review of R34's clinical record revealed: 8/28/23 - R34 was admitted to the facility with dementia. 8/29/23 - R34's care plan included R34 was dependent for care. 4/30/24 - R34's care plan included that the resident was resistive to care, refuses to wear extremity protectors, refuses skin assessment, refuse to take medications, and refuses wearing BIPAP r/t (related to) cognitive loss/dementia. R34's care plan did not include refusal of nail care or washing of hair. 9/3/24 - R34's annual MDS assessment documented that R34 was cognitively impaired, required extensive assistance for bathing and hygiene and had no rejection of care. Review of R34's October 2024 and November 2024 progress notes lacked evidence of offers of refusals of nail care or washing of hair. 11/1/24 through 11/24/24 - The CNA task sheet lacked evidence of showers, nail care or having her hair washed. Per the CNA task sheet, R34 had received bed baths. Observations on 11/12/24 10:00 AM, 11/15/24 10:28 AM, 11/15/23 1:349 PM and 11/21/24 2:27 PM, R34 was noted to have long nails with visible	F 677	Committee. Root Cause: It was determined that clinical leadership required education in the GDR process and compliance with psychological medication reviews.	

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F 677	Continued From page 27 blackish brown debris beneath them and R34's hair appeared greasy and disheveled. 11/15/24 1:36 PM - During an interview, E31 (LPN) stated that activities staff were responsible for manicures. The aides (CNA's) were responsible for keeping them (the residents' nails) clean. 11/15/24 1:40 PM - During an interview, E35 (CNA) stated that she was not sure who was responsible for nail care. 11/15/24 1:47 PM - During an interview, E32 (Activities) stated that activity staff were not responsible for nail care. They can paint nails but not cut them because she is not certified as a CNA. 11/21/24 - During an interview, E34 (CNA) confirmed that R34's nails had not been taken care of until the daughter came in yesterday (11/20/24). 11/22/24 9:30 AM - During an interview, E2 (DON) confirmed the facility lacked evidence of offering/attempting to provide nail or hair care. E2 also confirmed there was no evidence of refusal of care. 11/22/24 11:17 AM - During an interview, E33 (CNA) stated that R34 was total care for nails and hair. 3. Cross refer to F842 Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility.	F 677		

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F 677	Continued From page 28 7/28/24 - A quarterly MDS assessment revealed that R6 had no impairment to upper or lower extremities and uses a wheelchair. R6 was dependent for toileting hygiene, partial or moderate assistance for personal hygiene and upper body dressing, substantial/maximal assistance for lower body dressing, dependent for footwear. R6 required supervision or touching assistance for sitting to lying and lying to sitting. R6 required partial/moderate assistance for sitting to stand, transfer from bed/chair to wheelchair and to perform a toilet transfer. 7/18/24 - A care plan revealed that R6 was incontinent of bowel with a goal that the incontinence care needs be met by staff. The care plan further revealed that R6 required assistance for ADL care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer and toileting. The interventions for the ADL care revealed that R6 required extensive assist of one person for dressing, toileting and personal hygiene. 8/17/24 2:54 PM - The CNA documentation task sheet revealed E25 (CNA) inaccurately documented that R6 independently toileted, was continent of urine and was continent of bowel. The task sheet also showed that R6 was independent to transfer for a sit to stand, chair/bed to chair transfer and toileting transfer. The task sheet also documented that R6 was encouraged to independently turn and reposition and a skin check was completed every 2 hours. The aforementioned note was the only documentation of toileting for R6 on 8/17/24 during the 7:00 AM to 3:00 PM shift.	F 677		

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F 677	Continued From page 29 8/17/24 4:50 PM - A progress note for change in condition by E11 (RN) documented that at 3:00 PM on 8/17/24, R6 was observed sitting on the bed with clothing and bed linens visibly soiled with a noted odor. The progress note continued that R6 was, " ... Immediately assessed, no new skin issues noted. Buttocks slightly reddened, however, blanchable. Oncoming CNA immediately bathed and changed resident's linens. Calazinc cream applied to buttocks for protection. Transferred to wheelchair." 8/17/24 3:00 PM - A witness statement by E11 documented that R6 was observed at 9:30 AM and at 12:00 PM on 8/17/24. At 3:00 PM, E11 went into R6's room where R6 was sitting on the bed where the bed linens and clothing were soiled. R6 was immediately assessed, cleaned up by E27 (CNA), clothing and bed lines changed and transferred to the wheelchair. E11 also noted that E25 did not report any refusals of care during the 7:00 AM to 3:00 PM shift. 8/17/24 - A witness statement by E27 documented that R6 was observed on 8/17/24 at 3:00 PM with stool on her bottom and the bed sheets were soiled with stool and urine. 11/19/24 at 9:15 AM - An interview with E26 (CNA) revealed that R6 requires assistance of one for dressing, toileting, hygiene and transfers and would not be able to do it themselves. If R6 refuses, then we try to redirect or try again and ultimately will tell the nurse where it would be documented in the record as refused. 11/21/24 2:37 PM - An interview with E11 revealed that R6 was in bed during the entire 7:00 AM to 3:00 PM shift without being transferred.	F 677		

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F 677	Continued From page 30 E11 stated she observed R6 at 3:00 PM seated on the side of the bed with brown all around her and her sheets. E11 continued to say that R6 wore a brief and the amount of stool and urine observed absorbed into the bed sheets meant R6 did not receive care in a very long time. R6 required assistance for toileting and is not independent for care. 11/22/24 2:32 PM - An interview with E2 (DON) confirmed that E25 did not provide care for the resident. E2 stated that E25 had completed the shift on 8/17/24 and would not return the facilities calls to investigate and was terminated. The facility lacked evidence of a complete root cause analysis or any action beyond terminating an employee. 4. Review of R12's clinical record revealed: 9/25/20 - R12 was admitted to the facility. 9/25/20 - A care plan was initiated for R12 for risk of decreased ability to perform ADL's in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to impaired balance and cognitive decline. Interventions included provide total assist with one for locomotion, toileting and personal hygiene. 9/3/24 - A quarterly MDS documented R12 was dependent for ADL's including toileting, dressing, and personal hygiene. 11/12/24 9:57 AM - An observation of R12 with long nails on bilateral hands with dirt and debris noted under fingernails.	F 677		

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F 677	Continued From page 31 11/13/24 9:45 AM - An observation of R12 with long nails on bilateral hands with dirt and debris noted under fingernails. 11/14/24 8:53 AM - An observation of R12 was OOB to geri chair with long nails on bilateral hands with dirt and debris noted under fingernails. 11/14/24 11:21 AM - An interview with E16 (CNA) stated that the expectation during a shower that the resident gets hair washed, nail care, and grooming needs met. E16 confirmed that R12 received a shower on 11/13/24 during the overnight shift and confirmed that R12's nails were long and had debris noted underneath. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §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:	F 686		1/9/25

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F 686	Continued From page 32 Based on interview and record review, it was determined that for two (R6 and R5) out of four residents reviewed for pressure ulcers, the facility failed to provided necessary treatment to promote healing of a current pressure ulcer. Cross refer to F842 1. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 3/16/23 - A care plan for R6 was initiated for having skin breakdown related to decreased activity, reluctance to offload heels in bed, impaired cognition and comorbidities. Interventions included but not limited to providing preventative skin care as ordered, encouraging resident to turn and reposition and to check skin every two hours. 7/7/24 - A care plan for R6 was initiated for having a documented pressure ulcer. Interventions included to complete a mini nutritional evaluation and to educate the resident or representative on the importance of keeping skin clean and moisturized. 7/28/24 - A quarterly MDS assessment revealed that R6 required supervision or touching assistance of one person for sitting to lying and lying to sitting. R6 required partial/moderate assistance of one person for sitting to stand, transferring from bed/chair to wheelchair and to perform a toilet transfer. R6 had no range of motion impairments bilaterally to upper or lower extremities and uses a wheelchair. The MDS assessment also identified R6 was at risk for pressure ulcers/injuries and had one or more	F 686	F686- Failure to provide necessary treatments 1. The facility failed to provide necessary treatment to promote healing of pressure ulcers for 2 residents, R5 and R6. Order clarification for R5 completed by the director of nursing services and care plan updated. R5 areas have been resolved. R6 orders were clarified and tasks updated to reflect correctly. 2.The facility has determined that all residents have the potential to be affected by this deficient practice. Current residents with treatment orders have had their treatment administration record reviewed for the past 14 days to ensure there are no documented treatment omissions. 3.An in-service education program will be conducted by the nurse practice educator, skin lead nurse and/or Nursing Leadership with licensed nursing staff addressing completing and documenting treatments as ordered. Staff will be educated to report refusals to clinical management and document such refusals in PCC. If refused, the physician and Responsible party will be notified. Care plans will also be updated as needed. 4. Skin Lead nurse and/or clinical leadership will conduct a random audit of at least five residents per week for 4 weeks then monthly for 2 months until substantial compliance is achieved or as otherwise determined by the Risk	

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F 686	Continued From page 33 unhealed pressure ulcers. 7/3/24 - R6's physicians orders documented to cleanse right heel with wound cleanser, apply Medi-honey and cover with Optifoam every other day until healed. 7/10/24 - The treatment administration record (TAR) documented by E11 (RN) that R6 was away from the facility and the treatment to R6's right heel was not able to be completed that shift. 7/12/24 - The treatment administration record (TAR) documented that E24 (LPN) had administered the treatment to R6's right heel. 7/14/24 - The treatment administration record (TAR) documented by E24 that R6 had refused the treatment to the right heel. 7/16/24 - A facility investigative report revealed that the wound dressing to R6's right heel was dated 7/8/24, revealing that 8 days had passed without wound treatment. 7/16/24 - A witness statement by E11 documented that on 7/10/24, R6 was out of the facility for an appointment therefore wound care was not completed. E11 stated that this was relayed to the next shift during the change of shift report. 7/16/24 - A witness statement by E24 documented that on 7/12/24, the TAR was signed off prior to the treatment being completed to R6's right heel and then she forgot to go back and complete the treatment later. 11/20/24 8:32 AM - An interview with E28 (LPN)	F 686	Management/Quality Assurance Committee. Root Cause: It has been determined that staff needs further education regarding resident refusals and wound care treatments. Compliance date 1-9-25	

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F 686	Continued From page 34 revealed that when a resident is out of the facility for a shift or refuses to have a wound treatment performed, the next shift is told this in the change of shift report and the next shift is to attempt to do the treatment. 11/20/24 9:44 AM - An interview with E2 (DON) confirmed that the wound dressing for R6 was dated 7/8/24 and did not get changed on 7/10/24, 7/12/24 and 7/14/24. E2 stated that if R6 was out for an appointment or refused during that shift, the next shift is supposed to do it. E2 stated that the nurse is to relay the information to the next shift in the change of shift report because if the treatment is signed off as refused or away and not completed, the electronic chart will not prompt the next shift that the treatment needs to be done. 2. Cross refer F657 Review of R5's clinical record revealed: 4/23/14 - R5 was admitted to the facility. 7/24/20 - A CNA task documented "preventative skin care: Apply multi-podus boot to left lower extremity (LLE) when pt is in bed. Perform skin checks before/after donning/doffing. Elevate right foot with pillow." 5/31/21 - A physician's order was written for adaptive equipment: multi-podus boot to left foot while in bed. 1/26/24 - A CNA task documented "adaptive equipment #2: Apply multi-podus boot to LLE when pt is in bed. Apply Prevalon soft boot to RLE while in bed. Perform skin checks before/after donning/doffing."	F 686		

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F 686	Continued From page 35 11/12/24 2:12 PM - An observation of R5 in bed and wearing Prevalon boots to bilateral feet. 11/13/24 11:30 AM - An observation of R5 out of bed in the wheelchair wearing the multi-podus boots to bilateral feet. 11/14/24 10:40 AM - An observation of R5 out of bed in the wheelchair wearing the multi-podus boots to bilateral feet. 11/15/24 11:53 AM - An interview with E16 revealed that R5 wears the soft boots while in bed and the multi-podus boots while up in the chair. E16 stated she does not know the names of boots she just knows when to put them on for R5. 11/15/24 1:33 PM - An interview with E14 (COTA) confirmed that the multi-podus boots have a harder bottom and the Prevalon boots are soft. 11/15/24 - A CNA task documented soft heel boots to bilateral feet while in bed. 11/19/24 3:01 PM - An interview with E14 confirmed that R5 should be wearing the soft heel boots to bilateral feet when in bed and that is the current recommendation from therapy. E14 stated that R5 was ordered the Prevalon boots for prevention and protection related to previous area noted to R5's heels. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		1/9/25

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F 689	Continued From page 36 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 interview and record review, it was determined that for one (R89) out of two residents reviewed for falls, the facility failed to assess for and implement interventions to reduce R89's risk for falling. R89 sustained twelve falls which included two falls resulting in head trauma that required transfer to an acute care hospital. Findings include: A facility policy titled Falls Management effective 9/15/01 (last revised 3/15/24) included: "Patient will be assessed for risk of falling as part of the nursing assessment process. Interventions to reduce risk and minimize injury will be implemented as appropriate. 1. All patients will be assessed for risk of falls upon admission, with reassessments (e.g. quarterly, post-fall) performed to determine ongoing need for fall prevention precautions. 2. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. 2.1 Adjust and document individualized interventions strategies as patient condition changes." Cross refer to F690 Review of R89's clinical record revealed:	F 689	F689 Free of Accidents/Hazards/ supervision 1.R 89 still resides at the facility and has not had a fall since 9-10-2024. The IDT team met and reviewed her fall care plan to ensure it reflected appropriate interventions. 2. Current residents will have their fall risk assessment reviewed and residents identified at risk will have a care plan review to ensure appropriate interventions are in place. 3. A fall packet will be placed on the nursing units that will include a list of possible interventions to initiate post fall. Nursing staff will be re-educated by the Director of Nursing , ADON and/or designee on the implementation of interventions immediately post fall and utilizing the fall packet to guide appropriate interventions. All falls will be reviewed in the clinical morning meeting to ensure an appropriate intervention has been added to the residents care plan 4. Falls that occurred will be reviewed by	

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F 689	Continued From page 37 2/12/24 - R89 was admitted to the facility with dementia. 2/12/24 5:14 PM - An admission fall risk assessment documented a fall risk score of three indicating that R89 was at low risk for falls, required supervision for ambulation, that R89 had sustained one to two falls in the past three months prior to admission, and lacked evidence of a documented ambulation/elimination status. 2/12/24 5:16 PM - A clinical admission assessment documented that R89 was continent of urine. 2/19/24 - An admission MDS assessment documented that R89 was cognitively intact with a BIMS of 13, required verbal cues or touching/steadying assistance by one staff member for toileting supervision/touching assistance for ambulation, was occasionally incontinent of urine and a trialed toileting program was not attempted. Review of R89's fall and incontinence care plans lacked evidence of an individualized toileting program to reduce R89's risk for falling. 3/3/24 7:48 PM - An incident report documented that R89 was found sitting on floor next to her bed. 3/5/24 4:30 AM - An incident report documented that nursing responded to the patient's call bell. Upon entry to the room the patient was observed sitting on the floor beside her bed. She stated she had been attempting to go to the restroom when she fell. There was no evidence the facility conducted a urinary continence assessment that	F 689	the Quality Manager or designee weekly x 4 weeks then monthly x 3 months to ensure appropriate interventions are initiated, added to the care plan and in place. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root Cause analysis: Lack of education of staff regarding fall process/procedure and lack of follow up to RMS with Nursing Leadership. Compliance date 1-9-25	

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F 689	Continued From page 38 included voiding patterns. 3/11/24 Approx. (approximately) 2:15 AM - An incident report documented that the nurse was called to assess the patient s/p (after) falling in her room. Upon entry to the room the patient was observed sitting on the floor beside her bed. 4/9/24 1:00 AM - An incident report documented that R89 was observed sitting on the floor next to her bed. When staff responded, resident stated that she was trying to get to the bathroom. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 5/7/24 8:30 PM - An incident report documented that R89 was lying on the floor in her bathroom. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 5/11/24 3:30 AM - An incident report documented that the nurse heard R89 yelling from her room, "Help, I am on the floor!" Upon entering resident's room, R89 was noted sitting on her buttocks on the floor beside her bed. 5/12/24 - R89's fall risk score was 19 which indicated that R89 was at high risk for falling. 5/23/24 - R89's fall risk assessment score was 21 which indicated that R89 was a high risk for falling. 5/24/24 - R89's bowel and bladder assessment included that R89 had urinary incontinence and to implement "pelvic floor rehabilitation." This intervention was not individualized related to R89	F 689		

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F 689	Continued From page 39	F 689		

having severely impaired cognition. In addition, there was no evidence the facility conducted a urinary continence assessment that included voiding patterns.

5/25/24 - A 5-day MDS assessment documented R89 was cognitively impaired with a BIMS of 6, that ambulation was not attempted due to a medical condition or safety concerns and required substantial/maximal assistance with toileting.

6/13/24 10:01 AM - An incident report documented that R89 was observed lying face down on the floor in the bathroom in her room. It was documented that R89 stated, "I was getting off the toilet and couldn't stand anymore." There was no evidence the facility conducted a urinary continence assessment that included voiding patterns.

6/21/24 8:37 PM - An incident report documented that R89 was found in her room next to the bed.

6/27/24 6:30 PM - An incident report documented R89 was observed scooting on the floor in the doorway of her room.

7/5/24 7:40 PM - An incident report documented that R89 reported falling from her bed after attempting to get up.

7/17/24 6:50 PM - An incident report documented that the nurse was notified that R89 had a fall in her room. Upon entry into the room R89 was observed sitting on the floor in the bathroom in front of the toilet. R89 stated that she had attempted to toilet herself but had missed and fallen. There was no evidence the facility conducted a urinary continence assessment that

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F 689	Continued From page 40 included voiding patterns. 7/18/24 10:55 PM - An incident report documented that the nurse heard a noise and then yelling. R89 was observed laying on the floor between the bed and wheelchair. R89's head was on the base of the bedside table. Once R89 was assisted to a seated position, a large amount of blood was on the floor. It was observed that R89 had a large laceration to the back of her head and was sent 911 to the hospital. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 7/19/2024 3:55 PM - A wound progress noted documented that R89 had a laceration to back of her head noted with 2 staples in it. This was as a result of the 7/18/24 fall. 8/14/24 - A quarterly MDS assessment documented that R89 was not assessed for cognition, was frequently incontinent, and was partial/moderate assistance for ambulation and toileting. 8/17/24 6:35 PM - An incident report submitted to the state agency documented that R89 sustained a fall with a forehead laceration with bleeding that was not controlled. R89 required a transfer to the hospital. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 11/19/24 9:23 AM - During an interview, E1 (NHA) and E2 (DON) confirmed that the facility was only conducting assessments for voiding patterns on admission and not on residents with repeated falls including when a residents had repeated falls	F 689		

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F 689	Continued From page 41 attempting to go to the bathroom. E2 also confirmed that a generic toileting plan is not beneficial to reduce risk for falls if the resident was not assessed for voiding patterns. 11/19/24 9:50 AM - During an interview, E1 (NHA) confirmed that R89 was not assessed for patterns of incontinence and that R89 was not on an individualized toileting program to attempt to reduce R89's risk for falling. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		1/9/25

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F 690	Continued From page 42 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 interview and record review it was determined that for four (R6, R43, R89 and R91) out of four residents reviewed for urinary incontinence, the facility failed to assess and provide care and services to maintain/restore bowel and bladder continence. Findings include: A facility policy titled Continence Management (effective 6/1/96 last revised 6/15/22) included: "Patients will be assessed for the need for continence management as part of the nursing assessment process. A urinary incontinence assessment and or bowel incontinence assessment will be completed upon admission or re-admission and with a change in condition or change in continence status. Continence status will be reviewed quarterly as part of the care planning process. Identify patient's incontinence management by conducting a nursing assessment. Assess components include but are not limited to ...voiding patterns." Cross refer to F689	F 690	F690- Bowel/Bladder Incontinence, Catheter, UTI. 1. R6, R89, R91 - has had a urinary incontinence assessment. R-43 no longer resides in the facility 2. Current residents who are incontinent of urine will be re-assessed for the ability to maintain/restore bladder continence. 3.Licensed nursing staff will be re-educated by Nurse Practice Educator, ADON and/or designee on assessing residents' continence status on admission/re-admission and with a change in condition. 4.The director of nursing, assistant director of nursing, and/or nurse educator will audit 5 random residents weekly x 4 then monthly x 2 to ensure that continence status has been assessed. This plan of correction will be monitored at	

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F 690	Continued From page 43 1. Review of R89's clinical record revealed: 2/12/24 - R89 was admitted to the facility with dementia. 2/12/24 5:16 PM - A clinical admission assessment documented that R89 was continent of urine. 2/19/24 - An admission MDS assessment documented that R89 was cognitively intact with a BIMs of 13, required verbal cues or touching/steadying assistance by one staff member for toileting, was occasionally incontinent of urine and a trialed toileting program was not attempted. There was no evidence the facility conducted a urinary continence assessment that included voiding patterns. 2/28/24 -R89's care plan included: - Complete an incontinence assessment at intervals according to policy and procedure. - Discuss and plan voiding schedule with resident. - Resident is incontinent of urine with potential for improved control or management of urinary elimination. - Resident will demonstrate improved urinary elimination control as evidenced by experiencing less than one episode of urinary incontinence per day. - Encourage resident to use toilet upon wakening, after meals, nightly and PRN (as needed). There was no evidence of individualized approaches to maintain/restore bladder	F 690	the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root cause analysis- Lack of education to licensed nursing staff on assessing continence status. Compliance date 1-9-25	

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F 690	Continued From page 44 continence. February 2/12/24 through 2/29/24 - Review of R89's continence record revealed that R89 was continent of urine 46 out of 55 opportunities, incontinent six times, and three opportunities the facility lacked evidence of being toileted or offered. March 2024 - Review of R89's continence record revealed that R89 was continent of urine 81 out of 94 opportunities, incontinent seven times, one time not rated, and four opportunities the facility lacked evidence of being toileted or offered. 3/5/24 - R89's CNA tasks included: assist with toileting. 3/12/24 - R89's incontinence care plan included: Toilet upon rising, before meals, and at bedtime as needed. April 2024 - Review of R89's continence record revealed that R89 was continent of urine 74 out of 94 opportunities, incontinent ten times, one time not rated, and nine times lacked evidence of being toileted or offered. May 2024 - Review of R89's continence record revealed that R89 was continent of urine 46 times out of 95 opportunities, incontinent 22 times, and was out to the hospital from 5/15/24 through 5/23/24. 5/13/24 - R89's incontinence care plan included: Assist with toileting upon waking up before meals. The facility lacked evidence of an assessment to create and implement this approach.	F 690		

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F 690	Continued From page 45 5/13/24 - R89's incontinence CNA tasks included to assist with toileting upon waking up, before meals, after meals, and prior to bedtime. This toileting schedule was different than the nursing care plan. 5/15/24 - R89's 5-day MDS documented that R89 was cognitively impaired with a BIMs of 8, required supervision/touching assistance for toileting, partial/moderate assistance for ambulation, was always continent of urine and was not on a toileting program. 5/24/24 - R89's bowel and bladder assessment included that R89 had urinary incontinence and to implement "pelvic floor rehabilitation". R89's EHR lacked evidence of this approach. A voiding diary was not a part of the assessment. June 2024 - Review of R89's continence record revealed that R89 was not continent at all out of 94 opportunities and four times lacked evidence of being toileted or offered toileting. July 2024 - Review of R89's continence record revealed that R89 was continent 44 out of 95 opportunities, incontinent 34 times and fifteen lacked evidence of being toileted or offering toileting. August 2024 - Review of R89's continence record revealed that R89 was continent 53 times out of 97 opportunities, incontinent 35 times and eight times lacked evidence of toileting or being offered toileting. 8/14/24 - R89's quarterly MDS documented that R89's BIMs was not assessed, required partial/moderate assistance for toileting, was	F 690		

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F 690	Continued From page 46 frequently incontinent, and was not on a toileting program. September 2024 - Review of R89's continence record revealed that R89 was continent 17 times out of 90 opportunities, incontinent 64 times, one time inapplicable and eight times lacked evidence of being toileted or being offered toileting. 9/4/24 - R89's fall risk care plan included: Toilet upon rising, before meals at bedtime and when needed as per resident. October 2024 - Review of R89's continence record revealed that R89's continence was unable to be determined. 10/31/24 - R89's fecal and urinary incontinence evaluation documented that R89 had urinary incontinence and a program of prompted voiding as an intervention. The facility lacked evidence of an individualized schedule based on a comprehensive assessment. 11/1/24 - 11/21/24 - Review of R89's continence record revealed that R89 was continent one time out of 63 opportunities, incontinent 61 times and two times lacked evidence of being toileted or being offered toileting. 11/6/24 - R89's quarterly MDS documented that R89 was cognitively impaired with a BIMs of four, required substantial/maximal assist for toileting, did not ambualte, was frequently incontinent and was not on a toileting program. Review of R89's EHR revealed that R89 had become increasingly incontinent of urine during her stay, and that the facility failed to thoroughly	F 690		

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F 690	Continued From page 47 assess and implement a comprehensive plan of care to prevent R89 from become becoming more incontinent. 11/19/24 11:25 AM - During an interview, E28 (LPN) confirmed that a 3-day voiding diary was not in the admission assessment. E28 stated that R89's continence assessments were in the CNA tasks. When the surveyor queried regarding who analyzes the CNA data to initiate a personalized plan of care for a toileting program, she could not articulate the process. During the same interview, E17 (RN) stated that she was not familiar with the process of who analyzes the incontinence data. 11/19/24 11:29 AM - During an interview, E1 (NHA) confirmed that a 3-day voiding diary was not completed upon admission and with changes in continence status. E1 also confirmed R89 had only two additional incontinence evaluations since admission on 5/24/24 and 10/31/24. Although R89's EHR revealed a significant change in continence since admission, the assessments were greater than five months apart. 11/22/24 3:18 - During an interview, E1, E2 (DON) and E26 (RCA) confirmed that the facility lacked evidence of a consistent individualized toileting program, and that R89 did experience an increase in urinary incontinence. E26 stated that it is the responsibility of the Unit Managers to review the CNA documentation to discern if a resident would benefit from an incontinence program. In addition, E26 confirmed R89's decline in continence and that the facility lacked evidence in the CNA tasks that R89 was consistently toileted. 11/25/24 9:50 AM - During an interview, E37	F 690		

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F 690	Continued From page 48	F 690		

(MDS) confirmed that the clinical team and the unit managers were to review residents for toileting programs. E3 confirmed that R89 had a decline in continence since admission as evidenced by review of R89's MDS assessments. In addition, E37 confirmed that R89's toileting program was not individualized related to lack of assessment.

11/25/24 10:09 AM - During an interview, E28 confirmed R89 did not have any voiding diaries throughout her stay to assess for an individualized toileting program and had a decline in urinary incontinence. In addition, E28 confirmed that pelvic floor exercises were not an appropriate intervention related to R89's impaired cognition. E28 stated that it was the responsibility of the primary nurses and the unit managers to monitor the need for new toileting interventions when there is a change in continence status. E28 confirmed that "those things are being missed" due to staffing.

2. Review of R91's clinical record:

3/14/24 - R91 was admitted to the facility.

3/15/24 - A care plan was initiated, decreased mobility to perform ADL's in bathing, grooming, personal hygiene, dressing, eating, bed mobility, locomotion and toileting. Interventions included provide queuing for safety and sequencing to maximize level of function. There were no interventions documented related to incontinence.

3/20/24 - The admission MDS documented R91 was admitted with an indwelling catheter.

3/21/24 - A nursing progress note documented "Foley removed ...condom cath applied, draining

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F 690	Continued From page 49 clear yellow urine resident is incontinent of urine..." 3/22/24 - A nursing progress note documented, Condom cath removed. 3/25/24 - A nursing progress note documented, "no continent episodes." 4/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder seventy-seven times out of ninety opportunities. and four opportunities the facility lacked evidence of being toileted or offered. 5/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder eighty-two times out of ninety- three opportunities, and three opportunities the facility lacked evidence of being toileted or offered. 6/12/24 - A quarterly MDS documented that R91 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R91 was dependant for toileting hygiene and toileting transfer. 6/2024- The CNA task flow sheet documented that R91 was incontinent of bladder eighty- three times out of ninety opportunities. 7/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder eighty-two times out of ninety-three opportunities. 8/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder eighty- one times out of eighty-nine opportunities.	F 690		

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F 690	Continued From page 50 9/10/24 - A quarterly MDS documented that R91 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R91 was dependant for toileting hygiene and toileting transfer. 9/2024 - The CNA task flow sheet documented that R91 was incontinent of bladder seventy-six times out of eighty-six opportunities. 11/19/24 10:12 AM - During an interview, E17 (RN) confirmed that the resident was incontinent of urine and upon admission had an indwelling catheter. R91 no longer has the catheter is incontinent of urine and wears adult briefs. E17 confirmed there was no evidence of a urinary assessment including a voiding diary. 11/19/24 10:38 AM - During an interview, E2 (DON) confirmed R91 was dependent for care and a toileting program was never initiated. In addition, E2 was unable to provide evidence of incontinence monitoring. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference. 3. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 7/24/24 - A quarterly MDS documented that R6 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R6 was dependent for toileting hygiene and partial/ moderate assist for toileting transfer. 7/2024 - The CNA task flow sheet documented that R6 was incontinent of bladder sixty-one times	F 690		

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F 690	Continued From page 51 out of ninety opportunities. 8/2024 - The CNA task flow sheet documented that R6 was incontinent of bladder sixty-seven times out of ninety opportunities. 9/2024 - The CNA task flow sheet documented that R6 was incontinent of bladder seventy-eight times out of ninety-one opportunities. 10/21/24 - A quarterly MDS documented that R6 was always incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R6 was dependent for toileting hygiene and partial/ moderate assist for toileting transfer. 10/2024 - The CNA task flow sheet documented that R6 was incontinent of bladder eighty-eight times out of nintey-three opportunities. 11/19/24 11:27 AM - An interview with E26 (CNA) stated that R6 was a one assist for toileting and was a mix of continent and incontinent. E26 stated that R6 was not on a toileting program and was assisted to the toilet every two hours. E26 confirmed that R6 can stand and pivot and able to use the toilet with staff assistance. 11/21/24 12:39 PM - An interview with E12 (UM) confirmed R6 was not on a toileting program at this time. 4. Review of R12's clinical record revealed: 9/25/20 - R12 was admitted to the facility. 6/6/24 - A quarterly MDS documented that R12 was frequently incontinent of bladder, always	F 690		

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F 690	Continued From page 52 incontinent of bowel and was not on a toileting program. The MDS also documented that R12 was dependent for toileting hygiene and for toileting transfer. 6/2024 - The CNA task flow sheet documented that R12 was incontinent of bladder eighty-one times out of nintey opportunities. 7/2024 - The CNA task flow sheet documented that R12 was incontinent of bladder eighty-three times out of nintey-one opportunities. 8/2024 - The CNA task flow sheet documented that R12 was incontinent of bladder eighty-six times out of nintey-three opportunities. 9/3/24 - An annual MDS documented that R12 was always incontinent of bowel and bladder and was not on a toileting program. The MDS also documented that R12 was dependent for toileting hygiene and for toileting transfer. 9/2024 - The CNA task flow sheet documented that R12 was incontinent of bladder ninety times out of nintey opportunities. 11/19/24 12:42 PM - An interview with E16 (CNA) stated that R12 was dependent for toileting and confirmed R12 was not on a toileting program. E16 also stated that R12 was not utilizing a urinal or bed pan for continence. E16 confirmed that R12 does not use the toilet. 5. Review of R43's clinical record revealed: 4/8/24 - R43 was admitted to the facility. 4/9/24 - A care plan was initiated for R43 requires	F 690		

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F 690	Continued From page 53 assistance for ADL care in bathing, grooming, person hygiene, transfer, and toileting. Interventions include provide cueing for safety and sequencing to maximize current level of functioning. 7/10/24 - A quarterly MDS documented that R43 is dependent for toileting and toileting hygiene. The MDS also documented that R43 is frequently incontinent of bowel and bladder and is not on a toileting program. 7/2024 - The CNA task flow sheet documented that R43 was incontinent of bladder eighty-one times out of ninety opportunities. 8/2024 - The CNA task flow sheet documented that R43 was incontinent of bladder eighty-three times out of ninety-one opportunities. 9/2024 - The CNA task flow sheet documented that R43 was incontinent of bladder eighty-four times out of ninety-one opportunities. 10/2024 - The CNA task flow sheet documented that R43 was incontinent of bladder eighty-seven times out of nine-three opportunities. 11/12/24 11:06 AM - An interview with R43 stated that she was continent and able to use the bed pan. R43 stated she was aware when she needs to use the bathroom and was often incontinent waiting for staff to answer the call bells. 11/19/24 11:59 AM - An interview with E26 (CNA) confirmed R43 was aware when she needs to use the bathroom. E26 confirmed that R43 was able to use the bed pan and confirmed resident was not on a toileting program.	F 690		

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F 690	Continued From page 54 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.	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 and interview, it was determined that for three (R89, 411, and 412) out of three residents reviewed for hydration, the facility failed to ensure that R411 and R412 were offered sufficient fluid intake to maintain proper hydration and health. R411 was emergently sent to hospital and was diagnosed with a BUN of 32, and acute kidney Injury. R412 received an order for IV (intravenous) hydration	F 692	F-692 Nutrition/Hydration Status Maintenance 1.R 411 no longer resides at the facility R 412 no longer resides at the facility R89 has been weighed and the physician and dietician were made aware of the current weight	1/9/25

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F 692	Continued From page 55 for a sodium level of 156, the facility failed to insert the IV and R412 sodium level rose to 161. R412 was emergently sent to the hospital 36 hours later with facial droop and lethargy. For R89, the facility failed to follow a physician's order and evaluate R89's weight when R89 had a significant weight loss. Findings include: A facility document titled, "Nutrition and Hydration Care and Services", dated 1/1/04 and reviewed 2/1/23 included, "Staff will provide nutritional and hydration care and service to each patient consistent with each patient's comprehensive assessment .... Monitor intake and output .... Diagnoses of dehydration with clinical findings .... At risk for dehydration ...." R411's clinical records revealed: 6/5/24 - R411 was admitted to the facility with diagnoses including acute kidney injury, acute osteomyelitis [infection of the bone] to the right hip bone and anal/rectal cancer. 6/5/24 - R411's physician's orders included cefepime [antibiotic] 2 gram/IVBP [intravenous piggyback] 100 ml every 12 hours and vancomycin [antibiotic to treat a bacterial infection] 1gram/200 IVBP every 24 hours, "...Patient will need vanco trough level [lowest concentration of vancomycin in the blood] 2 times weekly...and weekly CBC... [complete blood count] ...colostomy [a surgical opening in the intestinal wall or colon to allow stool to drain into a bag] care every shift." 6/6/24 - R411's care plan documented, "Resident exhibits or is at risk for dehydration as evidence by infection and .... vomiting, diarrhea ..." The	F 692	2. Current residents in the facility will have their fluid needs reviewed by the dietician to ensure they are appropriately calculated based on weight and medical diagnosis. 3. Current residents with an IV order in the past 30 days will have their chart reviewed to ensure that the IV was started and maintained as ordered. Current residents have been re-weighed. Residents with a weight loss of 5% or greater have been reviewed by the dietician for the need for intervention and the MD and responsible party have been updated. Licensed nursing staff will be re-educated by the nurse practice educator ,ADON and/or designee on signs and symptoms of dehydration and notifying the provider for orders to encourage or increase fluids if observed. Licensed nursing staff will be re-educated by the nurse practice educator and/or ADON on IV insertion and alternative to IV fluids if a line is unable to be placed. Licensed nursing staff and the dietitian will be re-educated by the nurse practice educator and/or the ADON on obtaining weights as ordered and notifying the provider, dietician and responsible party of significant weight loss. 4. Random audits of 5 residents will be conducted weekly x 4 then monthly x 2 by the Director of Nursing and/or the ADON to ensure that the resident has no signs or symptoms of dehydration. Residents receiving orders for IV fluids or medication will be audited weekly x 4 then monthly x2	

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F 692	Continued From page 56 interventions included, "Encourage resident to consume all fluids ...monitor lab work as ordered and report as indicated." 6/6/24 - R411's admission nutritional assessment documented a fluid goal of 1700 ml/24 hours. 6/10/24 - R411's clinical records documented a vancomycin peak [highest contraction of vancomycin level in the blood] of 9.8, a trough level of 9.8. Vancomycin therapeutic trough level is between 5.0 to 10.0, and the peak level is between 20.0 to 40.0. 6/11/24 - R411's admission MDS documented a BIMS score of 15, indicating a cognitively intact status. R411's MDS lacked documentation of the presence of a colostomy on the left lower abdomen. 6/12/24 3:44 PM - A nursing progress in R411's clinical records documented, "Resident has new orders per [E15] NP and Infectious Disease request: Increase Vancomycin ...daily until 7/14/2024." 6/13/24 - R411's clinical records documented a vancomycin peak of 12.3, trough of 12.3 and BUN [a blood test to measure kidney function] of 17, (normal range is between 7-17), and a creatine [a blood test to measure kidney function] level of 1.00 [normal range for women is between 0.6 to 1.1]. 6/17/24 - R411's clinical records documented a vancomycin peak of 12.5, a trough of 12.5, and a BUN level of 19.	F 692	by the Director of Nursing and/or ADON to ensure the IV was started when ordered and if unable to be started alternatives were ordered by the provider. Random audits of 5 residents weights will be conducted weekly x 4 then monthly x 2 by the Director of Nursing, ADON and/or Unit managers ensure that the resident has been weighed as ordered and if a significant weight loss is noted that the provider, dietician and responsible party have been made aware. The findings of the audits will be reported at the monthly and quarterly Quality Assessment and Assurance meeting until consistent compliance has been met. ROOT CAUSE: Licensed nursing staff lacked education on clinical processes. Compliance date 1-9-25	

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F 692	Continued From page 57 6/24/24 - R411's clinical records documented a vancomycin peak of 24.2, trough of 24.2 and BUN of 19. 6/27/24 - R411's clinical records documented a BUN 18, creatine 1.40. The Cefepime was decreased to 1 gram every 12 hours and vancomycin at 1 gram every 24 hours. A review of R411's daily documented fluid intake from 6/7/24 through 6/30/24 revealed: 6/6/24 - 690 ml, 6/7/24 - 1,040 ml, 6/8/24 - 1,020 ml, 6/9/24 - 1,620 ml, 6/10/24 - 950 ml, 6/11/24 - 1,620 ml, 6/12/24 - 500 ml, 6/13/24 - 840 ml, 6/14/23 - 720 ml, 6/15/24 - 1,450 ml, 6/16/24 - 1,450 ml, 6/17/25 - 1,150 ml, 6/18/24 - 1,190 ml, 6/19/24 - 980 ml, 6/20/24 - 1,040 ml, 6/21/24 - 810 ml, 622/24 - 730 ml, 6/23/24 - 1,240 ml, 6/24/24 - 1,100 ml, 6/25/24 - 1,190 ml, 6/26/24 - 1,260 ml, 6/27/24 - 1,260 ml, 6/28/24 - 340 ml, 6/29/24 - 960 ml, 6/30/24 - 580 ml	F 692		

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F 692	Continued From page 58 R411's did not meet the fluid goals of 1700 ml for 24 out of 24 days. 7/1/24 - R411's clinical records documented a vancomycin peak of 23.1, peak of 23.1, BUN of 32 (above the normal level) and creatine level of 2.60 (above the normal level). 7/1/24 9:17 AM - R411's clinical records documented, "Pt [patient] not feeling well this am, BM from colostomy all over bathroom with a very strong odor. Pt lethargic, not answering questions with full responses. Daughter in law came in to visit, also concerned with pt change in mental status. BP [blood pressure] 96/56 ...sent to the ER [emergency room] for evaluation." 7/1/24 9:51 AM - R411's clinical records documented (progress note from the NP, "Pt seen today for follow up. Pt was found resting in bed, in mild distress. Pt daughter at bedside. Pt stated " I don't feel well. Something is wrong." Pt c/o [complaint of] chills, diarrhea, weakness, sob [shortness of breath], BP 96/56 ...noted lethargy, sob and appeared ill. Pt was sent to ER for further evaluation." 7/1/24 1:37 PM - R411's clinical records documented, "Called Sussex ER for pt update. Per ER nurse-Pt still being evaluated, may be admitted due to abnormal labs ..." 7/1/24 6:06 PM - R411's emergency hospital records documented, "Patient was found to have acute kidney injury.... her creatinine peaked at 4.3, now trending down to 2.5, patient was seen by nephrology ...now improved to 2.5, s/p [status post] IV fluids. Labs show an acute kidney injury ...Patient will require admission to medicine	F 692		

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F 692	Continued From page 59 service for acute kidney injury likely from volume loss from C. difficile as well... final diagnoses - Acute kidney failure, dehydration." 11/21/24 10:00 AM - A review of R411's fluid intake records from 6/7/24 through 6/30/24 lacked evidence that R411 reached the fluid goals of 1700 ml/24 hours for 24 out of 24 opportunities. During an interview E15 (dietitian) provided the Surveyor with a facility document titled, "Week at a glance," menu. The menu documented the fluids served with each meal. 11/22/24 8:45 AM - During an interview, E21 (CNA) stated, "We give them {residents] what's on the tray, and they ask if they want anything more." 11/22/24 1:30 PM - The surveyor asked E13 (MD) during a telephone interview if the residents labs are reviewed by the facility's providers along with the infectious providers, E13 stated, "Yes, they are reviewed and signed by the providers in the building as well." 11/25/24 10:00 AM - During a telephone interview C1 (MA) stated, "We follow the levels for the antibiotics. The patient is in the building, and they must make sure she is drinking enough." The facility failed to monitor and ensure that R411 received sufficient fluid intake despite the diagnoses of acute kidney injury, the use of nephrotoxic (risk of damaging the kidneys) medications (which placed R411 at higher risk for diarrhea) and the presence of a colostomy. 2. R412's clinical records revealed:	F 692		

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F 692	Continued From page 60 7/20/22 - R412 was admitted to the facility with diagnoses including dementia, hypertension, chronic kidney disease and diabetic mellitus. 7/22/22 - R412's nutritional care plan documented, " ... Presents with nutritional risk r/t (related to) ....DM (diabetes mellitus) ... CKD (chronic kidney disease)." 4/19/24 - R412's quarterly MDS assessment documented a BIMS score of 2, indicating severe cognitive impairment. The MDS assessment also documented that R412 was independent with eating and needed substantial or total help from staff with all other activities of daily living. 6/26/24 9:33 AM - R412's nutritional assessment documented a fluid goal of 2,100 ml per day. 7/1/24 2:48 PM - R412's clinical records documented, "...Vomit x 1 episode..." 7/3/24 8:47 AM - R412's clinical records documented, "Patient to increase fluids today." R412's clinical records lacked evidence of documentation of increased fluids given. 7/4/24 1:27 PM - R412's clinical records titled "Interact" [a document for a change in condition] documented, " ...15.7-pound weight loss since 4/16/23 ..." R412's clinical records lacked evidence of interventions for the weight loss. 7/6/24 4:37 AM - R412's clinical records documented, "Nutrition note: no meals offered this shift, resident id d [did] consume a 240mL of	F 692		

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F 692	Continued From page 61 extra fluids ..." 7/6/24 11:46 AM - R412's clinical records documented, "Hypernatremia ... [high sodium level in the blood] ...Plan Give 1/2 NSS [normal saline] at 75cc/hr [hour] x1 liter. Repeat BMP [Basic Metabolic Panel] on Monday." 7/6/24 12:21 PM - R412's clinical records documented a sodium level of 156, and a BUN of 34. 7/7/24 11:49 AM - R412's clinical records documented, " ...Resident noted with a poor appetite for lunch. Consumed less than 25% of his lunch requiring assistance with feeding by nursing staff ..." 7/7/24 12:00 AM - R412's clinical records documented, " ...Attempts to restart iv were unsuccessful. Therefore, a phone call will b [be] made to [Name of IV Company}." R412's clinical records lacked evidence that the IV was started. 7/7/24 3:09 PM - R412's clinical records documented, " ...Resident has new orders to administer IV fluids sodium chloride 0.45% @ 75ml/hr [hour] X 1 liter for hypernatremia, However, previous shift unable to obtain IV access for fluid hydration. [Name of IV Company] notified by this writer confirmation # 319625. Spoke with "[Name of IV Company staff's name]". Who states "she doesn't have a ETA as of yet"? Also states "the technician has been dispatched". Oncoming nurse made aware of all the above mentioned and to follow up."	F 692		

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F 692	Continued From page 62 R412's clinical records lacked evidence that the IV company came out to start the IV access. 7/7/24 4:15 PM: E8 (NP) documented in R412's clinical records, " .... Seen today for IV access. Nurse attempted 2 times but unsuccessful to place PIV, Patient ordered for IVF for Hypernatremia of 156 .... Plan: Attempt to place PIV again, Call the IV team again and get an ETA." The clinical records lacked evidence of fluids given to R412. 7/8/24 10:35 AM - R412's clinical records documented lab results, "Sodium- 161 BUN 34.0." 7/8/24 11:37 AM - E8 (NP) documented in R412's clinical records, " ...Sent to hospital for critical sodium level and to rule out stroke .... seen today for increased sodium level and right mouth drooping. Nursing reports patient had a sodium level of156 on Saturday, nursing called on-call and patient was started on sodium chloride 0.45% at 75 mL/h IV for the hypernatremia. Nursing staff unable to get IV line started and had to order from outside company to come in and place a midline. Company schedule to come out Monday morning. Sodium rechecked on 7/8/2024 and was at 161 and chloride at 126. Patient found resting in bed and unable to answer questions, patient mumbling. Patient's right lip drooping. No line placed in patient yet for IV solution. Vitals are stable. Patient's sister present and updated that patient will be sent to the hospital to address the hypernatremia and rule out stroke .... Lab from 7/8/2024-sodium 161 and critical. Sent to the hospital due to no IV access and sodium needing	F 692		

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F 692	Continued From page 63 to be addressed. Patient unable to make out words, this is new for patient..." 7/8/24 1:43 PM - A facility document reported to the Division documented, "During clinical rounds this morning it was noted that an IV order from 7/6/24 was attempted multiple times by nursing staff unsuccessfully. The contracted IV placement specialists had not yet arrived in the facility to place the ordered midline. Investigation initiated and ongoing." 7/9/24 12:30 PM - R412's hospital records documented, "Hypernatremia with sodium as high as 158-160, this is improving with D5 water." 7/10/24 2:04 PM - R412 was readmitted to the facility. R412's hospital discharge summary documented, "AKI (acute kidney injury) on CKD, Resolved." 7/11/24 - R412 readmission nutrition assessment documented, "Readmit s/p [status post] hosp [hospitalization] for hypernatremia ...facial droop which corrected per hospital records s/p IV hydration." The assessment also documented, "Is there a nutritional problem?" And the answer was, " No." R412's readmission care plan and nutritional assessment lacked evidence of interventions for hydration despite the recent hospitalization for increased sodium level. 7/15/24 12:40 PM - E8 (NP) documented in R412's clinical records, " .... Readmitted ...was sent to emergency for evaluation secondary to elevated sodium levels and right facial droop. Facial droop improved ... may have been	F 692		

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F 692	Continued From page 64 secondary to hypernatremia .... Creatinine at baseline was 1.4-1.5 currently at 1.5-2.1. Patient stable and discharged back to facility for care." 7/24/24 - A facility document to the Division titled, "5 day follow up," included, " .... While a delay in treatment occurred, there was no negative outcome for the resident .... the IV contracting company will be contacted for discussion related to providing timely services and notification to facility. In addition, education was completed with facility licensed nursing staff to include concerns with ability to carry out physicians' orders to follow facility protocol of notifying Director of Nursing or Assistant Director of nursing for further direction and follow up. In addition, medical providers were notified that other types of supplemental hydration can be administered in place of peripheral to include by not limited to Hypodermoclysis [a method to give fluids under the skin for patients who need hydration] therapy. The kits have been ordered to have on hand. Licensed nursing staff have also been educated on this process and procedure." 11/20/24 10:00 PM - During an interview E7 (Dietitian) stated, "The residents' weights are reviewed to formulate what their fluids goals are, and that is added to their meal tickets." 11/22/24 10:30 PM - During a telephone interview the Surveyor asked E3 (NP) at what time would the plan of care have to be changed for the resident with a sodium level 156 and the IV hydration could not be started. E3 stated, "That would depend on what the nurses tell me, and how long it would take for [Name of IV Company] to come to the building. I don't think it should be longer than 8 hours if the patient is not drinking	F 692		

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F 692	Continued From page 65 though." 11/22/24 11:00 AM - During an interview E5 (LPN) stated, "The patient would have to go out for treatment really soon if they can't start the IV and he is not drinking." 11/22/24 11:15 AM - During an interview E6 (LPN) stated, "The patient would probably have to go out in about 4 hours if they can't get the IV started." 11/22/24 2:30 PM - During a telephone interview, the Surveyor asked E13 (MD) about the timeliness in care and treatment for a patient with a diagnoses of chronic kidney disease and a documented sodium level of 156 on 7/6/24 and a sodium level of 161 on 7/8/24. E13 stated, "That depends on if the resident was drinking fluids and if he looked sick. The facility sent him out when he started having symptoms." E13 further stated that R412 did not suffer from any adverse effects from the delay in treatment despite documented of lethargy and facial droop. 11/22/24 2:45 PM - A review of R412's clinical records from 6/20/24 through 7/20/24 lacked evidence that he was monitored for adequate fluid intake. The facility failed to ensure that R411 was offered sufficient fluid intake to maintain proper hydration and health. And that R412 received care and treatment in a timely manner for increasing sodium levels. 3. Review of R89's clinical record included: 2/12/24 - R89 was admitted to the facility.	F 692		

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F 692	Continued From page 66 2/12/24 - R89 weighed 15.2 pounds on admission. 7/1/24 - A nutrition note documented that R89 had a weight loss of 13.2 pounds (9.1%) in three months. 8/14/24 - A quarterly MDS assessment documented that R89 was a set up assistance for eating and not on a physician prescribed weight loss regimen. 10/1/24 - A physician order included: Weigh every day shift every Thursday for four weeks. 11/7/24 - Review of R89's EHR revealed that there were only initials and a check mark and no weight recorded. The facility lacked evidence of R89"s weekly weight being obtained. 11/11/24 10:53 AM - A nutrition progress note documented that R89 has had a significant unplanned, undesired weight loss of 12.6%. R89 had a 19 pound weight loss in six months. Although the facility implemented nutritional interventions, the facility failed to evaluate R89's 11/7/24 weight per physician order. 11/14/24 12:14 PM - During an interview, E28 (LPN) confirmed that the facility lacked evidence that R89's 11/7/24 weekly weight was obtained and that R89 had experienced a significant weight loss. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		1/9/25

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F 758	Continued From page 67 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 68 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R89) out of five residents reviewed for unnecessary medications, the facility lacked evidence of side effect monitoring for psychotropic medications. Findings include: Review of R89's clinical record revealed: 2/12/24 - R89 was admitted to the facility with the following diagnoses, but not limited to, including major depressive disorder, adjustment disorder with mixed anxiety and depressed moods, unspecified dementia with psychotic behaviors, and unspecified dementia with other behaviorial disturbances. 10/31/24 - A physician's order was written for Ativan 0.5 mg three times a day for anxiety. 11/2024 - A review of the November MAR lacked evidence of monitoring for side effects related to psychotropic medications. 11/15/24 2:43 PM - An interview with E12 (UM) confirmed that R89 did not have an order to monitor for side effects related to psychotropic	F 758	F758- Free from Unnec Psychotropic Meds/PRN Use 1.The facility lacked evidence of side effect monitoring for psychotropic medications for R89. Side effect monitoring has been added to R89 electronic medical record. 2.The facility has determined that all residents prescribed psychotropic medication have the potential to be affected by this alleged deficient practice.Current residents prescribed psychotropic medication have been reviewed to ensure side effect monitoring is in place. 3.Nurse Practice Educator, Adon and/or designee willl re- educate clinical management staff on monitoring side effects for psychotropic medication. 4.The DON and LNHA did an initial audit of all residents on antipsychotic medications. Routine GDR meetings are being held by the DON with the nursing	

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F 758	Continued From page 69 medications. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.	F 758	leadership, LNHA and medical director. The director of nursing, ADON or/and LHNA will conduct a random audit of at least five residents receiving psychotropic medication to ensure side effects are monitored. The audit will be conducted once a week for 4 weeks then monthly for 2 months until substantial compliance is achieved or as otherwise determined by the Risk Management/Quality Assurance Committee. Root Cause: It was determined that clinical leadership required education in the GDR process and compliance with psychological medication reviews. Compliance date 1-9-25	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, for one (R50) out of four residents	F 773	F773- Lab Srvcs Physician Order/Notify of Results	1/9/25

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F 773	Continued From page 70 sampled for laboratory services, the facility failed to promptly notify the ordering medical practitioner of laboratory results. Findings include: Review of R50's clinical record revealed: 12/29/23 - R50 was admitted to the facility. 10/31/24 - A provider (E18 NP) encounter note documented R50 was having malodorus urine with cloudy urine noted in foley tubing. E18 ordered a urine analysis (UA) and culture sensitivity (C & S). 11/1/24 5:06 PM - A review of lab results revealed that R50 was positive for a urinary tract infection. The culture was still pending at this time. 11/3/24 (Sunday) 4:18 PM - A review of lab results revealed the urine sample from R50 was positive for growth. 11/4/24 (Monday) 9:00 PM - A physician's order was written for Ciprofloxacin (anitibiotic) 500 mg give one tablet by mouth every twleve hours for urinary tract infection for seven days. 11/19/24 9:12 AM - An interview with E17 (RN) stated if lab results post during the weekend the nurse on duty is expected to review the results and if abnormal to notify the on call provider of the abnormal results. 11/19/24 9:40 AM - An interview with E12 (UM) stated that lab results are usually emailed to the Unit Managers on the weekend or they will be faxed to the facility. E12 confirmed that the results for R50 posted at 4:19 PM on 11/3/24. E12 confirmed the results were positive and the	F 773	1. R50 urine results from 11-3-2024 were reviewed 11-4-2024 by the nurse practitioner. 2.The facility has determined that all residents have the potential to be affected by this alleged deficient practice. Current residents lab results in the last 14 days have been reviewed to ensure abnormal results were reviewed with a medical provider. 3.Nurse Practice Educator, ADON, and/or designee will re- educate all licensed staff to include the process of running lab reports to reporting labs to the provider timely. 4.DON, ADON and/or designee will do an audit of at least 5 random residents for compliance with the laboratory process and reporting the results to the provider. These audits will be done weekly x4 weeks and then monthly x2 until substantial compliance is achieved or as otherwise determined by the Risk Management/Quality Assurance Committee. Root Cause: Staff not properly educated to report lab reports timely. Compliance date 1-9-25	

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F 773	Continued From page 71 results were not called to the provider. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 773		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		1/9/25

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	085010	A. BUILDING _____ B. WING _____	C 11/25/2024

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F 791	Continued From page 72 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R13) out of three residents sampled for dental services, the facility failed to assist the resident in obtaining routine dental services. Findings include: Review of R13's clincal record revealed: 8/19/21 - R13 was admitted to the facility. 4/21/24 - A significant change MDS documented that R13 had no natural teeth or tooth fragments, no abnormal mouth tisssue, and no obvious broken teeth. 11/12/24 2:58 PM - An interview with R13 revealed that R13 has several missing teeth. R13 stated that she only has approximately five teeth left. R13 stated she has not seen a dentist or has been offered dental services by the facility. 11/13/24 2:45 PM - An interview with E22 (CNA) confirmed that a dentist comes to the facility and residents also can go to outside dental providers. E22 stated that residents will request to see the dentist and will get added to the list.	F 791	F791- Routine/Emergency Dental Srvcs in NFs 1. R13 has been added to the contracted dental service that comes to the center . 2. The facility has determined that all residents have the potential to be affected by this deficient practice. Current residents will be reviewed to ensure that routine dental services are provided where needed. 3.Re- Education will be provided by DON, ADON and/or designee to the licensed nursing staff to include routine and emergency dental services per policy. 4. DON, ADON and/or NPE will do an audit of at least 5 random residents to determine if dental services have been received as necessary. These audits will be done weekly x4 weeks and then monthly x2 until substantial compliance is achieved or as otherwise determined by the Risk Management/Quality Assurance	

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F 791	Continued From page 73 11/13/24 3:02 PM - An interview with E23 (Unit Clerk) confirmed that there is a list of residents for the dentist to see. E23 stated she will call and request records for R13 and provide them if available. 11/18/24 1:39 PM - An interview with E23 confirmed the denist has no record of R13 being seen. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 791	Committee. Root Cause: Dental services not provided to residents per policy. Compliance date 1-9-25	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary 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:	F 812		1/9/25

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F 812	Continued From page 74 Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 1. 11/12/24 8:43 AM During a tour of the kitchen, the surveyor observed E29 (Dietary Manager) test the sanitizer level of the solution in two red sanitizing buckets. When E29 tested the sanitizing solution, the test strips from each of the buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. 2. 11/12/24 9:14 AM - Observation of the ceiling in the main kitchen area and the dry storage room adjacent to the main kitchen revealed patches of dark spotted staining, which appeared to be mold or mildew in the corners of several ceiling tiles. 3. 11/12/24 9:26 AM - The bottom of the door to the walk-in-freezer was damaged resulting in a poorly functioning seal and significant build-up of ice along the interior edge of the door. 4. 11/12/24 12:04 PM - A black substance and a significant amount of dust was observed on top of the tubes that supply the juice dispensing machine and the back of the machine. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 812	F812- The facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. 1.The level of chemical concentration in the sanitizing buckets was corrected.The identified ceiling tiles were removed and changed.Ice build up was removed from the walk in freezer door. The tubes that supply juice to the juice machine were cleaned. 2.The facility has determined that all residents have the potential to be affected by this alleged deficient practice. 3.Food Service and staff will be re-educated by Regional Management of Healthcare Services Group on the chemical concentration needed in the sanitization bucket, ensuring ice build up does not occur, and cleaning the tubes that supply juice to the juice machine. Maintenance staff have been re-educated on ensuring the ceiling tiles are free of stains 4. The chemical concentration of the sanitizing buckets, cleanliness of the tubes supplying the juice machine and presence of ice build up will be audited weekly x 4 weeks then monthly x 2 months by the HSGC management team. Regional Director of Maintenance and/or facility maintenance personnel will complete the audit weekly x 4 weeks then monthly x 2 months of the ceiling tiles. This plan of correction will be monitored at	

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F 812	Continued From page 75	F 812	the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Root Cause analysis- lack of education on cleaning and sanitizing in the kitchen. Compliance date 1-9-25	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		1/9/25

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F 842	Continued From page 76 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 842	F842 Resident Records Identifiable	

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F 842	Continued From page 77 determined that for one (R6) out of forty-six (46) residents in the investigative sample, the facility failed to ensure the clinical record contained accurate documentation. Findings include: 1 A. Cross refer F686. Review of R6's clinical record revealed: 3/25/22 - R6 was admitted to the facility. 7/3/24 - R6's physicians orders documented to cleanse right heel with wound cleanser, apply Medi-honey and cover with Optifoam every other day until healed. 7/12/24 - The treatment administration record (TAR) documented that E24 (LPN) had administered the treatment to R6's right heel. 7/16/24 - A facility investigative report revealed that the wound dressing to R6's right heel was dated 7/8/24, even after 8 days had passed. 7/16/24 - A statement by E24 documented that the TAR was signed off prior to the treatment being completed to R6's right heel and then forgot to go back and complete the treatment later. 11/20/24 9:44 AM - An interview with E2 (DON) confirmed that E24 signed the TAR off as completed and the treatment was not done. The facility provided education to E24 and all the staff. 1 B. Cross refer F677. Review of R6's clinical record revealed:	F 842	Information 1.R6 R Heel wound is resolved. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. Current residents with treatment orders have had their treatment administration record reviewed and a visual check of the treatment to ensure the treatment administration record reflects accurate documentation. 3.Nursing staff will be re-educated by the assistant director of nursing , nurse practice educator and/or designee on ensuring the clinical record contains accurate documentation. 4.The Director of Nursing and/or clinical leadership staff will randomly audit 5 resident□s treatment records weekly x 4 then monthly x 2 to ensure that treatment documentation reflects the current treatment in place on the resident. The findings of the audits will be reported at the monthly and quarterly Quality Assessment and Assurance meeting until consistent compliance has been met. Root cause analysis: Staff education needed regarding documentation to be done after treatment completed and not prior. Compliance date 1-9-25	

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F 842	Continued From page 78 3/25/22 - R6 was admitted to the facility. 7/18/24 - A care plan revealed that R6 required assistance for ADL care in bathing, grooming, personal hygiene, dressing, bed mobility, transfer and toileting. The interventions for the ADL care revealed that R6 required an extensive assist of one person for dressing, toileting and personal hygiene. 8/17/24 - The CNA task documentation sheet revealed that E25 (CNA) documented R6 independently used the toilet, completed their hygiene, dressed, and transferred without assistance from a helper. 11/19/24 at 9:15 AM - An interview with E26 (CNA) revealed that R6 requires assistance of one for dressing, toileting, hygiene and transfers and would not be able to do it themself. If R6 refuses, then we try to redirect or try again and ultimately will tell the nurse where it would be documented in the record as refused. 11/22/24 at 2:32 PM - An interview with E2 confirmed that E25 documented independent as the care received when R6 was not able to perform the task without assistance. 2. Review of R43's clinical record revealed: 4/8/24 - R43 was admitted to the facility. 10/4/24 - A quarterly MDS revealed that R43 is dependent for toileting and toileting hygiene. 11/21/24 12:24 PM - An interview with E16 (CNA) stated the expectation is to document each void and elimination as it occurs in the electronic	F 842		

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F 842	Continued From page 79 charting. E16 confirmed that multiple voids would require multiple entries into the system. E16 demonstrated how to document in the system for each void. E16 confirmed that this was not shown to staff during orientation and E16 stated she learned how to document this task by playing with the system. 11/21/24 12:39 PM - An interview with E12 (UM) confirmed the expectation is for the CNA's to document each void and elimation in the system. E12 stated she does not know how to do the documentation for the CNA's. 11/21/24 1:30 PM - An interview with E20 (CNA) stated that she documents one void per shift and did not know the expectation was to document each void. 11/21/24 1:43 PM - An interview with E21 (CNA) stated that she documents one void per shift and did not know the expectation was to document each void. 11/25/24 1:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 842		