**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

**STATE SURVEY REPORT**


**NAME OF FACILITY:** Cadia Rehabilitation Renaissance

**DATE SURVEY COMPLETED:** September 19, 2024

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|---|---|---|
| | The State Report incorporates by reference and also cites the findings specified in the Federal Report.<br><br>A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.<br><br>Survey Dates: 09/16/24 to 09/19/24<br>Survey Census: 116<br>Sample Size: 34<br>Supplemental Residents: 16 | Cross Refer to the CMS 2567-L survey completed September 19, 2024: F550, F554,F561, F604, F656, F657, F677, F689, F700, F742, F755, F760, F761, F803, F847, F848 and F880. | 11/15/24 |
| 3201 | | | |
| 3201.1.0 | **Regulations for Skilled and Intermediate Care Facilities** | | |
| 3201.1.2 | **Scope**<br><br>**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.**<br><br>**This requirement is not met as evidenced by:** | | |

Provider's Signature [signature] Title NHA Date 10/22/24

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Provider's Signature Mary Collen RN Title NHA Date 10/22/24

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|---|---|---|---|
| | 085052 | A. BUILDING _____ B. WING _____ | C 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CADIA REHABILITATION RENAISSANCE | 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 000 | Initial Comments<br><br>An Emergency Preparedness survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found to be in substantial compliance with 42 CFR 483.73.<br><br>Survey Dates: 09/16/24 to 09/19/24<br>Survey Census: 116<br>Sample Size: 34<br>Supplemental Residents: 11 | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.<br><br>Survey Dates: 09/16/24 to 09/19/24<br>Survey Census: 116<br>Sample Size: 34<br>Supplemental Residents: 16 | F 000 | | |
| F 550 SS=E | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident | F 550 | | 11/15/24 |

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

Electronically Signed | 10/15/2024

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 550 | Continued From page 1<br>with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of the facility's resident rights, the facility failed to ensure 1. residents were provided a homelike environment during meals for eight of eight residents (Resident (R) 46, R8, R25, R32, R36, R83, R111, R32, and R168) during dining; 2. | F 550 | F550 resident rights<br><br>1.<br><br>a. R32, R46, R168, R51 currently reside in the facility. The appropriate steps to | |

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| F 550 | Continued From page 2<br>privacy bags covered urinary catheter bags for R51; 3. and privacy with shower schedules was maintained. This failure placed the residents at risk of an undignified dining experience.<br><br>Findings include:<br><br>Review of the facility's "Resident Rights," dated 06/01/24 revealed "To promote the interest and well-being of the residents in long-term care facilities, all facilities must treat residents in accordance with the following resident rights: (1) Each resident shall have the right to receive considerate, respectful ...services ...recognizing each person's basic personal ...which include dignity and individuality ..."<br><br>1. Residents were not served meals in a homelike environment.<br><br>a. Review of R46's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 04/03/18 and most recently readmitted on 08/15/24 with diagnoses which included metabolic encephalopathy and unspecified dementia.<br><br>Review of R46's Medicare "5- Day Minimum Data Set (MDS)" with an assessment reference date (ARD) of 08/21/24 revealed a "Brief Interview for Mental Status (BIMS)" could not be completed as the resident was rarely/never understood. The facility assessed the resident to have short and long-term memory problems and assessed the resident to be moderately cognitively impaired in skill for daily decision making.<br><br>b. Review of R8's undated "Admission Record," | F 550 | rectify the noncompliance were immediately addressed.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate the Clinical staff on & providing meals in a home like environment including not to leave trays on plate warmers, not to use Styrofoam containers, appropriate utensils, offer clothing protectors and offer to wash resident hands before meal. A root cause analysis was conducted, and it was determined the clinical staff failed to provide a home-like environment during meals.<br>They staff left trays on plate warmers, used Styrofoam containers,did not offer clothing protector's and offer to wash the residetns hands.<br><br>d. The Staff Developer or designee will randomly have observed 5 residents on each unit during mealtime to ensure the residents, food is placed on the table, hands are washed, no Styrofoam containers and residents have clothing protectors. They will also make random Observation audits throughout the facility to ensure no residents have been | |

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| F 550 | Continued From page 3<br>located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 02/01/23 and most recently readmitted on 08/17/23 with diagnoses which included Bell's Palsy and Parkinson's Disease.<br><br>Review of R8's quarterly "MDS" with an ARD of 07/24/24 located in the resident's EMR under the "MDS" tab revealed the facility assessed the resident to have a "BIMS" score of three out of 15 which indicated the resident was severely cognitively impaired.<br><br>c. Review of R25's undated "Admission Record," located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 01/15/24 with diagnoses which included vascular dementia.<br><br>Review of R25's quarter "MDS" with an ARD of 07/17/24 and located in the resident's EMR under the "MDS" tab revealed the facility assessed the resident to have a "BIMS" score of eight out of 15 which indicated the resident was moderately cognitively impaired.<br><br>d. Review of R32's undated "Admission Record," located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 01/17/24 with diagnoses which included cognitive communication deficit.<br><br>Review of R32's quarterly "MDS" with an ARD of 07/17/24 and located in the resident's EMR under the "MDS" tab revealed the facility assessed the resident to have a "BIMS" score of 11 out of 15 which indicated the resident was moderately cognitively impaired. | F 550 | observed eating their food on a tray. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.<br><br>2. F550<br><br>a. R51 still resides in the facility. The facility took the appropriate steps to rectify the noncompliance and protect the residents by replacing the catheter bag with a privacy bag.<br><br>b. All residents with foley catheters have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. | |

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| F 550 | Continued From page 4<br>e. Review of R36's undated "Admission Record," located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 06/17/20 with diagnoses which included cognitive communication deficit.<br><br>Review of R36's significant change in status "MDS" with an ARD of 07/16/24 revealed the facility assessed the resident to have a "BIMS" score of zero out of 15 which indicated the resident was severely cognitively impaired.<br><br>f. Review of R83's undated "Admission Record," located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 08/05/24 and readmitted on 08/26/24 with diagnoses which included dementia.<br><br>Review of R83's admission "MDS" with an ARD of 08/01/24 and located in the resident's EMR under the "Profile" tab revealed a "BIMS" could not be completed on the resident as the resident was rarely or never understood. Staff assessed the resident to have short and long term memory problems, and the resident was severely cognitively impaired in skills for daily decision making.<br><br>g. Review of R111's undated "Admission Record," located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 08/26/24 with diagnoses which included dementia.<br><br>Review of R111's admission "MDS" with an ARD of 09/01/24 located in the resident's EMR under the "MDS" tab revealed the facility assessed the resident to have a "BIMS" score of three out of 15 which indicated the resident was severely | F 550 | c. An in-service will be conducted by the Assistant Director of Nursing or designee to educate the clinical staff on making sure they use privacy catheter bags on residents with catheter bags. A root cause analysis was conducted, and it was determined the nursing staff failed to provide R51 with a privacy catheter bag.<br><br>d. The Staff Developer or designee will audit resident with catheter bags to ensure they have privacy bags and no urine is visible. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.<br><br>3. 550 white boards<br><br>a. No resident was affected by this deficient practice. The facility took the appropriate steps to rectify the noncompliance. | |

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| F 550 | Continued From page 5<br>cognitively impaired.<br><br>Observation on 09/16/24 at 12:53 PM, of the lunch meal in the Fenwick dining room revealed the above seven residents in the dining room eating their lunch meal. Continued observation revealed all seven residents' meals were served on the dining room tables with the plates left on the plate warmer bottoms and the plate warmers/plates left on the serving trays. The residents' desert of emerald pear gelatin was in a round Styrofoam container and not on a regular dish.<br><br>During an interview on 09/16/24 at 1:15 PM, Certified Nurse Aide (CNA) 3 stated residents' lunch meal should not have been left on the serving trays and plate warmer bottoms. CNA3 also stated the residents' desert should not have been served to them in a Styrofoam container. When asked why the residents should not have been served their meal this way, CNA3 stated it was not homelike and she would not want to eat off of a serving tray at her home.<br><br>h. Review of R32's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR) revealed R32 was admitted on 01/17/24 with diagnoses that included transient ischemic cerebral attack, generalized muscle weakness, and depression.<br><br>Review of the quarterly "MDS," with an ARD of 07/17/24, revealed a "BIMS" score of 11 out of 15 which indicated the resident had moderate cognitive impairment. R32 was identified on the quarterly "MDS" to be able to feed herself with set up assistance. | F 550 | b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate the nursing staff that whiteboards will no longer be used to document shower compliance. A root cause analysis was conducted, and it was determined the nursing staff had written on a whiteboard in a common area with resident shower compliance, They failed to provide privacy for the residents.<br><br>d. The Staff Developer or designee will audit whiteboards in the common area to ensure shower documentation not written the white boards. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 550 | Continued From page 6<br>Review of R32's "Care Plan," revised on 07/29/24, revealed "The resident has an ADL (activity of daily living) self-care performance deficit r/t (related to) limited mobility. Assist with hygiene, grooming, toileting, dressing, oral care, and eating as needed."<br><br>During an observation, on 09/16/24 at 12:19 PM, of the "assisted dining" located in the activity room, R32 was waiting to be served lunch. At 1:10 PM, The lunch meal was served to R32 on the meal tray and with the bottom insulator left under the plate. Towels were placed R32's neck as a clothing protector.<br><br>On 09/16/24 at 1:20 PM, CNA4 was seated between two residents, with her back to R32. During the meal, R32 was observed to hold both hands up, chest high, fingers apart. No staff came to assist R32.<br><br>During an observation on 09/17/24 at 12:41 PM, R32 was served lunch by the Assistant Director of Nurses (ADON). The ADON left the bottom half of the insulator under the plate. R32 was observed to have her hands held up, out in front of her. R32 started to ask CNA5 a question, CNA5 stated "You want a napkin, I'll get it." R32 was provided with a paper towel.<br><br>During an observation, on 09/18/24 at 1:23 PM, R32 was seated at the table, with her hands in the air in front of her. R32 had a napkin in her left hand. When asked why she held her hands up, R32 stated "I like to have my hands clean. See my nails, they look dirty." The resident's index finger was observed to have dirt under the nail. When asked if she was offered a washcloth before or after meals to clean her hands, R32 | F 550 | | |

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| F 550 | Continued From page 7 | F 550 | | |

stated, "I would like that very much. I don't get that. You have to ask." When asked if she was routinely offered a washcloth or hand wipe before or after meals, R32 said, "No."

During an interview, 09/18/24 at 1:30 PM, CNA5 stated, "She always does that with her hands. She always wants a napkin." When asked if the resident is offered a washcloth or hand wipe before or after meals, CNA5 stated, "No we don't do that, we always wash their hands when we get them up."

During an interview, on 09/19/24 at 9:03 AM, CNA3 stated, "She just does that, that's her."

During an interview, on 09/19/24 at 9:04 AM, R32 was asked about holding her hands up and stated, "I like to have my hands clean, but I have to ask, I don't get a washcloth at meals."

i. Review of R168's "Admission Record," located in the EMR under the "Profile" tab, revealed an initial admission date of 03/13/22 and readmission of 02/07/24 with diagnoses that included major depressive disorder, recurrent; obsessive compulsive disorder; and adult failure to thrive.

Review of R168's significant change "MDS," with an "Assessment Reference Date (ARD)" of 08/14/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 12 out of 15 which indicated R168 had moderate cognitive impairment.

On 09/16/24 at 12:56 PM, R168 was observed in her room, sitting in a chair in her room, eating lunch. The only utensil present was a spoon.

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| F 550 | Continued From page 8<br><br>Review of R168's care plan, updated 02/08/24, located under the "RAI" tab in the EMR, revealed "[R168] has a safety hazard to self as evidenced by recent suicidal thoughts and attempt; resident readmitted after stay at psychiatric facility. [R168] will remain safe in her own environment and will verbalize any feelings or thoughts about harming herself to staff immediately. Allow [R168] to vent her feelings and encourage her to talk about her concerns and thoughts. Encourage [R168] to participate in activities of choice. Medications as ordered, report effectiveness, SE [side effects], or adverse reactions. Provide [R168] with finger foods, and not giving her utensils until evaluated by IDT [Interdisciplinary Team]."<br><br>During an interview on 09/19/24 at 12:02 PM, the Social Service Director (SSD) said she was not aware of the care plan that specified finger foods only.<br><br>During an interview, on 09/19/24 at 1:04 PM, R168 stated, "I don't get finger foods, what is that? I only get a spoon to eat with. I keep asking for the rest, a knife and fork. some foods are hard to eat with a spoon. I'm fine, I can have silverware."<br><br>Review of a list of "finger food" meals, provided by the Dietary Manager (DM), revealed three names on the list, and did not include R168.<br><br>During an interview, on 09/19/24 at 3:15 PM, the Administrator stated, the care plan needs to be updated to the current treatment provided, the accuracy of type of diet and utensils provided. During an interview on 09/19/24 at 12:12 PM, the Social Service Director (SSD) stated she hated | F 550 | | |

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| F 550 | Continued From page 9<br>the way it looked when residents were served their meal on trays. The SSD also stated it was not a dignified meal nor was it a homelike environment.<br><br>During an interview, on 09/19/24 at 12:30 PM, the Administrator said they had no policy on dignity or dignity and dining. The Administrator stated, "We will have to educate the staff. We've had the placemats, I purchased them, they know not to leave trays under the meals or insulators under the plate. We will need to educate to wash hands before and after meals not just when getting them up."<br><br>During an interview on 09/19/24 at 1:33 PM, Registered Nurse (RN) 2, who was the Fenwick Unit Manager, stated the CNAs were well aware they should not be leaving the meal on the trays.<br><br>During an interview on 09/19/24 at 2:15 PM, the Administrator stated it was her expectation the residents' lunch meal would have been served in a homelike environment.<br><br>2. Review of R51's quarterly "MDS" with an ARD date of 06/19/24, located in the "MDS" tab of the EMR, revealed an admission date of 10/21/21. R51 had a " BIMS" score of four out of 15 indicating R51's cognition was severely impaired and had diagnoses of Alzheimer's disease, dementia, and a neurogenic bladder, and had an indwelling catheter.<br><br>Review of R51's care plan, revised 11/09/23, located in the EMR under the "Care Plan" tab revealed "The resident has Indwelling Catheter: Neurogenic bladder." An intervention included "Catheter care as ordered." | F 550 | | |

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| F 550 | Continued From page 10<br><br>Review of R51's order, dated 11/09/23, located in the EMR under the "Order" tab revealed "Catheter Care q [every] shift, every shift."<br><br>On 09/16/24 at 10:21 AM, R51 was asleep in bed wearing a hospital gown and a catheter drainage bag half full of urine hanging from the bedframe. R51's door was open and the urine in the bag was visible from the hall. One of the entrances and exits to the unit was in proximity and visitors were observed passing by R51's room.<br><br>On 09/17/24 at 11:34 AM, R51 was asleep in bed wearing a hospital gown and a catheter drainage bag half full of urine hanging from the bedframe. R51's door was open and the urine in the bag was visible from the hall. One of the entrances and exits to the unit was in proximity and visitors were observed passing by R51's room.<br><br>On 09/18/24 at 12:17 PM, R51 was awake in bed with his lunch tray and a catheter drainage bag hanging on the bedframe. The bag contained urine that was visible from the hallway. R51 was asked about his care and R51 had no response.<br><br>During an interview on 09/18/24 at 12:31 PM, Licensed Practical Nurse (LPN)1 was asked about R51's catheter drainage bag with urine visible from the hall and entrance and exits door nearby where visitors could observe. LPN1 stated she thought privacy bags were only when residents left their room. LPN1 stated when she came to the facility to work, this facility required staff to use privacy bags. LPN1 confirmed the CNA should have used a privacy bag for R51. At this time LPN1 turned the urine side of the bag to the private side of the bag, making it not visible | F 550 | | |

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| F 550 | Continued From page 11<br>anymore.<br><br>During an interview on 09/19/24 at 7:21 AM, the Director of Nurse (DON) was asked about R51's urine being visible in the catheter drainage bag from the hall. The DON stated staff should be using a "Fig Leaf" urinary drain bag that hides R51's urine from view.<br><br>3. During an observation on 09/16/24 at 9:33 AM, a large whiteboard was observed near the nurse station on the 200 hallway in the common area. Written on the whiteboard for September 15, 2024, was a list of staff and room assignments. On the whiteboard "Showers" was documented with a list of the residents assigned to receive showers on that date. Staff had documented "done" and "refused" next to individual resident beds. An additional note written on the whiteboard documented "PS Check Behaviors Books before end of shift."<br><br>During an interview on 09/19/24 at 2:26 PM, the Administrator stated that showers should be recorded in the resident record, and documenting "refused" was not appropriate to be written in a common area. | F 550 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose | F 561 | | 11/15/24 |

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| F 561 | Continued From page 12<br>activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility's resident rights, the facility failed to honor a resident's right to 1. choose their preferred method of transferring for one of 34 sampled residents (Resident (R) 43) and 2. choose to go outside for one of 34 sampled residents (R42). This failure placed the residents at risk for psychosocial harm by diminishing their independence.<br><br>Findings include:<br><br>Review of the facility's "Resident Rights," dated 06/01/24 revealed "To promote the interest and well-being of the residents in long-term care facilities, all facilities must treat residents in accordance with the following resident rights: ... | F 561 | F561 self determention<br><br>a. R43 still resides in the facility. The facility took appropriate action to change the transfer status to a max assist of 2. No other residents were affected at this time.<br><br>b. All residents requiring mechanical lifts for transfers have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate | |

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| F 561 | Continued From page 13<br>(6) Each resident may refuse medication or treatment and must be informed of the medical consequences of all medication and treatment alternatives ...(21) Each resident has the right, personally, through other persons, or in combination with others to do any of the following: a. Exercise the resident's own rights ...(31) Each resident shall be free to make choices regarding activities, schedules, health care, and other aspects of the resident's life that are significant to the resident ..."<br><br>1. Review of R43's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 03/02/21 and readmitted on 05/28/22 with diagnoses which included acquired absence (amputation) of right and left leg below the knee. The "Admission Record" identified R43 as being his own responsible party.<br><br>Review of R43's significant change in status "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/07/24 and located in the resident's EMR under the "MDS" tab revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated the resident was cognitively intact. The facility also assessed the resident to need partial/moderate assistance for transferring to and from a bed to a chair.<br><br>Review of R43's "Care Plan" revised 09/09/22, located in the resident's EMR under the "Care Plan" tab revealed a problem of "[Resident's Name] has an ADL self-care performance deficit r/t [related to] balance concerns" with a goal of "The resident will maintain current level of | F 561 | the therapy staff if a Resident is refusing to transfer based on transfer order to re-evaluate the transfer status. A root cause analysis was conducted, and it was determined that therapy staff failed to re-evaluate R43 transfer status, based on documented refusals to transfer.<br><br>d. The Rehab Director or Designee will audit resident who refuse to transfer to ensure their transfer orders are appropriate. e audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.<br><br>2.<br>a. R42 resides in the facility. The facility took the appropriate steps to rectify the noncompliance to allow her to go outside upon request and when safe to do so.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>C. An in-service will be conducted by Staff Development or designee to educate | |

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| F 561 | Continued From page 14<br>function through the review date" and interventions which included "Assist with bed mobility and transfers per orders ...Hoyer lift ... Encourage the resident to participate to the fullest extent possible with each interaction ..."<br><br>Review of R43's care conference "Progress Note," dated 05/29/24 and located in the resident's EMR under the "Progress Notes" tab revealed "[Resident Name] ...does not want to use a hoyer lift [mechanical lift], and that is the recommendation for safety to transfer himself ..."<br><br>During an interview on 09/16/24 at 11:29 AM, R43 stated he was scared to use a mechanical lift for transfers and the facility would not assist him with transfers any other way. R43 stated he had a family member bring him a transfer board, so he did not have to use the mechanical lift.<br><br>During an interview on 09/18/24 at 10:00 AM, the Certified Occupational Therapy Assistant (COTA) stated he remembered when R43 got his own transfer board because he did not want to use the mechanical lift and would use the board to transfer himself from the bed and not use the mechanical lift. The COTA also stated R43 had been noncompliant with therapy's recommendations and safety measures and in May of 2024, the facility removed his transfer board from his room for safety reasons. The COTA further stated R43 had not been assessed for any other transfer devices including the slide board because it was not safe for him to use on his own. The COTA stated therapy was resident driven; however, it was the facility's protocol for residents not to independently use the boards.<br><br>During an interview on 09/18/24 at 10:41 AM, the | F 561 | the nursing staff that alert and oriented residents are allowed to go outside by themselves upon request when safe. A root cause analysis was conducted, and it was determined the Nursing staff failed to allow R42 to go outside by herself.<br><br>D. The Direct of Nursing or designee will do random interviews of residents asking if they are allowed to go outside when they want. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 561 | Continued From page 15<br>Director of Nursing (DON) stated if the therapy department assessed R43 for the use of the transfer board and determined it to be an unsafe practice and the resident was educated on why it was unsafe, then his decision to use the transfer board instead of the mechanical lift should be honored.<br><br>During an interview on 09/19/24 at 11:55 AM, the Social Service Director (SSD) stated R43 was set in his ways and she believed the mechanical lift issue came from fear. The SSD also stated during discussions about the resident refusing to use the mechanical lift, she voiced R43 had the right to make the decision not to use the mechanical lift even if it was a bad decision. The SSD further stated R43 was able to understand the risks versus the benefits.<br><br>During an interview on 09/19/24 at 1:08 PM, Registered Nurse (RN) 2 stated therapy directed R43's transfer status and nursing could not do anything against what therapy determined the resident's transfer status to be. RN2 stated nursing staff were directed they could not assist the resident with transfers unless it was using the mechanical lift.<br><br>During an interview on 09/19/24 at 1:57 PM, the Administrator stated residents were allowed to exercise their right of self-determination. The Administrator also stated the resident's choice should have been honored.<br><br>2. Review of R42's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed R42 was initially admitted on 06/11/20 and readmitted on 05/01/23 with diagnoses that included depression. | F 561 | | |

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| F 561 | Continued From page 16<br><br>Review of the quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/24/24, revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated R42 was cognitively intact.<br><br>Review of R42's "Care Plan," updated 07/31/24, located under the "Resident Assessment Instrument (RAI)" tab revealed R42 had a Care Plan, dated 07/31/24, for "(R42) is independent for meeting emotional, intellectual, physical, and social needs. She has little interest or pleasure in doing things. (R42) will engage self in independent activities as she chooses by next review. Activities will provide one on one room visits when (R42) does not attend activities or do independent leisure activities."<br><br>During an interview, on 09/16/24 at 11:18 AM, R42 said she did not attend the group activities, she liked to be in her room or outside.<br><br>During an interview on 09/16/24 at 12:54 PM, R42 stated, "It was the best when I had therapy, and the therapist took me outside. We even walked by my window so I could look in."<br><br>During an interview on 09/16/24 at 3:55 PM, R42 stated "I really could use a Diet Pepsi. I'd like to go sit on the deck and drink it, get some vitamin D." R42 denied having opportunities to sit outside stating, "I just look out my window."<br><br>During an interview on 09/18/24 at 12:45 PM, R42 stated, "They really have stupid rules around here. CNA's [certified nursing assistants] can only have 10 minutes outside with me. Sometimes Activities would go with, but not for a long time. | F 561 | | |

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| F 561 | Continued From page 17<br>They say I can't go out alone, you have to have a key card to get out and in. There is one CNA [CNA5] that is very good at everything. She will get me my Diet Pepsi and sit with me after her shift, for 10 minutes, if she has time sometimes."<br><br>During an interview on 09/19/24 at 8:55 AM, three staff members were asked if R42 was permitted to go outside on the deck. All three, CNA3, CNA4, and CNA6, said "No," in unison. When asked, "Why," CNA6 stated, "They can't go out without supervision, we don't have time."<br><br>During an interview on 09/19/24 at 11:37 AM, the Activity Coordinator/Temporary Activity Director (AD) stated, "R42 has a right to go outside. Yes, the door is locked. Activities generally takes the lead on that. I'm sure the prior AD took her out. I will take [R42] out, we can do that during our one-to-ones."<br><br>During an interview on 09/19/24 at 12:50 PM, R42 stated, "I like the back deck. I'd like to go outside again. I don't know what they think that I'm going to jump off?"<br><br>During an interview, on 09/19/24 at 1:45 PM, the Administrator said, "The resident can go outside, she may need supervision. We will have to educate the staff." | F 561 | | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any | F 604 | | 11/15/24 |

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| F 604 | Continued From page 18<br>physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents were free from physical restraints by applying a Wanderguard to prevent leaving the facility for one of 34 sampled residents (Resident (R) 43). R43 was outside in the facility's parking lot when the nursing staff physically pulled the resident back into the facility against his will while he was in his wheelchair. This deficient practice had the potential to cause psychosocial and physical harm to the resident. | F 604 | F604<br><br>a. R 43 still resides in the facility. The facility took the appropriate steps to rectify the noncompliance and allow R43 to go outside upon request and when safe to do so.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the | |

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| F 604 | Continued From page 19<br>Findings include:<br><br>Review of the facility's policy titled, "Restraint and Seclusion Policy," reviewed 01/03/24 revealed "It is the policy of [Facility Name] that residents have the right to be free from any physical or chemical restraints ...imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms ...Definitions: 'Physical Restraints' are defined as any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement ...Procedure: Restraint is never used as a means of resident coercion, discipline, convenience, or retaliation ..."<br><br>Review of R43's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 03/02/21 and readmitted on 05/28/22 with diagnoses which included acquired absence (amputation) of right and left leg below the knee. The "Admission Record" identified R43 as being his own responsible party.<br><br>Review of R43's significant change in status "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 08/07/24 and located in the resident's EMR under the "MDS" tab revealed the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated the resident was cognitively intact. The facility also assessed the resident to need partial/moderate assistance for transferring to and from a bed to a chair. | F 604 | corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate the nursing staff that residents with a BIMS score of 12 or greater have the right to be free from physical restraints and are allowed to go outside. A root cause analysis was conducted, and it was determined the Nursing staff failed to allow R43 to go outside.<br><br>d. The Direct of Nursing or designee will do random interviews of residents asking if they are allowed to go outside when they want. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 604 | Continued From page 20<br>During an interview on 09/18/24 at 10:43 AM, R43 stated back in June (2024) he was upset about something and just wanted to go outside the building to calm down. R43 stated staff followed him outside the building and eventually physically pulled him back in while he was in his wheelchair because he would not independently come back in. The resident also stated the facility put a device on his wheelchair (wanderguard) that locked the doors when he got close to them. R43 stated the next day he attempted to go outside using the front doors and the doors would not unlock. The resident stated he told staff he would pick the lock and get out anyway. R43 stated when he said that the staff pulled him and his wheelchair back away from the door and back to his hall. The resident stated this made him angry. R43 also stated he was a retired Marine Sergeant who served his country to make sure people had freedom and he gets to the nursing home and was denied the right to make any of his own decisions to do things on his own.<br><br>Review of R43's nursing "Progress Note," dated 06/17/24 at 10:10 PM and located in the resident's EMR under the "Progress Notes" tab, revealed "pt [patient] refused all medications [sic] pt went outside the building and refused to come back in. Pt was very angry and had to be pulled back in the building stating that he is upset about his food [sic] pt now in bed resting without any complaits [sic]."<br><br>Review of R43's nursing "Progress Note" dated 06/18/24 at 7:00 PM, located in the resident's EMR under the "Progress Notes" tab, revealed "No refusals of care or medication this shift. Resident still upset over dietary issues. Resident made his way out of the front door around 1645 | F 604 | | |

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| F 604 | Continued From page 21<br>[4:45 PM] hours. Attempts made to coerce resident back inside but the resident was adamant about staying outside. Staff members stayed with resident until he was willing to come back inside. Resident attempted to do the same later in the shift, but the resident was kept inside. Resident has a wanderguard attached to his wheelchair now."<br><br>During an interview on 09/18/24 at 10:25 AM, the Certified Occupational Therapy Assistant (COTA) stated R43 was his own decision maker, cognitively intact, and if someone pulled him in his wheelchair back into the facility and he did not want to come back in, or stopped him from leaving the building, then technically that would be a restraint.<br><br>During and interview on 09/18/24 at 10:48 AM, the Director of Nursing (DON) stated the resident did get outside the front doors and staff were afraid he was going to cross the road. The DON stated a wanderguard should never have been attached to his wheelchair. The DON also stated what occurred when the nursing staff pulled the resident back into the building met the definition of a physical restraint.<br><br>During an interview on 09/19/24 at 3:08 PM, Certified Nurse Aide (CNA) 7 stated she worked the evening the resident went outside and refused to come back inside the facility. CNA7 stated there was a new person who was working at the front lobby desk. The person working the desk was not supposed to let any residents out the front doors; however, R43 snuck by her, got outside the facility, and refused to come back into the facility. The CNA also stated R43's nurse was notified, and the nurse came outside with the | F 604 | | |

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| F 604 | Continued From page 22<br>agency CNA who was assigned to the resident to convince him to come back inside the facility. CNA7 stated the resident attempted to self-propel his wheelchair away from the staff and the agency CNA got in front of him and prevented him from propelling forward.<br><br>During an interview on 09/19/24 at 12:01 PM, the Social Service Director (SSD) stated if R43 wanted to go outside utilizing the facility's front door, then he should be able to do that. The SSD stated when R43 was pulled back inside the facility, this was a physical restraint. The SSD also stated R43 should not have been forcefully pulled back into the facility.<br><br>During an interview on 09/19/24 at 2:03 PM, the Administrator stated it was her expectation residents be free of restraints. The Administrator also stated, "We don't restrain here." | F 604 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and | F 656 | | 11/15/24 |

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| F 656 | Continued From page 23<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility's policy, the facility failed to develop and implement person centered comprehensive care plans for side rails and weight monitoring for palliative care for two (Resident (R) 62 and R51) of 34 sampled residents. This placed the residents at risk for decreased quality of life and quality of care and further exacerbation of an | F 656 | F656<br>1.<br><br>a. R62 still resides in the facility. R62 side rails were removed. | |

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| F 656 | Continued From page 24<br>illness.<br><br>Findings include:<br><br>Review of the facility policy titled "Care Planning," reviewed 01/03/24, provided by the facility revealed "A comprehensive care plan should be developed to address medical, nursing, nutritional, and psychosocial needs within 7 days of completion of the comprehensive assessment . . . Care plans should include: . . . Services furnished to maintain highest practical well-being . . . The resident's preferences."<br><br>Review of the facility titled "Palliative Care/ Hospice," reviewed 01/03/24, provided by the facility revealed "The palliative care treatment decision is communicated through Care Plans and Physician Orders."<br><br>1. Review of R62's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 08/14/24, located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 03/03/21. R62 had a "Brief Interview for Mental Status (BIMS)" score of eight out of 15 indicating R62's cognition was moderately impaired and had diagnoses of cerebrovascular accident, dementia, and chronic obstructive pulmonary disease.<br><br>Review of R62's orders, located in the EMR under the "Order" tab revealed no order related to bed mobility, side rails, or positioning devices/enablers.<br><br>Review of R62's assessments, located in the EMR under the "Evaluation" tab revealed no bed or side rail assessment. | F 656 | b. All residents who have siderails on their beds have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. The staff Developer/ designee will in-service nursing on developing and implementing person centered comprehensive care plans related to side rail use. A root cause analysis was conducted, and it was determined that R62□s rental wide bed (put in place as a fall prevention) came with siderails. Side rails should have ben removed upon delivery. A facility wide sweep was conducted and no other siderails are in use.<br><br>d. The Rehab Director or designee will randomly audit 10 random resident□s Care plans per week to ensure they are developed and implemented to be person centered comprehensive care plan to reflect the residents current level of care. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 656 | Continued From page 25<br><br>Review of R62's EMR revealed no informed consent for side or bed rails.<br><br>Review of R62's fall risk assessment, dated 08/09/24, located in the EMR under the "Evaluation" tab revealed R62 was at moderate risk with a score of 6.0.<br><br>Review of R62's care plan, dated 11/01/22, located in the EMR under the "Care Plan" tab revealed "R62 has an ADL [activities of daily living] self-care performance deficit r/t [related to] cognitive impairment due to dementia with behavioral disturbances, deconditioning, recent falls w/ [with] injury." An intervention included "Assist with bed mobility and transfers per orders." There was no care plan for the side rails or enabler devices.<br><br>On 09/16/24 at 11:02 AM, R62 was observed awake and in an oversized bed with padded side rails. No gaps were noted between the mattress and the side rails. R62 was pleasant and talkative but very confused.<br><br>During an interview on 09/19/24 at 10:07 AM, MDS Coordinator (MDSC) was asked if side rails should be care planned. MDSC stated, "yes, side rails should be care planned." MDSC was asked why R62's side rails were not care planned and who would care plan them. MDSC stated it would be nursing or anyone that sees the side rails. MDSC stated the care plans were interdisciplinary. MDSC went on to say she wasn't aware R62 had side rails. MDSC stated normally she knows what to care plan after she reviewed the physician orders and nurse notes to update the care plan. | F 656 | 2.<br>1.<br><br>a. R51 still resides in the facility. The facility took the appropriate steps to rectify the noncompliance by reviewing and updating her care plan to ensure they reflect current care nees and preferences to include No weight monitoring.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. The staff Developer/ designee will in-service nursing on developing and implementing person centered comprehensive care plans to include resident□s preferences to not be weighed. A root cause analysis was conducted, and it was determined that nursing failed to document no weight monitoring on the care plan<br><br>d. The Dietician or designee will randomly audit resident□s Care plans that have expressed a preference for no weights to reflect the residents current care needs and preferences.<br><br>The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will | |

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| F 656 | Continued From page 26<br><br>2. Review of R51's quarterly " MDS" with an ARD date of 06/19/24, located in the "MDS" tab of the EMR, revealed an admission date of 10/21/21. R51 had a " BIMS" score of four out of 15 indicating R51's cognition was severely impaired and had diagnoses of Alzheimer's disease, dementia, congestive health failure, malnutrition, and dysphagia.<br><br>Review of R51's order, dated 12/11/23, located in the EMR under the "Order" tab revealed "No weight monitoring -palliative care wishes."<br><br>Review of R51's "Palliative Conference Review and Plan" form, dated 10/20/23, located in the EMR under the "Miscellaneous" tab revealed "Weights- No"<br><br>Review of R51's weights located in the EMR under the "Weight/Vitals" tab revealed no current weights. R51's last weight was on 10/9/23 at 172.2 pounds.<br><br>Review of R51's care plan, revised 12/28/23, located in the EMR under the "Care Plan" tab revealed "R51 is at nutritional risk r/t malnutrition risk level; use of mechanically altered diet d/t [due to] dysphagia 2'ary [secondary] to CVA [cerebrovascular accident]; increased risk for wt [weight] change r/t CHF [congestive heart disease] dx [diagnosis] and limited mobility, election of passive plan of care with palliative orders in place."<br><br>During an interview on 09/19/24 at 8:14 AM, the facility Registered Dietitian (RD) was asked why there was no care plan for R51's "no weight monitoring due to palliative care." RD stated she | F 656 | continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 656 | Continued From page 27<br>didn't complete the nutritional assessment so she's not sure about the care plan.<br><br>During an interview on 09/19/24 at 10:05 AM, the MDSC was asked about R51's care plan and why the "no weight monitoring" for palliative care had not been care planned. MDSC stated the RD would do the "no weight monitoring" care plan. MDCS confirmed there was no care plan for no weight monitoring. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the | F 657 | | 11/15/24 |

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| F 657 | Continued From page 28<br>comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and review of facility policy, the facility failed to ensure the "Comprehensive Care Plan" was accurate and updated for one resident (Residents (R)265) in a total resident sample of 34 whose "Care Plans" were reviewed. This failure placed the residents at risk for unmet care needs and a diminished quality of life.<br><br>Findings include:<br><br>Review of the facility policy titled, "Care Planning," dated January 3, 2024, revealed, " ...To establish guidelines for developing and implementing person-centered care plans that are consistent with resident's rights that includes measurable objectives and timeframes to meet the resident's medical, nursing, and psychosocial needs ...Care plans should include ...Services furnished to maintain highest practical well-being ..."<br><br>1. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R265 was admitted to the facility on 06/22/24 with diagnoses that included chronic gout and diabetes.<br><br>Review of R265's admission "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 06/25/24 revealed a "Brief Interview of Mental Status (BIMS)" score of eight out of 15 which indicated R265 was moderately impaired in cognition and had one unstageable (US) pressure | F 657 | F657 Care plan timing and revisiion<br><br>a. R265 still resides in the facility. The facility updated his care plan to be specific to his wound care treatments and care needs.<br><br>b. All residents with wounds have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate the Wound Program RN to ensure the Comprehensive Care Plan is accurate to reflect the residents specific needs related to wound care. A root cause analysis was conducted, and it was determined nursing failed to develop A comprehensive care plan for R265 specific to wound care treatments.<br><br>d. The Director of Nursing or designee will audit cares plan of residents with wounds to ensure the care plan reflects the residents current level of care. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until | |

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| F 657 | Continued From page 29<br>ulcer upon admission to the facility.<br><br>Review of the 06/24/25 "Skin Impairment Care Plan" revealed, "Actual impairment to skin integrity L (left) heel (DTI-deep tissue injury)" Interventions included the following:<br>"Keep, skin clean and dry. Use lotion on dry skin." Dated 06/24/24 and revised on 07/19/24.<br>"Consult wound care provider, as indicated." Dated 06/24/24.<br>"Treatment as ordered." Dated 06/24/24.<br>"Use Barrier cream to perineal area after each incontinent care." Dated 06/24/24.<br>"Use Enhanced Barrier Protection (EBP) when providing wound care." Dated 06/24/24.<br>"Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations." Dated 06/24/24.<br><br>During an interview on 09/16/24 at 11:30 AM, R265 and his representative (RR) the RR1 stated, "There is no pillow or wedge, at the foot of the bed, to keep his foot off the bed. I added the wedge to the foot of the mattress, to make it longer." An observation was made of R265's left heel which showed a half-dollar sized necrotic (dead tissue) ulcer. The heel was observed flat on the bed without being off-loaded to relieve pressure on the heel.<br><br>During an interview on 09/18/24 at 10:11 AM, Licensed Practical Nurse (LPN) 4 stated, "His heel should be elevated on pillows, and not flat on the bed."<br><br>During an interview on 09/19/24 at 08:39 AM, the MDS Coordinator (MDSC) confirmed the "Skin | F 657 | 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 657 | Continued From page 30<br>Care Plan" interventions were not specific. The MDSC further stated, "There was a 'custom' tab to use when developing/revising the care plan, but mostly we just use the pre-set template which is not resident-specific." | F 657 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview, and record review, the facility failed to provide assistance with dining for one of three residents (Resident (R) 106) reviewed for activities of daily living (ADLs) of 34 sampled residents. This failure increased the potential for R106 to have a significant weight loss.<br><br>Findings include:<br><br>Review of R106's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed R106 was admitted to the facility on 08/08/24 with diagnoses that included Alzheimer's disease.<br><br>Review of R106's "Care Plan" located in the EMR under the "Care Plan" tab, dated 08/09/24, revealed R106 had an ADL (activities of daily living) performance deficit related to activity intolerance and dementia. Interventions included to assist with hygiene, grooming, toileting, dressing, oral care, and eating as needed. | F 677 | F677 ADL care provided for dep. resident<br>a. R 106 still resides in the facility. The facility took the appropriate steps to provide assistance with eating.<br><br>b. All residents who require assistance with feeding have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate the Nursing staff to provide assistance with meals to all residents who require cueing or assistance with feeding. A root cause analysis was conducted, and it was determined that nursing failed to provide adequate assistance to residents who require cueing to eat.<br><br>d. The Staff Developer or designee will audit the facilities dining rooms to ensure | 11/15/24 |

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| F 677 | Continued From page 31<br>Review of R106's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/14/24 and located under the "MDS" tab of the EMR, revealed R106 had a "Brief Interview for Mental Status (BIMS)" score of zero out of 15, which indicated R106 had significant cognitive impairment. It was recorded R106 was dependent on staff for eating with supervision or touching assistance, helper provides verbal cues or touching/steading assistance as resident completes activity.<br><br>R106 was observed in the dining room on 09/16/24 at 12:40 PM for lunch. The resident was observed seated at the dining room table, then pushed herself back from the table. She had an egg salad sandwich cut into quarters, lying on plastic wrap. Hospitality Aide (HA) was observed coming over to stand next to R106 and then pointed at the resident to eat her sandwich. The HA was then observed picking up the sandwich with her bare hands and encouraged the resident to eat. The HA walked away from the resident. The resident held a quarter of the sandwich momentarily in her hands, then placed it back on the table. She did not eat the sandwich. At 12:52 PM, the resident wheeled herself backwards away from the table. The resident was not cued or assisted again by facility staff. No additional food was provided to the resident during lunch service.<br><br>R106 was observed on 09/18/24 from 11:15 AM until 1:10 PM in the dining room for lunch.<br>-At 11:48 AM R106 was observed seated alone in the dining room at a small, wheeled table with her back to the rest of the residents<br>-At 11:53 AM R106 was served a plate with an egg salad sandwich cut into halves, peas, orange | F 677 | residents that are identified as needing assistance with meal are receiving assistance with meals . The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 677 | Continued From page 32<br>slices in a bowl, and a cup of tea. Staff put the plate down for the resident, and then left. The resident picked up her sandwich and ate a few bites from one section of the sandwich. She then put it back on the plate. She pushed herself backwards in her wheelchair away from her small table at 12:00 PM.<br>-At 12:05 PM, staff pushed the table back up next to R106, scrapped all the egg salad off of the bread, and left. The resident pushed her food around the plate with a spoon for approximately fifteen seconds, then put the spoon down.<br>-At 12:10 PM, the resident scooted herself backwards away from her plate again.<br>-At 12:15 PM, HA came back to the resident and pushed the table up to R106, pointed at the food, then left.<br>-At 12:28 PM, this was repeated again by staff.<br>-At 12:50 PM, R106 was still observed seated at her table, but did not touch her plate, utensils, or drink. Staff did not approach the resident to cue, assist or engage with the resident.<br>-At 12:51 PM, HA came back to the resident and pushed the table up to the resident, pointed at the food and said "eat" and then left.<br>-At 12:56 PM, R106 had been observed eating approximately 10% of her lunch. The HA was observed picking up the meal tray from R106. She stated she would bring the resident back some yogurt.<br>-At 1:01 PM, Licensed Practical Nurse (LPN) 1 was observed removing the table from R106.<br>-At 1:10 PM staff did not return with food or offer the resident anything additional or new to eat.<br><br>Record review revealed an 08/11/24 EMR Nutritional Assessment that recorded that the resident "does need feeding assistance." | F 677 | | |

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| F 677 | Continued From page 33<br>Record review revealed an 08/11/24 "Progress Note," under the EMR "Progress Notes" tab documented, "Ambulates independently, extensive assist with dressing, toileting, grooming and eating."<br><br>Record review revealed a 09/16/24 "Progress Note," under the EMR "Progress Notes" tab documented, "Husband met ...to discuss concerns ...she is not eating and is sleeping a lot ...He was very concerned about her eating ..."<br><br>Record review revealed a 09/19/24 "Progress Note," under the EMR "Progress Notes" tab documented, "Discussed with nursing concerns ...decreased po intake ...to d/c (discontinue) finger foods and to be 1:1 supervision with eating ...does feed herself but it's inconsistent."<br><br>During an interview on 09/19/24 at 10:08 AM, Minimum Data Set Coordinator (MDSC) stated that a resident that required supervision or touching assistance would mean that the staff would show and verbalize the food items to the resident. The MDSC said that she would consider cueing for the resident to be appropriate. She confirmed that the resident had some improved ambulation, and that the resident's inattention would benefit more from cueing at dining than being left alone.<br><br>During an interview on 09/19/24 at 10:40 AM, the Director of Nursing (DON) stated that R106 was totally dependent on ADLs (activities of daily living) and needed encouragement. She confirmed the resident could physically feed herself, but with dementia, she does not. The DON said R106 often ate sandwiches and would eat with her husband present. She stated that the | F 677 | | |

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| F 677 | Continued From page 34<br>resident would benefit from feeding assistance and one on one at meals.<br><br>During an interview on 09/19/24 at 11:25 AM, HA said that R106 ate well when her husband sat with her. She said the resident benefitted from direct engagement during mealtime, but no one regularly sat with the resident. She stated that LPN2 sat with the resident a prior evening and the resident had eaten very well.<br><br>During an interview on 09/19/24 at 11:30 AM, LPN2 said that R106 did well with direct engagement at mealtime. She said that she was currently completing an assessment for therapy because the resident would benefit from more one on one eating. LPN2 confirmed that the concern with R106 eating meals was about ensuring she had direct engagement due to her dementia decline.<br><br>During an interview on 09/19/24 at 1:43 PM, the Director of Rehabilitation (DOR) said that R106 would benefit from cueing, as she had been informed by LPN2 that the resident responded better with cueing than finger foods.<br><br>During an interview on 09/19/24 at 4:44 PM, the Nursing Home Administrator confirmed the facility did not have a policy regarding activities of daily living for assistance with eating. | F 677 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and | F 689 | | 11/15/24 |

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| F 689 | Continued From page 35<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to provide a safe toilet for one of two residents (Resident) R 42) reviewed for accident hazards out of a total sample of 34 residents creating the potential for a fall or skin injuries.<br><br>Findings include:<br><br>Review of R42's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed R42 was initially admitted on 06/11/20 and readmitted on 05/01/23 with diagnoses that included type II diabetes mellitus and acute kidney failure.<br><br>Review of the quarterly "Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/24, revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated R42 was cognitively intact.<br><br>Review of R42's "Care Plan," updated 07/31/24, located under the "Resident Assessment Instrument (RAI)" tab revealed R42 had a "Self-care deficit r/t (related to) deconditioned status secondary to weakness, cognitive decline. (R42) will maintain her current level of function with staff assistance. Assist with daily hygiene, eating, toileting, dressing, grooming and oral care as needed. Encourage participation in self-care tasks."<br><br>Observation of R42's bathroom on 09/16/24 at | F 689 | F689 free from accident hazards<br><br>a. R 42 still resides in the facility. The facility took the appropriate steps to replace the commode.<br><br>b. All residents who require commodes have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective action outlined below in section c.<br><br>c. Staff Development or designee will educate the therapy staff to report commode that are in disrepair to the Rehab Director. The Rehab Director will communicate to the Nursing Home administrator when a commode needs to discard a so new ones can be ordered. A root cause analysis was conducted, and it was determined the facility did not have a process in place to cycle out old commodes and purchase new ones. A facility wide sweep was conducted, and it was determined that all other commodes in use were in proper condition.<br>d. The Rehab Director or designee will audit the resident commode to identify if any need for repaired. The audits will be performed daily or until 100% compliance | |

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| F 689 | Continued From page 36<br>3:45 PM revealed the inside of the toilet was black. The commode, placed over the toilet, was wobbly; had a seat that was too small for the commode frame which allowed the cross bars to be exposed outside the front of the seat; and had an approximate six inch rusted bar on the front of the commode frame, directly underneath the commode seat. The exposed ends of the bars and the rusted metal had the potential to cause injury to R42.<br><br>During an interview on 09/16/24 at 3:48 PM, R42 stated, "They brought that in special for me. It's always been wobbly."<br><br>During an observation, on 09/16/24 at 4:02 PM, of the condition of the commode and inside of the toilet, was confirmed by the Certified Nurse Aide (CNA2), Environmental Services Supervisor (EVS), and the Director of Rehabilitation (DOR). The DOR stated, "that seat is too small." The EVS stated, "The toilet is stained, we would have to replace it."<br><br>During an interview on 09/19/24 at 2:55 PM, the Administrator said there was no policy for providing a safe, clean, comfortable, and homelike environment. | F 689 | is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. | F 700 | | 11/15/24 |

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| F 700 | Continued From page 37<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to assess the need for side rails and obtain informed consent for one (Resident (R)62) of one resident reviewed for side rails out of a total sample of 34 residents. This failure increased the risk that residents would have side rails without evaluation for the need and without making an informed decision knowing the risks and benefits.<br><br>Findings include:<br><br>Review of R62's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 08/14/24, located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 03/03/21. R62 had a "Brief Interview for Mental Status (BIMS)" score of eight out of 15 indicating R62's cognition was moderately impaired and had diagnoses of cerebrovascular disease, dementia, and dependence on supplemental oxygen. For | F 700 | F700 bedrails<br><br>a. R62 still resides in the facility. The facility took the appropriate step and removed the bedrails. No other residents were affected at this time.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate the Nursing and rehab staff if a side rail is used the facility must ensure correct installation, use and evaluation and maintenance of side rails, but A root cause analysis was conducted, and it was determined the facility failed to accurately evaluate for need of side rails. | |

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| F 700 | Continued From page 38<br>mobility, R62 required "partial/moderate assistance" to "roll left and right" and R62 required "partial/moderate assistance- helper does less than half the effort" for "lying to sitting on side of bed."<br><br>Review of R62's orders, located in the EMR under the "Order" tab revealed no order related to bed mobility or side rails.<br><br>Review of R62's assessments, located in the EMR under the "Evaluation" tab revealed no evaluation or assessment of side rail use.<br><br>Review of R62's fall risk assessment, dated 08/09/24, located in the EMR under the "Evaluation" tab revealed R62 was at moderate risk with a score of 6.0.<br><br>Review of R62's care plan, dated 11/01/22, located in the EMR under the "Care Plan" tab revealed "R62 has an ADL [activities of daily living] self-care performance deficit with an intervention that included "Assist with bed mobility and transfers per orders." There was no care plan for the side rails or enabler devices.<br><br>On 09/16/24 at 11:02 AM, R62 was observed awake and in an oversized bed with padded side rails. No gaps were noted between the mattress and the side rails. R62 was pleasant and talkative but very confused.<br><br>During an interview on 09/19/24 at 7:18 AM, the Director of Nurse (DON) was asked about R62's side rail evaluation and informed consent. The Administrator was present and stated, "the side rails are enablers." | F 700 | d. The Staff Developer or designee will audit residents who have side rails to ensure we are evaluating the risks and needs of side rails before application of the side rails.The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 700 | Continued From page 39<br>During an interview on 09/18/24 at 9:44 AM, Licensed Practical Nurse (LPN)2 was asked about R62's side rails and her oversized mattress and if a side rail assessment was completed. LPN2 stated that would be done by OT [occupational therapy] and PT [physical therapy].<br><br>During an interview on 09/18/24 at 2:31 PM, Certified Occupational Therapy Assistant (COTA), was asked if therapy conducted side rail assessments. COTA stated R62 had a bed with side rails that weren't removable. COTA stated R62 used the side rails for repositioning. COTA stated the side rails came with the bed so there was no evaluation for the side rails. COTA was asked who obtains informed consent for the side rails. COTA went on to say, "that would be PT [physical therapy]." No additional information concerning a side rail evaluation and/or informed consent was provided by the COTA prior to the survey exit.<br><br>During an interview on 09/19/24 at 10:07 AM, the MDS Coordinator (MDSC) was asked if side rails should be care planned. MDSC stated, "yes, side rails should be care planned." MDSC stated the care plans were interdisciplinary and "nursing or anyone [staff] that sees the side rails" can add a care plan. MDSC went on to say she wasn't aware R62 had side rails. | F 700 | | |
| F 742 SS=D | Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1)<br><br>§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that-<br>§483.40(b)(1)<br>A resident who displays or is diagnosed with | F 742 | | 11/15/24 |

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| F 742 | Continued From page 40<br>mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, record review, and review of facility policy, the facility failed to ensure one of one resident (Resident (R)80) reviewed for a diagnosis of with post-traumatic stress disorder (PTSD) out of a total sample of 34 residents, received appropriate treatment and services to attain his highest practicable mental and psychosocial well-being. This failure placed the resident at risk of unmet needs and a diminished quality of life.<br><br>Findings include:<br><br>Review of the facility policy titled, "Trauma-Informed Care," dated January 11, 2024, revealed " ...It is the policy of [facility] to provide trauma-informed care to all residents ...To address the trauma in the lives of the residents served by [facility]; to promote the understanding of trauma and its impact; to eliminate or mitigate triggers that may cause re-traumatization ...SCREENING: Screening will be completed upon admission to determine if an individual has a history of trauma ...A positive screen will warrant further evaluation by the provider ...CARE PLANNING: Care planning will be person-centered and incorporate the resident's experiences and preferences ...Trauma specific interventions may include ...Peer and/or family supports ...Resident-specific techniques to make the resident feel safe and calm | F 742 | F742 Treatment of/scv for mental/psych social concerns<br>a. R80 still resides in the facility. The facility took appropriate steps to review R80 for Diagnosis of post-traumatic stress disorder to receive the appropriate treatment and service.<br><br>b. All residents who have a positive trauma screen have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by the Staff Developer or designee to educate nursing staff on Trauma /PTSD and specific care needs for those residents who trigger for Trauma. Further, the trauma screen form was revised to include an area to document triggering behaviors specific to those residents. A root cause analysis was conducted, and it was determined the R80□s trauma screen did not include triggering behaviors that would have assisted R80. A facility wide sweep was conducted, and it was determined that no other residents had positive trauma screen without appropriate interventions. | |

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| F 742 | Continued From page 41<br>...Resident-specific techniques to eliminate or mitigate triggers ..."<br><br>Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R80 was admitted to the facility on 08/28/24 with diagnoses that included a stroke and Parkinson's disease (a neurological disorder).<br><br>Review of R80's admission "Minimum Data Set (MDS)"located in the "MDS "tab of the EMR with an Assessment Reference Date (ARD) of 09/03/24 revealed, R80 had a "Brief Interview of Mental Status (BIMS)"score of six out of 15 which indicated he was severely impaired in cognition.<br><br>Review of the "Psychology Initial Visit," located in the "Evaluations" tab of the EMR, dated 09/04/24 revealed, "R80 was depressed, had decreased energy, had mood swings, and was tearful." The assessment further showed that R80's family had indicated that he had episodes of visual hallucinations (a perceptual experience in which a person sees images that are not actually present.) In addition, the summary of the "Psychology Initial Visit" revealed, " ...Pt [patient] struggles to communicate. He displays limited emotional control. Psychotherapy to provide support and encouragement ..."<br><br>Review of the 09/04/24 "Trauma Screening-Social Service," located in the "Evaluations" tab of the EMR revealed, "Section A: We ask all of our residents if they have had any traumatic experiences. You do not need to tell me any specific details. Has there been any trauma in your life, and does it still affect you now."R80's Family Member (FM) stated, "Yes, | F 742 | d. The Social Service Director or designee will audit random residents with trauma screens to assure interventions and care needs are appropriate for that resident. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 742 | Continued From page 42<br>death of his twin brother recently." There was no further information to indicate what triggers occurred this trauma or what interventions would be beneficial.<br><br>Review of the 09/05/24 "Trauma-Informed Care Plan," revealed R80 had a positive trauma screen. Interventions included the following:<br>"Encourage resident to alert staff of any triggers."<br>"Encourage resident to express emotions r/t trauma."<br>"Refer to any needed outside agencies."<br>"Refer to psych services."<br><br>During an observation on 09/16/24 at 12:26 PM, R80 was reclined in a Geri chair (a chair which provides a resident with mobility and positioning problems to be out of bed) with the leg rest elevated in the common area of the unit. His eyes were open; however, he was unable to answer simple questions and had a flat affect.<br><br>During an interview on 09/19/24 at 8:27 AM , the Social Services Director (SSD) was asked if she was responsible for the "Trauma Screening." The SSD stated, "The Psychologist was the person who was responsible for this." The SSD was asked if there was any communication between herself and the Psychologist regarding trigger behaviors or interventions to be used for residents with a positive trauma screening. The SSD stated, "Sometimes. I also get information from the MDS Coordinator (MDSC)."The SSD reviewed the Psychologist notes from the 09/04/24 "Trauma Screening" and "Psychology Initial Visit" for R80 and stated, "The notes are very vague, and they do not identify any triggers or interventions for the trauma." | F 742 | | |

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| F 742 | Continued From page 43<br>The SSD was asked if there had been any in-services or education on the guidelines and/or protocols to assist residents with trauma/PTSD. The SSD stated, "No, we have not had any trauma/PTSD in-services for the residents identified with PTSD. "The SSD further stated, "The staff here needs this education as some of them do not know how to meet the needs of the residents with trauma."<br><br>During an interview on 09/19/24 at 8:32 AM, the MDSC stated, "When I see that a resident has a positive trauma screening, I notify the SSD and nursing personnel and then it's care planned especially if it warrants further discussion or insight." The MDSC further stated, "For the 'Trauma Screen,' there are privacy issues which is why there is nothing more listed on the form." The MDSC reviewed the 09/04/24 "Trauma Screen" and confirmed that the "Trauma Care Plan" was not specific on behaviors for R80 with trauma and it did not include trigger behaviors that would have assisted staff in helping him. | F 742 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide | F 755 | | 11/15/24 |

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| F 755 | Continued From page 44<br>pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and facility policy review, the facility failed to contact the pharmacy to ensure medications were available for administration for one of seven residents (Resident (R) 92) reviewed for medication administration out of a sample of 34 residents.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Electronic Interim Box," initiated 09/18 and last revised 08/20, revealed "The provider pharmacy will utilize an electronic interim box ...to provide an interim supply of medications for use in emergency and non-emergency dosing for nursing facility residents until the pharmacy is | F 755 | F755 Pharmacy SVCS/procedures<br><br>a. R 92 still reside in the facility. The facility took the appropriate steps to contact the pharmacy to provide medications to R92.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate | |

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| F 755 | Continued From page 45<br>able to provide a regular supply of medication to the nursing facility resident."<br><br>Review of R92's "Admission Record," found in the "Profile" tab of the electronic medical record (EMR), revealed he was admitted to the facility on 08/07/24. R92 was admitted with diagnoses including Parkinson's disease, hemiplegia and hemiparesis (paralysis and weakness on one side) following cerebral infarction (stroke) affecting right dominant side.<br><br>Review of R92's admission "Minimum Data Set (MDS)" assessment located in the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 08/13/24, revealed a "Brief Interview for Mental Status (BIMS)" assessment with a score of 15 out of 15 which indicated no cognitive impairment.<br><br>During an interview on 09/16/24 at 10:17 AM, R92 stated that he was supposed to get his eye drops multiple times a day. He said that the nurse had not administered them on this current morning, and that he had also not received them on other occasions. R92 said it happened "sometimes."<br><br>Review of R92's EMR under the "Orders" tab revealed an order, dated 08/08/24, for "Cyanocobalamin Oral Tablet 50 MCG (microgram) Give one tablet by mouth one time a day for supplement."<br><br>Review of R92's EMR under the "Orders" tab revealed the August 2024 "Medication Administration Record (MAR)" indicated that the Cyanocobalamin Oral Tablet 50 MCG was administered on 08/09/24, 08/15/24, 08/16/24, | F 755 | the Nursing staff if a medication is not available to notify the pharmacy and the physician. A root cause analysis was conducted, and it was determined the facility failed to restock the Omni-cell in a timely manner with medications delivered by the pharmacy. A facility wide sweep was conducted, and it was determined that no other residents were impacted by missing medications.<br><br>d. The Director Of Nursing or designee will audit the 24 hour report for medications that are not available. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. | |

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| F 755 | Continued From page 46<br>08/20/24, 08/21/24, and 08/29/24. The resident was not administered the medication on 18 of 24 opportunities.<br><br>Review of R92's revealed the September 2024 "MAR" indicated that the Cyanocobalamin Oral Tablet 50 MCG was administered on 09/02/24, 09/05/24, 09/06/24, 09/08/24, 09/09/24, 09/14/24, and 09/15/24. The resident was not administered the medication on eleven of 18 opportunities.<br><br>Review of R92's EMR under the "Orders" tab revealed an order, dated 08/22/24, for "Lubricating Eye Drops Ophthalmic Solutions 0.4-0.3% (Polyethylene Glycol-Propylene Glycol Instill one drop in both eyes two times a day for dry eyes."<br><br>Review of R92's EMR under the August 2024 "MAR" indicated that the Lubricating Eye Drops were not administered on 08/22/24. The resident was not administered the medication on one of nineteen opportunities.<br><br>Review of R92's revealed the September 2024 "MAR" indicated that the Lubricating Eye Drops were not administered 09/02/24 at 10:00 AM, 09/06/24 at10:00 PM, 09/13/24 at10:00 PM, 09/16/24 at 10:00 AM and 10:00 PM, 09/17/24 at 10:00 AM and 10:00 PM, and 09/18/24 at 10:00 AM. The resident was not administered the medication on eight of 35 opportunities.<br><br>Review of R92's "Progress Notes," under the "Progress Notes" tab documented: Cyanocobalamin Oral Tablet 50 MCG was "on order" on 08/08/24; "pending delivery from pharmacy" on 08/10/24, 08/11/24, 08/13/24, 08/14/24, 08/24/24, 08/25/24, 08/27/24, 08/28/24, | F 755 | | |

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| F 755 | Continued From page 47<br>09/03/24, 09/07/24, 09/10/24, 09/11/24, 09/16/24, and 09/17/24; "awaiting pharmacy "on 08/12/24, 08/17/24, 08/18/24, 08/31/24, 09/01/24, and 09/19/24; "reordered. Pending delivery. np (Nurse Practitioner) aware" on 08/19/24; "until available" on 08/22/24, 08/23/24, 08/26/24, 09/04/24, and 09/18/24; "on order from pharmacy" on 08/30/24; and "awaiting arrival from pharmacy" on 09/12/24 and 09/13/24.<br><br>Lubricating Eye Drops was "give when available" on 08/22/24; "on order" on 09/02/24 and 09/06/24; "awaiting delivery from pharmacy" on 09/13/24; "pending delivery from pharmacy on 09/16/24 and 09/17/24; "awaiting delivery" on 09/16/24; and "awaiting pharmacy delivery NP aware" on 09/19/24.<br><br>During an interview on 09/19/24 at 8:05 AM, Registered Nurse (RN) 2 stated that the facility had a Pyxis system which carried a lot of medications such as antibiotics and narcotics. She stated that if a medication were not available for administration the nurse would document that it was not available and contact the pharmacy. RN2 said that the goal was for residents to not miss medications. She confirmed that the pharmacy made three deliveries a day and could run STAT (urgent) as well.<br><br>During an additional interview on 09/19/24 at 8:45 AM, RN2 stated that staff should have taken the medication out of the Pyxis system. She said if a nurse documented that a medication was not given, they had to document a progress note why they did not get it. She confirmed that the "MAR" and "Progress Notes" indicated that R92 had not been getting his Lubricating Eye Drops and Cyanocobalamin Oral Tablets as ordered by the | F 755 | | |

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| F 755 | Continued From page 48<br>physician. RN2 said that the facility could have gone to a local pharmacy, and the resident should not have gone without the medication.<br><br>During a concurrent interview on 09/19/24 at 8:53 AM with Licensed Practical Nurse (LPN) 5 and RN2, LPN5 said that staff should have contacted the physician to get the medication. LPN5 confirmed R92 had gone without his eye drops and supplement. LPN5 said she did not know why certain medications were not automatically refilled.<br><br>During an interview on 09/19/24 at 10:27 AM, Nurse Practitioner (NP) 2 said that she was not made aware that R92 had gone without his medication. NP2 said she believed nurses were supposed to go to the unit manager and that individual would go to the Director of Nursing to get medication supply concerns addressed.<br><br>During an interview on 09/19/24 at 10:40 AM, the Director of Nursing (DON) said that most medications are significant, including antibiotics. She stated that the pharmacy made three deliveries a day and could also request medications more immediately. She stated that a resident should not go multiple days without medication. | F 755 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record reviews, and policy | F 760 | F760 | 11/15/24 |

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| F 760 | Continued From page 49<br>review, the facility failed to ensure that one of seven residents reviewed for unnecessary medications (Resident (R) 16) out of a total sample of 34 residents received antibiotics with diagnoses of tooth abscess and moderate protein-calorie malnutrition. This failure had the potential to increase the risk of infection, pain, and weight loss.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Electronic Interim Box," initiated 09/18 and last revised 08/20, revealed "The provider pharmacy will utilize an electronic interim box ...to provide an interim supply of medications for use in emergency and non-emergency dosing for nursing facility residents until the pharmacy is able to provide a regular supply of medication to the nursing facility resident."<br><br>Review of R16's "Admission Record," found in the "Profile" tab of the electronic medical record (EMR), revealed he was admitted to the facility on 07/12/21 and last readmitted on 10/02/23. R16 was admitted with diagnoses including moderate protein-calorie malnutrition.. R16 was identified with a tooth abscess on 09/12/24.<br><br>Review of R16's quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 06/26/24, revealed a "Brief Interview for Mental Status (BIMS)" assessment with a score of 14 out of 15 which indicated no cognitive impairment. R16 was documented with no dental concerns.<br><br>Review of R16's "Care Plan," dated 02/15/22 and | F 760 | a. R 16 still resides in the facility. The facility took the appropriate steps to contact the pharmacy to provide medications to R16.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. An in-service will be conducted by Staff Development or designee to educate the Nursing staff if a medication is not available to notify the pharmacy and the physician. A root cause analysis was conducted, and it was determined the facility failed to restock the Omni-cell in a timely manner with medications delivered by the pharmacy. A facility wide sweep was conducted, and it was determined that no other residents were impacted by missing medications.<br><br>d. The Director Of Nursing or designee will audit the 24 hour report for medications that are not available. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the | |

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| F 760 | Continued From page 50<br>last revised 11/09/22, located in the EMR under the "Care Plan" tab, indicated R16 had oral/dental health problems related to poor oral hygiene, missing teeth, and root tips exposed. Interventions included to administer medications as ordered.<br><br>Review of R16's EMR under the "Orders" tab revealed an order, dated 09/12/24, for "Amoxicillin Oral Capsule, 250 MG [milligrams]. Give two tablets by mouth four times a day for tooth abscess for 5 days." Medication was to be administered at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM.<br><br>Review of R16's EMR under the "Orders" tab revealed the September 2024 "Medication Administration Record (MAR)" indicated that the Amoxicillin 250 MG was not administered on 09/13/24 at 5:00 PM and 09/15/24 at 9:00 AM, 1:00 PM, nor 5:00 PM, and was not available from the pharmacy.<br><br>Review of R16's "Progress Notes," under the EMR "Progress Notes" tab documented "awaiting arrival from pharmacy" on 09/13/24, "Waiting for medication to come from pharmacy on 09/15/24, and "Oral antibiotics completed for tooth infection" on 09/19/24.<br><br>During an interview on 09/19/24 at 8:05 AM, Registered Nurse (RN) 2 stated that the facility had a Pyxis system which carried a lot of medications such as antibiotics and narcotics. She stated that if a medication were not available for administration the nurse would document that it was not available and contact the pharmacy. RN2 said that the goal was for residents to not miss medications. She confirmed that the | F 760 | Quality Assurance Committee. | |

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| F 760 | Continued From page 51<br>pharmacy made three deliveries a day and could run STAT (urgent) as well.<br><br>During an additional interview on 09/19/24 at 8:45 AM, RN2 stated that a significant medication would be any medication that a resident would take to prevent a change in condition, such as heart medication and antibiotics. RN2 confirmed R16 had missed multiple doses of the antibiotic. She stated that staff should have taken the medication out of the Pyxis system.<br><br>During an interview on 09/19/24 at 10:27 AM, Nurse Practitioner (NP) 2 stated that antibiotics would be considered significant medications. NP2 stated she was not aware that R16 had not received all of her antibiotic medication. NP2 said that if she had been informed of missing medication, she would have extended the order.<br><br>During an interview on 09/19/24 at 10:40 AM, the Director of Nursing said that most medications are significant, including antibiotics. She stated that a resident should not go multiple days without medication. and she was not aware that R16 had missed antibiotics. | F 760 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals | F 761 | | 11/15/24 |

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| F 761 | Continued From page 52<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the facility failed to ensure: 1. an insulin pen was not expired when used for one resident (Resident (R) 66) of four insulin pens reviewed on three medication carts and This failure increased the risk of insulin not being effective.<br><br>Findings include:<br><br>Review of the pharmacy policy titled, "Storage of Medications," dated September 2018 revealed, " ...Outdated, contaminated, or deteriorated medication ...are immediately removed from inventory, disposed of according to procedures for medication disposal and reordered from the pharmacy ..."<br><br>1. On 09/18/24 at 7:42 AM a review of the "Bethany Medication Cart 1" with Licensed Practical Nurse (LPN) 1 revealed a "Humalog | F 761 | F761 Label/Store Drugs and Biologicals<br>A. R 66 no longer resides in the facility.No residents were negatively impacted by this deficient practice. All undated opened medications were removed from the medication rooms and medication carts.<br>B. All residents have the potential to be impacted by inappropriate labeling and storage of medication. The facility did a whole house sweep to establish compliance with medication storage and labeling. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br>C. A root cause analysis determined that the nursing staff were not following the guidelines related to medication storage and dating medications upon opening. A facility-wide sweep was conducted, and | |

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| F 761 | Continued From page 53<br>(short-acting insulin) Kwik pen" for R66 with approximately 61 units remaining in the pen. The expiration date on the pen was 09/12/24. LPN 1 was asked if R66 had received any Humalog insulin since 09/12/24. LPN 1 stated, "Yes, at least five times." LPN 1 confirmed that the Humalog insulin should not have been administered after expiration.<br><br>Review of the current "Physician Orders" located in the "Orders" tab of the electronic medical record (EMR) and dated 06/20/24, revealed the following insulin order for R66: "Humalog Kwik Pen (Insulin Lispro) 100 Unit/ml ...Inject as per sliding scale."<br><br>During an interview on 09/18/24 at 8:27 AM, the Director of Nursing (DON) was asked what her expectation was regarding having expired insulin pens on the medication cart. The DON stated, "Don't administer it." | F 761 | no further issues were found. Nursing staff will be educated by the Staff Educator/ designee regarding dating bottles and vials of eyedrops upon opening.<br>D. The Unit Manager/designee will audit all medication carts and medication rooms for appropriate dating of opened bottled and vials of eyedrops. The audit process will be conducted three times a week until compliance is consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be performed to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. | |
| F 803 SS=D | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed; | F 803 | | 11/15/24 |

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| F 803 | Continued From page 54<br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to have menu extensions for finger foods for one (Resident (R)89) of three residents reviewed for diets in a total sample of 34 residents. The failure had the potential to cause R89 to lose weight by not receiving foods easy to eat.<br><br>Findings include:<br><br>On 09/19/24 at 1:45 PM, a policy for menus and menu development was requested. The Administrator stated at this time the facility did not have a policy for menus and menu development.<br><br>Review of the LTC [Long Term Care] dietary manual "Dining RD.com 2017," provided by the facility, revealed "The Finger Food Diet is used for individuals with dementia or cognitive impairment, such as Alzheimer's disease resulting in a loss of ability to recognize and use utensils, or for neuromuscular diseases affecting | F 803 | F803 Menus<br><br>F803<br><br>a. R89 still resides in the facility. Her menus options reviewed and customized to meet her needs.<br><br>b. All residents have the potential t Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. A root cause analysis was conducted, and it determined the new dietician was ordering finger foods unaware that Cadia does not provide an exchange for finger food items on the menu. The Dietitian was educated on Cadia□s menu options and processes to provide appropriate menu selections for residents depending upon | |

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| F 803 | Continued From page 55<br>muscle coordination such as in Parkinson's disease. The diet allows independence in eating, regardless of a decline in cognition or muscle coordination." "The Finger Foods Diet is designed to promote self-feeding for individuals who have difficulty using utensils due to cognitive or physical issues. The Regular Diet is followed with appropriate alternate foods 'specified' to help older adults with self-feeding. The foods offered are typically in bite size pieces and meats are offered as sandwiches. Soups are pureed and poured into a cup or mug for drinking. This diet will need to be adjusted to meet individual needs."<br><br>Review of the facility menu extensions for week two, dated 09/15/24 to 09/20/24, provided by the facility revealed diets listed included "Reg [regular]/Grd [ground] Meat, Mech [mechanical] Soft, Puree, CCD [controlled carbohydrate diet], and Cardiac."<br><br>Review of R89's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 08/15/24, located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 08/09/24. R89 had a "Brief Interview for Mental Status (BIMS)" score of two out of 15 indicating R89's cognition was severely impaired and had diagnoses of dementia and received hospice care.<br><br>Review of R89's diet order, dated 08/09/24, located in the EMR under the "Order" tab revealed "Regular diet, Regular texture, Thin consistency, Finger food only."<br><br>Review of R89's care plan, revised 08/13/24, located in the EMR under the "Care Plan" tab | F 803 | their dietary needs. A facility wide audit sweep was conducted and two other residents were identified with finger food orders. Their meal tickets were corrected and updated to meet their specific dietary needs.<br><br>d. The consultant dietician or designee will audit diet order and tray tags to assure finger foods are not ordered. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered | |

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| F 803 | Continued From page 56 | F 803 | | |

revealed "R89 has nutritional problem or potential nutritional problem r/t [related to] Low BMI [body mass index] and chronic dx [diagnosis] of Dementia, Depression, Hypokalemia, Respite care." An intervention included "Provide, serve diet as ordered-Finger Foods/regular texture/thin liquid. . . Monitor intake and record q [every] meal."

Review of R89's Nutrition Risk Assessment, dated 08/13/24, located in the EMR under the "Evaluation" tab revealed "Resident was admitted on a Regular-Finger Food /regular texture/thin liquid diet. No food allergies noted. No adaptive equipment needed. She needs set up help and supervision during meals. BMI is 18.2 indicating under weight [sic]."

On 09/16/24 at 12:27 PM, R89 was served her lunch in her room that included turkey, mashed potatoes, green beans, and canned pears. R89 had left her room with her meal only partly eaten and the pears and mashed potatoes untouched.

On 09/18/24 at 12:10 PM, R89 was observed feeding herself lunch at the dining room table using her fingers. R89 was served peas with onions, a peanut butter and jelly sandwich, canned mandarin oranges, and tea. The mandarin oranges were noted to be slipping through R89's fingers, and the peas became squashed when R89 would scoop them up to eat with her fingers. The resident did have utensils on her tray.

During an interview on 09/19/24 at 8:08 AM, the facility's Registered Dietitian (RD) was asked if she was aware R89 was ordered finger foods and the menu extensions didn't include finger foods.

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| F 803 | Continued From page 57<br>RD stated, "No," as the corporate RD (CRD) wrote the menus. The RD went on to say she was not in control of the menus, and she was not aware of the menu extensions not having a diet for finger foods. The RD was informed there were three residents with diet orders for finger foods and R89 was one of them.<br><br>During an interview on 09/19/24 at 8:35 AM, the dietary manager (DM) was asked about R89's diet order for finger foods. The DM stated he was not aware, but nursing staff should be communicating to the kitchen about R89's meals.<br><br>On 09/19/24 at 8:56 AM, R89 was observed feeding herself breakfast at the dining room table using her fingers. R89 was served pancakes, bacon, juice, milk and oatmeal. Review of R89's Meal Ticket provided by the facility revealed "Alerts: finger foods."<br><br>During an interview on 09/19/24 at 9:02 AM, Licensed Practical Nurse (LPN)2 was asked if she was aware R89's meal ticket reflected an alert for finger foods and there was a physician order for finger foods. LPN2 stated, "Yes, but it's just a recommendation, but R89 does well with finger foods." LPN2 stated "R89 doesn't use utensils, and sometimes the kitchen will include finger foods."<br><br>On 09/19/24 at 9:09 AM, R89's meal was taken away and R89 was noted to have eaten everything except the oatmeal.<br><br>During an interview on 09/19/24 at 1:33 PM, the CRD stated she only inputs the menus into the computer and the dietary manager tells her what they want on the menus. The CRD stated the | F 803 | | |

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| F 803 | Continued From page 58<br>menus were developed by each facility as the DM and the facility RD told her what to input. The CRD verified there were no extensions for finger foods. CRD was asked if she was aware there were three residents with diet orders for Finger Foods. The CRD was asked if oatmeal was a finger food and CRD stated, "No, oatmeal was not a good finger food." The CRD was informed R89 received oatmeal at breakfast on 09/19/24 at breakfast and was eating peas and canned mandarin oranges with her fingers on 09/18/24 at lunch. CRD stated peas and mandarin oranges could be finger foods. | F 803 | | |
| F 847 SS=E | Entering into Binding Arbitration Agreements<br>CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5)<br><br>§483.70(m) Binding Arbitration Agreements<br>If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.<br><br>§483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.<br><br>§483.70(m)(2) The facility must ensure that:<br>(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; | F 847 | | 11/15/24 |

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| F 847 | Continued From page 59<br>(ii) The resident or his or her representative acknowledges that he or she understands the agreement;<br><br>§483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.<br><br>§483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.<br><br>§483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record review, and review of the facility arbitration agreement, the facility failed to thoroughly explain the binding arbitration agreement to residents or their representative and provide an arbitration agreement that granted the resident or their representative the right to rescind the agreement within 30 days of signing it and communicate with federal, state, local officials and the ombudsman for three (Residents (R)11, R43, and R89) of three residents reviewed for arbitration in a sample of 34. This failure denied residents the opportunity to fully | F 847 | F847<br><br>a. R 11, R 43, R 89 still resides in the facility. No other residents were affected at this time.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C. | |

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| F 847 | Continued From page 60<br>understand what the agreement meant and the ability to rescind the agreement within 30 days of signing.<br><br>Findings include:<br><br>Review of the facility arbitration agreement, dated 01/01/24, provided by the facility in the admission packet revealed "...(3) this Agreement may be rescinded by written notice sent to the other party via Certified Mail, return receipt requested, within twenty-one (21) days of the date upon which it is signed. Rescission or waiver of this Agreement can only be effected in writing. If this Agreement is not rescinded within thirty (30) days of the date upon which it is signed, it is binding upon the parties in all matters regarding care and services provided to the Resident by the Facility, regardless of subsequent discharges and readmissions." The agreement did not include the resident, or their representative may communicate with federal, state, local officials and the ombudsman.<br><br>1. Review of R11's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 07/25/24, located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 07/18/24. R11 had a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 indicating R11's cognition was intact.<br><br>Review of R11's binding arbitration agreement, provided by the facility, revealed R11's name and signature, dated 09/10/24. R11's arbitration required the agreement be rescinded by written notice sent to the other party via Certified Mail, return receipt requested, within twenty-one (21) days of the date upon which it is signed. The | F 847 | c. An in-service will be conducted by Admission Director or designee to educate the admission coordinator on the arbitration agreement so she can fully explain the content to newly admitted residents/POA□s. A root cause analysis was conducted, and it was determined the admission coordinator needed to be educated on how to explain the arbitration agreement.<br><br>d. The Social service Director or designee will interview 3 random newly admitted residents per week to determine understanding of the arbitration agreement. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered.<br>All audits will be reviewed by the Quality Assurance Committee. | |

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| F 847 | Continued From page 61 | F 847 | | |

agreement did not include the resident, or their representative may communicate with federal, state, local officials and the ombudsman.

During an interview on 09/19/24 at 9:46 AM, the Admissions Coordinator (AC) stated the document was in the admission packet and she explained it with the other paperwork. AC stated, "if the resident's BIMS score was a 13 to 15, it was okay for the resident to sign it, otherwise the RP [resident representative] signed it if the resident's mental capacity isn't there." The AC stated she summed the agreement up by telling them, "If they and the facility had a disagreement they [the facility] like to use an arbitrator." The AC stated if they ask about it further, she told them a third party was used but that was all she told them. The AC stated she was not aware of the 30-day time frame to rescind the agreement.

On 09/19/24 at 10:29 AM, R11 was asked if she signed an arbitration agreement. R11 responded by asking what that was. The surveyor explained that it was a binding agreement that was used in case she had a dispute with the facility, and they would use an arbitrator instead of going to court. R11 stated, "No [she did not sign]" The document with her signature, dated 09/10/24, was shown to R11. R11 looked at the document and her signature.

2. Review of R43's significant change "MDS" with an ARD date of 07/25/24, located in the "MDS" tab of the EMR, revealed an admission date of 03/02/21. R43 had a "BIMS" score of 13 out of 15 indicating R43's cognition was intact.

Review of R43's binding arbitration agreement, provided by the facility, revealed R43's name and

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| F 847 | Continued From page 62<br>signature, dated 05/10/21. R43's arbitration required the agreement be rescinded by written notice sent to the other party via Certified Mail, return receipt requested, within twenty-one (21) days of the date upon which it is signed. The agreement did not include the resident, or their representative may communicate with federal, state, local officials and the ombudsman.<br><br>During an interview on 09/19/24 at 2:00 PM, R43 was asked about signing an arbitration agreement. R43 was shown the 05/10/21 arbitration agreement. R43 confirmed he signed it, but stated it was not explained to him so that he understood what he was signing.<br><br>3. Review of R89's admission "MDS" with an ARD date of 08/15/24, located in the "MDS" tab of the EMR, revealed an admission date of 08/09/24. R89 had a "BIMS" score of two out of 15 indicating R89's cognition was severely impaired and had diagnoses of dementia, osteoporosis, and hypokalemia, and received hospice care.<br><br>Review of R89's binding arbitration agreement, provided by the facility, revealed R89's name and signature, dated 09/04/24. R89's arbitration required the agreement be rescinded by written notice sent to the other party via Certified Mail, return receipt requested, within twenty-one (21) days of the date upon which it is signed. The agreement did not include the resident, or their representative may communicate with federal, state, local officials and the ombudsman.<br><br>During an interview on 09/19/24 at 11:22 AM, the Administrator was asked. about the missing components such as communicating to federal, state, local officials and the ombudsman in the | F 847 | | |

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| F 847 | Continued From page 63<br>agreement, the 21- days verses the 30-days rescinding timeframes, and the AC's limited explanation and failing to inform residents and their RP the agreement was binding.<br><br>During a follow-up interview on 09/19/24 at 12:34 PM, the Administrator provided an updated arbitration agreement, dated 01/01/24, that contained the same information as the agreement found in the admission packet. | F 847 | | |
| F 848 SS=E | Binding Arbitration Agreements<br>CFR(s): 483.70(m), 483.70(m)(2)(iii)(iv)(6)<br><br>§483.70(m) Binding Arbitration Agreements.<br>If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.<br><br>§483.70(m)(2) The facility must ensure that:<br>(iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and<br>(iv) The agreement provides for the selection of a venue that is convenient to both parties.<br><br>§483.70(n)( (6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and record review, the facility failed to ensure the arbitration agreement provided for the selection of a neutral arbitrator | F 848 | F848 | 11/15/24 |

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| F 848 | Continued From page 64<br>without stipulations and the selection of a venue that is convenient for three (Residents (R)11, R43, and R89) of three residents reviewed for arbitration in a total sample of 34 residents. This placed residents at risk not having the opportunity to choose an arbitrator or venue.<br><br>Findings include:<br><br>Review of the facility arbitration agreement, dated 01/01/24, provided by the facility in the admission packet revealed "All arbitrators must be a retired state or federal court judge or a member of the state bar with at least ten (10) years of experience as an attorney." There was no mention of a venue that is convenient to both parties.<br><br>1. Review of R11's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 07/25/24, located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 07/18/24. R11 had a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 indicating R11's cognition was intact.<br><br>Review of R11's binding arbitration agreement, signed by R11 on 09/10/24, provided by the facility, revealed no mention of the selection of a venue or a neutral arbitrator. Stipulations were placed upon the arbitrator that included "All arbitrators must be a retired state or federal court judge or a member of the state bar with at least ten (10) years of experience as an attorney."<br><br>2. Review of R43's significant change "MDS" with an ARD date of 07/25/24, located in the "MDS" tab of the EMR, revealed an admission date of 03/02/21. R43 had a "BIMS" score of 13 out of 15 | F 848 | a. A R 11, R 43, R 89 still resides in the facility. The residents were not negatively impacted by this deficient practice.<br><br>b. All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br><br>c. The arbitration agreement will be updated to be in compliance with all required verbiage per CMC to includes choice of venue and neutral Arbitration.<br><br>d. The Admission Director or designee will audit random of three new arbitration agreements per week to ensure compliance. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 1 month. Once 100% compliance is met, the deficient practice will be considered | |

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| F 848 | Continued From page 65<br>indicating R43's cognition was intact.<br><br>Review of R43's binding arbitration agreement, signed by R43 on 05/10/21, provided by the facility, revealed no mention of the selection of a venue or a neutral arbitrator. Stipulations were placed upon the arbitrator that included "All arbitrators must be a retired state or federal court judge or a member of the state bar with at least ten (10) years of experience as an attorney."<br><br>3. Review of R89's admission "MDS" with an ARD date of 08/15/24, located in the "MDS" tab of the EMR, revealed an admission date of 08/09/24. R89 had a "BIMS" score of two out of 15 indicating R89's cognition was severely impaired.<br><br>Review of R89's binding arbitration agreement, signed by R89's RP on 09/05/24, provided by the facility, revealed no mention of the selection of a venue or a neutral arbitrator. Stipulations were placed upon the arbitrator that included "All arbitrators must be a retired state or federal court judge or a member of the state bar with at least ten (10) years of experience as an attorney."<br><br>During an interview on 09/19/24 at 9:46 AM, the Admissions Coordinator (AC) was asked about the arbitration agreement. The AC stated the document was in the admission packet and she explained it with the other paperwork. When asked the AC stated she did not discuss the right to neutral arbitrator and an agreed upon venue. The AC was asked if she ever read the facility's arbitration agreement herself. The AC stated, "No."<br><br>During an interview on 09/19/24 at 11:22 AM, the Administrator was asked about the binding | F 848 | | |

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| F 848 | Continued From page 66<br>arbitration agreement and the missing components of the selection of a venue and a neutral arbitrator as well as placing stipulations on what arbitrator could be used such as "all arbitrators must be a retired state or federal court judge or a member of the state bar with at least ten (10) years of experience as an attorney." The Administrator stated she would look into it.<br><br>During a follow-up interview on 09/19/24 at 12:34 PM, the Administrator provided an arbitration agreement, dated 01/01/24. However, this agreement was dated and contained the same information as the agreement found in the admission packet. | F 848 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment | F 880 | | 11/15/24 |

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| F 880 | Continued From page 67<br>conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of | F 880 | | |

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| F 880 | Continued From page 68<br>infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, document review, and policy review, the facility failed to develop and implement infection control protocols for 1. failed to ensure COVID19 infection control processes were followed by facility staff within a secured unit and soiled PPE was not kept out of reach for resident (Resident (R) 89); and 2. infection control was maintained during wound care for R104. These failures had the potential to affect all 116 residents in the facility.<br><br>Findings include:<br><br>Review of the facility's policy titled, "COVID-19," initiated March 23, 2020, and last revised October 19, 2022, revealed "The DON and the Infection Control Preventionist (IP) will conduct monitoring and surveillance in the facility for early detection and recognition of potential outbreaks of Coronavirus including all respiratory infections."<br><br>1. During an observation on 09/16/24 at 9:40 AM, a sign was posted on the outside of the secured 300-unit doors, near the main dining room. An isolation cart was placed in front of the door as a donning station. The sign documented, "Stop. Everyone in our facility must follow these precautions ...Contact Precautions. Everyone must wash their hands, including before entering the room and when exiting the room. Providers and staff must also put on gloves before entering the room and discard gloves when exiting the | F 880 | F880<br><br>1.<br><br>a. R89 remains in the facility and there was no harm by this deficient practice. Corrective action was immediately taken with providing additional isolation supplies (N95 masks, gowns, eye protection and alcohol handwashing gel) being stored in the outside isolation carts for easy access. A doffing area was created for staff to remove Personal Protective Equipment. Doffing containers were replaced with lids upon discovery.<br>b. All residents have the potential to be affected by this defiant practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br>c. A root cause analysis was conducted and it was determined that the facility did not have a process in place to replenish PPE for the isolation carts each shift and to determine how much PPE would be used during each shift. It was also determined that the signage on in the entrances of the unit were not clear on PPE guidance for staff. Furthermore, the facility did not have a process in place to cleaning their goggles when exiting the | |

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| F 880 | Continued From page 69<br>room ...must put on a gown before entering the room and discard the gown before exiting the room ...must use dedicated or disposable equipment, and they must clean and disinfect reusable equipment before use on another person. Droplet Precautions. Everyone must wash their hands, including before entering the room and when exiting the room. Everyone must make sure their eyes, nose and mouth are full covered before entering the room and remove face protection before exiting the room." The same sign was posted on the second entrance doors to the secured 300-unit off of the 200-unit hallway. Both isolation carts contained gowns, gloves, and masks. Neither station stocked eye protection.<br><br>During an interview on 09/16/24 at 9:43 AM, Activity Aide (AA) stated that a staff member who worked on the secured 300 unit had tested positive for COVID on 09/14/24. She said that the secured 300 unit was now on precautionary isolation. Both entrances to this unit had donning PPE (Personal Protective Equipment) carts outside the doors to the unit. AA said that all staff were required to wear full PPE when entering the secured unit, which included a gown, face shield, N95 mask, and gloves. She said residents had been tested on 09/15/24 and were negative.<br><br>During an interview on 09/16/24 at 12:55 PM, the Infection Preventionist (IP) stated that two staff tested positive the prior week. She said they were now testing residents on the secured 300-unit, and no one was symptomatic. She said they had placed the residents in the secured unit on quarantine. The doffing station was posted on the inside doors to the secured 300-unit. There were two doffing bins, one for reusable gowns and one | F 880 | unit. The Infection Preventionist will educate all clinical staff on the appropriate procedures for donning/doffing PPE, cleaning eyewear, and storage of PPE. Education will also include using an additional meal cart which is kept in the unit so that the meal carts are not leaving the unit when precautions are in place.<br>d. The Infection Control Preventionist will audit Infection control practices to include hand washing with wound care, COVID, and PPE. The audit process will be conducted five times a week until compliance consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.<br><br>2b<br>a. R104 remains in the facility and there was no harm by this deficient practice. The staff member was immediately educated on glove removal hand washing | |

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| F 880 | Continued From page 70<br>for disposable gowns and gloves. Neither bin had a lid to prevent easy access to residents on the secure unit. There were no sanitizing wipes to clean off eye protection, nor a place to store the eye equipment. IP confirmed there was no established cleaning and storing process for eye protection after doffing PPE. She confirmed there was no easily accessible hand sanitizer at the doffing station after doffing PPE.<br><br>During an observation on 09/17/24 at 12:15 PM, the isolation cart for the secured 300-unit off of the 200-unit hallway contained no eye protection. On 09/17/24 at 12:17 PM, the isolation cart for the main secured 300-unit contained one pair of goggles.<br><br>During an observation on 09/18/24 at 11:15 AM on the secured 300-unit, the main entrance isolation cart had no eye protection present. Central Supply (CS) was observed bringing newly washed reusable gowns to the isolation cart. CS confirmed there was no eye protection face shields or goggles present in the cart. She knocked on the door to the secured 300-unit and requested eye protection from LPN1, working in the unit. LPN1, observed only wearing prescription glasses, handed a pair of goggles to CS. LPN1 said she was not wearing goggles because she was working on the medication cart, and not near the residents. LPN1 said the nursing staff on the secured 300-unit were still "figuring" the PPE requirements out. Staff were observed not wearing gloves on the unit.<br><br>On 09/18/24 at 11:35 AM, Resident (R) 89 was observed ambulating down the secured 300-unit hallway, to the exit, connected to the 200 hallway. She was observed pulling doffed gowns out of the | F 880 | during wound care upon discovery.<br>b. All residents with wounds have the potential to be affected by this defiant practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in Section C.<br>c. A root cause analysis was conducted and it was determined that the nurse failed to change her gloves and perform hand hygiene during wound care. The nurse identified that proper handwashing and glove changing was not performed after a review. Education shall be completed by the Staff Educator on proper infection control technique with wound care for all professional nursing staff.<br>d. The Infection Control Preventionist will audit Infection control practices to include hand washing with wound care. The audit process will be conducted five times a week until compliance consistently reached 100% of the time during 3 consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over 3 consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, re-assessment of on-going issues and corrective actions will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. | |

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|---|---|---|---|
| | 085052 | A. BUILDING _____ B. WING _____ | C 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CADIA REHABILITATION RENAISSANCE | 26002 JOHN J WILLIAMS HIGHWAY MILLSBORO, DE 19966 |

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| F 880 | Continued From page 71 | F 880 | | |

doffing bins (no lids) with bare hands. AA was observed redirecting the resident away from the open bins, removing the gowns from her hands, and returning them to the bin. The resident was escorted back down the hallway without hand sanitizing. AA confirmed that the facility did not put lids on the doffing bins, and she had to redirect the resident after touching the gowns.

During an observation on 09/18/24 at 12:58 PM, two meal carts were observed pushed out of the secured unit after lunch by dietary staff. The meal carts were not cleaned prior to exiting the unit.

During an observation on 09/18/24 at 1:15 PM, the laundry cart was observed pushed out of the secured unit by laundry staff. The cart was not cleaned prior to exiting the unit. The laundry staff were observed wearing eye protection off of the unit without cleaning or removing them.

During an observation on 09/19/24 at 8:00 AM, no eye protection was found in either isolation cart.

During an interview and observation on 09/19/24 at 12:00 PM with the IP, she confirmed that the isolation carts should always have eye protection, and staff were to wear them on the unit. She confirmed there was no doffing station to clean or store eye protection. The IP said that the doffing bins were supposed to have lids on them, and was surprised none of them had any. She confirmed all staff should be following both droplet and contact PPE precautions according to the posted sign on the doors. She stated that the signs could be confusing, and that the signs did not specify gloves to only be worn while providing cares and touching food. She said that she was not sure what the correct process should be for

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| F 880 | Continued From page 72<br>meal carts and laundry carts that would come on and off the units, as it had not been discussed.<br><br>During an interview on 09/19/24 at 1:41 PM, the Staff Development Coordinator (SDC) said the isolation carts would be set up by IP, and stocked by CS. She said that if a cart was empty or missing PPE, the supervisors could restock items. She said the carts should always have gowns, N95 masks, hand sanitizer, eye gear, and regular surgical masks for visitors. She stated that when staff doff inside the secured unit, they were educated to take off their gloves, they take off their gown to dispose of in the correct bin, then hand sanitize. She said staff should doff and clean the eye protection. Doffing bins should have lids on them, especially for wandering residents. She confirmed that laundry bins and meal carts should be wiped down on the outside before leaving the secured unit.<br><br>2. Review of the "Admission Record" located in the "Profile" tab of the EMR revealed R104 was admitted to the facility on 08/01/24 with a diagnosis of a stroke and a sacral pressure ulcer.<br><br>Review of R104's admission "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 08/07/24 revealed R104 had a staff assessed "Brief Interview of Mental Status (BIMS)" which indicated R104 was severely impaired in cognition. The assessment further revealed that R104 had an unstageable pressure ulcer that was present upon admission to the facility.<br><br>Review of the "Physician Orders" located in the "Orders" tab of the EMR revealed, "Metronidazole [an antibiotic] 500mg three times daily from | F 880 | | |

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| F 880 | Continued From page 73<br>09/13/24 to 09/23/24 for wound infection."<br><br>During a wound care observation on 09/18/24 at 10:15 AM, Licensed Practical Nurse (LPN) 4 donned PPE (personal protective equipment) to perform the wound care. LPN 4 removed the soiled dressing and packing from the sacrum and then removed her soiled gloves, used hand sanitizer, and donned new gloves.<br><br>After LPN 4 donned new gloves, she obtained gauze and cleaned fecal material on R104's buttocks, then proceeded to clean the wound. Without removing the soiled gloves or performing hand hygiene, LPN 4 obtained the prescribed ointment, put it on her the same gloved fingers and coated the wound bed with the ointment, as prescribed, and then placed the calcium alginate into the wound bed. During the wound care, LPN 4 was asked if she had changed gloves prior to putting the ointment into the wound bed with her gloved hands. LPN 4 stated, "No, I should have changed gloves after cleaning him up and before placing the santyl and calcium alginate." LPN 4 was asked if there was anything else she could have used, instead of her fingers, to apply ointment to the wound bed. LPN4 stated, "Yes, I could have used Q-tips." LPN 4 finished wound care removed her soiled gloves and washed her hands.<br><br>During an interview on 09/18/24 at 1:35 PM, the Director of Nursing (DON) was told about the wound care observation and was asked what her expectation was regarding providing wound care in a manner that prevents infection. The DON stated, "After LPN4 had cleaned up the resident, she should have changed gloves, put on new gloves and either used a Q-tip or tongue | F 880 | | |

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| F 880 | Continued From page 74<br>depressor as he has a large wound." | F 880 | | |