STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015443	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robertsdale Rehabilitation & Healthcare Ctr	18700 U S Highway 90 Robertsdale, AL 36567

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27104 Based on record review, observation, interview, and facility policy review, the facility failed to ensure one of two residents (Resident (R) 83) observed for dining out of 35 sample residents was positioned to ensure the resident could access their food without difficulty and at a comfortable position. This had the potential for the resident to have a decline in nutritional status and a negative dining experience. Findings include: Review of the facility's policy titled, Dining Services with the last revision date of 10/17, revealed Meal service is provided for all residents in a safe and sanitary environment and in a manner that preserves the dignity and respect of each resident .Every effort is made to provide a homelike environment in the dining room . During meal service: 3. b. Residents shall be positioned by nursing staff to enable the resident to consume food served in the safest, most efficient, and more comfortable manner possible. Review of R83's undated Face Sheet provided by the facility revealed the resident was readmitted to the facility on [DATE] with diagnoses of abnormal posture and muscle weakness. Review of R83's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/24 located in the electronic medical record (EMR) under the MDS tab revealed the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated the resident was severely cognitively impaired. She was noted to be independent with eating after set-up. During an observation on 08/05/24 at 11:30 AM, R83 was in the dining room at a table eating her lunch. She was in a chair that was in a reclined position. She was not sitting in an upright position. She had to lean forward and reach above her head to reach her utensils and the food on her plate. The resident's chin was level with the table. During an observation on 08/06/24 at 12:05 PM, R83 was in the dining room eating her lunch in the same chair that was in a reclined position. R83 reached up over her head and had to lean forward in order to reach her iced tea so she could drink it. She was observed to reach above her head to reach her utensils and her plate of food. R83 leaned forward to reach her cranberry juice and spilled some as she was trying to bring it closer to her mouth. She was observed to feed herself her lunch, however had to lean forward to reach it. (continued on next page)

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/24 at 12:05 PM, Licensed Practical Nurse (LPN) 6, who was in the dining room at the time of the observation, confirmed the table was too high for the resident to comfortably reach her food to feed herself. LPN6 said she tried to get R83 to move to a lower table, however the resident insisted on sitting at her current table with her friends. LPN6 confirmed other alternatives should be attempted so the resident could reach her utensils, plates, and beverages without leaning forward and reaching above her head so she could continue to sit at the table of her choosing. LPN6 then got a pillow and placed it behind R83's back so she was closer to the table. R83 thanked her and said it was much better and she could reach her food easier. During an observation on 08/08/24 at 12:13 PM, R83 was sitting at her usual table, in her chair that was reclined back. No pillow was observed behind the resident or any other assistive device so she would be positioned closer to the table to make it more comfortable. She again was having to reach above her head to reach her food and beverages. At the time of the observation the Speech Language Pathologist (SLP) was sitting at the table with R83. The SLP confirmed the resident was seated too low and she was struggling to see and reach her food. She confirmed she fed herself independently, however, could use some device so she was up higher and/or something behind her back, so she didn't have to lean forward to see her food and reach her utensils and beverage cups. The SLP confirmed R83 wanted to be at this particular table with her friends and said, so we need to figure out what adaptive devices we can use to make her more comfortable when she is eating.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 20064 27104 40847 Based on record review, interview, and facility policy review, the facility failed to protect the resident's right to be free from abuse for seven of nine residents (Resident (R) 48, R83, R267, R15, R117, R76, and R80) reviewed for abuse. This failure had the potential to affect resident safety. Findings include: Review of the facility policy titled, Administrative Policy, Subject: Abuse, Neglect and Exploitation, last revised ,d+[DATE], revealed Each resident of any facility .has the right to be free from verbal, sexual, physical, or mental abuse, neglect, exploitation, and misappropriation of his or her property. 1. a. Review of R12's undated "Admission Record," provided by the facility revealed R12 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, psychotic disorder with delusions due to known physiological condition, dementia without behavioral disturbance, anxiety disorder, and major depressive. Review of R12's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. Review of R12's care plan, provided by the facility and dated [DATE], revealed exhibited following behaviors: attempted to bite staff, cursing and demeaning staff, and combative (hitting) at nursing staff. Refuses meds and BG's [blood glucose] DX. [diagnoses] Major Depressive Disorder: Psychotic diagnosis known psychological condition. Anxiety [DATE] hit another resident in response to that resident hitting her by accident, alteration in communication related to diagnosis of dementia. Residents have fragmented thought processes and slow processing, and resident was at risk for side effects from antidepressant medication use. b. Review of R48's undated "Admission Record," provided by the facility, revealed R48 was admitted to the facility on [DATE] with diagnoses including dementia, moderate with psychotic disturbance, cognitive communication deficit, diffuse traumatic brain injury without loss of consciousness subsequent encounter, anxiety disorders, delusional disorders, and macular degeneration. Review of R48's quarterly MDS with an ARD of [DATE] revealed a BIMS score of nine out of 15 which indicated resident was moderately cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R48's care plan, provided by the facility and dated [DATE], revealed at risk for medication side effects related to psychotropic medication use, diagnosis of macular degeneration, she requires adapting of activities and assistance secondary to visual impairments, has behaviors: inappropriate behaviors, paranoia, delusions, nightmares, swatting at nurse, grabbing at nurse, yelling at staff, and increased Sundowner's. Refuses meds at times, combative with staff during care and trying to care for others. Diagnosis: Dementia with Psychotic Features- gets into others faces r/t [related to] unable to see or hear; REVISED [DATE] combative with other residents. Review of the Facility Reported Incident, provided by the facility and dated [DATE], revealed R48 was being pushed by Certified Nursing Assistant (CNA) 4 and R48 accidentally hit R12 as she was passing her in the hallway. R12 responded by hitting resident R48 in response. The residents were separated immediately, and CNA4 reported the incident to her charge nurse. The facility documented due to the cognitive status of both residents' intentional harm was deemed unlikely. During an interview on [DATE] at 4:42 PM, CNA4 stated R48 could not really see and did not intentionally hit R12. CNA4 stated R48 did swing her arm out to touch R12. CNA4 stated R48 was a touchy person, but her hand unintentionally landed wrong on R12. CNA4 stated R12 wasn't having a good day and struck R48 back in response. CNA4 stated she immediately pushed R48 away from R12 and told the charge nurse. CNA4 stated she checked on R12 to see if her day had gotten better and R12 did not have any memory or effects to the incident. 2. a. Review of R83's undated Face Sheet provided by the facility revealed the resident was readmitted to the facility on [DATE] with diagnoses of dementia, abnormal posture, and muscle weakness. Review of R83's annual MDS with an ARD of [DATE] located in the electronic medical record (EMR) under the MDS tab revealed the resident had a BIMS score of three out of 15 indicating the resident was severely cognitively impaired. b. Review of R269's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE] with a diagnosis of dementia with other behavioral disturbances. R269 passed away while on hospice on [DATE]. Review of R269's quarterly MDS with an ARD of [DATE] revealed the resident's BIMS score was a nine out of 15 indicating she was moderately cognitively impaired. Review of a copy of the online form titled, Incident Reporting System, provided by the facility, revealed an incident occurred on [DATE] where R269 slapped R83 in the face in the sitting room by the nurses' station. R269 said she slapped her because it was her granddaughter, and she shouldn't move. R83 was noted with redness to the skin. Both residents were immediately separated. R269 was placed on one-on one until an order was obtained and she was sent to the hospital for evaluation where she was diagnosed with a urinary tract infection (UTI). Witness statements were obtained from staff and residents. R269 was readmitted to the facility and moved to another unit in an attempt to further separate the two residents. Since her re-admission there have been no further incidents. Given the incident was witnessed, abuse was substantiated. During an interview on [DATE] at 10:30 AM, R83 revealed she recalled she was slapped, and did not know why R269 slapped her. She confirmed she had not been abused previously or since the incident by any resident or staff member. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:25 PM, the Administrator confirmed the investigation showed the abuse happened to R83. He further confirmed there were no other incidents involving R269 or R83. 3. a. Review of R15's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE] with a diagnosis of vascular dementia. Review of R15's quarterly MDS with an ARD of [DATE] (at the time of the incident) revealed a BIMS score of 11 out of 15 which indicated she was moderately cognitively impaired. Her quarterly MDS with an ARD of [DATE] revealed a BIMS score of 10 out of 15 which indicated she was moderately cognitively impaired. b. Review of R267's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE] with a diagnosis of altered mental status. R267 passed away at the facility on [DATE]. Review of the facility's investigation, provided by the facility, revealed the incident between R15 and R267 occurred on [DATE]. R15 and R267 were roommates. Two nurses observed R15 slapping R267 and R267 retaliated by slapping her back. R267 sustained a skin tear. There was no serious bodily injury. R267's skin tear was assessed and treated. The residents were separated as they both continued to swing and yell at each other. R15 was discharged to a Senior Behavioral Health Hospital. Both residents were interviewed. R15 could not recall what was said that provoked the incident. However, R15 did say, she swung first so I hit her before she could hit me. R267 said she did not know why R15 came up to her and slapped her and did not know why she deserved it. Review of the conclusion of the investigation revealed R15 was separated from R267 and was sent to the Senior Behavioral Health Unit. It was determined she did have a UTI and was kept there for a three-day evaluation. R15 was readmitted to the facility on [DATE] and placed on the Rehab unit. Both women continued to be closely monitored, followed by the psych team, and remained in space away from each other. Interactions with other residents will be observed. The allegation was substantiated. During an interview on [DATE] at 10:30 AM, R15 revealed the resident did not recall the incident from five years ago. She revealed she had not been abused by any resident or staff member. During an interview on [DATE] at 2:30 PM, the Administrator revealed he was not employed at the facility five years ago when the incident occurred between R15 and R267. He confirmed the abuse did happen per the investigation. 4. Review of R117's Face Sheet located in the EMR under the Face Sheet tab, revealed R117 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia, osteoporosis, difficulty in walking, not elsewhere classified, other lack of coordination, other abnormalities of gait and mobility, and anxiety disorder. Review of R117's Care Plan, dated [DATE] and located under the Care Plan tab of the EMR, indicated R117 had a history of episodes of psychosis, hallucinations, increased agitation, and going in and out of other resident's rooms. Interventions included encouraging resident's family to visit, involve resident in conversations, and psych consult as needed. Review of R117's record indicated she expired on [DATE] under the care of hospice services. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation, provided by the facility and dated [DATE], revealed R117 was on the secure unit when another resident approached her, slapped her on the hand, cursed her, and told her to move. The residents were separated. R117 was assessed, and no injuries were noted. The facility staff attempted to interview R117, and the other resident involved. Neither resident was able to recall the incident and could not answer questions due to cognitive impairment. The facility substantiated abuse occurred. During an interview on [DATE] at 11:08 AM, CNA2 stated she did not remember R117 or any incident that occurred but knew to report any suspected abuse immediately. She stated she would tell the charge nurse or higher ups if nothing was done. During an interview on [DATE] at 11:16 AM, Licensed Practical Nurse (LPN) 7 stated she did not recall any incident related to R117 but would report any sort of abuse or suspected abuse immediately. She said CNAs reported any issues related to abuse or anything out of the ordinary to charge nurses. 5. Review of R76's undated Face Sheet in the EMR under the Face Sheet tab, revealed R76 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, mood disturbance, and depressed mood. Review of R76's quarterly MDS with an ARD of [DATE] located in the EMR under the MDS tab, revealed R76's BIMS score was three out of 15 which indicated the resident was severely cognitively impaired. R76 was documented as exhibiting behaviors, and required extensive assistance from one person for transfers, dressing and toilet use and limited assistance for personal hygiene. Review of R 76's Care Plan, last revised [DATE], located in the EMR under the Care Plan tab, indicated Resident experiences resisting care, combative with staff, and yelling at times. Interventions included observing resident for behavior triggers which might lead to combativeness, assess and approaches that worked with resident including tone of voice and mannerisms. Review of a facility reported incident, dated [DATE], indicated a nurse told R42 to shut up and go to his room. The facility investigated, took witness statements, and determined that R42 was nowhere around according to the witness statements. The nurse was speaking to R76 and told him to shut up and go to his room. The nurse was terminated. She denied saying anything to R42 or R76. The facility substantiated that verbal abuse occurred. During an interview on [DATE] at 11:08 AM, CNA4 stated she has been working at the facility seven years on the secure unit. She stated she recalled the incident related to R76. CNA4 stated she heard the nurse tell R76 to shut up and go to his room. She said it was reported R42 was the resident who was told to shut up and go to his room, but it was actually R76. She said neither resident remembered the incident and the nurse was terminated. 6. a. Review of R80's Face Sheet located in the EMR under the Face Sheet tab, revealed R80 was admitted on [DATE] with diagnoses that included unspecified dementia with behavioral disturbances. Review of the quarterly MDS dated [DATE], noted R80 had a BIMS score of one out of 15 which indicated R80 was severely cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of R101's Face Sheet located in the EMR under the Face Sheet tab, revealed R101 was initially admitted [DATE] and readmitted [DATE] with diagnoses that included vascular dementia with behavior disturbances, restlessness, and agitation. Review of the significant change MDS, dated [DATE], noted R101 had a BIMS score of zero out of 15 which indicated R101 was severely cognitively impaired. Review of a facility investigation, dated [DATE], revealed R80 was physically struck by R101 on [DATE] at 7:30 PM. The incident occurred, on the secured dementia care unit, after R101 wandered into R80's room and R80 yelled at R101 to get out. R101 was reported to have struck R80 on her left shoulder. During an observation on [DATE] at 2:48 PM, R80 was seated in a wheelchair moving herself about the secured dementia care unit using her feet. During an observation on [DATE] at 2:43 PM R101 was in bed, with the bedcovers up to her chin. R101 said she was very tired. During an interview on [DATE] at 2:51 PM, with the CNA4 revealed R80 generally wandered about the unit in her wheelchair and R101 was often in bed due to a fracture following a fall on [DATE]. During an interview on [DATE] at 12:21 PM, the Director of Nursing (DON) revealed R101 had not had other incidents of physical abuse of a resident. R101 was identified to have various incidents of increased agitation and physical aggression of unit property including windows. During those instances, the DON said R101 was transferred out to a Geri-psych unit for an evaluation. R101 received Geri-psych consults weekly to bi-monthly for medication management. During an interview on [DATE] at 1:27 PM, the Administrator stated that the incident was substantiated because it was witnessed by staff and was reported as a Facility Reported Incident.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27104 Based on record review, interview, and facility policy review, the facility failed to notify the Ombudsman of hospital transfers in writing for three of three residents (Resident (R) 16, R38, and R93) out of a total sample of 35 residents reviewed for hospitalization . This had the potential for the residents to have no added protection if the residents were being inappropriately discharged or transferred so they could inform them of their rights and options. Findings include: Review of the facility's policy titled, Transfer and Discharge of a Resident (including AMA [against medical advice], revised 02/04, revealed no information regarding the facility's responsibility of notifying the Ombudsman of transfers and discharges. 1. Review of R16's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of a Departmental Note, provided by the facility and dated 07/24/24, revealed at 8:50 PM, R16's oxygen saturation (O2) was 60 percent (%). He was noted to be disoriented and projectile vomiting. The on-call physician was notified and gave an order to send the resident to the hospital for evaluation and treatment. There was no evidence in the medical record that the Ombudsman was notified of the transfer. The resident remained at the hospital. 2. Review of R38's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of a Departmental Note, provided by the facility and dated 05/30/24, revealed the resident was not able to be aroused and was unresponsive to commands. The physician was notified, and an order was received to send the resident to the hospital for evaluation and treatment. The resident was admitted to the hospital for respiratory failure. The resident was readmitted to the facility on [DATE]. Review of a Departmental Note, provided by the facility and dated 07/10/24, revealed the resident was noted to be lethargic, disoriented, and unable to complete full sentences. The resident was transported to the hospital. There was no evidence in the medical record that the Ombudsman was notified of either transfer. The resident was readmitted to the facility on [DATE]. 3. Review of R93's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a Department Note, provided by the facility and dated 04/02/24, revealed upon entering the resident's room labored breathing was noted. An order was received to send the resident to the hospital for evaluation and treatment. The resident left the facility at 4:59 PM. The resident returned to the facility on [DATE] at 3:20 PM. At 4:23 PM the resident was having difficulty breathing and a new order was received to send the resident back to the hospital for evaluation and treatment. There was no evidence in the medical record that the Ombudsman was notified of the transfer. The resident was readmitted to the facility on [DATE]. During an interview on 08/08/24 at 1:10 PM, the Administrator confirmed no notices have been sent to the Ombudsman for transfers or discharges. He revealed they had not been doing that since COVID.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20064 Based on observations, record review, interview, and job description review, the facility failed to ensure two of four residents (Residents (R) 5 and R 37) reviewed for activities of daily living received adequate assistance with shaving. This failure had the potential to negatively impact the quality of life and self esteem for the affected residents. Findings include: 1. Review of R5's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, indicated he was admitted to the facility on [DATE] with diagnoses including paraplegia, anxiety, urinary tract infection, abnormal posture, and history of stroke. Review of R5's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/31/24 and located in the EMR under the MDS tab, indicated he had a Brief Interview for Mental Status (BIMS) of 14 out of 15 which indicated the resident had intact cognition. R5 required extensive assistance by one staff member with personal hygiene. Review of R5's Care Plan, located in the EMR under the Care Plan tab, most recently revised on 05/31/24, revealed the resident had a self-care deficit related to his diagnoses of weakness and paraplegia, a required assistance with activities of daily living (ADL) including personal hygiene. During an interview on 08/05/24, at 10:58 AM, R5 was in his room in bed, he was alert and able to answer questions. He stated he was doing okay in the facility but needed a shave and was usure when he was last shaved. His face had approximately one-half inch long whiskers at that time. During an observation on 08/06/24 at 2:14 PM, R5 was in his room. He had whiskers on his face. During an observation on 08/07/24 at 10:07 AM, R5 was in his room in his wheelchair, his face was unshaven. During an interview on 08/07/24 at 11:08 AM, Certified Nursing Assistant (CNA) 2 stated she did not shave residents unless as needed. During an interview on 08/07/24 at 11:11 AM, CNA1 (assigned to R5) stated she did not shave residents and was not sure who was responsible for shaving residents. During an interview on 08/07/24 at 11:12 AM, Licensed Practical Nurse (LPN) 2 stated CNAs should have been shaving residents every other day and more often as needed. During an interview on 08/07/24 at 11:12 AM, LPN7 said CNAs should have been shaving residents every other day and more often as needed. During an interview on 08/07/24 at 2:20 PM, the Director of Nursing (DON) stated CNAs should have been shaving the residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R37's undated Face Sheet located in the EMR under the Face Sheet tab, indicated he was admitted on [DATE] with diagnoses of left above the knee amputation (AKA), history of stroke, osteoporosis, and reduced mobility. Review of R37's quarterly MDS with an ARD of 05/24/24 and located in the EMR under the MDS tab, revealed a BIMS score of nine out of 15 which indicated the resident had moderately impaired cognition. R5 required substantial/ maximum assistance with personal hygiene. Review of R37's Care Plan, located in the EMR under the Care Plan tab, most recently revised on 05/24/24, revealed the resident had a self-care deficit related to his diagnoses of weakness, required assistance with activities of daily living including personal hygiene. During an observation and interview on 08/05/24 at 3:05 PM, R37 stated he needed a shave; he stated it took a week after you asked to be shaved. During an observation on 08/06/24 at 2:15 PM, the resident was in room in bed, unshaven. During an observation 08/07/24 at 10:15 AM, the resident was in room in bed awake watching TV, unshaven. During an interview on 08/07/24 at 11:58 AM, the DON stated CNAs should have shaved the residents on shower days and upon request. During an interview on 08/08/24 at 3:52 PM, the Administrator stated he did not have a policy on ADLs. He provided a policy titled Nursing Assistant Job Description, dated May 2003 which revealed Essential Job Functions: Personal Care Functions- Duties: Assist with daily bath, dressing, grooming, dental care, bowel and bladder functions.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20064 Based on observations, interviews, and record review the facility failed to ensure staff were providing appropriate and timely urinary catheter care for one of four residents (Resident (R) 5) reviewed for catheters and urinary tract infections of 35 sample residents. This failure placed the residents at risk for infection to the urinary tract and urethral trauma. Findings include: Review of R5's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, indicated he was admitted to the facility on [DATE] with diagnoses including paraplegia, anxiety, urinary tract infection, abnormal posture, and history of stroke. Review of R5's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/31/24 and located in the EMR under the MDS tab, revealed he had a Brief Interview for Mental Status (BIMS) of 14 out of 15 which indicated the resident had intact cognition. R5 required extensive assistance by one staff member with personal hygiene. Review of R5's physicians orders, located in the EMR under the Orders tab, indicated: provide catheter care every shift and as needed. Review of R5's Care Plan, located in the EMR under the Care Plan tab, most recently revised on 05/31/24, revealed the resident had alteration in elimination related to incontinence of bowel and bladder functions. He had a Foley catheter inserted for urinary retention. The care plan included R5 had a history of chronic urinary tract infections (UTIs) and received a maintenance dose of antibiotics. The goal was R5 would not be hospitalized due to a UTI through the next review. He was at risk for infection related to the Foley catheter. Approaches were to position catheter and tubing to facilitate proper drainage, provide catheter care every shift and as needed. During an observation and interview on 08/5/24 at 10:58 AM, R5 was in his room in bed, he was alert and able to answer questions. He had a Foley catheter in place. He stated he was unsure of why he had the catheter. During an interview on 08/07/24 at 11:08 AM, Certified Nursing Assistant (CNA) 2 stated she did not do catheter care. She stated she only emptied the drainage bag. During an interview on 08/07/24 at 11:11 AM, CNA1 stated she did not provide catheter care. She stated the nurses did catheter care and she only emptied the drainage bag and documented the amount of urine. During an interview on 08/07/24 at 11:12 AM, Licensed Practical Nurse (LPN) 2 stated CNAs should have been doing catheter care every shift. During an interview on 08/07/24 at 11:16 AM, with LPN7 stated CNAs should have been providing catheter care every shift and more often if the resident had a bowel movement and needed cleaning up. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of catheter care on 08/07/24 at 3:05 PM provided by CNA1 and CNA2 revealed supplies were gathered. Staff Development (SD) was in the room during the catheter care. CNA2 cleaned tubing near penis, turned resident on right side leaving drainage bag attached to bed on the left side of the bed causing tension and pulling. SD told the CNAs to make sure they moved the drainage bag with the resident, they then moved it up in the bed close to the resident's head (above the bladder). SD told the CNAs to move the drainage bag. They moved it to the right side of the bed, they continued the catheter care, and turned the resident on his side causing tension to the tubing. During an interview on 08/07/24 at 4:45 PM when asked about the catheter care provided for R5 the SD stated CNAs needed to be aware of the catheter placement when providing care. SD stated the CNAs needed more training. Review of the Personal Hygiene Roster, provided by the facility, indicated R5 was provided catheter care on 08/01/24, 08/03/24, and 08/06/24. There was no evidence catheter care was provided every shift as ordered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 11599 Based on observation, interview, and facility policy review, the facility failed to ensure ceiling vents did not drip condensation onto the tray line and scoops were stored appropriately. This deficient practice had the potential to affect 100 of 113 residents who received meals prepared in the facility's kitchen. Findings include: Review of the facility's policy titled, Supplies and Equipment, dated 11/08, revealed Equipment will be ready for use at all times day or night to serve the resident's needs. Review of the facility's policy titled, STORAGE OF CANNED AND DRY FOOD, revised 11/23, revealed Dry lbod [food] products such as flour, commeal [cornmeal], sugar, etc [etcetera], that are stored in bins are removed from their original packaging. These bins are cleaned and sanitized according to facility cleaning schedule. Scoops are stored in covered containers and not in thc [the] storage bin unless hanging on a hook and out offood [of food] product. 1. The tray line was observed on 08/07/24 from 11:14 AM through 12:53 PM. Two ceiling vents above the steam table were observed to drip condensation onto the shelf where meals were being prepared for delivery to residents. No condensation was observed to drip into food. The Dietary Manager (DM) and three Dietary Aides (DA1, DA2, and DA5) confirmed the dripping. During an interview on 08/08/24 at 10:45 AM, the Registered Dietitian (RD) stated that she inspected the kitchen once a month without being aware of the condensation from the ceiling vents. On 08/08/24 at 10:55 AM, the two ceiling vents were confirmed by the DM, RD, and Maintenance Director (MD), to drip onto the steam table. 2. During a tour of the kitchen on 08/05/24 at 9:25 AM, with the DM, a scoop was observed inside the flour container; a scoop was observed inside the cornmeal container; and an uncovered scoop was observed on top of the sugar container which had food particles on top. The observations were confirmed by the DM who stated, they know better, I'll have to remind them to put the scoops in the bags as expected.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27104 Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to ensure four of six residents (Resident (R) 15, R83, R93, and R94) reviewed for pneumococcal vaccines out of total sample of 35 residents were either offered pneumococcal vaccines or offered additional pneumococcal vaccines per CDC guidelines. Additionally, the facility failed to obtain consents and provide the risks and benefits to the residents and/or responsible party (RP) prior to administering pneumococcal vaccines. Additionally, the facility failed to ensure R93 was offered an influenza vaccine. The failure of not offering/providing pneumococcal vaccines increased the risk for residents to contract pneumonia. The failure for not offering influenza vaccine increased the risk for the resident to contract influenza. Findings include: Review of the facility's policy titled, Influenza, Pneumococcal, COVID-19 and Respiratory Syncytial Virus (RSV) Vaccines with a most recent revised date of 10/23, revealed PURPOSE: The facility offers all residents the Influenza, Pneumonia .vaccines unless medically contraindicated or the resident has already received the vaccines. STANDARD: Influenza Vaccine: All resident will be offered an influenza vaccine October 1 through March 31 annually, unless the vaccine is medially contraindicated or the resident has already been vaccinated during this time. Pneumonia Vaccine: All residents will be offered a pneumonia vaccine unless the vaccine is medically contraindicated, or the resident has already been vaccinated. There are multiple Pneumonia vaccines approved for use in the US [United States]. Prevnar 13 (PCV 13), Prevnar 15 (PCV15), Prevnar 20 (PCV20), and Pneumovax 23 (PPSV23). The vaccine will be administered based on the age of the resident and previous pneumonia vaccines administered. As an alternative, based on assessment and practitioner recommendation, a second pneumonia vaccine may be given after 5 years following the first vaccine, unless medically contraindicated or the resident or legal representative refused the second immunization .PROCESS: a) Upon admission and annually in September of each year the facility will send a letter to each resident, sponsor, or legal representative inform them that vaccinations are about to be administered to the residents. The letter will include a consent form and educational information, including benefits and potential side effects of the vaccinations . d) The resident or legal representative will have the opportunity to refuse vaccines and document the refusal on the Resident Acceptance/ Declination Form. e) The consent form for the vaccines will be made available for the resident or resident's legal representative. Benefits and potential side effects of the vaccines will be explained on the consent form. The consent form will be stored in the resident's medical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CDC website titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, effective 01/28/22 and located at https://cdc.gov/vaccines/chp/acip-recs/vacc-specific/pneumo.html, indicated .CDC recommends pneumococcal vaccination for all adults [AGE] years or older .For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you .Give 1 dose of PCV [Pneumococcal Conjugate Vaccine] 15 or PCV20 .If PCV15 is used, this should be followed by a dose of PPSV 23 at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak .If PCV20 is used, a dose of PPSV23 is NOT indicated .For adults [AGE] years or older who have only received a PPSV23, CDC recommends you .May give 1 dose of PCV15 or PCV20 .The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults [AGE] years or older who have only received PCV13, CDC recommends you .Give PPSV23 as previously recommended . For adults who have received PCV13 but have not completed their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are complete . 1. Review of R15's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE] and was [AGE] years old at the time of admission. Diagnoses included chronic respiratory failure and chronic obstructive pulmonary disease (COPD). Review of R15's Physician Orders List, provided by the facility and dated 04/21/21, revealed the resident was ordered Prevnar 13 pneumococcal vaccine and it was administered on 04/21/21. There was no evidence in the medical record that a consent was obtained by the resident's RP prior to administering the Prevnar 13 pneumococcal vaccine or that risks and benefits were explained to the RP. Additionally, per CDC guidelines, there was no evidence R15 received one dose of PCV20 or PPSV23 at least one year after PCV13. 2. Review of R83's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE] and was [AGE] years old at the time of admission. The Face Sheet also indicated R83 was given a pneumococcal vaccine, however, there was no date, or any indication of which vaccine was given. Additionally, there was no evidence the RP signed a consent for the vaccine or that the risks and benefits were explained to the RP. 3. Review of R93's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE] and was [AGE] years old at the time of admission. There was no evidence in the resident's medical record that she was offered the influenza or pneumococcal vaccine. 4. Review of R94's undated Face Sheet provided by the facility revealed the resident was admitted to the facility on [DATE] and was [AGE] years old at the time of admission. There was no evidence in the resident's medical record that he was offered a pneumococcal vaccine. During an interview on 08/08/24 at 1:00 PM, the Assistant Director of Nursing (ADON)/ Infection Preventionist (IP) confirmed the above findings regarding pneumococcal vaccines for R15, R83, R93, R94, as well as R93 not being offered an influenza vaccine. During an interview on 08/08/24 at 1:54 PM, the Director of Nursing (DON) revealed she was not sure why the four residents were not offered the pneumococcal vaccines or why R93 was not offered an influenza vaccine.