

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/13/2024
NAME OF PROVIDER OR SUPPLIER Centinela Skilled Nursing & Wellness Centre West		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Flower Street Inglewood, CA 90301	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure two out of six sampled residents (Resident 27 and 24) were dressed appropriately. This deficient practice of the Residents 24 and 27 not wearing their own clothes had the potential to make the residents feel left out from socialization (activities that contributes to the integrity of an individual's health and wellness). Findings: a. During a review of Resident 27's Admission Record (Face Sheet), the Face Sheet indicated Resident 27 was admitted to the facility on [DATE]. Resident 27's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), chronic kidney disease (a condition where the kidneys do not work as well as they should), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 27's History and Physical (H&P), dated 6/12/2024, the H&P indicated Resident 27 could make needs known but could not make medical decisions. During a review of Resident 27's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 6/29/2024 the MDS indicated, Resident 27 was usually able to understand others. The MDS indicated Resident 27 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated Resident 27 was dependent with staff for chair/bed to chair transfer. During observations on 10/12/2024 between the hours 8:30 a.m. through 6:00 p.m., Resident 27 was observed wearing a hospital gown. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/12/2024 at 6:21 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 27's room, Resident 27 was observed lying in the bed wearing a hospital gown. CNA 1 stated Resident 27 was wearing a hospital gown. CNA 1 stated Resident 27 was not dressed daily. CNA 1 stated Resident 27 was only dressed when the staff took the resident to the dining room or when Resident 27 had a visitor. CNA 1 stated Resident 27 should be dressed in clothes during the day. CNA 1 stated dressing Resident 27 daily would help with socialization (by engaging in group activities, such as games, music, or arts and crafts) and a sense of belonging (a feeling of security and support when there is inclusion) with the other residents. CNA 1 stated if Resident 27 was not dressed daily the resident could have the potential to feel depressed and not feel good. During an interview on 10/12/2024 at 6:26 p.m. with the Director of Nursing (DON), the DON stated the staff dress the residents if the residents were going out of their room. The DON stated if the residents were total care and were in the bed staff kept the residents in their gowns. The DON stated there was no policy for keeping residents in hospital gowns during the day. The DON stated it was important to dress Resident 27 in clothing to look presentable. b. During a review of Resident 24's Admission Record (Face Sheet), the Face Sheet indicated Resident 24 was initially admitted to the facility on [DATE]. Resident 24's diagnoses included heart failure (a condition in which the heart does not pump blood as well as it should), dysphasia (difficulty swallowing), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 24's H&P, dated 8/26/2024, the H&P indicated Resident 24 had fluctuating capacity to understand and make decisions. During a review of Resident 24's MDS, dated [DATE] the MDS indicated, Resident 24's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 24 required substantial assistance with staff for personal hygiene, showering, and dressing. The MDS indicated Resident 24 required substantial assistance with staff for chair/bed to chair transfer. During an observation on 10/12/2024 between the hours 8:35 a.m. through 6:05 p.m., Resident 24 was observed wearing a hospital gown. During a concurrent observation and interview on 10/12/2024 at 6:31 p.m. with CNA 1, in Resident 24's room, Resident 24 was observed lying in the bed wearing a hospital gown. CNA 1 stated Resident 24 was wearing a hospital gown, and his clothes were in the closet. CNA 1 stated it was important to dress Resident 24 in clothing so he would feel togetherness with the other residents. CNA 1 stated if Resident 24 was not dressed daily he could feel demoralized and become depressed. During an interview on 10/12/2024 at 6:58 p.m. with the DON, the DON stated it was important to dress Resident 24 in clothing. The DON stated not having the resident dressed was a dignity issue and could make the resident feel sad about not being changed daily. During a review of the facility's policy and procedure (P&P) titled, Certified Nursing assistant Job Description, date unknown, the P&P indicated a nursing assistant responsible for providing routine nursing care to assure that the highest degree of quality resident care can be maintained at all times. The P&P indicated dress residents neatly in their own clothing. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Resident Rights, dated 1/2012, the P&P indicated Resident's receive care and does not hamper, compel by force, treat differently, or retaliate against a resident for exercising his or her rights. The P&P indicated personal care needs, such as bathing methods, grooming styles, and dress, During a review of the facility's P&P titled, Resident Rights-Quality of Life, dated 3/2017, the P&P indicated to ensure the resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The P&P indicated Residents are encouraged and assisted to dress in their own clothes rather in hospital gowns.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure one out six sampled residents (Resident 24) was offered his dentures before eating. This deficient practice of not offering Resident 24 his dentures while eating had the potential to not be able to chew food effectively. Findings: During a review of Resident 24's Admission Record (Face Sheet), the Face Sheet indicated Resident 24 was initially admitted to the facility on [DATE]. Resident 24's diagnoses included heart failure (a condition in which the heart does not pump blood as well as it should), dysphasia (difficulty swallowing), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 24's History and Physical (H&P), dated 8/26/2024, the H&P indicated Resident 24 had fluctuating capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 7/1/2024 the MDS indicated, Resident 24's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 24 required substantial assistance with staff for personal hygiene, showering, and dressing. The MDS indicated Resident 24 required substantial assistance with staff for chair/bed to chair transfer. During an observation on 10/12/2024 at 8:15 a.m., 12:40 p.m., and at 6:15 p.m., in Resident 24's room, Resident 24's certified nursing assistant (CNA) did not provide Resident 24 with dentures while feeding the resident his meals. During an observation on 10/13/2024 at 12:45 p.m., in the dining room, Resident 24 was observed eating his meal without dentures. Resident 24 was not offered dentures while eating his meal. During a concurrent observation and interview on 10/12/2024 at 6:40 p.m., with CNA 1, in Resident 24's room, Resident 24 was observed lying in bed with no dentures in his mouth. CNA 1 located the dentures in Resident 24's bedside table. CNA 1 stated Resident 24 did not eat at times. CNA 1 stated it was important to offer the dentures to help the resident with chewing and eating his food. CNA 1 stated providing the dentures would help give Resident 24 a normal feeling while eating. During an interview on 10/13/2024 at 2:54 p.m. with the Director of Nursing (DON), the DON stated Resident 24 required feeding assistance and the staff should offer the resident dentures. The DON stated it was important for Resident 24 to wear dentures while eating so he could eat more food. The DON stated not providing the dentures could have an affect how he looked and felt during the day. (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Rights-Accommodation of Needs, dated 1/2012, the P&P indicated to ensure that the facility provides an environment and services that meet residents' individual needs. The P&P indicated facility staff arranges personal items within easy reach of the resident. The P&P indicated facility staff helps to keep aids, glasses and other adaptive devices clean and in working order for the resident. During a review During a review of the facility's P&P titled, Resident Rights-Quality of Life, dated 3/2017, the P&P indicated to ensure each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-center manner, as well as those that support resident in attaining or maintaining his/her highest practicable well-being. The P&P indicated facility staff treats cognitively impaired resident with dignity and sensitivity.		

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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** 46144 Based on observation, interview, and record review, the facility failed to ensure one out of six sampled residents (Resident 27) had the appropriate call light device to call for assistance. This deficient practice of not having the appropriate call light device had the potential for Resident 27 to not get assistance in a timely manner. Findings: During a review of Resident 27's Admission Record (Face Sheet), the Face Sheet indicated Resident 27 was admitted to the facility on [DATE]. Resident 27's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), chronic kidney disease (a condition where the kidneys do not work as well as they should), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 27's History and Physical (H&P), dated 6/12/2024, the H&P indicated Resident 27 could make needs known but could not make medical decisions. During a review of Resident 27's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 6/29/2024 the MDS indicated, Resident 27 was usually understood others. The MDS indicated Resident 27 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated Resident 27 was dependent on staff for chair/bed to chair transfer. During an observation on 10/12/2024 at 9:49 a.m., in Resident 27's room, Resident 27 was observed lying in the bed awake. Resident 27 attempted to reach for the call light and was not able to grasp the call light and press the button for assistance. During an interview on 10/13/2024 at 1:56 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 27 was slow to talk and slow to touch the call light device. LVN 1 stated Resident 27 would benefit from having the touch pad call light. LVN 1 stated it would be easier for Resident 27 to call for assistance. LVN 1 stated it was important to have the touch paid call light just in case the resident was falling or choking. LVN 1 stated the call light was needed to save a life or to offer assistance when she needed help. During an interview on 10/13/2024 at 3:00 p.m. with the Director of Nursing (DON), the DON stated Resident 27 did not have the correct call light device because she could not press the call light button. The DON stated Resident 27 should have had the touch pad call light device. The DON stated it was important for Resident 27 to have the appropriate the touch pad call light to make it easier to call for assistance. The DON stated by not having the appropriate call light for Resident 27 staff would not be able to assist her with her accommodations (the facility's efforts to individualize the resident's physical environment). (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Rights- Accommodation of Needs, date unknown, the P&P indicated, the facility's environment is designed to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being. The P&P indicated Residents' individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to inform and provide the Notice of Medicare Non-Coverage (NOMNC) form 48 hours prior to the end of skilled nursing services for one of three sampled residents (Resident 205). This deficient practice had the potential to result in the resident not being able to exercise his right to file an appeal and unknowingly paying for non-covered care expenses. Findings: During a review of Resident 205's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 205 was admitted to the facility on [DATE]. Resident 205's diagnoses included chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing), alcoholic liver disease (damage to the liver and its function due to alcohol abuse), and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 205's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 4/30/2024, the MDS indicated, Resident 205's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS also indicated, Resident 205 required supervision (helper provides verbal cues) in oral hygiene, toileting hygiene, and upper and lower body dressing. During a concurrent interview and record review on 10/12/2024 at 3:10 p.m. with the Social Service Director (SSD), Resident 205's NOMNC form was reviewed. The SSD stated she was responsible in completing, providing and maintaining signed copies of the NOMNC form. The SSD stated Resident 205's last covered day for Medicare Part A skilled services would end on 6/20/2024. The SSD stated Resident 205's NOMNC was given to the resident on 6/19/2024. The SSD stated the facility process was to give NOMNC to the resident 48 to 72 hours prior to the end of Medicare Part A skilled services so the resident would have enough time to make an appeal. The SSD stated Resident 205's right to appeal for financial coverage was not honored. During a review of the facility's policy and procedure (P&P), titled Medicare Denial Process, dated 3/2018, the P&P indicated, Medicare beneficiaries will be properly notified when it is determined that they do not meet the requirements for covered skilled services under the Medicare program. The P&P also indicated the Medicare status change form is completed by the Director of Nursing (DON) or designee upon admission and or minimum of 2 days prior to the last Medicare covered day.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review, the facility failed to ensure one out of six sampled residents (Resident 34) was provided a homelike environment and did not have chipped paint on the wall next to the resident's bed. This deficient practice of not providing a homelike environment for Resident 34 had the potential to negatively impact the resident quality of life. Findings: During a review of Resident 34's Admission Record (Face Sheet), the Face Sheet indicated Resident 34 was initially admitted to the facility on [DATE] and last readmitted [DATE]. Resident 34's diagnoses included aphasia (a disorder that makes it difficult to speak), chronic kidney disease (a condition where the kidneys do not work as well as they should), and atherosclerotic heart disease (a chronic inflammatory disease that causes plaque buildup in the walls of arteries, narrowing them and restricting blood flow). During a review of Resident 34's History and Physical (H&P), dated 8/29/2024, the H&P indicated Resident 34 did not have the capacity to understand and make decisions. During a review of Resident 34's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/16/2024 the MDS indicated, Resident 34 was able to usually understand others. The MDS indicated Resident 34 required substantial assistance with staff for personal hygiene, showering, and dressing. During an observation on 10/12/2024 at 9:55 a.m. in Resident 34's room, observed scattered chipped paint along the wall next to Resident 34's bed. During a concurrent observation and interview on 10/12/2024 at 4:55 p.m. with the Administrator (ADM), in Resident 34's room, there was scattered chipped paint observed along the wall next to Resident 34's bed. The ADM stated he was aware of the chipped paint on the wall in Resident 34's room. The ADM stated when Resident 34 was lying in the bed the resident may not like looking at chipped paint. The ADM stated the wall needed to be repaired and painted. The ADM stated it was important to have the room looking nice and presentable, so the resident could feel good. The ADM stated the wall needed to be repaired and painted. During an interview on 10/12/2024 at 5:12 p.m. with the Maintenance Director (MD), the Maintenance Log, dated 9/17/2024 was reviewed. The Maintenance Log indicated on 9/17/2024 Resident 34's room walls needed paint. The MD stated the staff reported and put it the maintenance book. The MD stated it would take him one day to paint the room. The MD stated it would make the Resident feel a bit sad if the room did not look nice. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Rights- Accommodation of Needs, date unknown, the P&P indicated to ensure that the facility provides an environment and services that meet resident's individual needs. The P&P indicated Resident's individual needs are accounted for in the facility's provision of a clean comfortable environment and is consistent with individual resident needs.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and record review, the facility failed to ensure one out of six sampled residents (Resident 2) had a care plan (a communication tool for patient care between nurses) for the refusal of dental services. This deficient practice of not having a care plan for refusal of dental services had the potential to place Resident 2 at risk for not receiving the appropriate interventions to prevent discomfort when eating. Findings: During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included chronic kidney disease (damage to kidneys and can't filter blood the way they should), dysphagia (difficulty swallowing), and aortic aneurysm (a bulge in the wall of an artery). During a review of Resident 2's History and Physical (H&P), dated 7/22/2024, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2s Minimum Data Set ([MDS] a federally mandated assessment tool), dated 7/8/2024 the MDS indicated, Resident 2's cognition (ability to learn, reason, remember, understand, and make decisions) was intact. The MDS indicated Resident 2 required supervision from staff for personal hygiene, showering, and dressing. The MDS indicated Resident 2 required supervision from staff for chair/bed to chair transfer. During a review of Resident 2's dental record titled, Elite Mobile Dental, dated 8/22/2024, the Elite Mobile Dental indicated, Resident 2 refused treatment. During an interview on 10/13/2024 at 11:34 a.m. with Resident 2, Resident 2 stated the staff did not review the risks and benefits of not having dentures. Resident 2 stated it would be easier to chew food with dentures. During a concurrent interview and record review on 10/13/2024 at 2:06 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's dental record titled, Elite Mobile Dental, dated 8/22/2024 was reviewed. The Elite Mobile Dental indicated on 8/22/2024 Resident 2 refused treatment. LVN 1 stated when Resident 2 refused to have dental treatment a care plan needed to be developed. LVN 1 stated it was important to have a care plan to set goals and interventions that would help the resident with dental care. LVN 1 stated having a care plan would help with prevention of mouth infection. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/13/2024 at 2:48 p.m. with the Director of Nursing (DON), Resident 2's dental record titled, Elite Mobile Dental, dated 8/22/2024 was reviewed. The Elite Mobile Dental indicated on 8/22/2024 Resident 2 refused treatment. The DON stated when the resident refused dental treatment the staff were to complete a care plan. The DON stated it was important to find out the reason for the refusal and educate Resident 2 the risks and benefits of the treatment. The DON stated the staff was to identify the problem and provide the care according to the resident preferences. During a review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated to ensure that a comprehensive person-centered care plan is developed for each resident. The P&P indicated additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident. The P&P indicated the comprehensive care plan will be periodically reviewed and revised following onset of new problems and to address changes in behavior and care.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/13/2024
NAME OF PROVIDER OR SUPPLIER Centinela Skilled Nursing & Wellness Centre West		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Flower Street Inglewood, CA 90301	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, by failing to measure the abdominal girth (the measurement of the distance around the abdomen at a specific point, usually at the level of the belly button) weekly per the physician's order for one of one sampled resident (Resident 45) who had a diagnosis of ascites (a condition where fluid builds up in the abdomen). This deficient practice would put Resident 45 at risk for abdominal pain and shortness of breath possibly leading to medical complications requiring hospitalization . Findings: During a review of Resident 45's Admission Record, the Admission Record indicated, Resident 45 was admitted to the facility on [DATE]. Resident 45's diagnoses included ascites, chronic kidney disease (kidneys are damaged and can't filter blood they way they should), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 45's History and Physical (H&P), dated 9/2/2024, the H&P indicated, Resident 45 had fluctuating capacity to understand and make decisions. During a review of Resident 45's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/6/2024, the MDS indicated, Resident 45's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 45 required supervision (helper provides verbal cues) in oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 45's Order Summary Report (a document containing active orders), dated 10/1/2024, the Order Summary Report indicated, Resident 45 had a physician order to measure abdominal girth weekly on Wednesday and to call medical doctor for any significant change in resident's abdominal girth. During a concurrent interview and record review on 10/12/2024 at 4:53 p.m. with the Director of Nursing (DON), Resident 45's Treatment Administration Record ([TAR] a report detailing the treatment administered to a patient by a healthcare professional at a facility) for September and October 2024 was reviewed. The DON stated Resident 45's abdominal girth on 9/4/2024, 9/11/2024, 9/18/2024, 9/25/2024, 10/2/2024, and 10/9/2024 were not measured. The DON stated it was the responsibility of the licensed nurse to measure the abdominal girth of Resident 45 and record in the TAR. The DON stated all physician orders must be followed as standard of practice. The DON stated it was essential to measure Resident 45's abdominal girth as a guide for the licensed nurses to know if Resident 45 was accumulating more fluids in the abdomen. The DON stated failure to measure and monitor the abdominal girth of resident with a diagnosis of ascites would cause negative effect such as abdominal discomfort, weakness and shortness of breath. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Quality of Care Compliance Requirements, dated 6/2016, the P&P indicated, The facility is committed to providing care and services necessary to attain or maintain a resident's highest practicable physical, mental and psychosocial wellbeing.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress ([LALM] a mattress designed to prevent and treat pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) was set and maintained at the correct setting for one of three sampled residents (Resident 6). This deficient practice placed Resident 6 at risk for worsening of pressure ulcer/injury ([PU] localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and further skin breakdown. Findings: During a review of Resident 6's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 6 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 6's diagnoses included PU Stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible) on the sacral (large triangular bone at the base of the spine) area, heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dementia (a progressive state of decline in mental abilities). During a review of Resident 6's History and Physical (H&P), dated 9/10/2024, the H&P indicated, Resident 6 had fluctuating capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/1/2024, the MDS indicated, Resident 6's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS also indicated, Resident 6 was totally dependent (helper does all of the effort) on staff in oral hygiene, toileting hygiene, and personal hygiene. The MDS also indicated, Resident 6 was at risk of developing PU. During a review of Resident 6's Weight Summary Report, dated 10/3/2024, the Weight Summary Report indicated, Resident 6's weight was 100. 2 pounds ([lbs.] unit of mass and weight). During a review of Resident 6's Order Summary Report (a document containing active orders), dated 10/1/2024, the Order Summary Report indicated, Resident 6's physician prescribed a LALM for skin management. During a review of Resident 6's care plan titled, Impaired skin integrity related to sacral Stage 3 PU with severe moisture associated skin damage ([MASD] caused from prolonged exposure to moisture) dated 9/10/2024, the care plan indicated staff interventions included to provide pressure redistributing devices and assess for effectiveness. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/12/2024 at 9:53 a.m. with the Director of Nursing (DON), in Resident 6's room, Resident 6 was observed lying in bed. The DON stated Resident 6 was lying on a LALM with a setting of 350 pounds (lbs.- unit of measurement in weight). The DON stated Resident 6 did not weigh 350 lbs. The DON stated the setting of the LALM should be based on Resident 6's current weight. The DON stated the purpose of the LALM was for wound management. The DON stated an incorrect setting of the LALM would result in delayed wound healing and possibly worsening of Resident 6's PU. During an interview on 10/12/2024 at 10:10 a.m. with Treatment Nurse 1 (TN 1), TN 1 stated it was the responsibility of the licensed nurses to check the correct setting of the LALM. TN 1 stated if the LALM was not properly set based on the resident's weight then it would defeat its purpose and it would cause extra pressure on the bony prominence and the resident would be uncomfortable. During a review of the facility's undated policy and procedure (P&P) titled, Mattress Resource, the P&P indicated, A low air loss mattress is designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown by letting out air very slowly through micro holes which helps keep the skin dry and [NAME] moisture away. The P&P also indicated to follow manufacturer guidelines to ensure appropriate settings.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure a resident who received hemodialysis ([HD]) a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) treatment received care in accordance with standards of practice for one of two sampled residents (Resident 204) by failing to monitor and record the resident's daily fluid restriction (medical treatment that limits the amount of fluids a person can consume each day). This deficient practice placed Resident 204 at risk for swelling, discomfort, and shortness of breath. Findings: During a review of Resident 204's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 204 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 204's diagnoses included end stage renal disease ([ESRD] irreversible kidney failure) and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 204's History and Physical (H&P), dated 8/23/2024, the H&P indicated, Resident 204 had a fluctuating capacity to understand and make decisions. During a review of Resident 204's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/29/2024, the MDS indicated, Resident 204's cognitive (ability to think and reason) skills for daily decision making was moderately impaired. The MDS indicated, Resident 204 required maximum assistance (helper does more than half the effort) from staff with toileting hygiene and lower body dressing. During a review of Resident 204's Order Summary Report (a document containing active orders), dated 10/1/2024, the Order Summary Report indicated, Resident 204 had a physician's order of 1200 milliliter ([ml] unit of measurement in volume) of fluid restriction in 24 hours. During a concurrent interview and record review on 10/13/2024 at 12:19 p.m. with Registered Nurse 1 (RN 1), Resident 204's Medication Administration Record ([MAR] a report detailing the medications administered to a patient by a healthcare professional at a facility) for September and October 2024 was reviewed. RN 1 stated Resident 204's 1200 ml fluid restriction from 9/1/2024 to 10/12/2024 was not monitored and recorded in the MARs. RN 1 stated it was the responsibility of the licensed nurses to monitor and record Resident 204's fluid restriction in the MAR. RN 1 stated it was very important to follow Resident 204's physician's order for 1200 ml fluid restriction accurately since the resident was receiving HD treatment and too much fluid would cause fluid overload such as swelling shortness of breath, and chest pain. During a review of the facility's policy and procedure (P&P) titled, Intake and Output Recording, dated 4/15/2021, the P&P indicated, Residents with an order for fluid restriction will have an intake recorded for the duration of the order unless otherwise specified by the physician. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Fluid Restrictions, dated 4/21/2022, the P&P indicated, Residents on fluid restriction will be monitored for intake and will receive appropriate interventions to alleviate discomfort from the fluid restriction for the duration of the attending physician order. The P&P also indicated the licensed nurse will initiate strict intake measurement per the attending physician's order and will record any fluids given on the intake and output record.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to: 1. Ensure a resident with a diagnosis of dementia was free from the use of antipsychotic medication (class of drug to treat mental illness) for one out of five sampled residents (Resident 49). This deficient practice had the potential to result in use of unnecessary psychotropic drugs (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) for Resident 49. Findings: During a review of Resident 49's admission record (face sheet), the admission record indicated Resident 49 was admitted to the facility on [DATE]. Resident 49's diagnoses included dementia (a decline in mental functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life), urinary tract infection (a bacterial infection that occurs when bacteria enter the urinary tract and multiply), cerebral ischemia (a condition that occurs when there isn't enough blood flow to the brain) and muscle weakness (a loss of muscle strength or the inability to contract muscles properly). During a review of Resident 49's Minimum Data Set Assessment (MDS- a federally mandated resident assessment tool), dated 10/7/2024, indicated Resident 49 was severely cognitively impaired (ability to think and reason). The MDS indicated Resident 49 required maximal assistance with toileting, showering, and upper/lower body dressing. The MDS also indicated Resident 49 did not exhibit any physical behavioral symptoms directed towards others. During a review of Resident 49's Medication Administration Record (MAR), for the month of October 2024, the MAR indicated Resident 49 was receiving Seroquel 50 milligrams (mg- unit of measurement) by mouth two times a day for psychotic features manifested by constant screaming. During a concurrent interview and record review, on 10/13/2024, at 1:46 p.m., with the Director of Nursing (DON), Resident 49's MAR for the month of October 2024 was reviewed. The DON stated the protocol before administering antipsychotic medications was to monitor a resident's behavior for 72 hours. The DON stated Resident 49's original Seroquel order was placed on 10/4/2024 and indicated the reason for Seroquel usage was for dementia. The DON stated she revised Resident 49's Seroquel order on 10/12/24 to indicate the reason was for psychotic features. The DON stated Resident 49 was constantly screaming. The DON stated there was no behavioral screening log to monitor Resident 47's behavior. The DON stated the risk of giving an antipsychotic medication for dementia could result in a resident receiving unnecessary medication. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), dated 8/2019, titled Unnecessary Medications, the P&P indicated, Residents who have not used anti-psychotic drugs are not given these drugs unless anti-psychotic drug therapy is necessary to treat a specific condition diagnosed and documented in the clinical record.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to: 1. Ensure a dental services follow-up was completed for one of five sampled residents (Resident 17). This deficient practice had the potential to result in a decreased appetite and weight loss for Resident 17. Findings: During a review of Resident 17's admission record (face sheet), the admission record indicated Resident 17 was admitted to the facility on [DATE]. Resident 17's diagnoses included metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood that affects brain function), dysphagia (difficulty swallowing), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and iron deficiency (a condition where the body's total iron content decreases). During a review of Resident 17's Minimum Data Set Assessment (MDS- a federally mandated resident assessment tool), dated 7/19/2024, the MDS indicated Resident 17 was cognitively intact (ability to think and reason). The MDS indicated Resident 17 required maximal assistance with toileting, showering, and upper/lower body dressing. The MDS indicated Resident 17 required supervision and set up assistance with eating and oral hygiene. During an interview, on 10/12/2024, at 10:15 a.m., with Resident 17, Resident 17 stated she had a toothache one month ago and did not receive any follow-up regarding dental services. Resident 17 stated she wanted to see a dentist and obtain dentures. Resident 17 stated she had last seen the facility's dentist in August 2024. During an interview on 10/13/2024, at 11:56 a.m., with the Social Services Director (SSD), the SSD stated Resident 17 received a dental recommendation for teeth extraction in August 2024. The SSD stated Resident 17 needed a medical clearance for the procedure. The SSD stated she was responsible for following up with the medical clearance needed for teeth extraction so Resident 17 could obtain dentures. The SSD stated she did not follow up with the medical clearance or dental services for Resident 17. The SSD stated the risk of not following up on dental services could result in a resident being uncomfortable, tooth pain and not being able to chew or eat properly. During an interview on 10/13/2024, at 1:36 p.m., with the Director of Nursing (DON), the DON stated the Social Services Department was responsible for ensuring dental services, referrals and follow up appointments for all residents. The DON stated there was no follow up on dental services for Resident 17. The DON stated the risk of not providing follow up dental services for residents could result in a potential for weight loss, not eating or being able to chew properly and low self-esteem. The DON stated, I will ensure the follow-up for Resident 17's extraction is completed. (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), dated 7/14/2017, titled Oral Healthcare & Dental Services, the P&P indicated, The Social Services Staff/designee is responsible for assisting with arranging necessary dental appointments. And All requests for routine and emergency dental services should be directed to the Social Services Staff/designee to ensure that appointments are made in a timely manner. Social Services will document extenuating circumstances that led to delayed referrals.		