| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105411 | A. Building<br>B. Wing | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Abbey Delray South | 1717 Homewood Blvd<br>Delray Beach, FL 33445 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0584<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837<br><br>Based on observations and interviews the facility failed to ensure a homelike environment with overbed lights having pull cords attached for 2 out of 70 occupied beds.<br><br>The findings included:<br><br>On 02/17/25 at 10:49 AM, an observation was made in room [ROOM NUMBER]-B of overbed light located on the wall above the head of the bed with no pull cord attached.<br><br>On 02/17/25 10:56 AM, an observation was made of room [ROOM NUMBER]-B of overbed light located on wall above the head of the bed with no pull cord attached.<br><br>On 02/18/25 at 9:05 AM, an observation was made in room [ROOM NUMBER]-B of overbed light located on the wall above the head of the bed with no pull cord attached.<br><br>During a side by side observation conducted on 02/18/25 from 10:15 AM to 10:30 AM with the Maintenance Supervisor who acknowledged the pull cords for the overbed lights were missing in rooms 22-B and 28-B.<br><br>During an interview conducted on 02/18/25 at 10:30 AM with the Maintenance Supervisor who stated each overbed light should have a pull cord long enough for each resident to be able to turn the overbed light on and off themselves. |

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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105411 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/20/2025 |
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| NAME OF PROVIDER OR SUPPLIER Abbey Delray South | | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 Homewood Blvd Delray Beach, FL 33445 | |

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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** 40153

Based on observations, interviews and record review, the facility failed to follow the care plan's interventions to prevent falls for 2 of 2 resident reviewed for accidents (Resident #69 and Resident #64).

The findings included:

1.) A review of the facility's policy titled, Comprehensive Care Plan, revised on 09/06/2022, revealed the following: The resident care plan will include measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs and will be developed and implemented for each resident. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met, c. When the resident has been readmitted to the facility from a hospital stay.

A review of the facility's policy titled, Fall Prevention and Management Program revised on 09/23/2019 showed the following: Post-fall: there are two key elements of the post-fall response and management: Initial post fall evaluation, documentations and follow-up include ongoing monitoring for resident changes in condition where medically indicated, and the care plan will be reviewed and updated as indicated.

2.) A record review showed that Resident #69 was readmitted to the facility on [DATE], had a fall on 09/23/24, and was transferred to the hospital. On 10/3/24, Resident #69 returned to the facility with a diagnosis of a right hip fracture, Dementia and General Anxiety. The significant change Minimum Data Set (MDS) assessment completed on 10/11/24 showed that Resident #69 had a Brief Interview Mental Status (BIMS) score of 03, which indicated the resident was cognitively impaired. She required extensive assistance of two people with transfer and bed mobility.

A review of the Quarterly MDS dated [DATE] showed the following: for chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair), Resident #69 was coded for substantial with maximum assistance. The helper does more than half the effort, lifts or holds trunks or limbs and provides more than half the effort. This did not show that Resident #69 needed two person assist with transfer and bed mobility.

In an observation conducted on 02/17/25 at 11:10 AM, Resident #69 was noted in bed with the bed in a low position and a fall mat noted on the right side of the bed. No fall mat was noted on the left side of the bed.

In an observation conducted on 02/18/25 at 11:10 AM, Resident #69 was noted in bed with the bed in a low position and a fall mat noted on the right side of the bed. No fall mat was noted on the left side of the bed.

In an observation conducted on 02/19/25 at 3:45 PM, Resident #69 was noted in her bed. A floor mat was noted on the right side of her bed, folded against her drawers, and no floor mat was noted on the left side of the bed.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105411 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/20/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Abbey Delray South | 1717 Homewood Blvd<br>Delray Beach, FL 33445 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the medical record did not show that a post fall assessment was completed for Resident #69 after her fall on 09/23/24.<br><br>The care plan initiated on 10/4/24, after Resident #69 came back from the hospital, showed keeping the bed in the lowest position when resident in bed, keeping the room and floor free from spills and clutter, and floor safety mats. For transfers, it showed that Resident #69 needs extensive assistance from one staff member to move between surfaces.<br><br>The Care plan initiated on 02/19/25 revealed that Resident #69 had a fall and is at risk for additional falls related to history of falls, Impaired mobility, Increased muscle weakness, Poor safety awareness, Refusal for assistance with mobility.<br><br>An interview conducted on 02/19/25 at 3:06 PM with the Director of Nursing ( DON) stated that Resident #69 did not have a post-fall evaluation since they went to the hospital and were not in the building, but she would have expected staff to complete a post-fall assessment. The DON reported that the care plan needs to be reviewed and updated after a fall. She further said that if the care plan says mats, then the expectation is to have two-floor mats on each side of the bed.<br><br>In an interview conducted on 02/19/25 at 3:36 PM with Staff M, a Certified Nursing Assistant, stated that Resident #69 was at risk for falls. She must make sure that the call light is within reach and that she has a floor mattress on each side of the bed.<br><br>In an interview conducted on 2/19/25 at 3:40 PM with Staff C, the Registered Nurse stated that Resident #69 is at risk for falls. She conducts frequent rounds and ensures that there are mats on each side of the bed. Staff C said that Resident #69 tried to get out of bed at times and that she is coded for one-person assistance. A post-fall evaluation is always completed after a fall, even if the resident is transferred to the hospital.<br><br>51137<br><br>3.) Review of the Record revealed Resident #64 was admitted to the facility 06/16/23 with a primary diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #64 had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 15 scale, indicating the resident had severe cognitive impairment. Review of the fall risk assessment evaluation created on 02/16/24 revealed Resident #64 had a fall risk score of 11. This same assessment documented, Upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan.<br><br>Review of the Care Plan dated 01/13/25 documented Resident is at risk for falls related to impaired cognition, impaired mobility. This same care plan revealed interventions such as Keep bed in lowest position while resident is in bed, keep call light within reach and encourage resident to use for assistance as needed, and keep personal items within reach.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Abbey Delray South | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1717 Homewood Blvd Delray Beach, FL 33445 | |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 02/17/25 at 11:15 AM, a fall mat was observed placed behind the Resident's recliner against the wall, photographic evidence obtained. Resident #64's personal belongings were not observed within reach and her bedside table was placed by the Resident's recliner in front of the fall mat on the wall. On a follow up observation on 02/17/25 at 2:57 PM, the fall mat was still observed against the wall.<br><br>Review of the active orders on 02/17/2025 revealed there were no orders for a fall mat.<br><br>Review of the active orders on 02/18/2025 revealed a new order floor mat as need.<br><br>During an observation on 02/18/25 at 11:13 AM, the floor mat was observed on the left side of Resident's bed; the Resident's belongings and call light were not within reach.<br><br>During an observation on 02/19/25 at 11:42 AM, the Resident was observed in bed in a high position approximately 36 inches from the floor and the call light and personal belongings were not within reach. The resident's spouse walked in the room at approximately 12:00 PM. There were no staff present in the room with the Resident for over 25 minutes.<br><br>On 02/19/25 at 12:08 PM, an interview was conducted with Staff O, Registered Nurse (RN.) When asked why Resident #64's bed was left in a high position for over 25 minutes with no staff present in the room, she stated the Certified Nursing Assistants (CNA)s usually leave the bed in the lowest position when they leave the room. She stated that during mealtimes, the Resident's spouse requests for the bed to be up high while he is present in the room. Staff O was made aware that the husband was not present in the room during the majority of the observation and that he entered towards the last couple of minutes of the observation. When asked if Resident #64 was at risk for falls, Staff O stated that she did not believe they were a fall risk because they hadn't fallen or tried to get out of bed. When asked if her mental status and diagnoses could play a role in her being a fall risk, she repeated The resident has not fallen and stays in bed. When asked why the floor mat was not on the floor on Monday, Staff O stated that she did see it in the room on Monday up against the wall. When asked why it was on the wall and not the floor she stated, maybe they were cleaning and left it like that.<br><br>During an interview on 02/19/25 at 12:42 PM, the Director of Nursing (DON) was made aware of the observations made throughout the week regarding Resident #64. The (DON) agreed with the findings and stated it should not have happened since the Resident was identified as at risk for falls. She stated that if a floor mat was already in the room prior to having an order in place for it, it should have been placed back on the ground. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153<br><br>Based on observation, interviews and record review, the facility failed to provide assistance during dining for 1 of 2 residents reviewed for nutrition (Resident #12).<br><br>The findings included:<br><br>Resident #12 was admitted to the facility on [DATE] with diagnoses of Dementia, Osteoporosis, and Hemiplegia. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #12 has a Brief Interview of Mental Status (BIMS) score of 13, which is cognitively intact. Section GG of this MDS showed that for eating, Resident #12 was coded for supervision or touching assistance only. A review of the Physicians' orders revealed an order for assistance with feeding with every meal-careful oral assisted feeding by hand every shift dated 2/11/25.<br><br>In an interview conducted on 02/17/25 at 11:15 AM with Resident #12, she stated that she eats as much as she can and has lost some weight, but she is not sure how much. She is given Ensure Supplements and has tried to drink them when they are provided.<br><br>In an observation conducted on 02/17/25 at 1:03 PM, Resident #12 was eating her lunch with no staff noted in the room. Continued observation at 1:25 PM showed that Resident #12 ate about 50% of her meal.<br><br>In an observation conducted on 02/18/25 at 9:07 AM, Resident #12 was eating her breakfast meal with no staff noted in the room.<br><br>A nutrition dietary progress note dated 2/12/25 showed that Resident #12 had 9.6% weight loss in 3 months and that she is receiving Ensure supplements 3 times a day. Her meal intake varies mostly between 25% and 75%. It further showed that a new order was placed to assist with feeding with every meal.<br><br>A review of the care plan dated 02/19/24 showed the following: Resident #12 is at nutritional/dehydration risk related to mechanically altered diet, dementia, use of laxatives, and history of significant weight change. It showed staff to provide the necessary assistance with meals.<br><br>In an interview conducted on 02/19/25 at 1:30 PM, Resident 12 stated that she needed assistance during dining. She stated that in the past, she was able to eat on her own, but now she needs more help during meals.<br><br>An interview conducted on 02/19/25 at 1:40 PM with Staff L, a Certified Nursing Assistant, stated that Resident #12 can eat on her own and that she only needs assistance with setting up meals and opening containers. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interviews and record review, the facility failed to acquire a Physician order for a urinary catheter and failed to initiate a urinary catheter Care Plan for 1 of 2 sampled residents, Resident # 502; and failed to keep the urinary catheter anchored for 1 of the 2 residents, Resident #69.<br><br>The findings included:<br><br>A review of a facility policy titled, Indwelling Catheter Use and Removal dated 01/06/25, revealed under the Compliance Guidelines that if an indwelling catheter is in use, the community will provide appropriate care for the catheter in accordance with current professional standards of practice, will identify and document clinical indications for use of the catheter, and will keep the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral dislodgement of the catheter.<br><br>1) A record review for Resident #502 revealed the resident was admitted on [DATE] with diagnoses including Malignant Neoplasm of Cervix, Acute Cystitis, and Urinary Tract Infection.<br><br>A review of the admission Minimum Data Set (MDS) assessment for Resident #502 dated 02/14/25, revealed resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating slightly impaired mental cognition. A review of Section H revealed a no for indwelling urinary catheter. A review of Section V revealed the triggering condition of an occasional urinary incontinence.<br><br>A record review of Physician orders for Resident #502 dated 02/17/25, revealed no urinary catheter care and maintenance, urinary catheter size, and indication for insertion of urinary catheter.<br><br>A review of the Care plans for Resident #502 dated 02/16/25 did not indicate the focus, plan and interventions for urinary catheter for Resident #502.<br><br>In an observation conducted on 02/18/25 at 11:00 AM, Resident #502 was in her room trying to use her phone. When asked where she was yesterday, she responded, I had to see my doctor. This resident was observed with a urinary bag strapped on her right leg. When asked if she is comfortable wearing the urinary bag on her leg, she responded, Yes. She added, Staff empty the urinary bag before it gets full.<br><br>During an interview conducted on 02/19/25 at 9:00 AM, with Staff T, Certified Nursing Assistant (CNA), who when asked if she had emptied the urinary bag of the resident, she responded, The other CNA did it.<br><br>In an interview conducted on 02/19/25 at 2:30 PM with the Staff G, Admission Registered Nurse (RN), when requested to have the Resident #502's orders printed, she responded, Is it alright, I just put the order for the urinary catheter today? When asked how long the resident had had the urinary catheter, she did not respond.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 41837<br><br>2) Record review for Resident #69 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on 10/03/24 with diagnoses that included in part the following: Other Obstructive and Reflux Uropathy, Neuromuscular Dysfunction of Bladder, and Dementia.<br><br>Review of the Minimum Data Set for Resident #69 dated 01/11/25 documented in Section C a Brief Interview of Mental Status score of 2 indicating severe cognitive impairment.<br><br>Review of the Physician's Orders for Resident #69 revealed an order dated 10/03/24 for Catheter: Foley, Size:16 FR, Balloon Size:10 CC Diagnosis: Neurogenic Bladder.<br><br>Review of the Physician's Orders for Resident #69 revealed an order dated 10/03/24 to secure catheter to leg. Be Sure to Keep Bag Off Floor. Catheter Size:16 FR, Reason: Neurogenic bladder.<br><br>Review of the Medication Administration Record and the Treatment Administration Record for Resident #69 from 02/01/25 to 02/19/25 revealed no documentation of securing the catheter to the leg.<br><br>Review of the Nursing Progress Notes for Resident #69 from 02/01/25 to 02/19/25 revealed no documentation of securing the catheter to the leg.<br><br>Review of the Tasks for Resident #69 from 02/01/25 to 02/19/25 revealed no documentation of securing the catheter to the leg.<br><br>Review of the Care Plan for Resident #69 dated 05/10/23 indicated a focus of the resident having an urinary catheter for Neurogenic Bladder and Obstructive Uropathy. She has recurrent UTI (Urinary Tract Infection) secondary to indwelling catheter. Collaboration with hospice services. The goal was for the Resident to be/remain free from catheter-related trauma and/or complications through next review date. The interventions included in part the following: Secure catheter to leg when up to avoid tension on urinary meatus.<br><br>On 02/19/25 at 10:00 AM, an observation was conducted of the catheter care being performed for Resident #69 by Staff P, Certified Nursing Assistant (CNA) and assisted by Staff Q, Certified Nursing Assistant (CNA). The resident was lying in bed with the indwelling urinary catheter not secured to her leg. The catheter care was performed with good technique and staff wore appropriate Personal Protective Equipment. When Staff P and Staff Q were finished with the care for the resident they did not secure the indwelling urinary catheter to the resident's leg.<br><br>During an interview conducted on 02/19/25 at 10:30 AM with Staff P and Staff Q, who were asked if they secure the indwelling urinary catheter, they said no. They have seen some residents with a leg strap to secure the catheter, but they acknowledged Resident #69 did not have a leg strap.<br><br>During an interview conducted on 02/19/25 at 10:40 AM with the Director of Nursing who was asked about indwelling urinary catheters being anchored, she said it is best practice for the catheter to be anchored. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153<br><br>Based on observations, interviews and record review, the facility failed to meet the nutritional needs and provided the correct nutritional supplement for 1 of 2 residents reviewed for nutrition (Resident #47).<br><br>The findings included:<br><br>A record review revealed that Resident #47 was admitted to the facility on [DATE] with diagnoses of Cerebral infarction and Dementia. The quarterly 10/29/24 Minimum Data Set (MDS) showed that Resident #47 had a Brief Interview of Mental Status (BIMS) score of 02, which is cognitively impaired.<br><br>In an interview conducted on 02/17/25 at 1:00 PM, Resident 47's family stated that Resident #47 had lost some weight and that he used to be around 180 pounds. He receives Ensure supplements twice a day and drinks them all. In this interview, a bottle of Ensure original was noted on the side table near Resident #47.<br><br>In an observation conducted on 02/18/25 at 9:07 AM, Resident #47 was eating his breakfast. Staff were in the room setting up the breakfast meal for Resident #47. At 9:13 AM, Resident #47 was in the room, eating with no staff present. At 9:20 AM, Resident #47 only ate the eggs on the breakfast plate.<br><br>A review of the weight log showed the following weights for Resident #47:<br><br>08/08/24, a weight of 180.2 pounds was recorded.<br><br>09/06/24, a weight of 159.8 pounds was recorded.<br><br>09/13/24 a weight of 160.9 pounds recorded.<br><br>09/25/24, a weight of 151.8 pounds was recorded.<br><br>On 11/7/24, a weight of 152.8 pounds was recorded.<br><br>On 12/2/24, a weight of 157.8 pounds was recorded.<br><br>On 1/13/25, a weight of 156.0 pounds was recorded.<br><br>On 2/3/25, a weight of 155.0 pounds was recorded.<br><br>A review of the nutrition follow-up note dated 09/12/24 showed that Resident #47 had recently lost 11.3% of weight in one month. Ensure high-protein nutritional supplements are recommended twice a day. This note documented that Resident #47 was eating between 50% and 75% of meals.<br><br>The follow-up nutritional note dated 09/26/24 showed that the Ensure high protein twice a day provided 1060 calories and 44 grams of protein.<br><br>(continued on next page) |

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|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A nutrition note dated 11/25/24 showed that the Ensure high protein supplement was decreased from two times a day to one time a day and that Resident #47 was eating between 50% to 75% of his needs.<br><br>The quarterly nutritional assessment dated [DATE] revealed that Resident #47's estimated nutritional needs were 1914 to 2340 calories a day. A review of the Certified Nursing Assistants documentation showed that between 02/5/25 and 02/17/25, Resident #47 ate between 47% and 71% of his meals.<br><br>A review of the weekly nutrient summary revealed that Resident #47 was provided with an average of 2130 calories a day. This showed that Resident #47's intake of meals with the one bottle of Ensure original (250 calories a bottle), was only around 1123 calories to 1762 calories. This was meeting 65% of his lower end estimated needs and 75% of his higher end of estimated needs.<br><br>In an interview conducted on 02/18/25 at 10:45 AM, Staff D, a Certified Nursing Assistant, stated that she oversees ordering nutritional supplements. The Registered Dietitian will let her know of any supplements that need ordering. She said that the last time she ordered Ensure High Protein was last year, but she was not sure when last year.<br><br>In an interview conducted on 02/18/25 at 10:50 AM with Staff E, Registered Dietitian, she stated that for a resident with a supplement they do not have in-house, she would ask to order the supplement or change it to another type of supplement with similar nutritive value. Resident #47 should not have been given Ensure original instead of Ensure high protein. Staff E then went to the storage room to show this Surveyor what they had in stock. The storage room did not have Ensure high protein in stock, and Staff E was not sure when the last time they had this supplement was in-house. She further acknowledged that the diet order with the Ensure original once a day was not meeting Resident #47's nutritional needs.<br><br>An interview conducted on 02/18/25 at 11:12 AM with Staff F, Licensed Practical Nurse, stated that Resident #47 had an order for Ensure High Protein, which she did not give this morning. She left a message for the doctor to change the order for Ensure Original, which they have in-house. She cared for Resident #47 last week and was unsure what type of Ensure was given. According to her, they get different kinds of Ensure supplements, and they have to go back and forth between them.<br><br>In an interview conducted on 02/18/25 at 11:20 AM with Staff C, the Registered Nurse stated that she has been giving Ensure Original to all residents. She said they had not had Ensure High Protein for some time and could not remember the last time they had it in-house. |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Abbey Delray South | | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 Homewood Blvd Delray Beach, FL 33445 | |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interview and record review, the facility failed to have an order for oxygen for 1 of 1 sampled residents, Resident #501.<br><br>The findings included:<br><br>A record review of a facility policy titled,Oxygen Administration with a revision date of 10/2010, revealed to verify that there is a physician's order for oxygen administration.<br><br>A record review for Resident #501 revealed the resident was admitted on [DATE] with diagnoses that included Displaced Intertrochanteric Fracture of Right Femur, Chronic Obstructive Pulmonary Disease (COPD), and Chronic Systolic Congestive Heart Failure.<br><br>A review of the Minimum Data Set (MDS) assessment for Resident #501 dated 02/18/25 revealed it was blank for the Brief Interview for Mental Status (BIMS) score. A review of Section I revealed a yes response to Asthma. A review of Section O was blank for oxygen therapy.<br><br>A review of Physician Orders for Resident #501 revealed there was no order for oxygen indication, administration, care and management.<br><br>A record review of the Care Plan for Resident #501 initiated on 02/16/25, and with the target date of 05/16/25, revealed a focus on COPD related to smoking. The goals were Resident will be free of signs and symptoms of respiratory infections through next review date.<br><br>The interventions included: Give aerosol or bronchodilators as ordered; Monitor/document any side effects and effectiveness; Monitor for difficulty breathing (Dyspnea) on exertion; Monitor for signs and symptoms of acute respiratory insufficiency; Oxygen setting at 2 Liters via nasal prong as ordered.<br><br>During an observation conducted on 02/17/25 at 10:53 AM, Resident #501 was asleep with the oxygen nasal cannulae on both nares, and a portable oxygen tank next to the bed, set at 2 Liters (L) per minute mark. There was no date tag observed on the oxygen tubing.<br><br>During another observation conducted on 02/18/25 at 10:00 AM, there was a red oxygen sign posted on the door of Resident #501's room. The resident was able to answer questions. She was wearing the the oxygen nasal cannulae on both nares. There was no tag on the oxygen tubing and the meter flow was set at 2 L per minute on the portable oxygen tank.<br><br>In an interview conducted with Resident #501 on 02/18/25 at 10:08 AM, when asked if the oxygen is helping her breath better, she responded Yes. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153<br><br>Based on observations, interviews, and record review, the facility failed to ensure that psychotropic medication PRN (as needed) orders were limited to 14 days for 1 of 5 residents reviewed for Unnecessary Medication (Resident #17).<br><br>The findings included:<br><br>A review of the policy titled, Medication Utilization and Prescribing-Clinical Protocol, revised in April 2018, showed the following: As part of the overall review, the Physician and staff will evaluate the rationale for existing medications that lack a clear indication or are being used intermittently on a PRN. The Physician will provide and or document rationale when the indication, dose, duration, or frequency of a prescribed medication is more significant than commonly accepted practice. The Consultant Pharmacist can help by reviewing facility medication usage patterns and trends and by intensifying medication reviews of individuals taking medications that present clinically significant risks.<br><br>Resident #17 was admitted to the facility on [DATE] with diagnoses of bipolar disorder and major depressive disorder. The admission Minimum Data Set (MDS), dated [DATE], showed that Resident #17 had a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact.<br><br>A review of the Physician's order revealed an order for Lorazepam 0.5 milligrams, given one tablet by mouth every 8 hours as needed for anxiety for 30 days, dated 01/30/25.<br><br>In a Pharmacy review conducted on 02/4/25 (five days later), the Consultant Pharmacist reviewed all medications for Resident #17. In this review, he wrote no irregularities and did not address the 30-day PRN medication of Lorazepam.<br><br>In an interview with the Director of Nursing (DON) on 02/19/25 at 12:30 PM, she stated that for any psychotropic medication that has been PRN for the past 14 days, the nurse and the pharmacist will contact the prescribing Physician to discuss the necessity of the medication.<br><br>In a phone interview conducted on 02/20/25 at 9:16 AM with the Consultant Pharmacist, he stated that for any psychotropic medication that is PRN past 14 days, he will recommend discontinuing the medication and will contact the Physician. The pharmacy recommendations always go to the Doctor for further review.<br><br>In an interview conducted on 02/20/25 at 1:00 PM with the DON, she acknowledged all findings. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153<br><br>Based on observations, interviews, and record review, the facility failed to monitor behaviors and side effects for 2 of 5 residents on antipsychotic medication (Resident #17 and Resident #501).<br><br>The findings included:<br><br>A review of the policy titled, Medication Utilization and Prescribing-Clinical Protocol revised in April 2018, showed the following: The staff and Physician will monitor the progress of anyone with a probable adverse drug reaction and anyone for whom the medications has been adjusted because of the probability of an adverse drug interaction.<br><br>1.) Resident #17 was admitted to the facility on [DATE] with diagnoses of bipolar disorder and major depressive disorder. The admission Minimum Data Set (MDS) dated [DATE], showed that Resident #17 had a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact.<br><br>A review of the Physician's order revealed an order for Rexulti (antipsychotic medication), 4 milligrams given 1 tablet by mouth at bedtime for bipolar disorder, dated 01/22/25. Further review did not show any orders to monitor the medication's side effects or behaviors.<br><br>A review of the Medication Administrator Record (MAR) for February 2025 did not show that the side effects and behaviors of the antipsychotic medication have been documented.<br><br>A review of the care plan initiated on 02/05/25 showed the following: The resident has a mood problem diagnosis of anxiety, depression, and bipolar disorder. Monitor and document for side effects and effectiveness. The resident uses psychotropic medication related to depression, which was initiated on 01/20/25. Monitor, document, and report any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person.<br><br>In an interview conducted on 02/19/25 at 11:50 AM with Staff I, a Licensed Practical Nurse, the Surveyor asked if Resident #17 was on any antipsychotic medication. She did not know. She proceeded to look in the electronic system and stated that Resident #17 was on antidepressants and antianxiety medications but did not see any antipsychotic medication for Resident #17. The Surveyor said that Resident #17 was receiving Rexulti oral tablet 4 milligrams give 1 tablet by mouth at bedtime for bipolar disorder dated 01/22/25, which was an antipsychotic medication. When asked if Resident #17 was monitored for side effects or behaviors of the Rexulti medication, she said yes. Staff I reported that it is documented in the Medication Administration Record and attempted to show the Surveyor in the electronic system but was unable to show documentation. Then, said, We need to update the orders.<br><br>50370<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2.) A record review revealed Resident #501 was admitted on [DATE] with diagnoses including Displaced Intertrochanteric Fracture of Right Femur, Type 2 Diabetes Mellitus, and Anxiety Disorder.<br><br>A record review of the Minimum Data Set (MDS) assessment for Resident #501 dated 02/18/25 revealed it is in progress. Section C for Brief Interview for Mental Status score was blank. Section I revealed, yes responses to anxiety and depression.<br><br>A record review of Physician Orders dated 02/16/25 revealed Escitalopram Oxalate (Anti-depressant) 10 MG (milligram), to give by mouth one time a day for depression.<br><br>An additional review of Physician Orders for Resident #501 revealed to monitor for signs and symptoms of depression and to include the following numerical codes : 0-None, 1-Isolation, 2-Sadness, 3-Withdrawn, 4-Lack of interest, 5-Crying, 6-Other, see nurses note, every day and night shift, and document the corresponding number(s) reflecting any sign and symptom of depression.<br><br>A further review of the Medication Administration Record (MAR) revealed that the medication Escitalopram 10 MG was administered on 02/17/25 at 9:00 AM. The MAR box for the medication revealed no statement to monitor for signs and symptoms of depression including the numerical codes. Additional review of MAR revealed no anti-depressant side effects were monitored after the administration of Escitalopram.<br><br>A review of the Care Plan revealed no goal, plan or interventions related to the resident's depression.<br><br>During observation on 02/17/25 at 10:53 AM, Resident #501 was asleep.<br><br>During an interview conducted on 02/18/25 at 11 AM, Resident #501 was able to respond to questions. She stated she was not happy in the facility.<br><br>In an interview conducted on 02/19/25 at 12:30 PM with Staff G, Admission Registered Nurse (RN), when asked regarding Resident #501's discharge instructions regarding the antidepressant and antianxiety medications, she responded she talked with the Psychiatry Nurse Practioner and was told that the antianxiety, anti-psychotic, and anti-depressant medications were all ordered by the resident's Cardiologist.<br><br>When asked if the facility staff perform behavior monitoring related to the medications, she responded behavior monitoring is always done, with the PCC drop down menu, and staff may add this indicator in the MAR.<br><br>When asked regarding depression monitoring, she stated, depression monitoring is numbered from 1 to 6 and recorded in the MAR. The anti-depressant side effects are also monitored with numbers from 1 to 19 and recorded in MAR.<br><br>When asked if there would be instances when a staff nurse might forget to put the behavior monitoring and side effects monitoring for anti-depressant medications, she added that all the staff nurses know how to put an order.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview conducted with Staff C, RN, when asked about antidepressant medications monitoring, she responded, Yes, the staff monitor the behavior when residents are receiving anti-depressants. The behaviors are represented by numbers. Nurses document the residents' behaviors in the MAR. She added that staff nurses always put the behavior in the MAR as proof of documentation before giving anti-depressant medications.<br><br>When asked if staff nurses monitor the side effects of anti-depressant medications, she responded, she is not sure and will get back to this surveyor. Until the end of the survey, Staff C, RN did not provide an answer. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837<br><br>Based on observations, interviews and record review, the facility failed to ensure medications were secured at the bedside for 1 of 22 sampled residents (Resident #645).<br><br>The findings included:<br><br>Review of the facility's policy titled, Medication Labeling and Storage with a revised date of February 2023 included in part the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.<br><br>Review of the facility's policy titled, Self-Administration of Medications with a revised date of February 2021 included in part the following: As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: The resident is able to safely and securely store the medication. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan.<br><br>Record review for Resident #645 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Acute Myocardial Infarction, Personal History of Malignant Neoplasm of Tongue.<br><br>Review of Resident #645's record revealed no documentation of a Brief Interview of Mental Status having been attempted or completed.<br><br>Review of the resident's record revealed no evaluation of self-administering medications.<br><br>On 02/17/25 at 10:49 AM, an observation was made of Resident #645 sitting up in bed and on the nightstand next to the bed was a clear plastic bag with ChapStick and Nystatin ointment 100,000 units per gram.<br><br>On 02/18/25 at 9:05 AM, an observation was made of Resident #645 sitting up in the bed with the overbed table in front of him, and on the overbed table next to his breakfast was a clear plastic bag with ChapStick and Nystatin ointment 100,000 units per gram.<br><br>During an interview conducted on 02/18/25 at 9:05 AM with Resident #645 who was asked about the Nystatin ointment in the bag on the overbed table, he stated that is his denture adhesive and he puts it on his gums daily.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview conducted on 02/18/25 at 9:15 AM with Staff P, Certified Nursing Assistant (CNA) who entered Resident #645's room and acknowledged the Nystatin ointment at the bedside and said medications are not supposed to be at the bedside and removed the medication to give to the Director of Nursing.<br><br>During an interview conducted on 02/18/25 at 9:55 AM with Staff H, Registered Nurse (RN) who was asked if residents can have medications at the bedside, she said no the residents cannot have medications at the bedside and acknowledged the resident was not evaluated for self-administration of medications. |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837<br><br>Based on observations, interviews, and record review, the facility failed to provide water consistent with resident needs for 1 of 3 residents on thickened liquids (Resident #645).<br><br>The findings included:<br><br>Review of the facility's policy titled, Menus and Therapeutic Diets with a revised date of 04/14/20 that included in part the following: Nectar, honey and pudding thickened liquids are offered as ordered by the physician.<br><br>Record review for Resident #645 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Acute Myocardial Infarction, Personal History of Malignant Neoplasm of Tongue.<br><br>Review of Resident #645's record revealed no documentation of a Brief Interview of Mental Status having been completed.<br><br>Review of the Physician's orders for Resident #645 revealed an order dated 02/13/25 for NAS (No Added Salt) diet Mechanical Soft texture, Nectar Thick Liquids consistency, and was discontinued on 02/18/25.<br><br>Review of the Physician's orders for Resident #645 revealed an order dated 02/18/25 NAS diet Pureed Diet texture, Nectar Thick Liquids consistency.<br><br>Review of the Care Plan for Resident #645 revealed no care plan for nutrition or hydration.<br><br>On 02/17/25 at 10:49 AM, an observation was made of Resident #645 sitting up in chair at bedside, with overbed table in front of him with a full 20 ounce Styrofoam cup of ice water with straw. Thickener packets were located on the nightstand next to bed on the opposite side of the bed from where Resident #645 was sitting.<br><br>During a side-by-side observation conducted on 02/17/25 at 11:10 AM with Staff H, Registered Nurse (RN) in Resident #645's room, the resident was sitting up in bed and in front of the resident was a full 20 ounce Styrofoam cup of ice water with a straw. Staff H acknowledged the resident was on nectar thickened liquids and should not have regular water at the bedside. Staff H immediately removed the water. When asked when water is passed to the residents she said it would have been at the end of the previous shift or at the beginning of the shift for today.<br><br>(continued on next page) |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview conducted at Resident #645's bedside with the Speech Therapist (ST) who was asked about the liquid consistency and straws for the resident, the ST stated the resident is on nectar thickened liquids and it is okay for the resident to use a straw. The ST stated the resident had tongue cancer and has an issue with using his tongue but has no problem swallowing the nectar thickened liquids with a straw. When asked why she was seeing the resident today, she stated the resident had difficulty with his mechanical soft diet this morning and the Resident #645's son was present, and the son had requested his diet be changed to pureed.<br><br>During an interview conducted on 02/20/25 at 9:15 AM with Staff P, Certified Nursing Assistant (CNA) who was asked how often water is provided to residents, she stated they provide water to residents once or twice a shift and as needed. When asked if a resident is on thickened liquids how she would know, she said the nurse will tell them. When asked how they provide thickened water to residents who are on thickened liquids, she said they are provided with containers of water or juice that are kept in a cooler at the bedside. When asked what the shifts for Certified Nursing Assistants are, she said 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153<br><br>Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety and sanitary conditions and to ensure the prevention of foodborne illnesses for 2 of 2 visits to the central kitchen. Facility failed to store resident's food in the appropriate temperature during 1 of 2 dining observations for Resident #648.<br><br>The findings included:<br><br>In a tour conducted on 02/17/25 at 10:00 AM, in the main kitchen, the following were noted:<br><br>1. Staff A, Dietary Aid, did not have facial hair restraints while in the food production area.<br><br>2. Staff B, Chef, did not have facial hair restraints while in the food production area.<br><br>3. A round garbage bin in the food production area is noted to have food debris and is not covered by the lid.<br><br>4. A square garbage bin in the food production area was noted to have food debris and was not covered.<br><br>5. The walk-in refrigerator was noted with the following:<br><br>6. A large metal container with slices of raw fish with today's date of 02/15/25 and used by date of 02/20/25.<br><br>7. A large metal container of cooked shrimps with today's date of 02/15/25 and used by date of 02/19/25.<br><br>8. Eight (8) -10 pounds rolls of raw ground meat not dated or labeled with a red bloody drainage on the bottom enough to cover the entire bottom of the container.<br><br>9. A large metal container with chunks of filet [NAME] dated 02/14/25 to 02/20/25.<br><br>10. Four large pieces of unidentified raw meat that were not labeled or dated.<br><br>11. Two large boxes of raw chicken that were opened and exposed to the air.<br><br>12. A large box of raw Pork was noted with a sign of use or freeze by 03/13/25.<br><br>13. The walk-in freezer was noted to have condensation above the food, and food boxes exposed.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Abbey Delray South | | STREET ADDRESS, CITY, STATE, ZIP CODE 1717 Homewood Blvd Delray Beach, FL 33445 | |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 14. In a tour conducted on 02/19/25 at 11:15 AM in the Satellite kitchen, the following were noted: Staff N, Dietary Aide, was observed wearing round earrings that were about 2 inches long while handling prepared foods on the tray line. While on the tray line, she was observed dumping the water and the chemicals in the red sanitation bucket and using it to scoop the hot water from the tray line. She then proceeded to handle the prepared foods without changing her gloves first.<br><br>41837<br><br>Review of the facility's policy titled, Foods Brought by Family/Visitors with a revised date of March 2022 included in part the following: Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from the facility-prepared food .Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date.<br><br>Record review for Resident #648 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Cognitive Communication Deficit and Parkinsonism.<br><br>The Minimum Data Set for Resident #648 dated 02/04/25 documented in Section C a Brief Interview of Mental Status score of 14 indicating a cognitive response.<br><br>On 02/17/25 at 11:00 AM, an observation was made of Resident #648 sitting in the wheelchair next to the bed, on the overbed table in front of the resident was an opened container of cut up mango with no label from facility, with manufacturer label keep refrigerated, a closed container of egg salad with label dated 02/14/25 and a use by date of 02/17/25, and a closed container of fish with a label dated 02/15/25.<br><br>During an interview conducted on 02/17/25 at 11:05 AM with Resident #648 who stated the food is brought in by relatives and he keeps Kosher and they are Kosher foods. The resident stated the food has been on his table all weekend long. When asked if staff had offered to put his perishable food items in the refrigerator for him, he said no.<br><br>During an interview conducted on 02/17/25 at 11:10 AM with Staff H, Registered Nurse who stated she has worked at the facility for just over a year. When asked about food brought in from the outside, she said it needs to be labeled and dated. When asked about the food on Resident #648's overbed table, she acknowledged it should have been in the refrigerator. Staff H stated the items were probably no longer any good since they have not been refrigerated and should be thrown out. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>41837<br><br>Based on interviews and record reviews, the facility failed to maintain an effective system to obtain and use of feedback and input from (Minimum Data Set (MDS) Department and ensure an effective QAPI/PIP (Quality Assurance Performance Improvement/Performance Improvement Plan) to ensure MDS assessments were completed timely with the potential to affect 70 out of 70 residents.<br><br>The findings included: .<br><br>Review of the facility's policy titled, Quality Assurance and Performance Improvement Program Plan with a revised and reviewed date of 08/31/22 indicated in part the following:<br><br>Each facility's Administrator will be accountable for leadership and will provide coordination of the overall health center QAPI program. Together with members of the QAPI Committee, the Administrator will be responsible for planning, designing, implementing, and coordinating care and services and selecting QAPI activities to meet the needs of residents.<br><br>Guidelines for Performance Improvement Projects: The facility will have a plan for conducting PIPs to improve care and services. This will be accomplished by: PIPs will be identified by the department representative as discovered in conversation, complaints, observations for opportunities for improvement, improved practices, new standards, new rules or as recommended among the team. The facility will monitor all PIPs within the organization.<br><br>Communication of QAPI: By conveying the message that nay and every team member is expected to raise quality concerns and to think about how we can improve our systems, and that it is safe for team members to raise quality concerns and issues.<br><br>The facility will maintain documentation and demonstrate evidence of its ongoing QAPI efforts that serve to identify, report, investigate, analyze, and prevent adverse events. Documentation will reflect the development, implementation, and evaluation of corrective actions or performance improvement initiatives. In order to maintain an effective QAPI plan, the plan will include all team members, all departments and all services provided and specific to each facility. QAPI will be adequately resourced.<br><br>Review of the PIP titled, Late MDS Assessments with an initiated date of 12/12/24 with Staff R -MDS Coordinator and it included in part the following:<br><br>Priority: Medium<br><br>Problem or Opportunity for Improvement: Late assessments averaging 55% in last month.<br><br>Root Cause Analysis: Turnover in IDT and high volume of admissions and discharges.<br><br>Goals: Reduce the number of assessments that are completed late on a monthly basis by 5%.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Meetings:<br><br>12/19/24 assessments late 61.73%<br><br>12/26/24 continue with late assessments 70.49%<br><br>01/02/25 continue with late assessments 47.62%<br><br>01/09/25 assessments completed for month end late 61.54%<br><br>01/16/25 continue with schedule late 50%<br><br>01/23/25 assessments continue to fall behind (no percentage documented)<br><br>01/30/25 continue with late assessments 61.8%<br><br>02/06/25 assistance provided from support team to assist with late assessments 78.%<br><br>02/13/25 assessments remain late 72%<br><br>Review of the QAPI Committee Meeting sign - in sheet for 12/20/24 indicated the Attendees included the Administrator, the Director of Nursing and Staff R, MDS Coordinator. When asked about MDS assessments still listed as in progress, Staff R stated that they have been having problems closing MDS assessment due to change in staff. Some areas of the assessments performed by other departments were not done timely. When asked when this was identified and if she notified anyone, she stated it was identified in December of 2024 and at the time she notified the Administrator, DON (Director of Nursing), and the Regional MDS Director. Staff R also added that it was discussed in QAPI and the PIP was initiated by her. Staff R showed the PIP to the surveyor which was initiated on 12/12/24. Staff R stated they discuss the action plan at the weekly IDT meeting, and she discussed which resident assessments were due and which ones are late. When asked if it is one particular department that is late on doing their assessments and entering their information in the MDS assessments she stated it is predominately the Social Services Department.<br><br>During an interview conducted on 02/19/25 at 9:15 AM with the Administrator who was asked about care plans for advanced directives, he said they would be completed by a social worker, but they identified an issue last week of the Social Services Department not having completed care plans, evaluations and BIMS evaluations in a timely manner due to high volume of admissions and discharges as well as only having 1 full time Social Worker. When they identified this issue last week, they put a PIP in place for the Social Services Documentation on 02/12/25.<br><br>During an interview conducted on 02/19/25 at 12:15 PM with the Administrator who was asked if he was made aware of the MDS assessments not being completed in a timely manner, he said he was aware of the issue in January 2025. When asked if there was a PIP in place for the MDS assessments not being completed timely, he said yes he believed Staff R MDS Coordinator started a PIP in January 2025. When asked if the PIP has been effective, he said he is not really sure, but they are working on it. When asked if he has reviewed the PIP, he said he believed he did not. The Administrator said he thinks they talked about it in QAPI at the end of January 2025.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview conducted on 02/20/25 at 12:30 PM with the Administrator who was asked about the Late MDS Assessments PIP he stated at the QAPI meeting held on 12/20/24, the MDS Coordinator was not present at the meeting, and he was not aware or told that she started a PIP on 12/12/24 and this was something that she started on her own and not everything is brought to his attention. When asked if any other staff member was involved in the PIP, he said maybe her Regional Supervisor, but he was not sure.<br><br>During an interview conducted on 02/20/25 at 1:50 PM with the Social Service Director who was asked when Staff R, MDS Coordinator informed her the MDS assessments were late, she said it has been going on for a while at least several weeks. When asked if she attends monthly QAPI meetings, she stated yes she does. When asked if it has ever been brought up at QAPI meetings about the MDS assessments being late, she stated yes she believes it was the Administrator who brought it up but did not go into much detail about it. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interviews and record reviews, the facility failed to maintain an effective Infection Prevention and Control Program, for 3 sampled residents, as evidenced by staff failed to wear Personal Protective Equipment (PPE) while providing direct care for residents on Enhanced Barrier Precaution (EBP) for Resident #545 and Resident #38; and failed to have an order and care plan for EBP for Resident #501.<br><br>The findings included:<br><br>The Center for Disease Control and Prevention (CDC) Enhanced Barrier Precautions included the following: Everyone must clean their hands, when entering and leaving the room. Providers and Staff must also wear gloves and a gown for the following: High-contact care resident care activities - dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care with any skin opening requiring a dressing. https://www.cdc.gov/long-term-care facilities/media/pdfs/<br><br>A review of the facility policy titled, Enhanced Barrier Precaution, with a revision date of 04/05/24, revealed the facility adheres to the CDC recommendation on implementing EBP in their health care center. The policy explained that EBP will be implemented for the following: indwelling medical devices (e.g. central line, urinary catheter, feeding tube); chronic wounds including pressure ulcer, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. It also stated that all team members will wear appropriate PPE (gown and gloves) for high contact resident care but not limited to peri-care, device care (urinary catheter and feeding tube), and wound care.<br><br>1) Record review of Resident #545 revealed the resident was admitted to the facility on [DATE], with diagnoses that included Cachexia, Adult Failure to Thrive, Malignant Neoplasm of the Esophagus, Percutaneous Endoscopic Gastrostomy (PEG) tube, and Sacral Pressure Ulcer. A review of the Minimum Data Set (MDS) assessment for Resident #545 dated 02/12/25 revealed a blank space in Section C for the Brief Interview for Mental Status (BIMS) score.<br><br>Record review of Physician Orders for Resident #545 dated 02/11/25 revealed an order for EBP: gown and gloves should be worn while providing high-contact resident care (dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting), every day and night shift for percutaneous endoscopic gastrostomy (PEG) tube.<br><br>A further review of Physician Orders for Resident #545 revealed an order for wound care dated 02/15/25, Wound: sacrum- cleanse with Normal Saline, apply Medi honey, apply Calcium alginate, cover with foam dressing every day shift for pressure injury.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation conducted on 02/18/25 at 3:20 PM, Staff K, Certified Nursing Assistant (CNA) entered a room with an EBP sign without performing hand hygiene. She donned gloves, drew the privacy curtain and stood by the foot of bed. Then Staff C, Registered Nurse (RN) came in and told the resident that she would change the dressing on the left buttock and Staff K would assist. Staff C went inside the bathroom and performed hand washing, donned on gloves, yellow gown and asked for the resident to turn to his right side. She opened the left side of the resident's brief and proceeded with the wound care without any concerns. After she completed the wound care, Staff C, RN asked Staff K, CNA to change the resident's brief. Staff K obtained a brief and approached Resident #545, wearing only a pair of gloves and no gown. She proceeded to change the resident's brief, with her blue uniform touching the resident's bed linens.<br><br>In an interview conducted on 02/18/25 at 3:32 PM with Staff C, RN, when asked why Staff K, CNA was not wearing a gown while assisting with wound care and changing of the resident's briefs, she responded, I reminded her. When asked if all facility staff receive training and in-services for EBP, she responded yes.<br><br>In an interview conducted with Staff K, CNA on 02/18/25 at 4:14 PM, when asked why she did not put on gown, she responded, I was just asked to help the nurse. I did not look at the EBP sign on the door. When she was shown the EBP sign on resident's door, she responded, I should have put on gown.<br><br>2) A record review of Resident #501 revealed he was admitted on [DATE] with the diagnoses that included Displaced Intertrochanteric Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Type 2 Diabetes Mellitus, and Right Heel Pressure Ulcer.<br><br>A review of the Minimum Data Set (MDS) assessment for Resident #501 dated 02/18/25 revealed it was blank for the Brief Interview for Mental Status (BIMS) score.<br><br>A review of Physician Orders dated 02/16/25 revealed that there was no EBP order related to the right heel pressure ulcer.<br><br>A further review of the care plan revealed there was no EBP focus, plan or interventions related to Resident #501's right heel pressure ulcer.<br><br>In an interview conducted with Staff J, CNA on 02/18/25 at 3:42 PM regarding the EBP sign on the resident's door, she stated, Staff must wear mask and gloves when providing care to resident such as during the changing of briefs and bed linens. When asked if she needed to wear a gown, she responded no, gown is only used for very contagious diseases like COVID and C. difficile.<br><br>51137<br><br>3) Review of Record revealed Resident #38 was admitted to the facility 01/09/25. He was admitted with a primary diagnosis of chronic obstructive pulmonary disease with (acute) exacerbation Other diagnoses included: respiratory failure with hypoxia (low levels of oxygen in your body tissues), metapneumovirus pneumonia(a lung infection caused by the human metapneumovirus virus), and hypoxemia (a condition where there is an abnormally low level of oxygen in the blood.)<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the active orders revealed there was an Enhanced Barrier Precaution (EBP) order, Gown and Gloves should be worn while providing high-contact resident care (Dressing, Bathing/showering, Transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting.)<br><br>Further review revealed an active order for a midline catheter to the right arm (a thin, flexible tube inserted into a vein in the upper arm, typically near the elbow or just below the armpit) for intravenous administration of antibiotics due to a pneumonia diagnosis.<br><br>Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, which indicated the resident was cognitively intact. This same MDS also documented the Resident required continuous oxygen therapy.<br><br>During an initial observation and interview on 02/17/25 at 11:53 AM, Resident #38 was observed wearing a nasal cannula and had a midline catheter to the right upper arm. When asked how care was, the Resident stated they've had an issue with her maintaining normal oxygen levels. Resident #38 stated she had acquired several respiratory infections over a short period of time that required her to be on antibiotic therapy.<br><br>A medication administration observation was conducted on Resident #38 on 02/18/25 at 09:32 AM with Staff I, Licensed Practical Nurse (LPN). The medication administration included oral medications, intranasal spray, a medication patch and a respiratory nebulizer treatment. Upon entering the Resident's room an (EBP) sign was observed by the Resident's door and another one on the wall in front of the Resident's bed. Staff I performed hand hygiene and donned gloves; she stated she had already completed vital signs on the Resident. Staff I proceeded with the administration of the medications while the resident was in her wheelchair; no additional Personal Protective Equipment (PPE) was donned. Staff I performed a respiratory assessment and listened to Resident #38's lungs with her stethoscope and afterwards the Resident requested to complete her treatment in bed. Staff I assisted to transfer the Resident from the wheelchair into bed; she then helped position her up in bed to a comfortable position. Staff I performed hand hygiene and donned new gloves; she then placed the nebulizer solution into the mask and placed it on the Resident. At the end of the respiratory treatment she performed another respiratory assessment.<br><br>During an interview on 02/18/25 at 10:16 AM, when asked if Resident #38 was on (EBP), Staff I stated yes for direct care. When asked if giving the multiple types of medications and transferring the resident would be considered direct care, she stated she was unsure and asked the surveyor if she should of wore a gown. When asked what education was provided by the facility on residents requiring (EBP), she began to read the sign placed by Resident #38's door. Staff I was still unsure and stated, I probably should have worn it.<br><br>An infection prevention interview was conducted on 02/19/25 at 10:00 AM with the Director of Nursing (DON) who was filling in for the Infection Preventionist for the week. The (DON) was made aware of the observations regarding Resident #38 and agreed that it was best practice to wear (PPE) for all direct contact activities especially if the Resident was transferred during the process. |