STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105462	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clewiston Nursing & Rehabilitation	301 South Gloria St Clewiston, FL 33440

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on observation, record review, and interview, the facility failed to ensure the comprehensive assessment accurately reflect the dental status of 2 (Residents #39 and #90) of 14 sampled residents. The findings included: 1. Review of the clinical record for Resident #39 revealed an admitted [DATE], and a readmitted [DATE]. An outside provider's screening report for dental services for Resident #39 dated 1/25/23 noted, Upper and lower edentulous (no teeth) with two asymptomatic root tips. The Admission Nursing Comprehensive Evaluation dated 8/9/23 noted Resident #39 did not have dentures and was missing some teeth. The Admission Minimum Data Set (MDS) assessment with a target date of 8/14/23 was not checked off for No natural teeth or tooth fragment(s). On 4/10/24 at 10:00 a.m., Resident #39 was observed to be edentulous with two teeth broken below the gum line on his bottom jaw. On 4/10/24 at 1:09 p.m., in an interview the MDS Coordinator said she uses the documentation in the nursing assessment to code the dental status on the MDS. She stated she did not assess the resident's oral status and could not say for sure if the nursing documentation accurately reflected the resident's oral and dental status. 2. Review of the clinical record revealed Resident #90 was admitted to the facility on [DATE]. Review of the Brief Interview for Mental Status dated 4/1/24 showed Resident #90's cognition was intact with a score of 15. On 4/8/24 at 12:11 p.m., in an interview Resident #90 stated he lost all his teeth in an accident when he was hit by the car. (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 11:00 a.m., Resident #90's oral cavity was observed with his permission. He was completely edentulous. Review of the Admission MDS assessment dated [DATE] showed Resident #90 was not edentulous. On 4/10/24 at 1:09 p.m. The MDS Coordinator said she uses the nursing assessments to complete the dental aspect of the MDS. She stated she did not assess the resident's oral or dental condition at the time of the assessment look back. She stated she could not say for sure the nursing documentation is accurate as to the resident's oral assessment. Review of the Resident Assessment Instrument Manual 3.0 instructions for coding oral/dental status on the MDS showed to, Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth . Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. 38570 Based on record review and staff interview, the facility failed to ensure completion of the quarterly minimum data set (MDS) within 92 days from the assessment reference date of the last completed assessment for 14 (Resident #7, #17, #41, #45, #62, #66, #67, #72, #73, #79, #82, #84, #88, and #91} of 14 residents sampled. This had the potential to delay assessment and revision of the plan of care. Quarterly assessments are used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. The findings included: On record review for Resident #7s Minimum Data Set Assessments (MDS) revealed the resident has an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 164 days. The assessment was completed by the facilities MDS coordinator on 1/31/24. Then Signed off by RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion on 2/1/24. Transmitted to CMS (Center for Medicare and Medicaid Services) on 2/7/24. On record review for Resident #17's MDS assessments revealed the resident has an admission assessment done on 8/19/23 and did not have their next Quarterly assessment coded and completed for 130 days. The assessment was completed by the facilities MDS coordinator on 12/27/23. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 12/27/23. Then transmitted to CMS on 1/2/24. On record review for Resident #41's MDS assessments revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 130 days. The assessment was completed by the facilities MDS coordinator on 12/27/23. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 12/27/23. Then transmitted to CMS on 1/2/24. On record review for Resident #45's MDS assessments revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 170 days. The assessment was completed by the facilities MDS coordinator on 2/6/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 2/6/24. Then transmitted to CMS on 2/9/24. On record review for Resident #62's MDS assessments revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 159 days. The assessment was completed by the facilities MDS coordinator on 1/26/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 1/26/24. Then transmitted to CMS on 1/31/24. On record review for Resident #66's MDS assessmemts revealed the resident had an admission assessment done on 8/19/23 and did not have their next Quarterly assessment coded and completed for 138 days. The assessment was completed by the facilities MDS coordinator on 1/4/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 1/4/24. Then transmitted to CMS on 1/4/24. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On record, review for Resident #67's MDS assessments revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 159 days. The assessment was completed by the facilities MDS coordinator on 1/26/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 1/26/24. Then transmitted to CMS on 1/31/24. On record review for Resident #72's MDS assessments revealed the resident had an admission assessment done on 8/21/23 and did not have their next Quarterly assessment coded and completed for 164 days. The assessment was completed by the facilities MDS coordinator on 1/31/23. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 2/1/24. Then transmitted to CMS on 2/7/24. On record review for Resident #73's MDS assessments revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 143 days. The assessment was completed by the facilities MDS coordinator on 1/5/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 1/10/24. Then transmitted to CMS on 1/12/24. On record review for Resident #79's MDS revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 138 days. The assessment was completed by the facilities MDS coordinator on 1/4/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 1/5/24. Then transmitted to CMS on 1/5/24. On record review for Resident #82's MDS assessments revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 183 days. The assessment was completed by the facilities MDS coordinator on 2/19/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 2/6/24. Then transmitted to CMS on 2/21/24. On record review for Resident #84's MDS assessments revealed the resident had an admission assessment done on 8/21/23 and did not have their next Quarterly assessment coded and completed for 137 days. The assessment was completed by the facilities MDS coordinator on 1/4/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 1/5/24. Then transmitted to CMS on 1/5/24. On record review for Resident #88's MDS assessments revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 163 days. The assessment was completed by the facilities MDS coordinator on 1/30/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 1/30/24. Then transmitted to CMS on 1/31/24. On record review for Resident #91's MDS assessments revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 168 days. The assessment was completed by the facilities MDS coordinator on 2/4/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 2/2/24. Then transmitted to CMS on 2/9/24. During an interview on 4/10/24 at 1:45 p.m., the MDS coordinator stated that it is correct that Residents #7, #17, #41, #45, #62, #66, #67, #72, #73, #79, #82, #84, #88, and #91. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not have a completed quarterly assessment coded, completed and transmitted within the 92 days that they should have been completed from the prior assessment. MDS coordinator said she only works part time and was unable and is still unable to get all the MDS assessments done. MDS Coordinator Nurse stated that the extent of the issues is for all the residents in the facility. During an interview on 4/10/24 at 3:29 PM, [NAME] President (VP) of Clinical Services/Risk Management stated that the facility has been struggling to be able to complete all the Minimum Data Set assessments. The VP stated the MDS nurse was working part time and was unable to complete all the assessments.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 38570 Based on record review and staff interview, the facility failed to ensure completion and transmission of completed resident Quarterly Minimum Data Set (MDS) data to the Center for Medicare and Medicaid Services (CMS) System Within 14 days after a facility completes a resident's assessment for 2 (Resident #17 and 82) of 14 residents reviewed. The findings included: Record review for Resident #17's Minimum Data Set Assessments (MDS) revealed the resident has an admission assessment done on 8/19/23 and did not have their next Quarterly assessment coded and completed for 130 days. The assessment was completed by the facilities MDS coordinator on 12/27/23. Then Signed off by the Registered Nurse (RN) Assessment Coordinator verifying Assessment Completion on 12/27/23. Then transmitted to CMS on 1/2/24. Record review for Resident #82's Minimum Data Set Assessments (MDS) revealed the resident had an admission assessment done on 8/20/23 and did not have their next Quarterly assessment coded and completed for 183 days. The assessment was completed by the facilities MDS coordinator on 2/19/24. Then Signed off by RN Assessment Coordinator verifying Assessment Completion on 2/6/24. Then transmitted to CMS on 2/21/24. On 4/10/24 at 1:45 p.m., in an interview the Minimum Data Set (MDS) coordinator stated that Residents' #17, #82, MDS assessments were not transmitted to CMS within the 14-day timeline from completion. On 4/10/24 at 3:29 p.m., the [NAME] President (VP) of Clinical Services/Risk Management stated that the facility has been struggling to complete all the Minimum Data Set (MDS) assessments and get them transmitted to CMS within the time frame. The VP stated that the MDS nurse was working part time and was unable to complete all the assessments.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of the clinical record, and resident and staff interviews, the facility failed to provide the necessary care and services to maintain personal hygiene for 2 (Residents #81 and #303) of 3 residents reviewed for activities of daily living (ADLs). The findings included: The facility policy Activities of Daily Living (ADL), Supporting documented Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADL's . Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care. 1. Review of the clinical record revealed Resident #81 had a readmitted [DATE] with diagnoses including pacemaker, hypertension, adjustment disorder, right eye prosthesis, history of falls and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 2/1/24 documented Resident #81 required supervision for showers and was independent for personal hygiene. The MDS noted Resident #81's cognitive skills for daily decision making were moderately impaired. The care plan for Resident #81 identified an ADL self-care performance deficit related to dementia. On 4/8/24 at 9:06 a.m., Resident #81 was observed in bed, and responded to simple questions. He was noted to have long fingernails extending approximately 1/2 inch with brown substance under the nails. He was unshaven with approximately four days of facial hair growth. He was dressed in long pants and a T-shirt. Resident #81 said, I'm okay. He looked at his nails and said, they need to be cleaned. When asked if was able to shave himself, he rubbed his face and said, I could use a shave. On 4/8/24 at 1:30 p.m., Resident #81 remained with fingernails extending approximately 1/2 inch with an accumulation of brown substance under the nails, and approximately four days of facial hair growth. Resident #81 had a moderate malodorous body odor. On 4/9/24 at 9:26 a.m., Resident #81 was observed in his room in bed dressed in the same clothing as the prior day. He felt his face and said, they shave me once in a while. His mouth was dry and caked food was noted on his teeth, he said he did not know how he gets his teeth brushed or who helps him. When asked if he was the receiving the care he needed he said, I can't complain, it doesn't do no good. On 4/10/24 at 1:12 p.m., in an interview Certified Nursing Assistant (CNA) Staff G said Resident #81 was showered by staff but independent with some tasks being able to transfer himself, walk in room with a walker or uses the wheelchair. He is assisted to shave and can feed himself and toilet himself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/10/24 at 1:42 p.m., during an observation and interview, CNA Staff G was in the room with Resident #81 and was shaving the resident. The CNA said, the shaves are done during showers and whenever needed. She said she was assigned to the resident today and usually works on his assignment, but this was her first day back as she was scheduled off for a few days. Review of the Weekly Shower List revealed Resident #81 was scheduled for showers on Tuesdays, Thursdays, and Saturdays on the 7:00 a.m., to 3:00 p.m., shift. Review of the CNA documentation did not show documentation Resident #81 received his scheduled showers. On 4/11/24 at 10:02 a.m., in an interview the Director of Nursing (DON) said the CNAs document showers on a shower sheet that is given to the nurse. Once the nurse reviews the shower sheet, it is shredded. The DON provided four CNA shower sheets documenting Resident #81 received a shower on 12/11/23, 1/23/24, 2/2/24 and 2/14/24. The DON said, That is all I have. 2. Review of the clinical record revealed Resident #303 had a readmitted [DATE] with diagnoses including bipolar disorder, lung cancer with metastasis to the brain status post chemoradiation. The care plan initiated 4/10/24 documented the resident had a self-care performance deficit related to a stroke, terminal illness, and pain. On 4/8/24 at 10:08 a.m., during an observation and interview, Resident #303 was in her bed, her fingernails extended approximately half an inch with a sticky substance under the nails and on the thumb and index fingers of the left hand. The resident said it was blood from her nose. Resident #303 said she had been picking her nose and it had bled. No active bleeding was observed at this time. She said she did not know when she was supposed to get a shower and could not remember the last time she had a shower. Review of the facility shower list revealed the resident was scheduled for showers on the 3:00 p.m., to 11:00 p.m., shift on Tuesdays, Thursdays, and Saturdays. Review of the CNA documentation, the electronic record and the paper chart for Resident #303 revealed no documentation of showers provided for the resident. The facility was unable to locate any documentation the resident received her scheduled showers. On 4/11/24 review of the CNA Care Kardex (provided instructions for care) updated on 4/10/24 showed Resident #303's showers were scheduled for Mondays, Wednesdays and Fridays, and hospice was to provide the showers. Review of the electronic record and the paper chart showed no documentation of a Hospice Care Plan or hospice aide documentation of showers provided to the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/24 at 10:04 a.m., in an interview the DON said the facility had contacted the Hospice to request the aide shower documentation and the care plan. They are getting it together and are going to send it to us. The DON confirmed there was no documentation at this time that showed the resident received her scheduled showers. On 4/11/24 at 12:11 p.m., review of the Hospice Collaboration of Care provided by the facility revealed since her admission on 3/13/24, Resident #303 received a sponge bath on 4/6/24, 4/7/24, and a shower on 3/28/24 and 4/4/24.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, record review, facility policy review, resident and staff interview, the facility failed to provide an ongoing program of activities to meet the resident's interests and support the resident physical, mental and psychosocial well-being for 4 (Residents #8, #42 #51 and #82) of 4 residents reviewed for involvement in the activity program. The lack of an ongoing activity program could lead to a decline in the residents' self-esteem, physical, mental, and psychosocial well-being. The findings included: Review of the undated Activity Programs policy revealed the activity programs were designed to meet the interests of and the physical, mental, and psychosocial well-being of each resident. The activities program was provided to support the well-being of each resident and to encourage both independence and community interaction. The activity program was ongoing and included facility-organized group activities, independent individual activities and assisted individual activities. All activities were to be documented in the resident's medical record. 1. Review of the clinical record revealed Resident #8 had a readmitted [DATE] with diagnoses including dementia, psychosis, major depressive disorder, and anxiety. Review of the care plan initiated on 3/3/20 noted Resident #8 was at risk for decreased social interaction and activity participation due to cognitive impairment. The care plan specified the resident enjoyed listening to music, watching various television shows, fresh air, and religious activities. The goal for Resident #8 was for her to participate in daily group activities weekly. On 4/8/24 during observations at 10:50 a.m., and 12:15 p.m., Resident #8 was observed in her room in a reclining wheelchair wedged between the bed and a dresser. The room was dark, and she had the sheet over her head. There was no music or television turned on. Review of the activity calendar specified on 4/8/24 activities 8:00 a.m., daily puzzle, 10:00 a.m., daily breeze, 2:00 p.m., women's club, 4:00 p.m., spa day, 5:30, grooming. On 4/9/24 at 9:54 a.m., Resident #8 was observed in her room in a chair wedged between the bed and the dresser, with no television or music in the room. On 4/9/24 at 10:03 a.m., to 12:00 p.m., Resident #8 was observed in her room in the reclining chair wedged between the bed and the dresser. The resident was yelling and calling out, I'm hungry. Lord help me, repeatedly as staff in the hallway walked by her room and did not stop to assist her. The activity calendar for 4/9/24 specified 8:00 a.m., daily puzzle, 10:00 a.m., fresh air, 2:00 p.m., happy hour, 4:00 p.m., movie. 2. Review of the clinical record documented Resident #42 had a readmitted [DATE] with diagnoses including dementia, Alzheimer's, anxiety, and major depressive disorder. The record indicated the resident's primary language was Spanish. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan initiated 3/18/22 identified the resident was at risk for decreased social interaction and activity participation due to her dementia diagnosis. The care plan specified the resident enjoys listening to Spanish music and watching Spanish television shows and movies. During random observations on 4/8/24 at 9:15 a.m.,12:30 p.m., and 3:21 p.m., Resident #42 was observed in her bed sleeping. Review of the activity calendar specified on 4/8/24 activities 8:00 a.m., daily puzzle, 10:00 a.m., daily breeze, 2:00 p.m., women's club, 4:00 p.m., spa day, 5:30 grooming. On 4/9/24 at 8:52 a.m., Resident #42 was observed in the unit dining room having finished with the morning meal and was assisted in a reclining wheelchair to sit in the hall in front of the nursing station outside of the dining room. On 4/9/24 at 9:46 a.m., Resident #42 was assisted to bed. On 4/9/24 at 11:34 a.m., Resident #42 was observed in her bed sleeping. There was no Spanish music or television on in the room. On 4/9/24 at 1:00 p.m., Resident #42 was observed in bed sleeping. On 4/9/24 at 1:00 p.m., Resident #42's roommate said she was the Resident Council President. She said, She (Resident #42) sleeps all the time. I speak Spanish and she really does not talk anymore. Maybe a few words but she is always sleeping. They just let her sleep. The activity calendar for 4/9/24 specified 8:00 daily puzzle, 10:00 a.m., fresh air, 2:00 p.m., happy hour, 4:00 p.m., movie. On 4/9/24 at 3:02 p.m., in an interview CNA Staff H said she was assigned to do activities in the memory care unit. Staff H said the Activity Director was not here every day, she goes to school during the day. They have an activity calendar they are supposed to follow, it is not the same as the one for the other residents. She said no one tells her what to do, she just keeps the residents busy. Staff H said the Activity Director does not supervise the activities during the day since she's not at the facility. Staff H said, there are two activity aides in the facility, me and the other CNA but she is not here today, she is off so it is just me and I don't do activities on the other units. On 4/9/24 at 3:10 p.m., in an interview the Activity Director said she was also a CNA. She said she was in school during the day therefore worked the evening shift from 3:00 p.m., to 11:00 p.m. Review of the activity calendar revealed activities end between 4:00 p.m., and 5:30 p.m. The Activity Director said she did, whatever the residents want me to do. Sometimes I play a movie, I do 1-1, it depends on what they want to do, I do it. The Activity Director said she tracks activity attendance in a logbook and the activity aides mark the activities the residents attend. She said she also sometimes works as a CNA in the evening, help feed residents and do CNA work. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the activity logbook provided by the Activity Director showed Resident #42 attended five activity programs on 4/8/24 during the time when she was observed in bed sleeping. The activity logbook documented Resident #8 attended three activity programs on 4/8/24 during the time she was observed in her room. The Activity Director said, All I know is I asked the girls if the residents were up. They said the residents were out of bed and in activities. I'm going to have to find out about that one. On 4/10/24 at 8:03 a.m., in an interview the [NAME] President of Clinical Services/Risk Management said after an investigation the activity assistant confirmed she did not know which residents actually attended the activities on 4/8/24. 25618 3. Review of the Activity Director's (AD) job description, signed and dated 8/15/22, revealed they were required to plan, organize, develop, and direct the overall operations of the Activities Department in accordance with federal, state, and local standards. They AD was required to develop a preliminary and comprehensive assessment of the activity needs of each resident, encourage the resident and family to participate in the development and review of the resident's plan of care, ensure that all activities personnel were aware of the care plan and that care plans were used in providing daily activities for the resident, review nurses' notes to determine if the activity care plans was being followed, and to review and revise care plans and assessments, as necessary but at least quarterly. On 4/8/24 from 1:09 p.m., to 4:00 p.m., Resident #51 was observed in his bedroom, laying on his bed without the television (TV) or radio on, and/or being involved in an activity program. Resident #51 was not interviewable due to cognitive impairment. On 4/9/24 at 10:15 a.m., and from 12:50 p.m., to 4:15 p.m., Resident #51 was observed in his bedroom laying on his bed without the TV or radio on and/or being involved in an activity program. Review of Resident #51's medical record revealed he was admitted to the facility was 12/22/23 with a readmission on 4/5/24. The latest Activities Admission Evaluation, dated 1/4/24, stated his primary spoken language was Creole. Resident #51's activity preferences stated he liked activities in the morning, afternoon and evening and he enjoyed being in the comfort of his room watching various TV shows and listening to Creole music. The activity plan of care initiated on 12/27/23 and revised 2/1/24 stated Resident #51 enjoyed being in his room watching various TV shows, listening to music, and talking with staff at times. The interventions/tasks section stated staff would encourage the family to bring a radio/compact disc (CD) player for the resident, and the facility staff would encourage Resident #51 to join in an activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #51's activity program attendance and participation form/documentation noted music was not offered to Resident #51 in January, February, and April of 2024. Resident #51 was offered music four times in March of 2024. Documentation on the activity program attendance and participation form revealed from 2/1/24 through 2/22/24, and 3/15/24 through 3/31/24, Resident #51 had not attended nor was invited to attend any facility activity as required in his activity plan of care. 4. On 4/8/24 at 10:25 a.m., from 1:30 p.m. to 4:30 p.m., Resident #82 was observed in her bedroom laying on her bed without a radio/music on nor involved in an activity program. Resident #82 did not have a TV in her room. Resident #82 was not interviewable due to cognitive impairment. On 4/9/24 at 9:27 a.m., and from 1:00 p.m., to 4:35 p.m., Resident #82 was observed in her bedroom laying on her bed without a radio/music on nor involved in an activity program. Review of Resident #82's medical record revealed an admission to the facility on [DATE] with a readmission on 8/13/23. The Activities Admission Evaluation, dated 6/9/22, stated her primary spoken language was Creole. Resident #82's activity preferences stated she liked activities in the morning, afternoon and evening and she enjoyed independent, group and 1:1 (one to one) activity. Resident #82 was at the facility for long term care. She had some behaviors and participated in some activities which fluctuated with her mood. Resident #82 enjoyed listening to Haitian music. Resident #82's current activity plan of care initiated on 7/13/22 and revised 7/25/22 stated Resident #82 was at risk for decreased social interaction/activity participation related to language barrier, impaired cognition and a left below the knee amputation. Activity preferences included watching TV/movies and listening to music. The interventions/tasks section stated staff was to assist with television programs of choice, invite Resident #82 to daily group programs, provide assistance to daily group programs, and encourage social interactions with staff and peers. Review of Resident #82's activity program attendance and participation form revealed documentation noted music was not offered to Resident #82 in January, February, and March of 2024. Resident #82 was offered music 2 times out of 8 days in April of 2024. The activity program attendance and participation form revealed from 2/1/24, through 2/16/24, and 2/24/24, through 2/29/24, and 3/15/24, through 3/31/24, Resident #82 had not attended nor was invited to attend any facility activity as required in her activity plan of care. On 4/10/24 at 11:19 a.m., in an interview with Certified Nursing Assistant (CNA) and activity aid Staff A, she said she was one of the activity aids who conducted the activity programs on the long-term care section of the facility. She said for the 155-bed facility they had one activity aid in the memory care unit and one activity aid for the long-term care side of the facility. She said the Activity Director went to school during the day and came to the facility after school around 3:00 p.m. She said Resident #51's and Resident #82's primary language was Creole, and they did not speak English. She said both residents liked to stay in their rooms, and she did not remember the last time they attended a group or an out of room activity. She said they did not have any activity programs for residents who only speak Creole. On 4/10/24 at 11:42 a.m., in an interview with CNA Staff C, she said Resident #51 spoke primarily Creole and only knew a few words in English. She said Resident #51 stayed primarily in his room and she didn't remember Resident #51 attending any of the facility's activity programs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/24 at 2:51 p.m., in an interview with CNA Staff B, she said Resident #82 spoke Creole only and when she needed to communicate with Resident #82, she had to find a staff member who could speak Creole. She said Resident #82 stayed in her room the majority of times and she didn't remember Resident #82 attending any out of the room facility activity programs. She said Resident #82 did not have a radio/CD player or a TV in her room. On 4/10/24 at 4:10 p.m., in an interview with the Activity Director, she said she became the Activity Director in August 2022. She said she was in school Monday through Friday, during the day, every week, and she came to work around 3:00 p.m. She depended on her activity staff to conduct the resident's activity program as written. She confirmed Resident #51's, and Resident #82's primary language was Creole, and they spent a lot of their time in their room. She said because the activity department did not have activities for residents who only speak Creole, she had put a radio/CD player in Resident #51's and Resident #82's rooms with Creole music on CDs, so the activity staff could play Creole music for Residents #51 and #82 as written in their activity plan of care. The Activity Director toured Resident #51's and Resident #82's rooms and confirmed neither resident had a radio/CD player with Creole music on CDs in their room and confirmed Resident #82 did not have a TV in her room. The Activity Director reviewed Resident #51's and Resident #82's activity program attendance and participation form and confirmed the activity staff did not conduct each resident's music activity program and did not conduct the resident's overall activity program consistently as required and documented on their activity plan of care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy and procedures, record review and staff interviews, the facility failed to maintain urinary catheters in a safe and sanitary manner for 1(Resident #303) of 3 residents reviewed with an indwelling urinary catheter. The findings included: The facility policy Catheter Care documented It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. Review of the clinical record documented Resident #303 had an admitted [DATE] with diagnoses including urinary retention. The care plan for Resident #303 initiated on 4/10/24 identified the resident had an indwelling catheter (catheter inserted in the bladder to drain urine) with the goal she would have no signs or symptoms of a urinary tract infection. On 4/8/24 at 10:06 a.m., Resident #303 was in her room in bed and was observed to have an indwelling catheter. The catheter drainage bag was on the safety mat and the drainage spout was open. On 4/8/24 at 12:47 p.m., Resident #303's drainage bag spout was observed to be closed but it remained on the floor mat. On 4/8/24 at 1:19 p.m., Licensed Practical Nurse Staff I verified the catheter drainage bag was lying on the safety mat on the floor and said she was not aware it could not be on the mat but would take care of it.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policies and procedures, staff and resident interviews, and record review, the facility failed to ensure 3 (Residents #24, #42 and #100) of 29 residents with bed rails were assessed for alternative interventions prior to the use of bed rails, and failed to ensure residents were assessed for danger of entrapment prior to use of bed rails. In addition, the facility failed to inform the residents and/or their representative of the risks and benefits of bed rails or obtain an informed consent prior to use of the bed rails. The findings included: The facility policy Proper Use of Bed Rails documented, Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used the facility ensures correct installation, use and maintenance of the rails. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the residents' assessed needs. The resident assessment should assess the resident's risk of entrapment between the mattress and the bed rail or in the bed rail itself. Entrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails the information should be presented in an understandable manner and consent given voluntarily free from coercion. The information that the facility should provide to the residents or resident representatives includes but is not limited to what assessed medical needs would be addressed by the use of the bedrails the residents' benefits from the use of the bed rails and the likelihood of these benefits period the residents risk from the use of the bed rails and how these risks will be mitigated. Alternatives attempted that failed to meet the residents' needs and alternatives considered but not attempted because they were considered to be inappropriate. The facility will ensure the correct installation and maintenance of bed rails prior to use. This includes checking with the manufacturer to make sure the bed rails mattress and bed frames are compatible. Confirming that the bed rails are appropriate for the size and weight of the resident using the bed. Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment. Checking bed rails regularly to make sure they are still installed correctly and have not shifted or loosened overtime. Conducting routine preventive maintenance of the bed rails and beds to ensure they meet current safety standards and are not in need of repair. 1. Review of the clinical record revealed Resident #42 had a readmitted [DATE] with diagnoses including falls, dementia, anxiety, major depressive disorder and Alzheimer's. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 2/7/24 documented Resident #42 was dependent on staff for mobility including rolling side to side in bed and specified bed rails were not used. The MDS noted Resident #42's cognitive skills for daily decision making were severely impaired. The care plan for Resident #42 initiated 2/12/19 identified the resident was at risk for falls. The interventions included 1/2 side-rails up in bed as an enabler, date Initiated: 10/12/2022. 1/4 side-rails up in bed as an enabler, date Initiated: 2/19/2022. On 4/8/24 at 11:00 a.m., Resident #42 was observed in bed with 1/2 rails in the raised position on both sides of the upper bed. 4/10/24 at 9:08 a.m., in an interview the Administrator said the facility did not use side rails but if the family or the resident wanted them, they provided education and have them sign the consent form. The Administrator said the nurse and therapy assess the resident and attempt alternate interventions first. She confirmed she no had additional documentation for the use of the bed rails that indicated the alternative interventions were attempted for Resident #42. On 4/10/24 at 9:36 a.m., in an interview the Maintenance Director (with the Housekeeping Supervisor interpreting) said he checks the bed rails daily to make sure they are not loose, and he tightens them. The Maintenance Director entered a resident's room where 1/4 rails were on the bed and shook the rail to show that it was secure. The rail was very loose and required tightening of the bolts. He said he puts the bed rails on when the nurse gives him a paper to put them on. The Maintenance Director said he did not keep records of inspection of the bed rails for entrapment zones or inspection for the compatibility of mattresses and the beds rails. He said, each side rail is different, and he cannot put one side on a bed because it may not match, and it has to match the bed. The Maintenance Director said several times, no resident can get their head through any of the bed rails in use. On 4/10/24 at 10:35 a.m., in an interview the Housekeeping Supervisor confirmed the Maintenance Director did not have any record the bed rails were assessed for entrapment zones. She confirmed there was no on-going, periodic assessment to ensure the bed rails were secured and mattresses did not have gaps. The Housekeeping Supervisor provided a copy of the Bed Rail and Enabler Measurement Tool. Review of the Bed Rail and Enabler Measurement Tool documented To ensure resident is not at risk for entrapment, measurements are to be completed on a quarterly basis. 25618 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/24 at 10:11 a.m., Resident #24 was observed in bed with 1/2 size bed rails elevated on both sides of the upper half of the bed in the upright position. On 4/10/24 at 3:45 p.m. Resident #24's bed was observed to have had the 1/2 size side rails replaced with 1/4 size side rails on both sides of the upper half of the bed. On 4/9/24 at 4:28 p.m., in an interview Resident #24 said someone came in and had her sign a consent for the side rails today but did not explain the risks of having side rails. On 4/10/24 at 3:48 p.m., in an interview Registered Nurse (RN) Staff D confirmed Resident #24 signed a consent for the bedrails on 4/9/24. Review of the consent for side rails for Resident #24 showed the form was dated 2/24/24. RN Staff D verified she wrote 2/24/24 on the consent form and it should have been 4/9/24. On 4/10/24 at 4:00 p.m., in an interview Occupational Therapist Staff F said he assessed Resident #24 today for the use of side rails. He said the resident had 1/4 rails in use on the bed when he conducted the assessment. He said he had not assessed the resident for alternatives before installation of the bed rails. On 4/11/24 at 12:20 p.m., in an interview the interim Director of Nursing verified no appropriate alternatives were tried prior to installing the bed rails for Resident #24.