STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105843	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Altamonte Nursing & Rehabilitation Center	1099 West Town Parkway Altamonte Springs, FL 32714

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50401 Based on observation, interview, and record review the facility failed to treat residents with dignity and care to promote quality of life by standing while feeding them and referring to residents as feeders for 2 of 6 residents reviewed for assisted dining, of a total sample of 37, (#15 and #29). Findings: 1. On 10/16/24 at 9:45 AM, resident #15's assigned Certified Nursing Assistant (CNA) D was observed in the residents room standing over the resident while feeding her. CNA D stated she was aware she was supposed to sit while feeding residents, but explained she was busy running from resident to resident and didn't get a chair. She stated she knew it was important to sit while assisting residents with their meals to be at eye level with them. On 10/16/24 at 12:41 PM, CNA C was observed as she delivered and set up the lunch tray in front of resident #15, then left the room. Two minutes later at 12:43 PM, resident #15 was observed eating the food from her lunch tray with her hands. At 12:44 PM, CNA D passed by resident #15 in the 'A' bed and delivered the meal tray to the roommate in the 'B' bed. She did not acknowledge resident #15 eating with her hands visibly in front of her, and left the room. A short time later at 12:56 PM, resident #15's daughter, was observed sitting in a chair next to her mother, assisting her with her lunch meal. She stated she was concerned her mother did not receive the assistance she needed to eat her meals. She stated when she walked into her mother's room today, her mother was not being assisted to eat or drink and instead was attempting to do it herself. She stated she had previously voiced concerns to the facility for her mother to get assistance with meals. Resident #15's daughter stated she had been assured this had been handled, and she added she was not here every day to assist her mother. On 10/16/24 at 1:13 PM, CNA C explained when she brought the lunch tray to resident #15 earlier she was not aware if she was a feeder or not. She stated she had asked her co-worker, CNA D, who the feeders were on the unit, and CNA D told her she had six of them. She stated this morning she assisted resident's in the dining room with the breakfast meal and was not that familiar with the residents on this unit. She continued, she was a CNA who worked on a variety of units floating as needed (PRN) and usually worked the overnight shift. She stated she was not aware she should not refer to residents as, feeders, and did not know it was not an acceptable practice. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 1:30 PM, CNA D stated if CNA C was not aware that resident #15 was a feeder, she should have left the tray on the cart and asked for clarification instead of just setting up the tray for the resident. CNA D stated she was also a floating PRN CNA and had only been working at the facility a few months. She added, it was important to know which residents were feeders and not to leave the tray at the resident's bedside unattended if they needed assistance for safety and hygiene reasons. She explained the tray could be knocked over by the resident accidentally or they could put their hands in the food and also to keep the food warm. She continued, it was important to help maintain the resident's dignity. She stated she was aware she should not refer to residents as feeders and she didn't do it in front of them. 2. On 10/16/24 at 12:54 PM, CNA D was overheard saying, Feeder, feeder, feeder aloud in the hallway outside resident rooms, to indicate which residents needed assistance with their meals, and as she figured out which resident's room to go to next. On 10/16/24 at 1:05 PM, CNA C was observed standing up over resident #29, feeding him his lunch meal. On 10/16/24 at 1:10 PM, CNA C confirmed she had been standing while she fed resident #29 their lunch today. She explained she stood because she was in a hurry. She stated she was aware she was supposed to sit while she fed a resident in order to be at their level. On 10/17/24 at 4:38 PM, in a joint interview with the G and R Unit Manager and the Director of Nursing (DON), the Unit Manager stated when CNAs assisted a resident with their meal, she expected them to wash their own and the resident's hands, to set up the meal comfortably and then sit down with the resident at eye level. She added that CNAs needed to refer to residents using their preferred name and not use labels, like feeders. The DON added no staff were to use the term feeder, but instead were to use the terminology, assisted diners. The DON continued, when CNAs were working a shift on a unit they were not familiar with, they were expected to get information about the resident's needs as they rounded and huddled in the morning. She explained they could use the Kardex as a resource and they could ask the nurse. They were not to leave a meal tray at a resident's bedside if they didn't know if the resident needed assistance or not, but were to leave the meal on the cart and find out first. They should bring the meal to the resident only when they were ready to assist them for the entire dining process. The facility's policy entitled Promoting/Maintaining Resident Dignity dated 3/01/22 and revised 4/01/22 indicated staff were to pay attention to each resident as an individual, explain care and procedures before initiating an activity, speak respectfully to residents and avoid discussions about residents that may be overheard by others.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level I evaluation was completed, (#33), and failed to request a Level I and/or Level II PASARR evaluation after a new major mental disorder diagnosis, (#65), for 2 of 2 residents reviewed for PASARR, of a total sample of 37. Findings: 1. Resident #33 was readmitted to the facility from the hospital on 3/29/24 but was initially admitted on [DATE]. On admission she had diagnoses that included cerebral infarction stroke), aphasia (difficulty speaking), vascular dementia with other behavioral disturbances, major depressive disorder, and mood disorder. Review of Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed that resident #33 was severely cognitively impaired, had impairments to both upper and lower extremities limiting range of motion, was bedbound, and dependent for all activities of daily living (ADLs). Review of the medical record for resident #33 revealed a PASARR Level I dated 10/25/23 that had no mental illness (MI) diagnoses listed. On 10/17/24 at 1:04 PM, the Director of Nursing (DON) stated she was the person responsible for completing the PASARRs. She explained she was new to the facility and had just gotten around to auditing the PASARRs for all of the residents to make sure they were complete. She confirmed resident #33 had been readmitted to the facility on [DATE] and a new PASARR should have been done. She said that the Admissions office was responsible for verifying that the PASARRs were completed and if they were not, they needed to let the her know so that she could submit a new one. 50875 2. Review of the medical record revealed resident #65 was admitted to the facility on [DATE] from the hospital. Her diagnoses included chronic atrial fibrillation, type 2 diabetes with hyperglycemia, dementia, major depressive disorder, recurrent unspecified, mood disorder due to known physiological condition with mixed features and insomnia. Resident # 65's Quarterly MDS assessment with assessment reference date of 8/05/24 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status which indicated she had no cognitive impairment. The assessment indicated she had rejection of care. Her active diagnoses listed non-Alzheimer's dementia, depression and bipolar disorder. Review of resident #65's medical record showed a Care Plan dated 6/13/22, which indicated resident #65 had behaviors, was paranoid, hateful toward her family, aggressive, would ask for her room to be changed if it was shared with a roommate, pulled out her hair, and took items from the activity room then claimed the items were hers. Another care plan dated 11/02/22 revealed resident #65 refused medications, food and showers, and personal care. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #65's Order Summary Report and the Medication Administration Record showed the resident had an order for Trazodone 100 milligrams (mg) by mouth at bedtime for depression, Depakote 250 mg in the morning and 500 mg two times a day for dementia and other diseases classified elsewhere, moderate with other behavioral disturbance: mood disorder due to known physiological condition with mixed features. The Order Summary Report also showed resident #65 was evaluated and treated by Psychology for depressive symptoms. On 10/14/24 at 1:26 PM, resident #65 was observed in her room and appeared anxious and upset. She explained her son brought herto the facility and she lost her apartment. She expressed she felt depressed but not to the point of hurting herself. A short time later the assigned nurse and the Unit Manager revealed resident #65 refused to let staff care for her at times. Further review of resident #65's electronic medical records, revealed the PASARR Level I screen dated 5/23/22, was found to be inaccurate as no Mental Illness diagnoses were listed in Section 1A of the form. On 10/16/24 at 1:44 PM, the DON and Assistant DON were asked about PASARRs being updated and the DON stated she was responsible for the PASARRs. She explained the initial PASARR was reviewed on admission and if there was a new diagnosis, the form would be updated. She stated there were no paper charts used at the facility, so the PASARR scanned in the resident's electronic medical record was correct and the only accessible one. On 10/16/24 at 1:53 PM, the Medical Records clerk verified the PASARR Level I dated 5/23/22 was the only one and there were no other updated forms. The DON and Assistant DON verified resident # 65's current diagnoses differed from those on the PASARR. They both confirmed it was an inaccurate PASARR because the mental illness diagnoses were not listed in Section 1A. The DON also acknowledged resident #65's 3008 Transfer form had a diagnosis which should have been listed in Section 1A. The DON said she would correct and update the Level I PASARR for resident #65. Review of the Facility's Policy on Resident Assessment -Coordination with PASARR Program implemented 3/01/22 revealed the facility coordinated assessments with the PASARR program under Medicaid to ensure that individuals with mental disorders, intellectual disability or a related condition received care and services in the most integrated setting appropriate for their needs. Compliance guidelines included a PASARR Level I was completed prior to admission and that a negative Level I screen permitted the admission to proceed and ended the PASARR process unless a possible serious mental disorder or intellectual disability arose later.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on observation, interview, and record review, the facility failed to provide immediate and thorough nursing assessment and treatment services related to burns for 1 of 2 residents, (#27), and failed to obtain an order for treatment and date a treatment dressing for 1 of 2 residents reviewed for pressure wounds, (#84), of a total sample of 37 residents. The facility's failure to ensure a complete and timely assessment including accurate identification of burns resulted in actual harm. Resident #27 was transferred to a higher level of care initially for treatment and was transferred again to another hospital with a specialized burn unit. Resident #27 was admitted to the stepdown trauma unit with second degree burns to her left arm, left hand, abdomen and left thigh. She remained there for 5 days. Findings: Cross reference F689 and F813 1. Resident #27 was admitted to the facility on [DATE] with diagnoses to include left sided hemiplegia and hemiparesis, type 2 diabetes mellitus with diabetic neuropathy (nerve damage caused by diabetes), and contracture of the left hand. Hemiplegia and hemiparesis are similar in that they describe effects to one side to your body.hemiplegia refers to one sided paralysis while hemiparesis refers to one sided weakness, (retrieved from www.my.clevelandclinc.org on 10/21/24). The resident's quarterly Minimum Data Set (MDS) assessment, with Assessment Reference Date (ARD) of 8/21/24, revealed the resident was cognitively intact with a Brief Interview of Mental Status of 14/15. The record revealed the resident had left sided weakness and paralysis due to a stroke. Her left hand was contracted. The MDS indicated she was a set up assistance for eating and could feed herself. Review of Order Summary Report revealed an order dated 10/02/24 for triple antibiotic cream to be applied to a skin tear to left hand. Review of the Weekly Skin Check Sheet dated 10/02/24 revealed the sheet was incomplete/blank except for the date and the nurse's signature. Review of a Nurse's Progress Note dated 10/02/24 at 7:33 PM, by Licensed Practical Nurse (LPN) J revealed, the Certified Nursing Assistant (CNA) notified him that resident #27 burned herself with a noodle soup that she was eating. He documented that, Upon assessment resident have a skin tear on left hand. No complaint of pain /discomfort. Physician notified as well her daughter. There was no further documentation from LPN J or other nurses regarding the assessment/reassessment or treatment for resident #27 in the medical record. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/15/24 at 3:45 PM, the Administrator provided an overview of the investigation. She said on 10/02/24 at about 5:30 PM resident #27 had a cup of noodle soup that you add water to and cook in the microwave. Resident #27 asked CNA K to heat it for her and the CNA took it to the unit kitchen and cooked it in the microwave. The Administrator explained the food should have been heated in the kitchen. She stated CNA K told the Administrator it was dinner time, and she warmed up soup for resident #27. The CNA said she rested the soup on the table and then resident #27 tried to move a plate and it bumped the soup. CNA K said she tried to catch it, but it spilled on the resident's left arm. The CNA stated she reported it to the nurse. The Administrator stated she asked CNA K to demonstrate what happened and as CNA K was setting the soup down resident #27 hit the cup with a plate and it spilled toward the resident spilling onto her. The Administrator reviewed the statement from resident #27's assigned LPN J who wrote that CNA K notified him that resident #27 burned herself while she was eating noodle soup. He wrote that upon his assessment the resident had a skin tear on her left hand. He indicated he notified the physician as well as the resident's daughter. The Administrator stated the Director of Nursing (DON) called her around 9:00 PM the night of the incident and explained resident #27 was sent to the hospital. She recalled the DON told her that resident #27 got burned, and after the family came in 911 was called and resident was transported to the hospital. The Administrator stated it did not sound like an urgent situation to her. She said the DON told her the soup got spilled on resident #27's hand and she was treated. She explained she was trying to figure out why resident #27 had to go out if she received treatment. The Administrator stated the incident was being discussed in the morning meeting when the daughter arrived. The Administrator remembered resident #27's daughter came to see her the next morning, 10/03/24. She was upset that the staff did not respond appropriately to her mom. The Administrator explained resident #27's daughter showed her a picture of the resident's arm and it had some discolored skin. There were other areas on her arm that did not look like they were treated. The Administrator stated the daughter explained when she arrived to the facility to see her mother, the nurse was passing medications and CNA K was working in the fall risk area. The daughter stated she knew accidents happened, but the staff did not act concerned about her mother's burns. The Administrator explained the daughter told her that resident #27 called her and told her she needed to come here to see her. The daughter said her mother was in pain when she arrived at the facility around 6:30 or 6:40 PM on 10/02/24 and explained LPN J was still passing medications and had not been back to see resident #27 after the initial visit so the daughter called 911. The Administrator was asked if LPN J should have done a head-to-toe assessment when he first went to see resident #27 and her response was, LPN J stated he treated what he saw and went on to do medication administration. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/14/24 at 6:45 PM, via the telephone, resident #27's daughter stated CNA K fixed a cup of soup and after she set it on the table, the soup spilled on her mother. The daughter explained she received a call from the nurse that her mother was burned. The daughter said she came to the facility and spoke to the Supervisor who had no idea her mother was burned. She stated the Supervisor told her he would get the nurse, and they could discuss what happened, but when he found the nurse, the Supervisor went into the room and talked to him. The daughter said she got upset because the nurse and Supervisor were supposed to discuss what happened with her and they went in a room to talk amongst themselves. The daughter said she called 911 because she felt her mother needed to go to the hospital, and the police because she wanted to find out what happened. The daughter explained the Emergency Personnel took her mother to a nearby Hospital emergency room where she was assessed. Shortly afterwards the hospital transferred her to the to the specialized burn unit at a larger Level One hospital. The daughter stated when resident #27 got to the first hospital, they had to pour some kind of liquid on her clothes to remove them, as she the wet clothes had not been removed from the burned areas of her skin by the nursing home staff for almost two hours. She said after that is when they decided to send her to the larger hospital with the burn unit. She remained in the hospital a total of 5 days with second degree burns. On 10/16/24 at 1:47 PM, LPN J was interviewed by telephone. He stated CNA K had called him to say resident #27 burned herself while she was eating noodle soup. He stated he went to the room and the resident was sitting in her wheelchair. LPN J stated he asked the resident what happened and she said see my hand? He recalled the resident told him she had spilled the hot soup and he saw a skin tear on the resident's left arm. The LPN said he left resident #27 sitting in her wheelchair and went to the nurses' station, and called the doctor and daughter about what happened. He stated he came back to the resident's room and applied an antibiotic ointment to the resident's left arm as ordered by the physician then went back out to continue his medication pass. LPN J verified he was not aware the resident had spilled the hot soup on her left leg and stomach. He replied, No she did not tell me that. The LPN stated he did not notice her clothing was wet and had not performed a head-to-toe assessment when he learned of the incident. LPN J explained he was going to reassess resident #27 later when he finished his medication pass. A second degree or deep partial thickness burn involves damage or destruction of the first and second layers of the skin, which will be painful and often blistered. A full thickness burn can destroy nerves so pain might not be felt and will often look brown, black, or white and feel dry and leathery. You should go to the Emergency Department if the skin looks leathery, or there are patches of brown, black or white or if the burn involves the hands, airway, face or genitals. The first thing you should do if someone has a burn is to take off any contaminated clothing unless it is sticking to you and wash the affected area with plenty of cool water for up to 60 minutes. As soon as possible any clothing or jewelry should be removed, unless they are stuck to the burn, then it should be covered with something clean. Consequences of burn injuries that may progress without treatment include ischemia (obstruction of blood flow) due to increased swelling (edema), and infection, (retrieved on 10/31/24 from www.healthdirect.gov). On 10/17/24 at 11:30 AM, the DON stated she would expect the nurse would immediately complete a head-to-toe assessment and provide any necessary emergency treatment as ordered if a resident had a burn or any injury. She explained because it was a burn it should never had been presented to the physician as a skin tear. She added, the resident should have been reassessed because the skin did not always show the extent of the burn(s) right away. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/16/24 at 1:10 PM, via telephone interview resident #27 stated the burn occurred around dinner time, on 10/02/24 approximately 5:00 to 5:30 PM. The resident stated staff brought her meal tray and she was eating a piece of pie. She said she tried to move the pie when the cup of noodles spilled the very hot liquid all over. She said when the hot liquid hit her skin it hurt and she started screaming and hollering. Resident #27 said CNA K called the nurse and told him that a couple noodles got spilled on her and by the time LPN J got there her arm was burning. Resident #27 said LPN J later put something on her arm. The resident said she told the nurse her stomach and leg were burning, but he did not even look at it. Resident #27 explained she then called her daughter and told her she needed to come. The resident stated by the time her daughter got there she had a blister down to her thumb. She said her daughter called 911 and the police and she went to the hospital. Resident #27 said when she arrived at the hospital, they poured something on her to remove the clothes that were now stuck to her burned skin. She stated the doctor told her she had second degree burns and they gave her something for pain so she was out of it. The resident said she then went to the burn unit. She explained she could move her arm and leg now, but her stomach still hurt where it was burned. She said she got medication for the pain that took the edge off, so she could move her leg but when they get her up for therapy it hurts. The resident stated, They did not change me I went to the hospital in the same wet clothes. Review of the burn unit hospital records for resident #27, dated 10/02/24, skin assessment revealed, Partial thickness burn wounds with blistering to the left dorsal forearm extending to the lateral aspect of the base of the thumb and extending mid-way to the ventral aspect of the forearm. The open areas blanch well. Partial thickness burn wounds with blistering to the left lower anterior abdominal wall, left anterior and posterior thigh. The total body surface area prior to debridement is approximately 4 %. Mental status: She is alert and oriented to person, place and time. Review of the Skin Assessment Policy, dated 3/01/22 and revised 3/01/24, revealed a full body, or head-to-toe skin assessment would be conducted by a licensed or registered nurse upon admission/re-admission, and at least weekly thereafter and may also be performed after a change of condition. Patients with burn injuries are complex and have high mortality. Burns are traumatic injuries that can cause profound shock within minutes and can affect every body system. Nurses must prioritize assessment of the airway, the cause of burn, depth, and TBSA [total body surface area] during the initial screening. These assessments are important to appropriately resuscitate the patient and decrease the risk of burn shock. Patients with burns are at considerable risk for infection and hypothermia. Nurses should keep patients warm and transfer them to a certified burn center as soon as possible for the best outcomes. Providing early, quality nursing care to patients with burns will make all the difference in the outcome, (retrieved on 10/22/24 from www.nursingcenter.com/cearticle). 50401 2. On 10/17/24 at 3:25 PM, an undated treatment bandage was observed on the right forearm near the elbow of resident #84. The resident stated someone put the bandage on a couple of days ago after an injury. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of resident #84's Progress Notes, the record of weekly skin checks indicated on 10/07/24, the resident had a skin tear to right elbow. On 10/12/24, the resident had a skin tear to right elbow and treatment was in progress, and on 10/16/24, the weekly skin check also indicated the resident had a skin tear to right arm. On 10/17/24 at 3:27 PM, Registered Nurse (RN) I verified there was an undated bandage on right upper arm near the elbow of resident #84. RN I removed the bandage and noted there to be a gauze dressing under the bandage which was saturated with blood. She confirmed this finding and stated she would change the dressing. RN I then checked the computer record for a physician's treatment order and found there was not one. She stated she needed a physician's order for treatment so she would reach out to the physician for one. The G and R Unit Manager also present verified there was not a physician order for this treatment. She confirmed all treatment needed a physician's order to be provided. The facility's policy entitled Wound Treatment Management dated 3/01/22 and revised 3/01/24, revealed the facility was to provide evidence-based treatments in accordance with current standards of practice and physician orders. This would include dating a bandage when it was placed along with the method used to clean the wound, the type of dressing, and the frequency the dressing was to be changed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, record review, and facility's policy review, the facility failed to ensure care and services consistent with professional standards of practice to prevent pressure ulcers was provided, by failing to follow physician's order for weekly skin sweeps for 1 of 4 residents reviewed for pressure ulcer, of a total sample of 37 residents, (#42). Findings: Resident #42, a [AGE] year-old male was admitted to the facility on [DATE], and readmitted on [DATE]. His diagnoses included heart failure, cognitive communication deficit, diabetes type II, peripheral vascular disease, and malignant neoplasm (cancer) of the prostate. The resident's significant change Minimum Data Set assessment, with Assessment Reference Date of 9/08/24, revealed the resident's cognition was moderately impaired, with a Brief Interview of Mental Status score of 10 out of 15. The assessment noted the resident had functional limitation in range of motion to one side of his lower extremity, was dependent on staff assistance for toileting hygiene, and mobility. He required partial/moderate assistance to roll left and right. The assessment noted the resident was at risk for pressure ulcer and had one unhealed pressure ulcer that was classified as an unstageable deep tissue injury. Review of the resident's physician's order summary revealed a physician's order dated 7/03/24 for weekly skin sweeps on the 7 AM-3 PM shift every Wednesday. Physician's order on 9/11/24 was for skin prep wipes to be applied to the resident's bilateral heels three times daily for preventative treatment. Clinical record review revealed a weekly skin sweep was conducted for resident #42 on 7/09/24, and on 8/21/24. Documentation of additional skin sweeps could not be identified. On 10/17/24 at 9:30 AM, Licensed Practical Nurse (LPN) I stated skin sweeps were scheduled, based on the location of residents' beds. She explained that skin sweeps were conducted for residents in the A bed on the 7 AM to 3 PM shifts, and for residents in the B beds on the 3 PM to 11 PM shifts and schedule would be included in the residents' physician's orders. LPN I stated she usually worked on Tuesdays, and Thursdays, and resident #42's skin sweep was scheduled for Wednesdays, on the 7 AM-3 PM shift. The resident's clinical records were reviewed with the LPN, and she acknowledged that skin sweeps were conducted on 7/09/24, and on 8/21/24, and no other skin sweep documentation could be identified. (continued on next page)

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	105843	A. Building B. Wing	10/17/2024

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West Altamonte Nursing & Rehabilitation Center	1099 West Town Parkway Altamonte Springs, FL 32714

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 9:34 AM, the G&R Unit Manager (UM) stated weekly skin sweeps were as per physician's order. She stated skin sweeps were done to monitor the resident's skin, and to identify any skin issue, and the order would populate to the resident's Treatment Administration Record (TAR) or the Medication Administration Record (MAR). The resident's MAR was reviewed with the UM, and revealed signatures on 8/14/24, 8/28/24, 9/04/24, 9/11/24, 9/18/24, 9/25/24, 10/02/24, 10/09/24, and on 10/16/24 indicating skin sweeps were conducted for the resident. However, skin sweep documentation could not be identified for the dates documented/signed off on the MAR. The UM acknowledged the resident's physician's order for weekly skin sweep, and the two completed skin sweep documentation on 7/09/24, and 8/21/24, and acknowledged that no other documentation could be identified to indicate skin sweeps were actually conducted for the resident weekly as ordered by the physician. The UM stated the expectation was that nurses would complete residents' skin sweeps as order and stated a weekly skin assessment was to be completed and documented under the Assessment tab in the resident's electronic medical record (EMR). On 10/17/24 at 9:42 AM, the Assistant Director of Nursing (ADON) reviewed resident #42's MAR. She acknowledged signatures for the dates identified, and confirmed that no weekly skin sweep documents could be identified for the dates signed off on the MAR. On 10/17/24 at 10:07 AM, Registered Nurse (RN) A demonstrated how, and where skin sweeps would be documented in the resident's EMR. She stated that normally the UM provided staff with the schedule for residents' skin sweep daily. RN A stated staff were instructed to follow the User-Defined Assessments calendar for resident's skin sweep schedule. The RN said she never did skin sweeps for the resident, because it was not on the User-Defined Assessments calendar. She stated her signature on the resident's MAR on 8/07/24,8/28/24, 9/04/24, 9/11/24, and 9/25/24 indicated the order for skin sweep was acknowledged, not that it was completed. On 10/17/24 at 10:14 AM, an interview was conducted with the Director of Nursing (DON), the ADON, and the G&R UM. They all stated that if nurses signed off on an order, the signature would indicate that the task was completed as ordered. The facility's policy Skin Assessment implemented on 3/01/22 read, A full body, or head-to-toe skin assessment will be conducted by a licensed or registered nurse upon admission/ re-admission and at least weekly thereafter.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on interview and record review the facility failed to prevent an avoidable accident for a resident by not checking the temperature of microwaved noodles provided by staff for 1 of 2 residents reviewed for accidents, of a total sample of 37 residents, (#27). The facility's failure to provide a policy and ensure all staff were educated regarding the heating and reheating of resident food resulted in actual harm. Resident #27 was transferred to a higher level of care, then transferred again to another hospital with a specialized burn unit. Resident #27 was admitted to the stepdown trauma unit with second degree burns to her left arm, left hand, abdomen and left thigh. She remained in the hospital for 5 days. Findings: Cross reference F684 and F813 Resident #27 was admitted to the facility on [DATE] with diagnoses to include left sided hemiplegia and hemiparesis (one sided weakness and paralysis), type 2 diabetes mellitus with diabetic neuropathy (diabetic nerve damage), and contracture of the left hand. The resident's quarterly Minimum Data Set (MDS) assessment, with Assessment Reference Date (ARD) of 8/21/24, revealed the resident was cognitively intact with a Brief Interview of Mental Status of 14/15. The record revealed the resident had left sided weakness and paralysis due to a stroke. Her left hand was contracted. The MDS read she was a set up assistance for eating and could feed herself. Review of a Nurse's Progress Note dated 10/02/24 at 7:33 PM, by Licensed Practical Nurse (LPN) J revealed, the Certified Nursing Assistant (CNA) notified him that resident #27 burned herself with a noodle soup that she was eating. He documented that, Upon assessment resident have a skin tear on left hand. No complaint of pain /discomfort. Physician notified as well her daughter. There was no further documentation from LPN J or other nurses regarding the assessment/reassessment or treatment for resident #27 in the medical record. On 10/14/24 at 11:30 AM, resident #11 (roommate of #27) stated she did not see what happened when her roommate got burned, but she heard her and CNA K both scream. She recalled when she looked over CNA K said the soup spilled on her roommate. Resident #11 stated that CNA K made the cup of noodles frequently for resident #27. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/14/24 at 6:45 PM, via the telephone, resident #27's daughter stated CNA K fixed a cup of soup and after she set it on the table, the soup spilled on her mother. The daughter explained she received a call from the nurse that her mother was burned. The daughter said she came to the facility and spoke to the Supervisor who had no idea her mother was burned. She stated the Supervisor told her he would get the nurse, and they could discuss what happened, but when he found the nurse, the Supervisor went into the room and talked to him. The daughter said she got upset because the nurse and Supervisor were supposed to discuss what happened with her and they went in a room to talk amongst themselves. The daughter said she called 911 because she felt her mother needed to go to the hospital, and the police because she wanted to find out what happened. The daughter explained the Emergency Personnel took her mother to a nearby Hospital emergency room where she was assessed. Shortly afterwards the hospital transferred her to the to the specialized burn unit at a larger Level One hospital. The daughter stated when resident #27 got to the first hospital, they had to pour some kind of liquid on her clothes to remove them, as she the wet clothes had not been removed from the burned areas of her skin by the nursing home staff for almost two hours. She said after that is when they decided to send her to the larger hospital with the burn unit. She remained in the hospital a total of 5 days with second degree burns. A second degree or deep partial thickness burn involves damage or destruction of the first and second layers of the skin, which will be painful and often blistered. A full thickness burn can destroy nerves so pain might not be felt and will often look brown, black, or white and feel dry and leathery. You should go to the Emergency Department if the skin looks leathery, or if there are patches of brown, black or white or if the burn involves the hands, airway, face or genitals. Consequences of burn injuries that may progress without treatment include ischemia (obstruction of blood flow) due to increased swelling (edema), and infection, (retrieved on 10/31/24 from www.healthdirect.gov). On 10/16/24 at 1:10 PM, via telephone interview resident #27 stated the burn occurred around dinner time, on 10/02/24 at approximately 5:00 to 5:30 PM. The resident stated staff brought her meal tray and she was eating a piece of pie. She said she tried to move the pie when the cup of noodles spilled the very hot liquid all over. She said when the hot liquid hit her skin it hurt and she started screaming and hollering. Resident #27 said CNA K called the nurse and told him that a couple noodles got spilled on her and by the time LPN J got there her arm was burning. Resident #27 said LPN J later put something on her arm. The resident said she told the nurse her stomach and leg were burning, but he did not even look at it. Resident #27 explained she then called her daughter and told her she needed to come to the facility. The resident stated by the time her daughter got there she had a blister down to her thumb. The resident explained her daughter called 911 and said, They did not change me I went to the hospital in the same clothes. At the hospital, she recalled they poured something on her to remove the clothes that were now stuck to her burned skin. She stated the doctor told her she had second degree burns and they gave her something for the pain. The resident said she then went to the burn unit at another hospital. She explained she could move her arm and leg now, but her stomach still hurt where it was burned. She said she got medication for the pain that took the edge off, so she could move her leg but when they get her up for therapy it hurt. Review of the burn unit hospital records dated 10/02/24, skin assessment for resident #27 revealed, Partial thickness burn wounds with blistering to the left dorsal forearm extending to the lateral aspect of the base of the thumb and extending mid-way to the ventral aspect of the forearm. The open areas blanch well. Partial thickness burn wounds with blistering to the left lower anterior abdominal wall, left anterior and posterior thigh. The total body surface area prior to debridement is approximately 4 %. Mental status: She is alert and oriented to person, place and time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/15/24 at 3:42 PM, the Administrator stated on 10/02/24 at about 5:30 PM, resident #27 had a cup of noodle soup that you add water to and cook in the microwave. The resident asked CNA K to prepare it for her which she did. The Administrator stated the food should have been heated in the kitchen, instead of on the unit. The Administrator stated a few weeks prior to the incident she was given a stack a paper from the Weekend Supervisor. It included an in-service regarding a resident asking for food to be reheated because one of the nurses had the misconception that the resident food could be reheated on the unit. The Administrator stated she had the microwaves removed from the units and they had a conversation about not reheating food outside of the kitchen. The Administrator said, somehow there was still one microwave available. The Administrator conveyed that CNA K told her she was not aware of that in-service. On 10/16/24 at 10:41 AM, the former Director of Nursing (DON) who was DON at the time of the incident, stated she was not sure what the food policy was regarding heating or rewarming food for residents. She stated the Administration staff discussed rewarming the food due to a grievance, and that staff were supposed to take it to the kitchen if it needed to be warmed or rewarmed. The DON stated the staff did not get educated at that time. On 10/16/24 at 11:01 AM, the Assistant Director of Nursing (ADON) said the staff had not been educated about warming food prior to the incident. On 10/17/24 at 2:30 PM, the Administrator added the facility looked to see if there was any education provided to the staff regarding heating and reheating food, at any time prior to her administration and were unable to find any record. On 10/16/24 at 1:47 PM, LPN J stated he had never received education regarding heating/reheating food to the appropriate temperature to ensure the food provided was at a temperature to minimize the risk for burning or scalding residents. He stated he was not aware that CNA K had been making the noodles for the resident in the microwave. He said he did not recall ever seeing a thermometer in the unit kitchen to take the temperature of the food. On 10/16/24 at 4:55 PM, LPN L stated he was the Evening Supervisor on the night that resident # 27 was burned. He stated he did not recall getting education regarding heating and reheating resident food. He also said he could not recall seeing a thermometer in any of the unit kitchens for taking the temperature of the food. On 10/15/24 at 5:25 PM, and again on 10/16/24 at 11:37 AM attempts were made to contact CNA K by phone. Voice mail was left with both calls and no return response from the CNA was received. CNA K was no longer employed by the facility. Policy review revealed the facility food policies, Safety of Hot Liquids no date, Food Safety Requirements date implemented 3/01/22, revised 6/01/24, Use and Storage of Food Brought in by Family and Visitors dated 3/01/21 and revised 4/01/23, did not include instructions for staff to take food for the residents to the kitchen to be heated/reheated, nor any guidance for appropriate temperatures for the heating/reheating of food.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875 Based on observation, interview, and record review, the facility failed to ensure respiratory therapy was provided as per physician orders for 1 out of 1 resident reviewed for respiratory care, of a total sample of 37 residents, (#93). Findings: Resident #93 was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), heart disease, hyperlipidemia, hypotension, history of falling, cognitive communication deficit, ischemic cardiomyopathy, and essential hypertension. Review of the Significant Change Minimum Data Set assessment with reference date 5/29/24, revealed resident #93 had mild cognitive impairment, had no behaviors, nor refused care, and required the use of oxygen. Resident #93 was dependent for transfers and used a wheelchair for mobility. Review of resident #93's Physician Orders for continuous oxygen was 1 liter per minute (LPM) every shift for Shortness of breath. Resident #93 had a baseline Care Plan for required use of oxygen as ordered because of the resident's diagnosis of COPD. On 10/14/24 at 1:33 PM, resident #93 was observed in bed and was alert and oriented. Observation of the oxygen concentrator showed it was set at 1.5 liters of oxygen per minute and the bag attached to the oxygen concentrator dated with 10/14/24 contained the oxygen tubing and nasal cannula. She was not wearing the nasal cannula for the oxygen. Resident #93 stated she did not think she needed it because she rarely used it. On 10/14/24 at 1:48 PM, assigned nurse Licensed Practical Nurse (LPN) F entered resident #93's room to bring pain medication for the resident. After she administered the medication, she placed the nasal cannula which she removed from the bag attached to the oxygen concentrator on the resident. When asked why the resident was not connected to her oxygen, LPN F stated the order was for oxygen as needed. LPN F was then asked to verify the number of liters on the concentrator to which she verified the flow rate was set at 1.5 LPM. After LPN F exited the resident's room, she was asked to verify the physician's orders for oxygen in resident #93's electronic medical record. LPN F confirmed the physician's order was for continuous oxygen at 1 LPM and proceeded to correct the concentrator setting. LPN F explained she often checked at the beginning of her shift and verified the orders but was not sure what happened today. LPN F explained that neither the certified nursing assistant (CNA) nor the resident would have adjusted the flow rate on the oxygen concentrator, and it was the nurse's responsibility. LPN F acknowledged the amount was incorrect and that the physician orders were not followed. On 10/16/24 at 12:30 PM, the Unit Manager (UM) for the Specialized Sub-acute Unit stated the expectation for residents on oxygen was that nurses checked and verified orders on all shifts. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 1:25 PM, the Director of Nursing explained the expectation was for nurses to follow the physician orders and check the setting of the concentrator at least once per shift. She acknowledged they failed to follow physician orders for resident #93. Review of the Oxygen Administration Policy implemented on 3/1/22 and revised 3/1/23 revealed oxygen was administered to residents who need it consistent with professional standards of practice, the resident's care plan and the resident's choice. It also indicated as part of the compliance guidelines that oxygen was administered under orders of a physician except in emergencies and once the situation was under control, orders for oxygen were obtained as soon as practicable.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943 Based on interview, and record review, the facility failed to provide a policy or training to staff regarding reheating of food for residents. This lack of instruction caused the resident to receive second degree burns when her food was heated in the microwave, for 1 of 1 resident reviewed for burns, of a total sample of 39 residents, (#27). Findings: Resident #27 was admitted to the facility on [DATE] with diagnoses to include left sided hemiplegia and hemiparesis (one sided paralysis and weakness), type 2 diabetes mellitus with diabetic neuropathy (diabetic nerve damage), and contracture of the left hand. Review of a Nurse's Progress Note dated 10/02/24 at 7:33 PM, by Licensed Practical Nurse (LPN) J revealed, the Certified Nursing Assistant (CNA) notified him that resident #27 burned herself with a noodle soup that she was eating. He documented that, Upon assessment resident have a skin tear on left hand. No complaint of pain /discomfort. Physician notified as well her daughter. Per interview with the Administrator on 10/15/24 at 3:45 PM, including statements from CNA K revealed on 10/02/24 at approximately 5:30 PM, resident #27 asked CNA K to make her a cup of noodles which she purchased from the Activity Store at the facility. CNA K took the cup of noodles to the staff kitchen on the unit and added extra water per the resident request and cooked it in the microwave. The CNA brought the cup of noodles to the resident and as CNA K placed the noodles on resident #27's over bed tray table, the resident hit the cup and the cup of noodles spilled toward the resident ending in subsequent burns to the resident. On 10/14/24 at 11:30 AM, resident #11 (the roommate of resident #27) stated she did not see what happened, but she heard resident #27 and CNA K both scream and when she looked over CNA K said the soup spilled on the resident. Resident #11 stated that CNA K made the cup of noodles frequently for resident #27. On 10/15/24 at 3:42 PM, the Administrator stated the staff were not supposed to warm food for the residents and should take the food to the facility kitchen to be warmed. She stated she thought there was an in-service given a few weeks prior to the incident informing the staff that they should not warm anything for the residents themselves. She stated the microwaves had been removed from the unit kitchens but she could not explain why there was still one on the General and Restorative Unit which was used by CNA K On 10/16/24 at 10:41 AM, the former Director of Nursing (DON) stated she remembered a discussion about not heating or reheating resident food, but it was only discussed with the Administrative team. She said the staff did not get education at that time. On 10/16/24 at 1:47 PM, during a telephone interview with LPN J he stated he did not receive any education regarding heating resident food or the safe temperature for serving food. He stated he was not aware staff should not heat or reheat resident food. LPN J stated he did not recall ever seeing a thermometer in the unit kitchen for staff to check the temperature of foods. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 4:55 PM, LPN L stated he was the Evening Supervisor on the night that resident # 27 was burned. He stated he did not recall getting education regarding heating and reheating resident food. He said he could not recall seeing a thermometer in any of the unit kitchens for staff to check food temperature. On 10/17/24 at 11:30 AM, the Assistant Director of Nursing (ADON) stated the staff did not receive any education regarding reheating or heating food for residents until after this incident. Interview and policy review revealed the facility food policies, Safety of Hot Liquids no date, Food Safety Requirements date implemented 3/01/22, revised 6/01/24, Use and Storage of Food Brought in by Family and Visitors date 3/01/21 and revised 4/01/23, did not include instruction or guidance for staff to heat/reheat food themselves or for them to take resident food to the kitchen to be heated/reheated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on observation, interview, and record review the facility failed to follow proper infection control practices to prevent cross-contamination during wound care for 1 of 1 resident reviewed for pressure ulcers, of a total sample of 37 residents, (#33). Findings: Resident #33 was readmitted to the facility from the hospital on 3/29/24 with diagnoses that included cerebral infarction (stroke), vascular dementia, gastrostomy status, and multiple pressure ulcers. Review of Significant Change Minimum Data Set assessment dated [DATE] revealed that resident #33 was severely cognitively impaired, had impairments to both upper and lower extremities limiting range of motion, was bedbound, and dependent for all activities of daily living. She was at high risk for pressure ulcer development and at the time of the assessment had five facility acquired unstageable pressure ulcers. Review of resident #33's order summary report dated 10/17/24 revealed she had a wound order for the right buttocks. The physician orders directed the nurse to cleanse the wound with normal saline, pat dry, apply Leptospernum Honey ointment, and cover with 4x4 island dressing daily. The medical record also revealed a care plan for ADL self-care performance deficit related to dementia and limited mobility that included interventions for extensive assistance of one person to turn and reposition resident as well as extensive assistance of two people to move resident up in bed. The pressure ulcer care plan's goal as documented by the facility, was for pressure ulcer to show signs of healing and remain free from infection. On 10/16/24 resident #33 had an initial wound evaluation for the right buttocks wound completed by the Wound Care doctor. She diagnosed the wound as a stage 2 partial thickness pressure wound measuring 0.8 centimeters (cm) by 1.5 cm by 0.1 cm deep. The wound had light serous drainage and exposed dermis. The plan was to follow the wound treatment orders and reposition resident per facility protocol. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 10:12 AM, wound care was observed for resident #33 with the Wound Care nurse. The nurse had already set up the bedside table with her supplies and proceeded to wash her hands. She donned clean gloves and started dressing the wounds to the resident's bilateral legs and heels with no issue. She washed her hands again before treating the wound on the resident's buttocks. After donning the clean gloves, she went to the bedside table to gather the supplies (4x4 island dressing with Leptospernum Honey ointment already on it, extra gauze, and normal saline) and placed them on the bed. She informed the resident that she would be rolling her onto her left side and proceeded to do so with both hands. She used one arm to keep resident from rolling back and the other to remove the soiled dressing from the resident's right buttock. The wound appeared as described by the Wound Care doctor's documentation on 10/16/24. After removing the soiled dressing, the wound care nurse rolled the resident on her back and then removed the gloves to perform hand hygiene. She then donned clean gloves, rolled resident to her left side and held her with one arm. She used her free arm to moisten a gauze with normal saline and use it to clean the wound. After cleaning the wound, she patted it dry with a clean gauze and rolled the resident on her back and on to the bed. She performed hand hygiene and donned clean gloves again to roll resident on her left side to complete dressing the wound. She applied the 4x4 island dressing with ointment onto the resident's right buttock and rolled her on to her back. On 10/17/24 at 10:20 AM, the Wound Care nurse stated she was unable to have a second person in the room to help her because the Certified Nursing Assistant (CNA) was busy. She said she tried to maintain a clean environment to prevent cross- contamination when doing wound care to prevent infection, but it was not always possible, and she had many other residents to treat. On 10/17/24 at 11:41 AM, the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, stated that she did not observe the Wound Care nurse during wound care because she expected the Wound Care nurse to follow proper infection control practices. She agreed that the Wound Care nurse should have made sure she had proper assistance prior to completing wound care with resident #33 to prevent cross-contamination of the wound due to resident's inability to position herself. The ADON said that if the CNA was not available to assist with wound care, the Wound Care nurse should have asked someone else or should have waited until someone was available. Review of the facility's Policy and Procedures on Clean Dressing Change revised 4/01/23, revealed it was the policy of the facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Compliance guideline number 8 of 18 prompted the staff member to place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105843	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Altamonte Nursing & Rehabilitation Center	1099 West Town Parkway Altamonte Springs, FL 32714

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 50401 Based on observation, interview, and record review, the facility failed to provide a call device to allow residents to call for staff assistance for 2 of 18 residents observed for call lights, of a total sample of 37, (#30 and 55). Findings: 1. On 10/16/24 at 12:26 PM, resident #30, was observed in bed, alert and oriented to self and place. Resident #30's call device was a large, white square push/touch device seen on the nightstand on her right side, out of her reach. She stated she wanted to get out of bed and into her wheelchair. She then stated she didn't have a call device and had no way to reach staff for help. On 10/16/24 at 1:32 PM, Certified Nursing Assistant (CNA) D verified resident #30's call device was located on the nightstand and was not accessible to the resident. The call bell, was a larger, flat device designed specifically for residents who had difficulty pressing a regular call device. She moved the call device from the night stand and wrapped the cord around the bedrail so it would stay in place. She educated the resident on how and when to use the call device and the resident confirmed understanding and touched the call device, setting it off. 2. On 10/16/24 at 12:20 PM, resident #55's was observed in bed, she was alert and oriented to person, place and time. Her call bell device was observed to be wound up in the bed frame, hanging down toward the ground and not be in reach of the resident. On 10/16/24 at 1:45 PM, CNA C verified resident #55's call light was not accessible to her. The resident verbalized she could use the call bell, tried to reach it but said she could not. CNA C untangled the call light from the bed frame, brought it up within reach, to the resident's bed, and clipped it to the resident's bedsheet so it would not fall but would be within reach for her. On 10/17/24 at 4:38 PM, in an interview with the G and R Unit Manager and the Director of Nursing (DON), the Unit Manager stated call devices for residents needed to be placed within arm's reach of the resident. The DON clarified, call lights should be within hand's reach for all residents. She added, if a resident had difficulty using a call light, the facility provided a special larger, flat call light which just needed to be touched by the resident and was much easier to use. The facility's policy entitled Call Lights: Accessibility and Timely Response dated 1/01/23 indicated each resident should have access to a call light while in their bed and evaluated for any unique needs and preferences to determine any special accommodations needed in order for the resident to utilize the call system.