STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105955	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advinia Care at Venice	950 Pinebrook Road Venice, FL 34285

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38570 Based on observation, staff and family interview, and record review, the facility failed to revise and update the plan of care for 1 (Resident #16) of 2 residents reviewed for fall. Reviewing and updating of a resident's plan of care by the interdisciplinary team ensured the residents reached and maintained the highest practical safety measures and wellbeing. The findings included: Review of a facility policy titled, Falls Management Program, dated 2/7/21 indicates that the fall response steps are a comprehensive approach that forms the backbone of the falls Management Program (FMP). It includes the following eight steps: 1. Evaluate and monitor resident for 72 hours after the fall. 2. Investigate fall circumstances. 3. Record circumstances, resident outcome, and staff response. 4. Fax alert to primary care provider. 5. Implement immediate intervention within the first 24 hours. 6. Complete falls assessment. 7. Develop plan of care. 8. Monitor staff compliance and resident response. During an interview on 7/10/24 at 10:20 a.m., Resident #16 wife stated that she was very concerned about the falls with injuries her husband has had since admission to the facility. Resident #16's spouse said the resident fell from the bed, two of the three falls resulted in a transfer to the hospital. The wife said she was concerned her husband's room was the farthest from the nurses desk. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105955	A. Building B. Wing	07/11/2024

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record revealed Resident #16 was admitted to the facility on [DATE] with the following diagnoses: Cerebrovascular disease, Hemiplegia and hemiparesis following a stroke, right sided weakness, dysphagia, Aphasia, mood disorder, muscle spasm, atrial fibrillation, seizures and a chronic subdural hemorrhage. The quarterly Minimum Data Set (MDS) assessment dated [DATE] noted Resident #16 scored 00 on the Brief Interview for Mental Status (BIMS) indicating the assessment could not be done due to the resident's severe cognitive impairment. The assessment indicated that the resident had a fall with injury since admission and that the resident was dependent for all Activities of Daily Living (ADLs). Resident #16 was unable to use his right arm and hand which was contracted. The resident required the use of a mechanical lift and was dependent for all transfers from bed to reclining high back wheelchair. Review of the care plan initiated on 1/29/24 noted Resident #16 was at risk for falls. the goal was for the resident not to sustain serious injury through the review date. Review of the Order Summary Report revealed a physician's order dated 4/7/24 for Fall Mats at bedside while resident is in bed. The care plan was not updated with the order for fall mats at bedside while resident is in bed until 4/24/24 for Bilateral Floor mats to both sides of bed when resident in bed. Review of the clinical record revealed Resident #16 sustained a fall on 4/9/24, 4/26/24 and 5/4/24. Review of the incident investigations revealed on 4/9/24 Resident #16 was found face down on the floor in his room to the right side of his bed. A fall mat was in place on the left side of the bed, but not on the right side. Resident #16 sustained a laceration and swelling to his forehead resulting in a transfer to the local emergency room for evaluation and treatment of his injuries. On 7/10/24 at 3:10 p.m., in an interview the Director of Nursing (DON) confirmed that Resident #16 fall mats order was not initiated on the care plan until 4/24/24 and the resident only had one floor mat in place when he was found on the floor on right side of the bed on 4/9/24.

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NAME OF PROVIDER OR SUPPLIER: Advinia Care at Venice		STREET ADDRESS, CITY, STATE, ZIP CODE: 950 Pinebrook Road Venice, FL 34285	

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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 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 facility policy and procedure, review of the clinical record and resident and staff interview, the facility failed to provide the necessary care and services to maintain personal hygiene for 2 (Residents # 11 and #16) of 2 residents reviewed for ADLs (activities of daily living).

The findings included:

1. The facility policy CA-12 ADL Support initiated 7/2019 (revised 10/2022) documented Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 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 including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care).

Review of the clinical record revealed Resident #11 had a readmitted [DATE] with diagnoses including falls, acute respiratory failure, heart failure and anxiety.

The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 6/17/24 documented the resident was dependent on staff for bathing.

The MDS noted Resident #11's cognitive skills for daily decision making were moderately impaired.

The plan of care identified Resident #11 had an ADL self-care performance deficit related to weakness and infection. The interventions included, The resident is able to provide upper body hygiene with supply set up.

On 7/8/24 at 10:50 a.m., Resident #11 was in his room in a wheelchair (w/c). He was unshaven approximately 2 days growth. His fingernails extended approximately 1/2 inch in length with a brown and black substance under the nails. In an interview Resident #16 said, I don't like them this long; they need to be cut. I will have to find someone to cut them for me. The resident said he did not remember if he was receiving his scheduled showers.

On 7/9/24 at 10:24 a.m., during an observation Resident #11 remained unshaven.

On 7/9/24 at 1:50 p.m., in an interview Certified Nursing Assistant (CNA) Staff N said she was assigned to assist Resident #11. The CNA said men are shaved on the shower days and there was a schedule at the desk. The CNA said the residents are showered and shaved twice a week and as needed.

On 7/9/24 at 2:03 p.m., Resident #11 was observed in his room in a wheelchair. He was noted to have crumbs of food covering the front of his shirt and pants from the noon meal. He was unshaven. Resident #11 said his wife usually shaved him but she was ill and could not visit at this time.

(continued on next page)

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	105955	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advinia Care at Venice	950 Pinebrook Road Venice, FL 34285

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower assignments revealed Resident #11 scheduled showers were on Tuesdays and Fridays. Review of the CNA documentation for the previous 30 days revealed the resident received a shower on 6/14/24, 6/18/24, 6/21/24, 7/2/24 and 7/5/24. Resident #11 received 5 showers since his admission. The resident was scheduled for a shower on 7/9/24. On 7/10/24 at 10:01 a.m., Resident #11 was observed in his room in clean clothing. He remained unshaven. Licensed Practical Nurse Staff A was assisting the resident with his medications. Staff A confirmed the resident had not been shaved for several days. Staff A said shaving is to be done with daily care. On 7/10/24 at 1:49 p.m., in an interview CNA Staff N said Resident #11 was scheduled for a shower on 7/9/24. The CNA had documented not applicable on the documentation for 7/9/24. CNA Staff N said, the nurse wrote the wrong shower on the assignment sheet, and I showered another resident. When I realized the error, it was the end of my shift and I did not have time to shower or shave him. 38570 2. A review of an Admission Record indicated the facility admitted Resident #16 to the facility on [DATE] with the following diagnoses: Cerebrovascular disease, Hemiplegia and hemiparesis following a stroke, right sided weakness, dysphagia, Aphasia, mood disorder, muscle spasm, atrial fibrillation, seizures and a chronic subdural hemorrhage. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] noted Resident #16 had a Brief Interview for Mental Status (BIMS) score of 00 indicating the assessment could not be done due to the resident's severe cognitive impairment. The assessment indicated the resident was dependent for all Activities of Daily Living (ADLs). The resident was unable to use his right arm and hand. Resident #16 was dependent for all transfers from bed to reclining high back wheelchair. Review of Resident #16 Care Plan initiated 1/29/24. revealed no plan of care for Activities of Daily Living (ADLs) such as bathing, shaving, oral hygiene. On 7/8/24 at 9:52 a.m., Resident #16 was observed sitting in the hallway in front of the nurses station in a high back wheelchair. Resident #16 had a two to three days facial hair growth. His fingernails extended approximately 1/4 inch past his fingertips with a brown substance under his nails. On 7/9/24 at 1:53 p.m., Resident #16 was observed in the hallway in the high back wheelchair. Resident #16 did not answer any questions. The resident's fingernails remained long, extending 1/4 inch past the fingertips with a brown substance under the nails. The resident had a three to four days facial hair growth. On 7/10/24 at 10:20 a.m., in an interview Resident #16's wife said she was very concerned about the lack of bathing, shaving and nail car for her husband. The wife said he's frequently not shaved when she visits. She said she tries to trim his nails as he likes to reach in his incontinent briefs when he's soiled. She said it was very frustrating and he had voiced her concerns several times to the staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Advinia Care at Venice		STREET ADDRESS, CITY, STATE, ZIP CODE 950 Pinebrook Road Venice, FL 34285	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower assignments revealed Resident #16 was scheduled for showers on the evening shift on Mondays and Thursdays. Review of the Certified Nursing Assistants (CNAs) documentation revealed Resident #16 received four showers in the last 30 days. The most recent shower was dated 7/8/24 when the resident was observed unshaved, with a brown substance under the fingernails. On 7/10/24 at 11:14 a.m., in an interview Licensed Practical Nurse Staff A said Resident #16's showers were scheduled on Mondays and Thursdays. She said the CNAs are required to notify the nurse if the resident did not receive the scheduled shower.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy and procedure, record review and resident and staff interview, the facility failed to ensure they provided an ongoing program to support the residents in their choice of activities which are designed to meet the resident's interests and support the resident physical, mental and psychosocial well-being for 2 (residents #11, and #190) of 3 residents reviewed for involvement in activities. 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: The facility policy Activities effective 7/1/18 (revised 2/3/21) documented Activities refer to any endeavor, other than routine ADL's in which a resident participates that is intended to enhance her/his sense of well-being and to promote self-esteem, pleasure, comfort, education, creativity, success and independence. The facility shall provide, based on the comprehensive assessment and care plan and the preferences of each resident, an on-going program to support residents in their choice of activities, designed to meet the interests and need of the residents. The resident shall be involved in an ongoing program of activities that is designed to appeal to his or her interests and to enhance the residents highest practicable level of physical, mental and psychological well-being. 1. Review of the clinical record revealed Resident #11 had a readmitted [DATE] with diagnoses including falls and anxiety. The Admission Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 6/17/24 documented it was very important for the resident to go outside to get fresh air, to participate in religious services or practices, keep up with the news, have animals around and to have books, newspapers to read. The MDS noted Resident #11's cognitive skills for daily decision making were moderately impaired. Review of the plan of care failed to show documentation of a care plan to address the resident's activity needs. On 7/8/24 at 2:11 p.m., Resident #11 was observed in his room in his wheelchair, he had the television (TV) on but he was not watching it, and said he taking a nap. He said he attends activities when they have them, but they do not always have any. On 7/9/24 at 2:00 p.m., Resident #11 was in his room, the activity calendar at 2:00 p.m., specified chair exercises. On 7/11/24 at 2:04 p.m., Resident # 11 was observed sitting alone in his room, the TV was off and there was no music playing. The activity calendar specified at 1:15 p.m., candy dice game and at 2:30 p.m., pretty nails. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the clinical record revealed Resident #190 had an admitted [DATE] with diagnoses including dementia, Alzheimer's disease and depression. The Admissions MDS dated [DATE], documented the activities identified as very important to the resident included going outside, religious services, being involved in groups and keeping up with the news. The MDS noted Resident #190's cognitive skills for daily decision making were severely impaired. Review of the plan of care failed to show documentation of an activity care plan to address the resident's activity needs. On 7/8/24 at 11:21 a.m., Resident #190 was observed sitting in the hallway in her w/c in front of the nursing desk. She smiled when greeted but did not respond appropriately to any questions asked. Review of the activity calendar specified the activities at 11:00 a.m., were room visits and BINGO. On 7/9/24 at 10:41 a.m., Resident #190 was observed sitting in her w/c in the hallway in front of the nursing desk since 9:00 a.m. There was a bedside table next to her with a book on top of it. The resident was not engaged, and she paid no attention to the book. Several other residents were in the hallway, sitting in w/c's. Review of the activity calendar specified hangman at 9:45, mind games and Resident Council at 11:00 a.m. On 7/9/24 at 1:34 p.m., Resident #190 was observed in her w/c in the hallway in front of the nurse's desk. Review of the activity calendar specified canines 4 Christ at 1:30 p.m. On 7/10/24 at 9:08 a.m., in an interview the Activities Director said my assistants do 1-1 room visits daily and the certified nursing assistants will bring resident's out for group activities. The Activity Director said there was a TV room in the dining room of the unit and she puts on music for the residents. The Activity Director said for the residents sitting in the hallway by the nursing station she does activities such as play ball, trivia, hand massages and interacts with them for 15 to 30 minutes a day. The Activity Director said she had a TV installed in the dining room so the residents can watch the TV and she will put calming animal videos on for the residents. She said she identifies the residents who would like to come to the activity programs by the initial activity assessment completed. The Activity Director said she asks the residents what they like and if they can't express that she asks the family members. I do the MDS and put in a care plan. The Activity Director said she had a binder for 1-1 room visits provided. The binder was reviewed with the Activity Director and only 4 residents were listed to receive the 1-1 room visits. Resident's #11 and #190 were not included on the 1-1 visit list. The Activity Director said she keeps a log of the activities the residents attend each day. Review of the daily activity log did not show a daily form for Resident #11 or #190. The Activity Director confirmed there was no documentation Resident #11 and #190 attended any activities since July 1, 2024. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 9:22 a.m., Resident #190 was in the hallway in front of the nurse's desk facing the nurse's station. The TV in the dining room was off. There was no music and no activity in progress for the residents. On 7/10/24 at 9:43 a.m., Resident #190 remained in the hallway in front of the nurse's desk with no activity in progress. Resident #190 was observed attempting to get out of her w/c unassisted and was verbally encouraged by staff to sit down. On 7/11/24 at 1:51 p.m., Resident #190 was observed sitting in her w/c in the hall in front of the nurses station. There was no activity in progress on the unit. The activity calendar specified at 1:15 p.m., candy dice game in the activity room and 2:30 p.m., pretty nails. Review of the nursing progress note revealed a behavior note dated 7/6/2024 at 5:00 p.m., documented Patient is crying and seems she cannot express verbally what's the reason. Reassured the resident and diverted her attention which is effective. Antidepressant medication started.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38570 Based on observation, record review, and staff interviews, the facility failed to coordinate care and services for 1 (Resident #13) of 1 sampled resident's receiving dialysis by failing to ensure medications related to dialysis were administered as ordered by the physician. The findings included: Review of a facility policy titled; Dialysis Management dated 10/2022 indicates that the nurse will obtain orders for Medication as ordered to dialysis schedule. A review of an Admission Record indicated the facility admitted Resident #13 on 2/19/24 with the following diagnosis: End stage renal disease and dependence on renal dialysis. The quarterly Minimum Data Set (MDS) dated [DATE] indicated that the Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. MDS also indicated that the resident was currently receiving dialysis for end stage renal failure. Review of Resident #13's Care Plan initiated 2/28/24 indicated Resident #13 needed dialysis related to end stage renal disease and that Tuesday, Thursday and Saturday was her dialysis days. The comprehensive Care Plan did not address the resident need to receive her Phosphorus. binding medication sent with her to dialysis unit to be taken with breakfast. A review of Resident #13 physicians orders indicate the resident is to have dialysis 3 times a week on Tuesdays, Thursdays and Saturdays. Pick up time between 5:50 am and 6:20 am for a treatment time of 6:55 am. The resident was also ordered Sevelamer Carbonate 800 mg (to prevent high phosphate levels in dialysis patients) 1 tab three times a day with meals. to be given with meals. The medication was scheduled for 8:00 a.m. to be given with the breakfast meal. During an interview on 7/10/24 at 10:30 am Resident #13 said that she went to dialysis very early in the morning and was picked up before 6:00 a.m., most of the time. She said that she gets a bagged breakfast to take with her to dialysis but is not given any medication to take with her to take with her breakfast. A review of Resident #13 Medication Administration Record (MAR) revealed that resident did not receive the ordered Sevelamer Carbonate on 7/2/24, 7/4/24, 7/9/24 and 7/11/24. The medication is noted to be ordered for 8:00 a.m., each morning with breakfast but the resident is not in the facility at that time on Tuesdays, Thursday and Saturday, but at the dialysis unit. On 7/11/24 at 9:26 a.m., Licensed Practical Nurse (LPN) Staff A stated that she did not give the medication at 8:00 a.m., because the Resident #13 was not in the facility. She said the resident leave very early prior to her coming on shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 3:20 p.m., in an interview the Director of Nursing (DON) said that she was unaware the medication was not being given or had not been placed on the MAR to match the time resident was given breakfast and sent to dialysis. The DON acknowledged the medication should have been ordered to be sent with Resident #13 to dialysis to be taken with her breakfast.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38570 Based on observation, record review and staff and family interview the facility failed to document a thorough investigation including root cause analysis to prevent future falls for 1 (Resident #16) of 2 residents reviewed for falls. The facility also failed to coordinate care and implement interventions to minimize the risk of avoidable fall and fall related injuries for Resident #16 with a history of multiple falls. The findings included: Review of a facility policy titled, Falls Management Program, dated 2/7/21 indicates that the fall response steps are a comprehensive approach that forms the backbone of the falls Management Program (FMP). It includes the following eight steps: 1. Evaluate and monitor resident for 72 hours after the fall. 2. Investigate fall circumstances. 3. Record circumstances, resident outcome, and staff response. 4. Fax alert to primary care provider. 5. Implement immediate intervention within the first 24 hours. 6. Complete falls assessment. 7. Develop plan of care. 8. Monitor staff compliance and resident response. During an interview on 7/10/24 at 10:20 a.m., Resident #16 wife stated that she was very concerned about all the falls with injuries her husband has had since admission. The wife stated that his falls were from his bed and his room was one of the farthest from the nurses desk. A review of Admission Record was admitted to the facility on [DATE] with the following diagnoses: Cerebrovascular disease, Hemiplegia and hemiparesis following a stroke, right sided weakness, dysphagia, Aphasia, mood disorder, muscle spasm, atrial fibrillation, seizures and a chronic subdural hemorrhage. The quarterly Minimum Data Set (MDS) dated [DATE] indicates that resident #16 had a Brief Interview for Mental Status (BIMS) score of 00 because the assessment could not be done due to the resident severe cognitive impairment. The assessment indicated that the resident had a fall with injury since admission and that the resident was dependent for all Activities of Daily Living (ADLs). The Resident was unable to use his right arm and hand which was contracted. Resident #16 used a mechanical lift and was dependent on staff for all transfers from bed to reclining high back wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan initiated on 1/29/24 noted Resident #16 was at risk for falls. the goal was for the resident not to sustain serious injury through the review date. Review of the Order Summary Report revealed a physician's order dated 4/7/24 for Fall Mats at bedside while resident is in bed. Review of a facility incident investigations revealed on 4/9/24 at 4:07 p.m., Resident #16 was found face down on the floor in his room to the right side of his bed. No fall mat was in place on the right side of the bed where he was found. The resident sustained swelling and a laceration to his forehead requiring a transfer to the hospital for evaluation and treatment. The clinical record lacked documentation of a fall assessment risk upon the resident's return to the facility. The care plan was not updated with the order for fall mats at bedside while resident is in bed until 4/24/24 for Bilateral Floor mats to both sides of bed when resident in bed. On 4/26/24 at 4:40 p.m., documentation in the clinical record revealed Resident #16 was found on the floor in his room. The resident sustained a laceration to the left elbow, swelling and bump on top of his left eye. Resident #16 was transferred to the hospital for evaluation and treatment of his injuries. The incident investigation did not document which fall preventive measures, including fall mats were in place at the time of the incident. The clinical record lacked documentation of a fall assessment risk upon return to the facility. On 5/4/24 at 4:45 p.m., documentation in the clinical record revealed Resident #16 was found on the floor in his room. When the nurse arrived, the resident was on the fall mat on the side of the bed. the bed was in its lowest position. On 7/10/24 at 3:10 p.m., in an interview the Director of Nursing verified the physician's order for bilateral floor mats dated 4/7/24 was not added to the care plan until 4/24/24. She verified the fall mats were not in place as ordered on 4/9/24 when Resident #16 was found on the right side of the bed and sustained a laceration to the forehead. The DON also verified the lack of documentation the resident's falls were reviewed to determine the root cause of the falls. She said on 6/7/24 the care plan was updated to include a review of the past falls and attempt to determine the cause of the resident's multiple falls.

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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** 50649 Based on Interview and record review, the facility failed to provide appropriate care and services to prevent a decline in urinary continence for 1 Resident (#21) of 2 incontinent residents reviewed. The findings included: Review of the facility policy for bladder and bowel evaluation revised 1/2023: Residents are evaluated for continence on admission/readmission, quarterly, and with significant change in status. Residents who have been determined to be incontinent without a documented irreversible cause, presenting with a significant change in continence, will be further evaluated for potential bowel or bladder management. On admission, residents without a documented reversible cause for bowel or bladder incontinence will be assessed for the potential of bladder/bowel retraining program. Quarterly those residents with a significant change decline in bowel or bladder continence, that is not transient and self-limiting, will have a bowel and bladder evaluation completed, and will have bowel and bladder diary completed. Based on data collected from the patterning evaluation, residents will be provided a resident centered individualized continence management program. Scheduled toileting programs, retraining programs, and routine incontinent care will be added to the resident care plan. Review of the facility policy for Bladder Incontinence Assessment and Management revised on 1/2023: The staff and practitioner will appropriately screen for and manage individuals with urinary incontinence. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function .As part of its assessment, nursing staff will seek and document details related to continence. The nursing staff and physician will identify risk factors for becoming incontinent or for worsening of current incontinence, including diabetes, urinary tract infections, caffeine use, and excessive fluid intake. The physician and staff will address treatable causes or contributing factors related to urinary incontinence, including: changing medications that cause or exacerbating incontinence; treating underlying conditions that may impair continence .; implementing a fluid and/or bowel management program to meet assessed needs . If the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan .The staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 10 indicative of moderately impaired cognition. The MDS revealed Resident #21 was occasionally incontinent of bladder (less than 7 episodes of incontinence). Record review of the Quarterly MDS assessments dated 3/1/24, and 6/1/24 revealed Resident #21 was frequently incontinent of bladder. Review of the Certified Nursing Assistant's (CNA) task sheet for bladder continence from 6/9/24 through 7/8/24 revealed 54 episodes of incontinence and 2 episodes of continence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes from 12/1/23 to 6/29/24 revealed no documentation the facility addressed the resident's decline in bladder continence. There was no documentation the physician was notified of the decline in continence status. There was no documentation of a bladder evaluation, including a voiding diary or patterning. Review of Resident #21's care plan with focus on incontinence revealed the resident had potential for incontinence complications and was created on 12/10/23. The goal for the care plan was not developing complications associated with incontinence. The interventions included reporting lab results to the physician; providing incontinent care after all incontinent episodes; and reporting changes in bladder status to the physician. The three interventions were initiated on 12/10/23 with no care plan updates after the decline was identified. On 7/8/24 at 4:27 p.m., in an interview Resident #21 said she knows when she needs to urinate. She said she has the sensation that it is time to urinate and uses the call bell, but it can take an hour for staff to get to her. This forces her to urinate in her incontinent brief. Resident #21 stated it made her feel embarrassed. On 7/9/24 2:45 p.m., in an interview Certified Nursing Assistant (CNA) Staff R said Resident #21 was incontinent and did not like to go in the incontinent brief. She said she needed assistance for toileting. She said she checks the resident every two hours and she is usually wet. She said Resident #21 drank a lot of coffee and maybe that made her go. She said Resident #21 was with it and can hold a conversation. On 7/9/24 at 3:06 p.m., CNA Staff I said he checks residents every two hours. He said Resident #21 was mostly incontinent. He said she uses the call bell for water but is usually wet when he helps her with toileting. On 7/9/24 at 3:31 p.m., Licensed Practical Nurse (LPN) Staff B said staff check residents every two hours. She said when they check on Resident #21 she is already wet. She said the only thing in her history to make her incontinent would be the Metformin (a medication used to treat diabetes). On 7/10/24 at 8:54 a.m., in an interview Resident #21 said staff assist her with toileting, but when she needs to go she cannot wait. She said staff do not offer toileting throughout the day, when they do she has already wet herself. On 7/10/24 at 9:24 a.m., in an interview the MDS coordinator said Resident #21's continence status declined in the first three months she was at the facility. She said she would automatically be aware of that because the MDS system produces side by side results. She said she was responsible for updating the care plan interventions after changes, but she did not do that for the resident's incontinence decline. She said she does not know if anyone made the physician aware of the change in bladder status as instructed in the care plan. She said she could see an irreversible clinical condition for the resident's decline of continence. She said the resident was never assessed for a bladder retraining program and there was no bladder diary in the record. She said the facility did not attempt a toileting program or individualized voiding schedule to help decrease incontinence episodes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 10:22 a.m., in an interview the Director of Nursing (DON) said after the resident's continence decline was identified the facility should have completed a patterning assessment and notified the doctor to help identify possible causes. She said she did not know why it was not done. She said the decline was not discussed in the morning meetings and she was not aware of the problem.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50649 Based on observation, interview and record review, the facility failed to have a process in place to minimize loss or diversion of controlled narcotic medications. The findings included: Review of the facility policy for Controlled Substances: Documentation/Destruction/Storage revised 6/5/21: Once removed from count, discontinued drugs are stored in a double-locked area which is secure and accessible to the director of nursing and administrator only. On 7/1/24 at 12:36 p.m., Licensed Practical Nurse (LPN) Staff F said she gives the unused controlled substances from the medication cart to the Director of Nursing (DON) for destruction. She said the DON locks them in her drawer. On 7/11/24 at 12:36 p.m., observed the DON open her desk drawer with her key to reveal multiple narcotic drug packs and controlled substance record sheet. On 7/11/24 at 12:36 p.m., the DON was interviewed in her office. She said the unused controlled substances are stored in her desk in the left-hand side drawer. She said does not know which narcotics are in her drawer and does not have a list for which she could reconcile the narcotics with to make sure they were all there and accounted for. On 7/11/24 at 1:06 p.m., in a telephone interview the consultant pharmacist said he visits the facility for controlled substance disposal. He said he does not bring a list to reconcile the narcotics that should be at the facility ready for disposal. He said with the DON together they create the Controlled Substance Prescription Disposition list. He said the controlled substances in the DON's drawer are added to the list. He said the facility did not keep a list of narcotics that should be in the drawer. He said it would be nice if they kept a log of what was in the drawer so he would know all the controlled substances were accounted for, but they do not. He said he did not believe a log was a part of the regulation, but it would be nice if they had one.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41155 Based on observation, review of facility policy and procedure and staff interviews, the facility failed to prepare, and store food in a sanitary manner by failing to cover and date food in 1 reach-in refrigerator, failed to use proper hand hygiene during dish washing procedure, and failed to ensure hair restraints were used to cover facial hair. Additionally, the facility failed to properly assist residents during meals to prevent cross contamination. The lack of sanitation in the kitchen and dining services had the potential to affect all residents and staff. The findings included: The facility policy Food Safety and Sanitation initiated 2021 documented [NAME] nets are required when facial hair is visible are we cried when facial hair is visible. Employees will wash their hands just before they start to work in the kitchen and after smoking, sneezing, using the restroom, handling poisonous compounds or dirty dishes, and touching their face, hair, other people or surfaces or items with potential for contamination. All time and temperature control for safety foods including leftovers should be labeled, covered and dated it when stored. On 7/8/24 at 9:03 a.m., during an initial tour of the kitchen with the Director of Hospitality, the following observations were made: 1. In the kitchen there were employee personal drinks and items on the counters where food is stored and prepared. Photographic evidence obtained. 2. There was a thick layer of food, dust and debris on top of the dishwasher. Photographic evidence obtained. 3. Dietary Aide Staff O was observed using the high temp dishwasher. He was wearing disposable gloves, and placing dirty plates in the machine to be washed and sanitized. Staff O removed the clean and sanitized plates from the dishwasher with the same gloves used to load the dirty dishes in the machine. Staff O removed and held the clean plates against his body with the plates touching his dirty apron. Staff O placed the clean plates in the clean dish racks. 4. The trash cans in the kitchen were uncovered. The Director of hospitality verified the observation, grabbed the lids and covered the trash cans. Photographic evidence obtained. 5. In the reach-in refrigerator there was a tray of uncovered and undated desert fruit cups, and a covered plate of unlabeled and undated foods. The Director of hospitality said he could not identify the food on the plate. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Photographic evidence obtained. 6. There was a tin of fruit dated 6/26/24. The Director said the fruit was to be kept for three days. He removed and discarded the fruit. Photographic evidence obtained. 7. On the serving area where the toaster was located there were employee personal drinks and cups. The Director said, it's ok they are covered and have a lid. There was a wrapped sandwich on the shelf the of the serving area and the Director said it was for the staff. Photographic evidence obtained. 8. The floor drain in the main kitchen had dust, debris on the racks and a slimy bio-film in the bottom of the drain. The Director of hospitality said the maintenance department was responsible to clean the drains, but did not know when it was done. He said, I have only been here seven weeks now. Come on, this is a working kitchen. Photographic evidence obtained. 9. The walk-in refrigerator had there was a large plastic bin with lettuce/kale dated 5/8/24. The Director of hospitality said he did not have a chance to change the sticker yet. Photographic evidence obtained. 10. The clean plates in the plate warmers had no covers to protect the clean plates from dust and food particles. The Director of hospitality retrieved the covers and placed them on the clean plates. 11. There was a two-compartment sink in the prep section of the kitchen. Both sinks had grim, food and debris. The Director of hospitality said staff was not currently using the sink. The drain on the bottom of the sink had lettuce and other foods in the floor drain catch. The Director said, I never said they are not using it, they might throw something in there to rinse it out. Photographic evidence obtained. 12. In the walk-in refrigerator two turkeys were observed thawing on a tray in a rolling rack. Two dead insects were observed on the tray. Photographic evidence obtained. 13. On 7/8/24 at 12:07 p.m., during an initial observation in the main dining room the following observations were made: a. One resident was served her meal while the other three residents waited to be served because they required assistance with the meal. Over 10 minutes had passed before the other residents were served their meals. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Observed Registered Nurse Staff M providing feeding assistance to two residents at the same table. Staff M did not wash her hands in between using one residents' utensil and placing food into her mouth as she rubbed the residents back, and then picking up the other resident's spoon to assist her to place food into her mouth. Staff M would periodically stand as she moved around the table to assist the other residents at the table. Staff M was observed taking an empty glass from a resident who requested more juice and went to the juice machine and with the rim of the used and dirty glass pressed it against the dispensing nozzle to fill the glass with juice. Clean glasses were available next to the juice dispenser. c. Observed certified nursing assistant (CNA) Staff J providing feeding assistance to two residents at the same time, giving one resident a back rub as she assisted her and repositioning her in the wheelchair and then turning to provide feeding assistance to the other resident without performing proper hand hygiene to prevent cross contamination. d. Observed CNA Staff K feeding residents while standing and going from one resident to another picking up glasses and utensils and offering assistance without performing hand hygiene. e. CNA Staff L was observed standing beside a resident who was in a reclining wheelchair and reaching across the resident to access the residents' utensils and food. Staff L continued to stand on the side of the resident, and reaching across the resident to provide assistance throughout the meal. On 7/9/24 at 1:37 p.m., during an interview with the Director of Nursing she said the staff did inform her of the concerns with staff standing to assist residents with meals and feeding more than 1 resident without sanitizing their hands. She said she had instructed the staff on proper hand hygiene when assisting the residents but had no written policy for assisting residents with their meals. On 7/10/24 at 11:00 a.m., in an interview the Maintenance Director said the kitchen floor drain traps were cleaned every three months and as needed. He said pest control comes monthly and sprays the drain traps. On 7/10/24 at 12:00 p.m., during a second observation of the main kitchen with the Director of Hospitality, Dietary [NAME] Staff P had no facial covering on his beard and mustache as he prepared the food. The Dietary Manager was present and did not instruct him to put one on. Staff P was observed touching trays of meatballs without gloves. Staff P walked to the trash can and lifted the lid to throw away garbage, and then went to grab a clean tin container from the shelf and went back to preparing food. He did not wash his hands and did not have on gloves. The Director did not instruct the cook on hand hygiene to prevent cross contamination.