| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115120 | A. Building<br>B. Wing | 05/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Savannah Post Acute LLC | 815 East 63 Street<br>Savannah, GA 31405 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>49675<br><br>Based on resident and staff interviews and record review, the facility failed to promote care in a manner that maintained or enhanced dignity and respect for one of 49 sampled residents (R) (R72). Specifically, the facility failed to ensure the correct size brief was available to prevent incontinence leakage. This deficient practice had the potential to place R72 at risk of a diminished quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life.<br><br>Findings include:<br><br>Review of R72's clinical record revealed diagnoses including, but not limited to, morbid obesity due to excess calories, muscle weakness, and need for assistance with personal care.<br><br>Review of R72's Annual Minimum Data Set (MDS) assessment, dated 3/7/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented R72 required maximal assistance with toileting hygiene. Section H (Bladder and Bowel) documented that R72 was always incontinent of bladder and bowel.<br><br>Review of R72's care plan revealed a Focus of bowel and bladder incontinence. Interventions included checking every two to three hours and as needed, and providing incontinent care.<br><br>In an interview on 5/12/2025 at 1:26 pm, R72 stated that the facility often ran out of the correct size of brief he needed, resulting in him having to wear a smaller size, which caused leakage. He revealed this caused him to feel embarrassed, and he felt that he must request a bath each time this happened.<br><br>In an interview on 5/14/2025 at 11:42 am, Certified Nurse Assistant (CNA) CC stated that residents were measured to determine the size of the brief a resident needed. She stated residents had briefs in their rooms, and further stated there were times, if a resident was out of briefs, a brief from another resident's supply would be used, and it may not always be the correct size.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 5/14/2025 at 8:56 am, the Central Supplies Clerk stated residents were measured to ensure they received the correct brief size. She stated she entered measurements into a conversion program that the supplier offered on their ordering site. She confirmed that the facility was running out of 3x-size briefs. She stated her expectation was for residents to receive the correct size brief.<br><br>In an interview on 5/14/2025 at 10:36 am, the Administrator stated the facility ordered briefs weekly. She stated residents were measured to determine the size of the brief the resident required. She stated her expectation was for staff to ensure residents receive the correct size brief. She further stated she was aware that R72 was receiving a smaller brief than needed. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675<br><br>Based on resident and staff interviews, record review, and review of the facility policy titled Abuse, Neglect, and Misappropriations, the facility failed to report an allegation of abuse in a timely manner for one of seven residents (R) (R20) reviewed for abuse.<br><br>Findings include:<br><br>Review of the facility policy titled Abuse, Neglect, and Misappropriations, reviewed 1/1/2025, revealed the Policy Components section included, . G. Reporting/Response 1 . Reporting Guidelines: . Any allegation of neglect, exploitation, mistreatment, or misappropriation of resident property must be reported to the State Regulatory Agency within 24 hours.<br><br>Review of R20's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 99 (indicating the resident was unable to complete the interview).<br><br>Review of R20 diagnoses included, but were not limited to, schizophrenia, unspecified, type 2 diabetes mellitus with hyperglycemia, and muscle weakness.<br><br>Review of R20's clinical record revealed there was no documentation of a report of abuse allegation to other staff or the Administrator.<br><br>Review of the Facility Incident Report Form, dated 2/25/2025, documented that the date of the incident was 2/12/2025. The Details of Incident documented Resident came to the nurse's station reporting 'There was a man in my room. I needed to go home. He was trying to stick his penis in me.'<br><br>In an interview on 5/14/2025 at 10:25 am, the Assistant Director of Nursing (ADON) revealed that the allegation of abuse was reported to the State Agency late because the nurse to whom the resident reported the allegation only entered a note in the progress notes and did not report the incident to anyone. The ADON stated that the nurse no longer worked at the facility.<br><br>In an interview on 5/14/2025 at 10:36 am, the Administrator confirmed that the allegation of abuse involving R20 was not reported to the State Agency within the required time frame. She stated her expectation was for staff to report abuse allegations immediately, so it can be reported to the State Agency as required. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675<br><br>Based on resident and staff interviews, record reviews, and review of the facility policy titled Bed Hold and Returns Policy, the facility failed to ensure one of 49 residents (R) (R72) was provided with a written bed hold notice. This failure had the potential to place the resident or resident representative at risk of being uninformed about their rights related to their return to the facility.<br><br>Findings include:<br><br>Review of the facility policy titled Bed Hold and Returns Policy, dated 2/1/2024, revealed the Procedure section included, . 3. Prior to a transfer, written information will be given to the residents and the residents' representatives that explains in detail: a. The rights and limitations of the resident regarding bed holds. b. the reserve bed payment policy as indicated by the state plan c. the facility per diem rate required to hold a bed or to hold a bed beyond the stated bed hold period.<br><br>Review of R72's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment).<br><br>Review of R72's Clinical Resident Profile revealed the resident was his own responsible party.<br><br>Review of R72's Clinical Census revealed R72 was transferred to the hospital from the facility on 2/27/2025 and 4/29/2025.<br><br>Review of R72's clinical record revealed no evidence of the provision of a notice of bed hold provided to R72 on 2/27/2025 or 4/29/2025.<br><br>In an interview on 5/24/2025 at 1:00 pm, R72 stated the facility did not provide a written bed hold notice on 2/27/2025 or on 4/29/2025.<br><br>In an interview on 5/15/2025 at 11:17 am, Licensed Practical Nurse (LPN) BB stated that when a resident is transferred from the facility to a hospital, she prints the resident's orders, face sheet, and notifies the physician and family. She stated she will put a blank bed hold policy into the packet that goes with transport, but does not give anything in writing to the resident.<br><br>In an interview on 5/15/2025 at 11:26 am, the Director of Nursing (DON) stated that residents were to be given a bed hold policy when they transferred from the facility. She confirmed there was no record of R72 being given a bed hold policy on 2/27/2025 or 4/29/2025. She revealed that the resident should have been notified in writing of the bed hold policy at the time of each transfer. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377<br><br>Based on staff interview and record review, the facility failed to ensure that the Minimum Data Set (MDS) assessment was accurately coded for one of five sampled residents (R) (R24) with a Pre-Admission Screening and Resident Review (PASRR) Level II.<br><br>Findings include:<br><br>Review of R24's Annual MDS, dated [DATE], revealed Section A (Identification Information) documented the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Section I (Active Diagnoses) documented diagnoses including anxiety disorder, depression, and manic depression (bipolar).<br><br>Review of R24 's electronic medical record (EMR) revealed an admitted [DATE].<br><br>Review of R24's PASRR Level II revealed an approval date of 3/7/2022.<br><br>During an interview on 5/15/2025 at 12:08 pm, the MDS Coordinator stated she was unaware that R24 had received approval for a PASRR Level II. She stated she planned to submit a modification of R24's MDS to accurately code the PASRR Level II. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377<br><br>Based on staff interview and record review, the facility failed to ensure one of three residents (R) (R10) reviewed for Pre-Admission Screening and Resident Review (PASRR) Level II assessment was referred to the appropriate state-designated authority for review. This deficient practice had the potential to place R10 at risk of not receiving services or care according to their needs.<br><br>Findings include:<br><br>Review of R10's Annual Minimum Data Set (MDS) assessment, dated 12/30/2024, revealed Section A (Identification Information) documented R10 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Section I (Active Diagnoses) documented diagnoses including anxiety disorder and manic depression (bipolar disease).<br><br>Review of R10 's electronic medical record (EMR) revealed an admitted [DATE] with diagnoses including, but not limited to, bipolar disorder mixed severe with psychotic features, dated 11/23/2022 and created 3/8/2024.<br><br>Review of R10's EMR revealed no PASRR Level II.<br><br>Review of a facility-provided list of residents with PASRR Level II revealed that R10 was not included on the list.<br><br>In an interview on 5/13/2025 at 12:00 pm, the Administrator verified that R10 did not have a PASRR Level II and should have had a submission for one. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>36377<br><br>Based on observations, staff interviews, record review, and review of the facility policy titled Person Centered Care Plans, the facility failed to develop a person-centered care plan for one of 11 residents (R) (R24) who received oxygen (O2). In addition, the facility failed to implement the care plan for two of 11 R (R45 and R49) who received O2. These deficient practices had the potential to place R24, R45, and R49 at risk of respiratory complications, unmet needs, and a diminished quality of life.<br><br>Findings include:<br><br>Review of the facility policy titled Person Centered Care Plans, dated 2/1/2024, revealed the Policy Statement section included, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The Procedure section included, . 8. The comprehensive, person-centered care plan will: . b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>1. Review of R24's Annual Minimum Data Set (MDS) assessment, dated 2/17/2025, revealed Section O (Special Treatments, Procedures, and Programs) documented that R24 received O2.<br><br>Review of R24's Electronic Medical Record (EMR) revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) and acute respiratory failure with hypoxia.<br><br>Review of R24 's Clinical Physician Orders revealed an order dated 6/17/2024 for O2 at 2 liters per minute (LPM) via a nasal cannula (NC) continuously.<br><br>Review of R24's Care Plan Report revealed a Focus area, revised 1/31/2025, for being at risk for ineffective peripheral tissue perfusion, and was on continuous O2. There were no interventions for the use of O2 in the care plan.<br><br>Observations on 5/12/2025 at 12:35 pm and 2:05 pm revealed R24 receiving O2 by an O2 concentrator via a NC at a flow rate of 3.5 LPM.<br><br>2. Review of R45's Quarterly MDS assessment, dated 3/17/2025, revealed Section O (Special Treatments, Procedures, and Programs) documented that R45 received O2.<br><br>Review of R45's EMR revealed diagnoses including, but not limited to, COPD.<br><br>Review of R45's Clinical Physician Orders revealed an order dated 5/14/2024 for O2 at 2 LPM via NC O2: 90 percent or above. Every shift for shortness of breath.<br><br>Review of R45's Care Plan Report revealed a Focus area, revised 1/2/2025, for has a diagnosis of COPD and respiratory failure, is on O2. Interventions included O2 via nasal prongs at 2 LPM.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observations on 5/12/2025 at 10:01 am, 1:20 pm, and 6:00 pm revealed R45 was receiving O2 at 3.5 LPM via a NC.<br><br>50171<br><br>3. Review of R49's Admission MDS assessment, dated 4/18/2025, revealed Section O (Special Treatments, Procedures, and Programs) documented that R49 received O2.<br><br>Review of R45's EMR revealed diagnoses including, but not limited to, COPD and chronic respiratory failure with hypoxia.<br><br>Review of R49's Clinical Physician Orders revealed an order dated 4/18/2025 for O2 at 2 LPM via NC continuously for shortness of breath. O2 saturation to maintain saturation 90 percent or above every shift.<br><br>Review of R49's Care Plan Report revealed a Focus area, dated 4/23/2025, for has a history of chronic respiratory failure with hypoxia and a diagnosis of COPD. Interventions included O2 via nasal as ordered by the physician.<br><br>Observations on 5/12/2025 at 12:24 pm, 6:10 pm, and 5/13/2025 at 11:06 am revealed R49 receiving O2 via a NC at 3.5 LPM.<br><br>During an interview on 5/15/2025 at 12:28 pm, the MDS Coordinator confirmed O2 interventions were not addressed on R24's care plan. She stated the care plan interventions should be followed for R45 and R49, including the O2 flow rate. She further stated that the care plan served as a blueprint for nurses to provide resident care.<br><br>Cross-Reference F695 |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>36377<br><br>Based on observations, resident and staff interviews, and record review, the facility failed to ensure one of 49 sampled residents (R) (R12) received services to maintain or improve their functional abilities. Specifically, the facility failed to ensure a supportive footrest/leg rest was secured to R12's wheelchair. This deficient practice had the potential to place R12 at risk of unmet needs and a diminished quality of life.<br><br>Findings include:<br><br>Review of R12's Annual Minimum Data Set (MDS) assessment, dated 4/2/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview Mental Status Score (BIMS) of 14 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident had lower extremity impairment on both sides, required maximal assistance for lower body dressing, and was dependent for putting on and taking off footwear. Section M (Skin Conditions) documented that the resident was at risk for developing pressure ulcers and had one stage four pressure ulcer.<br><br>Review of R12's Care Plan Report revealed a Focus area, dated 5/20/2024, that the resident has peripheral vascular disease. Interventions included elevating legs when sitting or sleeping, monitoring/documenting for excessive edema, and encouraging the resident to elevate legs.<br><br>Review of R12 's clinical record revealed diagnoses including, but not limited to, varicose veins of right lower extremity with ulcer of ankle, non-pressure chronic ulcer of right heel and midfoot with unspecified severity, contracture right knee, hemiplegia and hemipareses following unspecified cerebrovascular disease affecting the right dominant side, long term use of anticoagulants, acquired absence of left leg above knee, hypertension, and peripheral vascular disease.<br><br>Observation on 5/12/2025 at 12:08 pm revealed R12 in a wheelchair, propelling himself in the hallway towards the activity room with his right lower extremity (RLE) highly elevated in the air and extended outward in an upward position without the support of a leg rest/footrest attachment.<br><br>Observation on 5/12/2025 at 1:00 pm revealed R12 sitting in a wheelchair in the activity area and holding his RLE in the air without the support of a leg rest or other supportive device.<br><br>In a concurrent observation and interview on 5/12/2025 at 3:00 pm, R12 was observed sitting in a wheelchair in the hallway and holding his RLE in the air without the support of a leg rest or other supportive device. R12 stated he had a leg rest with an attached footrest for the wheelchair and was unable to put it on the wheelchair unassisted, and that staff did not assist him.<br><br>Observations on 5/13/2025 at 12:01 pm and 3:00 pm, 5/14/2025 at 2:15 pm, and 5/15/2025 at 3:00 pm revealed R12 sitting in a wheelchair, propelling himself in the hallway with his RLE highly elevated in the air, extended outward and dangling in the air without the support of a leg rest or other supportive device.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a concurrent observation of R12 and interview on 5/15/2025 at 12:55 pm with the Physical Therapy (PT) Director and the Director of Nursing (DON), both confirmed R12 should not be positioned in his wheelchair without the attachment of a supportive device such as a leg rest/footrest due to R12's right ankle ulcer, contracture, and immobility. The PT Director stated that the therapy department had assessed R12 for a leg rest/footrest, obtained the device from R12's room, and attached it to the wheelchair. The DON stated the resident would be at risk of injury, pain, edema, added pressure, and discomfort by holding his RLE in an elevated position without the supportive device. The DON further stated she was unaware that R12's wheelchair did not have the leg rest/footrest attached. The DON stated that her expectation was for staff to ensure the resident's leg rest/footrest is attached to the wheelchair daily. She stated that nursing staff were responsible for ensuring that the resident's leg rest/footrest was applied as part of resident care services. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>36377<br><br>Based on observations, staff interviews, record review, and review of the facility policy titled Oxygen Administration, the facility failed to ensure that three of 11 sampled residents (R) (R24, R45, and R49) were administered oxygen (O2) therapy in accordance with the physician's orders. This failure had the potential to place R24, R45, and R49 at risk of respiratory complications and unmet needs.<br><br>Findings include:<br><br>Review of the facility policy titled Oxygen Administration, dated 2/1/2024, revealed the Preparation section included, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.<br><br>1. Review of R24's Annual Minimum Data Set (MDS) assessment, dated 2/17/2025, revealed Section O (Special Treatments, Procedures, and Programs) documented that R24 received O2.<br><br>Review of R24's Electronic Medical Record (EMR) revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) and acute respiratory failure with hypoxia.<br><br>Review of R24 's Clinical Physician Orders revealed an order dated 6/17/2024 for O2 at 2 liters per minute (LPM) via a nasal cannula (NC) continuously.<br><br>Observations on 5/12/2025 at 12:35 pm and 2:05 pm revealed R24 receiving O2 by an O2 concentrator via a NC at a flow rate of 3.5 LPM.<br><br>2. Review of R45's Quarterly MDS assessment, dated 3/17/2025, revealed Section O (Special Treatments, Procedures, and Programs) documented that R45 received O2.<br><br>Review of R45's EMR revealed diagnoses including, but not limited to, COPD.<br><br>Review of R45's Clinical Physician Orders revealed an order dated 5/14/2024 for O2 at 2 LPM via NC O2: 90 percent or above. Every shift for shortness of breath.<br><br>Observations on 5/12/2024 at 10:01 am and 6:00 pm revealed R45 receiving O2 by an O2 concentrator via a NC with the flow rate set at 4.5 LPM.<br><br>In an interview on 5/12/2024 at 1:20 pm, the Respiratory Therapist (RT) confirmed that R45 was receiving O2 at 4.5 LPM. The RT verified increasing the flow rate due to having concerns with the resident's O2 saturation reading of 88 percent. He verified that the physician's order was 2 LPM and adjusted the flow rate to 2 LPM.<br><br>In an interview on 5/15/2025 at 10:00 am, the Director of Nursing (DON) confirmed that R24 and R45 were receiving O2 at the wrong flow rate and not per physician orders. She stated that the RT should not be changing the flow rate without a physician's order. She reported being uncertain of which staff could have changed R24 's O2 flow rate.<br><br>(continued on next page) |

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|---|---|---|---|
| | 115120 | A. Building<br>B. Wing | 05/15/2025 |

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| Savannah Post Acute LLC | 815 East 63 Street<br>Savannah, GA 31405 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 50171<br><br>3. Review of R49's Admission MDS assessment, dated 4/18/2025, revealed Section C (Cognitive Patterns) documented a BIMS score of 13 (indicating little to no cognitive impairment). Section O (Special Treatments, Procedures, and Programs) documented that R49 received O2.<br><br>Review of R45's EMR revealed diagnoses including, but not limited to, COPD and chronic respiratory failure with hypoxia.<br><br>Review of R49's Clinical Physician Orders revealed an order dated 4/18/2025 for O2 at 2 LPM via NC continuously for shortness of breath. O2 saturation to maintain saturation 90 percent or above every shift.<br><br>In a concurrent observation and interview on 5/12/2025 at 12:24 pm, R49 was observed receiving O2 at 3.5 LPM via a NC. R49 stated her O2 should be set at 2 LPM, and it had been set at 3.5 LPM since she was admitted .<br><br>Observation on 5/12/2025 at 6:10 pm revealed R49 receiving O2 at 3.5 LPM via a NC.<br><br>In a concurrent observation and interview on 5/13/2025 at 11:00 am, Licensed Practical Nurse (LPN) DD confirmed that R49's oxygen was set on 3.5 LPM. LPN DD further confirmed the physician's order was for O2 at 2 LPM. LPN DD stated the nurses were responsible for ensuring the O2 flow rate was set correctly.<br><br>In an interview on 5/13/2024 at 3:06 pm, the DON stated that she expected nursing staff to ensure each resident's O2 was administered according to the physician's orders. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>49681<br><br>Based on observation, resident and staff interviews, and review of the facility policy titled Menus, the facility failed to ensure four of 49 sampled residents (R) (R90, R106, R103, and R72) were offered meal choices. In addition, the facility failed to ensure meal menus were followed for one of 49 sampled R (R72).<br><br>Findings include:<br><br>Review of the facility policy titled Menus, revised 10/2022, revealed the Procedures section included, . 6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. 8. Menus will be posted in the Dining Services department, dining rooms, and resident/patient care areas.<br><br>1. Review of R90's Quarterly Minimum Data Set (MDS) assessment, dated 3/18/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment).<br><br>In an interview on 5/13/2025 at 12:25 pm, R90 stated he was not given a choice of meals, and the only alternative food offered was a peanut butter and jelly sandwich. He stated he gets what the facility gives him for meals.<br><br>2. Review of R106's Quarterly Minimum Data Set (MDS) assessment, dated 3/14/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment).<br><br>In an interview on 5/14/25 3:04 pm, R106 stated that she eats in the dining area because she has a choice of food. R106 explained that she only eats in the dining room because when she eats in her room, she does not get to choose what she wants to eat. She stated that the only alternative offered was a peanut butter and jelly sandwich.<br><br>3. Review of R103's Quarterly Minimum Data Set (MDS) assessment, dated 3/7/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment).<br><br>In an interview on 5/14/2025 at 3:12 pm, R103 stated she never got to choose what meal she wanted since she ate in her room, and further stated that if she ate in the dining room, she would be able to make a meal choice.<br><br>49675<br><br>4. Review of R72's Annual Minimum Data Set (MDS) assessment, dated 3/7/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment).<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 5/12/2025 at 1:26 pm, R72 stated he never knew what he would be served at mealtimes. He stated residents who ate in their rooms were not provided a menu choice, and the menu was inaccurate. He stated he got what the facility gave him at meals.<br><br>Observation on 5/13/2025 at 1:02 pm revealed R72 sitting in his room, eating lunch. He was served ribs, mashed potatoes, and broccoli. His meal tray ticket indicated he was to receive a turkey burger on a bun, chips, tomato salad, fruit salad, and tea. The menu for the day stated the lunch meal would be a tuna salad hoagie or turkey burger, country tomato salad, creamy cucumber and onion salad, potato chips, macaroni salad, and deluxe fruit salad. R72 stated he was not asked what his choice for the meal was.<br><br>Observation on 5/14/2025 at 12:45 pm revealed R72 sitting in his wheelchair, eating lunch. His meal tray had a hamburger patty with gravy, mashed potatoes with gravy, and carrots. The meal tray ticket indicated he was to receive a garlic-baked pork chop, buttered rice, seasoned okra, dinner roll, and brownie. The menu for the day stated the lunch meal would be sausage jambalaya, Salisbury steak, seasoned okra, sliced parsley carrots, mashed potatoes, cornbread, and a double chocolate brownie. R72 stated he was not asked what his choice for the meal was.<br><br>In an interview on 5/14/2025 at 4:45 pm, the Dietary Manager (DM) confirmed that residents who receive lunch in their rooms do not know what meal they will receive, as substitutions are not written on the menus. She had no explanation for the discrepancies between what meal was posted to be served, what meal was on the tray tickets, and what was served. The DM confirmed that all residents should have the opportunity to have preferences of foods, and the posted meals should be served.<br><br>In an interview on 5/14/2025 at 4:55 pm, the Administrator stated residents should be informed of the menu and offered an alternative. The Administrator further stated that all residents should be given a menu and allowed to choose what foods they wanted for their meals. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>39786<br><br>Based on observation, staff interviews, and review of the facility's document titled Enhanced Barrier Precautions in Nursing Homes Algorithm, the facility failed to ensure respiratory staff followed infection control practices during tracheostomy care for one of two residents (R) (R13) with a tracheostomy. The deficient practice had the potential to place R13 at risk of respiratory illness and infection due to cross-contamination.<br><br>Findings included:<br><br>Review of the facility's document titled Enhanced Barrier Precautions in Nursing Homes Algorithm, dated 2022, revealed, The purpose of this algorithm is to outline when to use and how to implement enhanced barrier precautions (EBP). 1. EBP are indicated for the following residents who are: At increased risk of MDRO (multidrug-resistant organism) acquisition (e.g., resident has a wound or indwelling medical device) . In addition to following Standard Precautions, gowns and gloves should be worn during the following high-contact resident care activities: Device care or use. With implementation, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use . To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required personal protective equipment (PPE) (e.g., gown and gloves) . Definitions. Indwelling medical device: An indwelling medical device provided a direct pathway for pathogens in the environment to enter the body and cause infection. Examples include, but are not limited to . tracheostomy tubes .<br><br>Review of R13's Quarterly Minimum Data Set (MDS) assessment, dated 4/14/2025, revealed Section GG (Functional Abilities and Goals) documented R13 was dependent for activities of daily living (ADLs). Section I (Active Diagnoses) documented diagnoses including debility, cardiorespiratory conditions, aphasia, cerebrovascular accident (CVA), hemiplegia or hemiparesis, and respiratory failure. Section O (Special Treatments, Procedures, and Programs) documented that R13 received oxygen (O2), suctioning, and tracheostomy care.<br><br>Observation of R13's room door revealed EBP signage on the door indicating the type of precautions, the required PPE that all healthcare personnel must wear, and the high-contact resident care activities that required the use of a gown and gloves, which included tracheostomy care.<br><br>Observation on 5/14/2025 at 10:15 am of Respiratory Nurse Technician LL providing tracheostomy care for R13 revealed Respiratory Nurse Technician LL donned a mask and gloves. Respiratory Nurse Technician LL suctioned R13's tracheostomy, donned sterile gloves, connected the tube, placed a small amount of normal saline, and suctioned two passes. Respiratory Nurse Technician LL removed the tracheostomy collar and discarded it, removed the split gauze, cleaned around the tracheostomy stoma, assessed the stoma, placed new split gauze, placed a new collar, and secured the tracheostomy. The Respiratory Nurse Technician stated he changed the inner cannula twice a day, and the tracheostomy tube was changed once a month.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 5/14/2025 at 11:10 am, Respiratory Nurse Technician LL confirmed R13 was on EBP. He stated he did wear a mask and gloves during R13's tracheostomy care and did not wear a gown. Respiratory Nurse Technician LL stated he wore gloves and a mask while providing care to residents on EBP and a gown for residents on contact isolation-precautions.<br><br>In an interview on 5/15/2025 at 9:39 am, Respiratory Nurse Technician KK stated staff should wear gloves, a gown, and a mask when providing tracheostomy care.<br><br>In an interview on 5/15/2025 at 10:55 am, the Director of Nursing (DON) stated she expected staff to wear gloves and a gown while providing care to a resident on EBP, and to wear gloves, a gown, and a mask while providing tracheostomy care. |