STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115330	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of Smyrna	404 King Springs Village Pkwy Smyrna, GA 30082

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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. 49396 Based on observation, staff and resident interviews, record review, and review of the facility-provided document titled, Residents' Rights, the facility failed to maintain dignity by ensuring a dignity bag was provided for one of five residents (R) (R48) who had an indwelling urinary catheter. This deficient practice had the potential to diminish the resident's quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life. Findings include: A review of the undated facility-provided document titled Residents' Rights included Your right to be treated with dignity and respect is the foundation on which all other resident rights and responsibilities are based. A review of R48's Face Sheet revealed diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms. A review of R48's Quarterly Minimum Data Set (MDS) Assessment, dated 11/20/2024, revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 14 (indicating little to no cognitive impairment) and Section H (Bowel and Bladder) documented R48 had an indwelling urinary catheter. Observations on 12/17/2024 at 9:49 am and 12/18/2024 at 10:39 am revealed R48 was in bed, and a urinary catheter drainage bag was secured to the resident's bed, uncovered and visible from the hallway. During an observation on 12/18/2024 at 10:37 am, License Practical Nurse (LPN) HH confirmed R48's urinary catheter drainage bag was uncovered and visible from the hallway. In an interview on 12/18/2024 at 10:47 am, LPN HH stated urinary catheter drainage bags should always be in a privacy bag when visible to other residents, staff, and visitors. In an interview on 12/19/2024 at 1:39 pm, the Director of Nursing (DON) stated she expected staff to ensure urinary catheter drainage bags were covered in a privacy bag after each urinary catheter care incident.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50803 Based on observations, staff interviews, record review, and review of the facility policy titled, Medications, Self-Administration of, the facility failed to ensure unauthorized medications were not stored at the bedside for one of 28 sampled residents (R) (R85). This deficient practice had the potential to allow unauthorized access to unsecured medications to R85, other residents, and visitors. Findings include: Review of the facility's policy titled, Medications, Self-Administration of, reviewed 6/2021, revealed the Procedure section included 1. Before a resident is considered for self-administration of medications, an assessment will be performed by the charge nurse and reviewed by the interdisciplinary care plan team for approval. 2. Following approval of the assessment, the charge nurse will obtain a physician's order for the resident to self-administer medications, noting which medications may be self-administered. Review of R85's electronic medical record (EMR) revealed diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), respiratory failure, heart failure, dysphagia, and major depression. Review of R85's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 9 (indicating moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented R85 was dependent on a helper for toileting, bathing, lower body dressing, and transfers. Review of R85's care plan revealed no care plan area for self-administration of medications. Review of R85's Physician's Orders revealed an order dated 9/19/2024 for fluticasone furoate-vilanterol (a medication used to treat asthma and COPD) blister with device 100-25 micrograms (mcg)/dose, one puff inhalation once a day. Further review revealed no order for self-administration of medications. Review of R85's EMR revealed no assessment for self-administration of medications. Observation on 12/18/2024 at 9:38 am in R85's room revealed a fluticasone furoate and vilanterol inhaler on R85's bedside dresser. In an interview on 12/18/2024 at 9:46 am, Licensed Practical Nurse (LPN) EE confirmed the inhaler was on R85's bedside dresser and should not be. LPN EE further confirmed that R85 was not assessed for medication self-administration. In an interview on 12/19/2024 at 1:06 pm, the Director of Nursing (DON) stated that medications should not be kept at residents' bedside unless there was a physician's order for medication self-administration. She further stated she expected that the nurse should be administering medications for residents who are not assessed for medication self-administration.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49396 Based on observations, staff interviews, records review, and review of the facility policy titled, Care Management, the facility failed to ensure reasonable accommodation of needs was provided for one of 28 sampled residents (R) (R62) related to providing a wheelchair to accommodate a physician's order to elevate both feet at all times. The deficient practice had the potential to place R62 at risk for medical complications, unmet needs, and a diminished quality of life. Findings Include 1. Review of the facility policy titled, Care Management, revised 5/2021, revealed the Policy section included A. All Resident care is designed to meet a resident's individual needs and is directed toward conservation and restoration of an optimal physical and emotional state. Review of R62's electronic medical record (EMR) revealed diagnoses including impaired mobility and reperfusion edema. Review of R62's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section GG (Functional Abilities and Goals) documented that R62 had an impaired range of motion of upper and lower extremities on one side, used a wheelchair, required substantial/maximal assistance with mobility, was dependent on transfers, and was non-ambulatory. Review of R62's Physician's Orders revealed an order dated 12/2/2024 of Elevate legs above heart level all the time to reduce reperfusion edema. Review of R62's care plan dated 12/6/2024 revealed a Problem area of ADL (activities of daily living)/Mobility. Approaches included keeping the resident's legs elevated above heart level at all times. Observation on 12/17/2024 at 8:49 am of R62 in her room revealed her in a wheelchair with both feet on the floor. Observation on 12/17/2024 at 2:22 pm of R62 in the dining room revealed her in a wheelchair with her left foot on the floor. In an interview on 12/18/2024 at 10:25 am, Registered Nurse (RN) JJ stated R62's physician's orders included elevating her feet at all times. She confirmed R62's feet were not elevated and stated the facility didn't have an appropriate wheelchair available to elevate both of her feet. In an interview on 12/19/2024 at 12:41 pm, Unit Manager License Practical Nurse (LPN) II confirmed an order to keep R62's feet elevated at all times. She acknowledged compliance with the order was inconsistent and stated it may have been due to the facility not having the proper wheelchair equipment to ensure her feet remained elevated. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/19/2024 at 1:39 pm, the Director of Nursing (DON) confirmed R62's feet were not consistently elevated and stated the lack of proper wheelchair equipment contributed to this issue. She stated there was a delay in equipment availability.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49396 Based on observations, staff and family interviews, record review, and a review of the facility policy titled, Condition Change of the Resident, the facility failed to promptly notify the responsible party of a change in condition for one of 19 residents (R) (R62) reviewed for change in condition related to a deep tissue injury. Findings include: A review of the policy titled, Condition Change of the Resident, revised 7/2012, revealed the Procedure section included . 5. Notify resident's responsible party . Review of R62's Face Sheet revealed diagnoses included pressure-induced deep tissue damage of left 1st toe, non-pressure chronic ulcer of other part of left foot with fat layer exposed - left distal foot and left 2nd toe, vascular dementia, and hemiplegia ad hemiparesis right dominant side. Review of R62's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section GG (Functional Abilities and Goals) documented R62 required substantial/maximal assistance with bed mobility. Section M (Skin Conditions) documented no pressure ulcers or other skin conditions. Review of the care plan revealed a Problem area of the resident was at risk for skin breakdown. 10/30/2024: Left great toe discoloration and assessed as unstageable deep tissue injury pressure ulcer. The Approach section included treatment as ordered with a start date of 11/14/2024. Review of R62's Progress Notes revealed an entry dated 11/26/2024 of Resident returned from vascular appointment with new treatment order to paint left toes with and in between toes with Betadine and keep left foot dry. Further review revealed an entry dated 12/2/2024 of Resident returned from vascular appointment, post angiogram left foot. Dressing dry and intact, instruction to elevate leg above heart 24/7 as much as possible to reduce reperfusion edema. Review of R62's clinical record revealed no documentation of resident representative notification of R62's change in condition or treatment orders on 11/26/2024 or 12/2/2024. In an interview on 12/19/2024 at 12:22 pm, R62's resident representative stated she was not informed of the worsening of R62's toe or treatment plan. In an interview on 12/19/2024 at 1:22 pm, Unit Manager (UM) II confirmed there was no documentation to indicate when or how the resident representative was initially informed of the resident's toe condition. In an interview on 3/6/2020 at 1:26 pm, the Director of Nursing (DON) revealed that she expected the resident representative to be notified when the resident's condition or treatment plan changed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50803 Based on observations, staff and resident interviews, and record review, the facility failed to provide accurate Minimum Data Set (MDS) assessment data for two of 28 sampled residents (R) (R26 and R40). This deficient practice had the potential to affect the assessment of R26 and R40's care needs. Findings include: A facility policy for resident assessments was requested but not provided. 1. Review of R26's Face Sheet revealed diagnoses including, but not limited to, unspecified bilateral hearing loss. Review of R26's Admission MDS assessment dated [DATE] revealed Section B (Hearing, Speech, and Vision) documented R26's ability to hear was highly impaired, and speech clarity was coded as no speech-absence of spoken words. Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 14 (indicating little to no cognitive impairment). Review of R26's care plan dated 10/18/2024 revealed a Problem area of bilateral hearing loss. Goals included the resident will compensate for hearing loss by reading. Approaches included utilizing a communication board and providing a quiet, non-hurried environment, free of background noises and distractions. Review of R26's Physician's Orders revealed an order dated 10/18/2024 of Resident is deaf, please communicate with whiteboard. In an interview on 12/17/2024 at 10:46 am, a conversation was held with R26 by this surveyor writing on the whiteboard, and R26 responded verbally. 2. Review of R40's Face Sheet revealed diagnoses including, but not limited to, unspecified dementia. Review of R40's Quarterly MDS assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 7 (indicating severe cognitive impairment). Section I (Active Diagnoses) did not document a diagnosis of dementia. Review of R40's care plan dated 10/8/2020 indicated a Problem of Cognitive Loss/Dementia. Approaches included approaching resident in a calm manner. Review of R40's Physician's Orders revealed an order dated 9/18/2024 for memantine (a medication used to treat dementia) tablet 5 milligrams (mg) once a day. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/19/2024 at 10:39 am, the MDS Coordinator revealed she was responsible for the MDS assessments. She confirmed that R26 could speak verbally and was hard of hearing. She further confirmed that Section B of R26's MDS assessment inaccurately stated that R26 had no speech and should be revised. She confirmed R40's active diagnoses included dementia, and Section I of R40's MDS assessment was inaccurate, stating it should include a diagnosis of dementia. She stated the importance of accurate MDS assessments was to provide an adequate picture of the individual and what care should be provided.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44959 Based on observations, staff interviews, record review, and review of the facility policy titled, Care Plan Conference Interdisciplinary, the facility failed to develop a baseline care plan for enteral tube feeding for one of three residents (R) (R502) who received enteral tube feeding, within 48 hours of admission. This deficient practice had the potential to place R502 at risk for not receiving treatment and/or care according to their needs. Findings include: 1. Review of the facility policy titled, Care Plan Conference Interdisciplinary, revised May 2021, revealed the Standard section included An Interdisciplinary Care Plan Conference identifies resident needs and establishes obtainable goals. An appropriate plan of action is designed to ensure optimal levels of activity and independence for all residents . Documentation is done in the care conference action of the EHR [electronic health record]. The Purpose section included . 6. Initial care plan should be completed in (electronic health record) within 48 hours. Review of R502's clinical record revealed admitted [DATE]. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery and pneumonitis due to inhalation of food and vomit. Review of R502's Entry Tracking Record Minimum Data Set (MDS) dated [DATE] revealed it was in process and all care areas not completed . Review of R502's Physician's Orders revealed an order dated 12/12/2024 of Enteral Feeding: Formula (Nepro) 50 milliliters (ml) per hour. Review of R502's care plan dated 12/12/2024 revealed there was no care plan for enteral tube feeding. During initial screening on 12/17/2024 at 2:23 pm, observation revealed R502 was receiving enteral feeding via a feeding tube. Observation on 12/18/2024 at 12:49 pm revealed R502 lying in bed receiving enteral feeding via a feeding tube. During an interview on 12/19/2024 at 11:00 am, the Director of Nursing (DON) stated she expected an accurate care plan to be created for residents upon admission. During an interview on 12/19/2024 at 11:10 am, the MDS Director acknowledged that there was no baseline care plan created for enteral tube feeding for R502 and there should be one.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50803 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Care Plan Conference Interdisciplinary, the facility failed to ensure a comprehensive person-centered care plan was developed for one of seven residents (R) (R26) reviewed for the use of unnecessary medications. This deficient practice had the potential to place R26 at risk for not receiving treatment and/or care according to their needs. Findings include: Review of the facility's policy titled, Care Management, revised 5/2021, revealed the Policy section included A. All resident care is designed to meet a resident's individual needs and is directed toward conservation and restoration of an optimal physical and emotional state. B. Coordination of the plan of care is the responsibility of nursing. However, planning, implementation, and evaluation requires joint participation by each discipline rendering service. C. 5. The plan of care is reviewed and revised to reflect the current needs of the resident. Review of R26's electronic medical record (EMR) revealed R26 was admitted to the facility on [DATE] with diagnoses including spinal stenosis, sacroiliitis, and generalized anxiety disorder. Review of R26's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section M (Medications) documented R26 received an antipsychotic, an antianxiety, and an antidepressant. Review of R26's care plan revealed no care plan areas for the use of antidepressants, antipsychotics, or antianxiety. Review of R26's Physician's Orders revealed orders dated 10/18/2024 for amitriptyline (a medication used to treat depression) tablet 10 milligram (mg) oral at bedtime, 10/18/2024 for lorazepam (a medication used to treat anxiety) tablet 0.5mg oral twice a day, 10/18/2024 mirtazapine (a medication used to treat depression) disintegrating tablet 15 mg oral at bedtime, quetiapine (an antipsychotic medication) tablet 50 mg oral at bedtime, and trazodone (a medication used to treat depression) tablet 50mg oral at bedtime. In an interview on 12/19/2024 at 10:48 am, the MDS Coordinator (MDSC) verified she was involved with care plan development. She confirmed R26 received antipsychotic, antidepressant, and antianxiety medications. She further confirmed that there was no care plan areas for the medications and stated there should be. The MDSC stated that the importance of having care plan areas and interventions was to inform staff of the resident's care needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50803 Based on observations, staff and resident interviews, record review, and review of the facility's policy titled, Shaving, the facility failed to provide Activities of Daily Living (ADL) care for one of 28 sampled residents (R) (R21). Specifically, the facility failed to remove excessive facial hair for R21. This deficient practice placed R21 at risk for unmet needs and a diminished quality of life. Findings include: Review of the facility's policy titled, Shaving, reviewed 5/2021, revealed the Purpose section included To remove excessive hair from the face. To promote cleanliness. To improve resident morale and appearance. Review of R21's Face Sheet revealed diagnoses including, but not limited to, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, vascular dementia, and muscle weakness. Review of R21's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Section GG (Functional Abilities and Goals) documented R21 had impairment on one side for upper and lower extremities, was dependent for bathing, and required substantial/maximal assistance for personal hygiene. Review of R21's care plan dated 11/1/2023 revealed a Problem of ADL/Mobility with a deficit in ADL functioning and impaired mobility related to weakness and a history of cerebral Infarction with residual. Approaches included assisting with ADLs as needed or requested. Observations on 12/17/2024 at 11:33 am in R21's room revealed R21 with an excessive mustache and chin hair. Observation made on 12/18/2024 at 9:18 am in R21's room revealed R21 with an excessive mustache and chin hair. This observation was made the morning after R21's scheduled shower. In an interview on 12/19/2024 at 11:43 am, Certified Nursing Assistant (CNA) DD revealed she provided shaving assistance as she noticed facial hair growing. CNA DD stated that R21 never refused bathing or grooming. CNA DD confirmed that R21's facial hair was excessive and needed shaving. In an interview on 12/19/2024 at 12:37 pm, the Director of Nursing (DON) stated her expectations for ADL care for dependent residents included face washing and grooming. The DON stated her expectations for shaving female residents were that if the female resident would allow staff to shave, then staff should assist.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50803 Based on staff interviews, record review, and review of the facility's policy titled, Hemodialysis, the facility failed to ensure communication between the facility and dialysis center was documented after each dialysis session for one of one resident (R) (R85) reviewed for dialysis care. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life. The sample size was 25. Findings include: Review of the facility's policy titled, Hemodialysis, revised 1/2021, revealed the Policy section stated, To ensure effective communication and collaboration between the community and the resident's dialysis center. The Procedure section included 1. Nurse staff must complete the Dialysis Communication Form (DGE108) on days the resident attends dialysis. 2. Nursing staff must fax and/or send the Dialysis Communication Form to the dialysis. 5. Scan/drop completed Dialysis Communication Form received from dialysis center into the resident HER (electronic health record). Review of R85's electronic medical record (EMR) revealed diagnoses included, but were not limited to, end-stage renal disease and dependence on renal dialysis. Review of R85's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section O (Special Treatments, Procedures, and Programs) documented R85 received dialysis. Review of R85's care plan dated 9/10/2024 indicated a Problem area of dialysis. Approaches included Obtain and document pre and post-dialysis vital signs. Review of R85's Physician's Orders included an order dated 11/14/2024 for 11-7 to complete dialysis communication form and send to dialysis with patient. Once A Day on Mon, Wed, Fri. In an interview on 12/18/2024 at 9:46 am, Licensed Practical Nurse (LPN) EE stated the facility kept the dialysis communication forms for R85 in a binder at the nurse's station. In an interview on 12/18/2024 at 10:11 am, LPN EE confirmed R85 started dialysis on her admitted [DATE], but the first documented communication form was dated 11/20/2024. LPN EE stated the communication forms should have been completed since the first day of R85's dialysis sessions. LPN EE further stated the importance of maintaining communication between the facility and the dialysis center to provide continuity of care. In an interview on 12/19/2024 at 1:04 pm, the Director of Nursing (DON) stated she expected the dialysis communication form to be sent to the dialysis center with the resident and received back from the dialysis clinic. She confirmed there should be a communication form for each visit. She stated that maintaining communication between the facility and the dialysis center was important to monitor for side effects of dialysis.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50940 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Bed Mobility Assist Devices, the facility failed to ensure one of six residents (R) (R63) reviewed had the necessary consent, physician's order and completed assessment for the use of bilateral half-side rails on their bed. This deficient practice had the potential to place R63 at risk of physical injury and entrapment. Findings include: Review of the facility policy titled, Bed Mobility Assist Devices, dated 2/2021, revealed the Procedure section included, . 3. Once appropriate alternatives have been trialed and failed, a physician's order for an assist device should be obtained if the need for an assist device for bed mobility and transfer still exists. 4. A Bed Mobility Device Evaluation should be completed by the nurse upon the assessed need, quarterly, annually, and with significant change thereafter. 5. Bed Mobility Assist Device Informed Consent and Release form should be reviewed and signed by the resident and /or their representative upon the application of the assist device and yearly thereafter. Scan for in the EHR [electronic health record]. Review of R63's electronic medical record (EMR) revealed diagnoses included, but were not limited to, dementia, muscle weakness, and a history of falls. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) documented a BIMS score of 12 (indicating moderate cognitive impairment). Section P (Restraints and Alarms) documented bed rails were not used. Review of R63's Physician Orders revealed no order for the use of bed rails. Review of the EMR revealed no bed rail assessment was conducted. Review of R63's care plan dated 9/20/2024 documented that the resident was at risk for falls. Review of the Quarterly Risk assessment dated [DATE] indicated that the resident was at medium fall risk, with a Morse Fall Scale score of 40. Observations on 12/17/2024 at 10:08 am, 12/18/2024 at 9:30 am, 10:30 am, 1:05 pm, and 2:15 pm revealed R63 in bed with bilateral half-side rails in the up position. In an interview on 12/17/2024 at 10:08 am, R63 stated he did not know why the side rails were up. During an interview on 12/18/2024 at 1:10 pm, Licensed Practical Nurse (LPN) BB stated R63 was considered a fall risk, and the family requested side rails. She verified there was no physician's order, consent, or assessment for the use of side rails for R63. (continued on next page)

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	115330	A. Building B. Wing	12/19/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2024 at 1:30 pm, the Director of Nursing (DON) stated the steps required for using side rails were obtaining consent from the resident or responsible party, completing an observational assessment, and obtaining a physician's order. The DON confirmed that none of these steps were documented for R63. During an interview on 12/18/2024 at 1:45 pm, the MDS Coordinator stated a consent must be obtained prior to using side rails.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50803 Based on interviews, record review, and review of the facility's policy titled, Behaviors Using Person-Centered Care, Accommodating, the facility failed to ensure psychotropic medications were not ordered as needed (PRN) for more than 14 days unless clinically indicated for one of seven residents (R) (R31) reviewed for the use of unnecessary medications. This deficient practice had the potential to affect R31's highest practicable mental, physical, and psychosocial well-being. Findings include: Review of the facility's policy titled, Behaviors Using Person-Centered Care, Accommodating, revised 2/2021, revealed the Overview section included, VI. A PRN order for psychotropic medications should only be limited to 14 days. Review of R31's electronic medical record (EMR) revealed diagnoses including anxiety. Review of R31's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Section N (Medications) documented R31 received an antianxiety medication. Review of R31's Physician's Orders included an order dated 12/18/2023 for Ativan (lorazepam) [a psychotropic medication used to treat anxiety] tablet 0.5 milligrams (mg) for anxiety every 4 hours PRN. The end date was open-ended. In an interview on 12/19/2024 at 12:46 pm, the Director of Nursing (DON) confirmed there was no stop date for the physician's order of lorazepam 0.5 mg every four hours PRN. She further stated the order should have a definitive stop date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50803 Based on observations, staff interviews, record review, and review of the facility's policies titled, Handling of Soiled Linen and Resident Clothing, Isolation Precautions/Transmission Based Precautions, Hand Washing, and Cleaning Guidelines for Resident Care Equipment, the facility failed to ensure infection control procedures were followed. Specifically, the facility failed to ensure clean linen was covered during transport on one of five halls, failed to ensure Transmission Based Precautions (TBP) were followed for one resident (R) (R40) on TBP, failed to ensure a continuous positive airway pressure (CPAP) mask was properly stored when not in use for one R (R85), failed to ensure proper hand hygiene during medication pass, and failed to ensure shared medical equipment was cleaned between resident use. The deficient practices created the potential for cross-contamination and the spread of infections to the residents. The facility's census was 90 residents. Findings included: 1. Review of the facility's policy titled, Handling of Soiled Linen and Resident Clothing, dated 2/2024, revealed the Purpose section stated, The community is required to provide clean linen and must clean resident's clothing. Personnel must handle, store, process, and transport linen to prevent the spread of infection. The Linen Transport section included, Clean linen must be transported in clean covered carts. Observation on 12/17/2024 at 11:58 am in the hallway revealed housekeeping staff transporting residents' hanging laundry uncovered. Observation on 12/18/2024 at 9:23 am revealed Housekeeper MM transporting a clean laundry cart on the 9200 Hall with clean linen on it. The cover for the cart was draped over the side of the cart, and the linen was uncovered. After filling up the floor cart, she left the cart unattended and uncovered in the hallway. In an interview on 12/18/2024 at 9:23 am, Housekeeper MM stated the clean linen laundry cart should be covered when being pushed throughout the building. Housekeeper MM verified that the clean linen was not covered. In an interview on 12/18/2024 at 10:46 am, the Housekeeping Director stated he expected clean laundry being transported in carts and hanging racks to be covered using a blanket during transport. In an interview on 12/18/2024 at 2:14 pm, the Infection Preventionist (IP) stated she expected clean linen and laundry to be covered during transport. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the facility's policy titled, Isolation Precautions/Transmission Based Precautions, revised 2/2024, revealed the Purpose section stated, It is the policy of this community to, when necessary; prevent the transmission of infections within the community through the use of Isolation Precautions. The Transmission-Based Precautions section included 3. Contact Precautions: In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items. The above includes epidemiologically important organisms (multidrug-resistant organisms) such as methicillin-resistant Staphylococcus aureus (MRSA). Review of R40's electronic medical record (EMR) revealed diagnoses including, but not limited to, MRSA infection, neurogenic bladder, pressure ulcer of sacral region stage four, and a pressure ulcer of right heel stage four. Review of R40's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 7 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented R40 was dependent on staff for activities of daily living (ADLs) and mobility. Section H (Bladder and Bowel) documented R40 had an indwelling catheter and ostomy bag. Review of R40's care plan, dated 12/17/2024, indicated a Problem area of Infection and documented Resident has a multi-drug resistant organism MRSA that required the use of personal protective equipment during high contact activities. Goals included but were not limited to Resident will not exhibit complications to MDRO. Approaches included Resident is on Enhanced Barrier Precautions (EBP), staff must perform hand hygiene before and after providing care . Review of R40's Physician's Orders revealed an order dated 12/16/2024 for Bactrim DS (sulfamethoxazole-trimethoprim double strength) (a medication used to treat bacterial infections) 800-160 milligram (mg), one tablet by mouth twice a day for 10 days for MRSA. Observation on 12/17/2024 at 12:41 pm of R40's door revealed an EBP sign on the door and personal protective equipment (PPE) hanging inside the room on R40's closet door. Observation made on 12/18/2024 at 8:59 am of R40's door revealed no Transmission Based Precautions (TBP) sign on the door. Further observation revealed Certified Nursing Assistant (CNA) FF providing ADL care for R40 with gloves on but no gown. In an interview on 12/18/2024 at 9:08 am, CNA FF revealed she was cleaning R40's hands, washing her face, and removing nail polish from her nails. She confirmed she was wearing gloves and no gown. In an interview on 12/18/2024 at 1:57 pm, the IP confirmed that R40 was being treated for MRSA and should be on TBP. The IP stated there should be a sign on R40's door indicating TBP use. She confirmed staff should wear gloves and gowns while providing care to residents on EBP and TBP. In an interview on 12/19/2024 at 1:14 pm, the Director of Nursing (DON) stated TBP and contact precautions should be used for residents with MRSA. She further stated TBP signage should be on a resident's door to alert staff of the required PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of R85's EMR revealed diagnoses including, but not limited to, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), history of pneumonia, and chronic combined systolic and diastolic heart failure (CHF). Review of R85's Quarterly MDS assessment dated [DATE] revealed Section O (Special Treatments, Procedures, and Programs) documented R85 received oxygen therapy and a non-invasive mechanical ventilator. Review of R85's care plan dated 9/10/2024 revealed a Problem area of Respiratory and documented R85 required oxygen and a CPAP machine related to a history of COPD, CHF, and respiratory failure. Approaches included CPAP settings as ordered. Review of R85's Physician's Orders included an order dated 9/19/2024 for CPAP with home setting at 8 to 12 centimeters of water pressure (cm H20) at bedtime. Observation on 12/17/2024 at 11:48 am in R85's room revealed a CPAP mask at the bedside, not in use or placed in a bag. Observation made on 12/18/2024 at 9:38 am in R85's room revealed a CPAP mask at the bedside not being used, not in a bag, hanging from a bedside table, and lying on the floor. In an interview on 12/18/2024 at 9:46 am, Licensed Practical Nurse (LPN) EE confirmed the CPAP machine mask was not in use, unbagged, and lying on the floor. She stated the mask should be placed in a bag when not in use. In an interview on 12/18/2024 at 2:12 pm, the IP stated CPAP masks should be wiped down between uses and placed in a plastic bag by the bedside when not in use. In an interview on 12/19/2024 at 1:07 pm, the DON stated CPAP masks should be kept in a bag on the dresser and not lying on the floor when not in use. 50940 4. Review of the facility policy titled, Hand Washing, revised 2/2024, revealed the When to use Alcohol Hand Sanitizer section included . Before entering the resident's room. Before exiting the resident's room. Review of the facility's undated policy titled, Cleaning Guidelines for Resident Care Equipment, revealed the Policy section included, It is the policy of this facility that all resident care equipment will be cleaned after use and will be prepared for reuse by the same or another resident. The Procedure section included, 1. Resident equipment which is shared between residents must be cleaned after each use with an approved EPA [Environmental Protection Agency] disinfectant .The following items are recommended but not limited to: Blood pressure cuffs, Stethoscopes, Electronic thermometers, Glucometers . (continued on next page)

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