STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115362	A. Building B. Wing	04/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Macon Rehabilitation and Healthcare	505 Coliseum Drive Macon, GA 31217

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914 Based on observations, staff interviews, record review, and review of the facility's policy titled Urinary Catheter Care, Anchoring and Changing, the facility failed to ensure a urinary catheter privacy bag was provided for one of four residents (R) (R61) with a urinary catheter. This failure 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 facility's policy titled Urinary Catheter Care, Anchoring and Changing, revised April 2, 2024, revealed the Policy Statement was Each resident who is incontinent of bladder and has an indwelling catheter receives appropriate treatment of services to prevent urinary tract infections and to restore as much bladder function as possible. In order to avoid mucosal damage, catheter tubing will be anchored to prevent tension on the {name of catheter} insertion site. The Standards of Practice section stated, 16. Catheter drainage bags will be covered when residents are in a public area. 1. Record review revealed R61's diagnoses included, but were not limited to, bladder-neck obstruction, chronic obstructive pyelonephritis, interstitial cystitis with hematuria, and chronic kidney disease. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed Section H (Appliances) documented R61 had an indwelling urinary catheter. Observations on 4/19/2024 at 8:55 am and 4/20/2024 at 8:11 am revealed R61's urinary catheter drainage bag was uncovered and facing the door, allowing R61's urine to be visible to other residents, staff, and visitors from the hallway. An interview on 4/20/2024 at 8:15 am with Certified Nursing Assistant (CNA) AA confirmed that R61's catheter drainage bag contents were visible from the hallway and the bag should be in a privacy bag. An interview on 4/20/2024 at 8:28 am with Licensed Practical Nurse (LPN) BB confirmed R61's urinary catheter drainage bag was not in a privacy bag, and the contents were visible from the hallway. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/20/2024 at 8:43 am with the Director of Nursing (DON) revealed that there were four residents in the facility with a urinary catheter. Further interview revealed that R61 often removes the privacy bag and places it in the top drawer. She stated there should be attempts by staff to ensure that the bag is covered, and privacy is provided for the resident. Cross-reference F656

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41914 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled Care Plan Policy, the facility failed to ensure a care plan was developed or implemented for six of 37 residents (R) (R46, R51, R61, R4, R54, R67). Specifically, the facility failed to ensure the care plan was implemented for R46 and R51 for Activities of Daily Living (ADL), R61 for providing a privacy bag for a urinary catheter, R4 for oxygen use, and R54 for tube feeding. In addition, the facility failed to develop a care plan for R67 for the use of antipsychotic and anticoagulant medications. The deficient practices had the potential to place the residents at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: Review of the facility's policy titled Care Plan Policy, revised April 10, 2024, revealed the Policy Statement of Each resident will have a person-centered plan of care to identify problems, needs, and strengths that will identify how the facility staff will provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Review of R46's care plan revealed a Focus area of the resident had an ADL self-care performance deficit related to a cerebral vascular accident (CVA), hemiplegia and requires assistance with ADL care. The goal was for the resident to have a clean, neat, and odor-free appearance through the review date. Interventions included the resident preferred to keep their beard trimmed as needed/desired and assist with daily grooming of oral, skin, hair, and nails. Observations on 4/19/2024 at 10:21 am and 4/20/2024 at 7:45 am revealed that R46 had a full beard with food scattered throughout it. Further observation revealed R46's fingernails on the left hand were long, with a brown substance noted under the nails. 2. Review of R51 Quarterly Minimum Data Set (MDS) Assessment date 2/27/2024 section C (Cognition): A Brief Interview for Mental Status (BIMS) score of 11 (indicating moderate cognitive impairment). However, the resident was able to articulate that she was in a nursing facility and her preferences for nail care. Review of the care plan revealed a Focus area of R51 was at risk for skin tear/injury secondary to skin fragility with aging. Resident has a personal preference of long fingernails. The goal included that R51's personal preferences will be met through the review period. Interventions included to encourage resident nail care as allowed. Observation on 4/19/2024 at 9:31 am revealed R51's fingernails were long with a thick brown substance underneath her nails. An interview on 4/19/2024 at 9:45 am with R51 revealed that she does not want her nails cut but would like for them to be cleaned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R61's care plan revealed a Focus of R61 has an indwelling catheter due to obstructive and reflux uropathy, bladder neck obstruction, chronic obstructive pyelonephritis, and chronic kidney disease. Interventions included, but were not limited to, emptying the catheter, ensuring emptying when the bag is under 3/4 full, and ensuring the catheter bag remains below the level of the bladder so that gravity works to bring urine down and does not backflow into the bladder. Provide privacy device per resident preference. Observation on 4/19/2024 at 8:55 am revealed the catheter drainage bag was uncovered and facing the door with 2000 cubic centimeters (cc) of urine (filled to the top). Observation on 4/20/2024 at 8:11 am revealed the catheter drainage bag was visible from the door. No privacy bag was noted during the observation. The catheter drainage bag had 1600 cc of urine noted. An interview on 4/20/24 at 8:28 am with Licensed Practical Nurse (LPN) BB confirmed R61's urinary catheter drainage bag was not in a privacy bag, and the catheter drainage bag contained 1600 cc of urine and should be emptied. LPN BB confirmed that R61 had a care plan for a urinary catheter, and the care plan should be followed. An interview on 4/20/2024 at 8:43 am with the Director of Nursing (DON) revealed her expectation was for staff to provide care for the residents according to their care plan and the care needs of each resident. An interview on 4/20/2024 at 9:49 am with the MDS Director revealed that each resident had a care plan centered around their care needs. The MDS Director stated CNAs were notified of changes in residents' care needs through their charting system, which is used daily for resident care. She further stated that the nurses have access to the resident care plans, with their care needs documented, and were expected to follow the residents' care plan when providing care. 45813 4. Review of R4's care plan, initiated on 10/7/2021, revealed that the resident was at risk for impaired air exchange due to COPD and allergic rhinitis. Interventions included, but were not limited to, administering oxygen as needed. Observation on 4/19/2024 at 9:37 am revealed R4 receiving oxygen via a nasal cannula at 3 liters per minute (LPM). Observations on 4/20/2024 at 8:27 am and 12:20 pm revealed R4 receiving oxygen via a nasal cannula at 2 LPM. Review of R4's Physician Orders dated April 2024 revealed orders for oxygen at 2 LPM via a mask or nasal cannula as needed for oxygen saturation (SP02) less than 92 percent. If ineffective, notify physician as needed for shortness of breath (SOB), add humidification water bottle to oxygen concentrator for humidification, fill with distilled water, and check SP02 every shift, notify physician if less than 92 percent every shift related to chronic obstructive pulmonary disease. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the oxygen saturation section in the EMR under the Vital Signs tab and on the April 2024 Medication Administration Record (MAR) revealed no documented oxygen saturations less than 92 percent. An interview on 4/20/2024 at 1:04 pm with the DON verified R4 did not have documented oxygen saturations of 92 percent or below to indicate the use of the oxygen according to the physician's order, and she verified that R4's care plan was not being followed. 33548 5. Review of R54's care plan, dated 4/3/2024, revealed the resident has nutritional problems or potential nutritional problems due to an NPO (nothing by mouth) diet and experiences weight fluctuations. The resident receives continuous tube feeding with hourly water flushes. Interventions included, but were not limited to, providing and serving diet and supplements as ordered. R54 also had a care plan developed for potential fluid deficit due to NPO status. Interventions included, but were not limited to, administering medications and nutrition/flushes as ordered. Review of R54's Physicians Orders revealed an order dated 4/1/2024 for enteral tube feeding for continuous formula Nepro (a nutritional product administered for nutritional support) at 65 cubic centimeters (cc) per hour for 22 hours. Observation on 4/19/2024 at 9:00 am of R54 revealed that Glucerna (a nutritional product administered for nutritional support) tube feeding was being administered via a pump at 65cc per hour. During an interview and observation on 4/19/2024 at 3:15 pm, the DON confirmed that R54 was receiving Glucerna tube feeding and not the Nepro tube feeding that was ordered by the physician. An interview on 4/21/2024 at 9:52 am with Registered Nurse (RN) HH/MDS Director revealed that each resident had a care plan centered around their care needs and physician's orders. She further stated staff was expected to follow the care plan for each resident. Continued interview revealed care plan meetings were attended by the administrative staff, and if anything needs to be relayed back to the staff, we put it on the care plan and communicate it with the floor staff. 39786 6. Record review revealed R67's diagnoses included, but were not limited to, paraplegia complete, neuromuscular dysfunction of the bladder, and chronic pain syndrome. Review of the Quarterly MDS assessment dated [DATE] revealed Section N (Medications) documented that R67 had received antipsychotic, antidepressant, anticoagulant medications, and antipsychotics were received on a routine basis during the assessment period. Review of the Physician Orders revealed orders of: 4/11/2024: quetiapine fumarate 25 milligrams (mg) (a medication used to treat mental and mood disorders) 1 tablet by mouth (PO) twice a day related to unspecified mood (affective) disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/11/2024: venlafaxine hydrochloride ER (extended-release) (a medication used to treat depression and anxiety) 75mg tablet Q24h (every 24 hours) give 1 tablet PO one time a day for depression. 4/11/2024: Eliquis 5 mg (a medication used to treat and prevent blood clots) give 1 tablet PO twice a day for blood clot prevention. Review of R67's care plan revealed there were no care plan areas or interventions for the use of antipsychotic, antidepressant, and anticoagulant medications. An interview on 4/21/2024 at 9:20 am with RN HH/MDS Director revealed care plans were updated quarterly, annually, and as needed when something was going on with the resident. She stated she received information through interviews with residents and staff and a clinical record review. The interview further revealed she was behind on care plan revisions. She confirmed that R67's care plan had not been updated since he was readmitted from a hospitalization . An interview on 4/21/24 at 11:17 am with the DON revealed that R67 was recently readmitted to the facility from a hospitalization . She confirmed the care plan was not updated or revised to include care plan areas and interventions for the use of antipsychotic, antidepressant, and anticoagulant medications before 4/21/2024. She stated her expectation was for resident care plans to be revised and updated in a timely manner and when changes in conditions warrant revisions or additions to the care plan. Cross-reference F550, F677, F695, F693

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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. 39786 Based on observation, resident and staff interviews, and a review of the facility's policy titled Care Plan Policy, the facility failed to update the care plan for one resident (R) (R56) related to an indwelling urinary catheter that had been removed and discontinued. The sample size was 37 residents. This failure placed R56 at risk for unmet needs and a diminished quality of life. Findings include: A review of the facility's policy titled Care Plan Policy, revised April 10, 2024, revealed a Policy Statement of Each resident will have a person-centered plan of care to identify problems, needs, and strengths that will identify how the facility will provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The Standards of Practice section stated, 12. The plan of care is to be reviewed and updated as necessary at the completion of every assessment by the interdisciplinary team and resident representative party if so desired. A review of R56's Quarterly Minimum Data Set (MDS) assessment, dated 3/6/2024, revealed Section C (Cognition) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating no cognitive impairment), Section H documented no indwelling urinary catheter. A review of the care plan revealed a Focus area of [resident name] has an indwelling catheter. Goal and interventions were in place for an indwelling urinary catheter, and the last revision date was 9/20/2023. A review of the active Physician Orders revealed there was no order for an indwelling urinary catheter. An interview on 4/21/2024 at 9:20 am with Registered Nurse (RN) HH/MDS Director revealed she and the MDS Coordinator gathered information to update care plans by interviewing residents, reviewing their medication list, reviewing the clinical record, if the resident was not cognitive and could not be interviewed, they talked with staff for residents' functional mobility and behaviors, and discussed residents in the morning meetings. She stated care plans were updated quarterly, annually, with a change in condition, and as needed. She confirmed care plan revisions were behind. A continued interview revealed RN HH/MDS Director stated she was unaware of R56's urinary catheter being removed. During an observation on 4/21/2024 at 9:45 am, inside R56's room, RN HH/MDS Director confirmed R56 no longer had a urinary catheter. She stated the catheter must have been removed recently. R56 stated that staff took his catheter out five months ago in November 2023. An interview on 4/21/2024 at 10:58 am with the Director of Nursing (DON) revealed care plans must be completed and revised in a timely manner. She stated care plans were reviewed and updated quarterly and annually, with changes in condition and as needed. She confirmed that R56's urinary catheter was discontinued and removed on 11/1/2023. The DON stated her expectation was that care plans be revised and updated as indicated when changes in condition warrants.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914 Based on observations, resident and staff interviews, record review, and review of the facility's policies titled Activity of Daily Living, Quality of Life, Special Rehabilitative Services, and Nail Care (Finger and Toe), the facility failed to ensure five residents (R) (R51, R29, R21, R56, and R46) were provided care and services in accordance with their personal needs. Specifically, the facility failed to ensure R51 and R29's nails were clean and trimmed, R46's beard was trimmed and clean without food particles present, and R21 and R56 received baths and removal of facial hair. These failures placed R51, R29, R21, R56, and R46 at risk for unmet needs and a diminished quality of life. The sample size was 37 residents. Findings include: Review of the facility's policy titled Activity of Daily Living, Quality of Life, Special Rehabilitative Services, dated November 2022, revealed the Policy Statement included Each resident shall receive, and this facility will provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident comprehensive assessment and care plan. The Scope section stated, Residents will be given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living including hygiene bathing, grooming and oral care mobility, transfer, ambulation, elimination/ toileting, dining, eating, and communication functions. Review of the facility's policy titled Nail Care (Finger and Toe), dated April 1, 2024, revealed the Standard of Practice section included 1. Nails can be partially cleaned during bathing. 3. Nail care includes daily cleaning and regular trimming. 1. Record review revealed R51's diagnoses included, but were not limited to, the need for assistance with personal care, major depressive disorder, and adjustment disorder mixed with anxiety and depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognition) documented a Brief Interview for Mental Status (BIMS) score of 11 (indicating moderate cognitive impairment). However, the resident was able to articulate that she was in a nursing facility and her preferences for nail care. A continued review revealed that section GG (Functional Abilities and Goals) documented that R51 had functional limitations with impairment on both sides of the upper and lower extremities. Observation on 4/19/2024 at 9:31 am revealed R51's fingernails were long with a thick brown substance underneath her nails. An interview on 4/19/2024 at 9:45 am with R51 revealed that she does not want her nails cut but would like for them to be cleaned. Further interview also revealed that resident could not recall the last time her nails were cleaned by staff. 2. Record review revealed R46's diagnoses included, but were not limited to, generalized muscle weakness, lack of coordination, and need for assistance with personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Quarterly MDS assessment dated [DATE] revealed Section C (Cognition) documented a BIMS score of 7 (indicating moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented that R46 had functional limitations with impairment on one side of the upper extremities. Observation on 4/19/2024 at 10:21 am revealed R46 had a full beard with food scattered throughout it. R46 stated he did not want to shave his beard but would like it trimmed and shaped. Further observation revealed R46's fingernails on the left hand were long, with a brown substance noted under the nails. Observation on 4/20/2024 at 7:45 am revealed R46 lying in bed wearing the same clothes as the previous day. His beard continued to have food particles scattered throughout it, and the fingernails on his left hand had a brown substance noted underneath. An interview on 4/20/2024 at 8:47 a.m. with the Director of Nursing (DON) revealed her expectation was that residents have their nails cleaned and trimmed as needed. She stated that Certified Nursing Assistants (CNAs) should trim the residents' nails as part of their daily care. Further interview revealed the DON stated that R51 prefers to have her nails long, but there should be an attempt to clean the residents' nails as needed. The DON confirmed previous observations for R46 and R51. 39786 3. Record review revealed R21's diagnoses included, but were not limited to, Alzheimer's disease and muscle weakness. Review of the most recent Comprehensive Annual MDS assessment dated [DATE] revealed section G (Functional Abilities and Goals) documented R21 required extensive assistance for personal hygiene and was dependent for bathing. Review of the care plan revealed R21 required physical assistance with activities of daily living (ADL) care related to decreased mobility and Alzheimer's disease. Interventions included bathing assistance and skin assessment with shower. Review of the Task list included skin assessment with showers two times per week and as needed (PRN). Review of the Task Schedule revealed bath two times per week on Tuesday, Friday and PRN, every week on 7 am-3 pm shift for bathing/skin assessment with shower. Review of the Kardex revealed R21 required assistance with ADLs, including bathing, skin assessment with shower, and personal hygiene/oral. Review of the Bath Schedule revealed R21's scheduled bath days were every Monday and Friday on the 11 pm -7 am shift. No bath sheets were found in the nurses' station notebook for R21 for April 2024. The DON provided four bath sheets dated 4/2/2024, 4/5/2024, 4/9/2024, and 4/16/2024. Record review revealed that R21 only received four bed baths in 20 days, and staff did not document that R21's face was shaved on any day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/19/2024 at 8:58 am revealed R21 had long facial hair on her chin, and her hair was stringy and greasy. An interview on 4/20/2024 at 10:35 am with CNA JJ revealed they did not have a bath team, and the CNAs were responsible for bathing all residents according to the bath schedule. She stated the CNAs check the schedule to know who was scheduled each day and the resident's bath preference. CNA JJ revealed the bath should be documented in the electronic medical record (EMR) and a bath sheet completed and signed by the CNA and the nurse. She verified that if the bath was not documented, it was not done. An interview on 4/20/2024 at 10:50 am with Licensed Practical Nurse (LPN) BB revealed the residents have a scheduled day for their shower/bath and have a choice of the day. LPN BB stated the schedule and bath sheets were kept in a notebook at the nurse's station. She further stated the CNAs fill out the bath sheet every time they provide a shower or bath, and the nurse signs off on it. She confirmed the bath was not provided if the sheet was not filled out. 4. Review of the clinical record revealed R56's diagnoses included, but were not limited to, bilateral primary osteoarthritis of knee, morbid obesity, pain in left and right knee, muscle weakness. Review of R56's Quarterly MDS assessment dated [DATE] revealed Section C (Cognition) documented a BIMS score of 15 (indicating little to no cognitive impairment) Section GG (Functional Abilities and Goals) documented R56 required substantial/maximal assistance (which meant staff did more than half the effort) with bathing or showering and shower transfer. Review of the care plan revealed an ADL self-care performance deficit, and a risk for impaired skin integrity and wounds, related to morbid obesity, decreased mobility, and pain to bilateral knees. Interventions included assisting with bathing and daily grooming as needed. Review of the Task list included skin assessment with shower three times per week and PRN. The task care record for April 2024 had no documentation under bathing/skin assessment with shower. Review of the Task Schedule revealed bath two times per week on Monday and Thursday on the 3 pm-11 pm shift and PRN on the 11 pm -7 am shift. Review of the Kardex revealed R56 required assistance with bathing, daily grooming as needed, and skin care. Review of the Bath Schedule revealed R56's shower days were every Wednesday and Saturday on the 7 am - 3 pm shift and documented that R56 preferred showers. Review of the Bath/Shower Notebook revealed it contained the bath schedule, blank, and completed bath forms titled Daily Bath Sheet. Staff revealed these sheets were used to track when baths were given and should be completed every time a bath or shower was given. The sheet had the option of either a shower or bed bath and a checklist of care provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the bath sheets revealed R56 received one bath in the past 20 days. One sheet was dated 4/17/2024 and documented shower, showers self, use shower chair, apply clean clothing, change sheets, return to bed, return to chair, and was signed by the CNA and the Unit Manager. The other sheet was dated 4/6/2024 and documented refused, attempted three times, and was signed by the CNA and the Unit Manager. The DON provided three additional sheets dated 3/7/2024, 3/16/2024, and 3/21/2024 that revealed R56 received three showers in 31 days in March. Interview on 4/19/2024 at 11:32 am with R56 revealed he didn't get a shower like he should. He stated he was scheduled twice a week on Wednesday and Saturday but often got the runaround when he asked staff about his shower. He further stated that staff would tell him a specific day he was scheduled for a shower and, on the scheduled day, would tell him it was a different day. He also stated staff would tell him they were too busy or didn't have enough help to provide a shower. He revealed he gets frustrated because he never knew when he would receive a shower. Interview on 4/20/2024 at 8:28 am with R56 revealed he hadn't had a bath yet, and today was his shower day. Interview on 4/20/2024 at 11:03 am with CNA KK confirmed they did not have a bath team and the CNAs were responsible for doing all their resident's baths/showers. CNA KK revealed staff knew who was supposed to get a bath each day because they followed a bath schedule at the nurse station that was by room number and included the day of the week and shift. She revealed they documented in the EMR and on a bath sheet. She explained the CNA filled out the sheet, reported to the nurse, gave her the bath sheet, and both signed the form. CNA KK revealed they must do a bath sheet every time to show proof they did the bath, and if there was no bath sheet completed, the bath was not done. Interview on 4/21/2024 at 10:58 am with the DON revealed they do the bath schedule by starting with each resident's preference for bed bath or shower and time of day. She stated her expectation was for residents to get bathed on their shower day as desired. 33548 5. Review of the medical record revealed R29's diagnoses included, but were not limited to, Alzheimer's disease, depression, and weakness. Review of R29's Admission MDS assessment dated [DATE] revealed Section C (Cognition) documented a BIMS score of 9 (indicating moderately compromised cognition). However, R29 was oriented and able to make her needs known. Section GG (Functional Abilities and Goals) documented R29 was dependent on staff to perform all ADLs. Review of R29's bath/shower sheet revealed a bed bath was completed on 4/5/2024. Nail care was listed as an item for nursing staff to check as completed. The box for the nail care task was not marked, indicating the task was not done. The bath/shower sheet dated 4/12/2024 stated that R29 had a shower with therapy, and there were no boxes for care items marked as completed. During observation and interview on 4/19/2024 at 10:10 am, R29 stated that she would like her fingernails cut and polished, but she did not have any money for nail service. Observation of R29 fingernails revealed they were about 1 to 1.5 inches long, and the left-hand index finger and middle finger had broken nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 4/21/2024 at 10:00 am with the Activities Director (AD) and the Activities Assistant (AA) revealed that they scheduled an activity called Pretty Nails every two weeks on the resident activity schedule. The AD revealed that the Pretty Nails activity was held in the main dining room or solarium, and residents could get their nails trimmed and polished at the activity. The AD stated that they do go to the rooms of residents who do not come out of their rooms for activities and ask if they would like their nails trimmed and polished. The AA confirmed that R29 had not been approached and asked about nail care, but they will visit and ask if she would like her nails done. An interview on 4/21/2024 at 10:05 am with R29 revealed that she would really like her nails shortened and stated it had been difficult for her to do things when they were this long. An observation and interview on 4/21/2024 at 10:05 am with LPN II confirmed that R29 had long fingernails. LPN II stated that the CNAs were responsible for addressing resident fingernails during bathing. Cross-reference F656

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38991 Based on observation, resident and staff interviews, record review, and review of the facility's policy titled Nail Care (Finger and Toe), the facility failed to obtain a podiatry appointment for one resident (R) (R39) of 37 sampled residents. This deficient practice had the potential to cause R39 unnecessary discomfort and decreased quality of life. Findings include: Review of the facility's policy titled Nail Care (Finger and Toe), last reviewed April 1, 2024, revealed the section titled Standard of Practice stated, 4. Stop and report any evidence of ingrown toenails, infection, pain, or if nails are too hard or thick to cut with ease. The Step and Action section stated, 24. Report the condition of the resident's nails: . Complaints or problems with hands or feet. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognition) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating intact cognition), and Section GG (Functional Abilities and Goals) revealed R39 was dependent on staff for all Activities of Daily Living (ADL). In an interview on 4/19/2024 at 8:57 am, R39 asked about seeing the Podiatrist to get her nails clipped and stated she had asked staff, but no one had made her an appointment. Observation of R39's left foot revealed the left great toe had a thick, long toenail with jagged edges. In an interview on 4/20/2024 at 9:30 am, R39 revealed she spoke with the Social Worker the previous day, and the Social Worker was supposed to make an appointment for her to see the Doctor to get her toenails on her left foot taken care of. In an interview on 4/20/2024 at 10:00 am, the Social Services Director (SSD) revealed that R39 spoke with her on 4/19/2024, asking to be put on the list to see the Podiatrist to have her toenails trimmed. The SSD stated the staff who assisted R39 with bathing had not told her the resident needed to see the Podiatrist nor had R39 asked to see the Podiatrist until 4/19/2024. The SSD stated she relies on staff, residents, and family members to let her know when someone needs to see the Podiatrist and that R39 fell through the cracks. In an interview on 4/20/2024 at 10:25 am, R39 revealed she had told a Certified Nursing Assistant (CNA) that she needed her toenails trimmed, but no one had spoken with her about the need before 4/19/2024. In an interview on 4/20/2024 at 10:35 am, CNA DD revealed she informs the nurse when she identifies a need for a resident to see a Podiatrist. She revealed she informed a nurse a few weeks ago that R39 needed to see a Podiatrist and further stated she had also informed the SSD that R39 asked to see her about making a podiatry appointment.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33548 Based on observation, staff interview, record review, and review of the facility's policy titled Enteral Nutrition Policy, the facility failed to provide enteral (a method of supplying nutrients directly into the gastrointestinal tract) nutrition according to physician orders for one resident (R) (R54) of 10 residents receiving enteral feeding in the facility. This deficient practice placed R54 at risk for medical complications and a diminished quality of life. Findings include: Review of the facility's policy titled Enteral Nutrition Policy, last reviewed April 16, 2024, revealed the Policy Statement included Adequate nutritional support through enteral feeding will be provided to residents as ordered. Review of R54's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed section K (Swallowing and Nutrition) documented R54 received tube feeding while a resident in the facility. Review of the medical record revealed R54's diagnoses included, but were not limited to, cerebrovascular accident, dysphagia, type 2 diabetes, and mild protein-calorie malnutrition. Review of R54's Physician Orders revealed an order dated 4/1/2024 for enteral tube feeding for continuous formula Nepro (a nutritional product administered for nutritional support) at 65 cubic centimeters (cc) per hour for 22 hours. Review of R54's Medication Administration Record (MAR) for April 19, 2024, revealed that R54 was administered Nepro tube feeding daily. Observation on 4/19/2024 at 9:00 am of R54 revealed that Glucerna (a nutritional product administered for nutritional support) enteral tube feeding was being administered via a pump at 65cc per hour. Observation of R54 on 4/19/2024 at 3:15 pm with the Director of Nursing (DON) cothnfirmed that Glucerna tube feeding was being administered instead of the Nepro tube feeding formula that was ordered by the physician. She stated the nursing staff administered the wrong tube feeding product and that the resident should have been receiving Nepro. She further stated she would have the nursing staff administer the correct tube feeding. Cross-Reference F656

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914 Based on observations, staff interviews, record review, and review of the facility's policies titled Tracheostomy Policy, Emergency Management, Tracheostomy Care and Services, and Oxygen Therapy Policy, the facility failed to ensure two residents (R) (R71 and R14) had a written physicians order for the tracheostomy tube sizes in use. In addition, the failed to ensure respiratory supplies for R71 were available at the bedside. Additionally, the facility failed to ensure two residents (R24 and R4) receiving oxygen (O2) therapy had written physician orders for oxygen use, ensure oxygen was administered as ordered by the physician, and failed to ensure oxygen concentrator filters were free of dust and debris. The deficient practices had the potential to place the residents at risk for medical complications, unmet needs, and a diminished quality of life. The sample size was 37 residents. Findings include: Review of the facility's policy titled Tracheostomy Policy, Emergency Management, dated March 2024, revealed the Policy Statement Purpose stated, The main purposes of this clinical practice guideline is to ensure the care of residents with a tracheostomy is consistent with the residents' goals of care along with the prevention and identification of complications, such as accidental decannulation and occluded tracheostomies. Continued policy review revealed the Policy Interpretation and Implementation section stated, In case of emergency tracheostomy tube dislodgement (decannulation) appropriate supplies and equipment to be kept at the bedside and/ or immediately accessible; the this includes times when the resident is being transported from unit to unit or any time the resident leaves the facility. Review of the facility's policy titled Tracheostomy Care and Services, dated April 1, 2024, revealed the Policy Statement stated, The facility must provide consistent implementation of all aspects of care related to provision of tracheostomy care and services, in accordance with accepted professional standards of practice, including emergency interventions as appropriate. A care plan must be developed and implemented to include appropriate interventions for respiratory care. The facility must develop an individualized care plan based on the resident's assessment. Review of the facility's policy titled Oxygen Therapy Policy, dated April 2024, revealed the Standard of Practice section stated, 1. Oxygen therapy is to be used with a written order by a physician. A physician's order for O2 therapy is to contain liter flow per minute via mask or cannula. On an emergency basis, O2 may be used at 2 liters per minute until physician is notified. 1. Review of R71's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section O (Special Treatments, Procedures, and Programs) documented that R71 received oxygen therapy, required suctioning, required tracheostomy care, and had an invasive mechanical ventilator. Review of the medical record for R71 revealed the resident's diagnoses included, but were not limited to, anoxic brain damage, chronic respiratory failure, chronic obstructive pulmonary disease, and encounter for attention to tracheostomy. Review of R71's Physician Orders revealed there was no order for the tracheostomy tube size. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan revealed a Focus area of the resident has a tracheostomy related to chronic respiratory failure and anoxic brain damage. The Goal indicated that the resident would have no signs and symptoms of infection through the review date. Interventions included ensuring that trach ties are secured at all times, giving humidified oxygen as prescribed, providing good oral care daily and as needed, and suctioning as necessary. Observation on 4/19/2024 at 9:43 am of R71's room revealed no tracheostomy supplies were visible at the bedside. An interview on 4/19/2024 at 10:56 am with Licensed Practical Nurse (LPN) CC revealed sterile water, a tracheostomy cleaning kit, and suctioning supplies were usually kept at the bedside. LPN CC also revealed that the resident's replacement tracheostomy tube was kept in the supply or medication room. An interview on 4/19/2024 at 11:30 am with the Director of Nursing (DON) revealed that a Respiratory Therapist (RT) comes to the facility weekly on Wednesday to see residents who have a tracheostomy. During the interview, it was determined that the supplies that should be stored at the residents' bedside were a resuscitator, oxygen, suction machine, and a replacement tracheostomy tube, specifically one of the size that was inserted and one of the next smaller size. During the interview, the DON revealed that Central Supply staff was responsible for ensuring the supplies were at the resident's bedside and were replenished weekly. Further interview with the DON revealed R71's tracheostomy tube was downsized by the RT on 4/17/2024 from a 7.5 millimeter (mm) to a 6.5 mm size. During the interview, the DON confirmed that there was no written physician's order for R71 documenting the resident's tracheostomy tube size of 6.5 mm or that the resident had a written order for the previous tracheostomy size of 7.5 mm. She stated the RT does not write the orders for tracheostomy residents and further stated the RT would notify the charge nurse of the changes made, and the charge nurse was responsible for ensuring the order was written and placed in the residents' medical records. Observation on 4/19/2024 at 11:35 am with the DON of R71's tracheostomy supplies revealed a resuscitator was observed in the second drawer of the resident's dresser. There were no suction kits or gauze. However, a replacement tracheostomy tube one size below was visible in the room. The DON confirmed the observations. An interview on 4/19/2024 at 11:45 am with the Central Supply Clerk (CSC) revealed that she was responsible for ensuring supplies for tracheostomy residents were stocked at their bedside. The CSC stated the supplies were replenished once a week on Wednesday when the RT informed her what was needed for each resident. During the interview, she revealed that there was no documentation to indicate what size tracheostomy tube each of the tracheostomy residents needed. Further interview revealed that R71's respiratory supplies were not restocked this week due to the CSC being off on Wednesday, and there was no other staff member in the facility who restocked the respiratory supplies. An interview on 4/19/2024 at 1:00 pm with the RT revealed that she visits the facility weekly on Wednesday to see residents who have tracheostomies. She also stated that R71's tracheostomy was downgraded to a smaller size of 6.5 mm on 4/17/2024. During the interview, it was revealed that the RT does not write physician orders for the residents, and when changes are made for the tracheostomy residents, the charge nurse is notified so they can write the orders. 38991 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R14's Quarterly MDS assessment dated [DATE] revealed Section I (Active Diagnoses) documented diagnoses including, but not limited to, respiratory failure, and Section O (Special Treatments and Programs) documented the resident received oxygen, suctioning, and tracheostomy care. Review of the electronic medical record (EMR) revealed a physician order dated 10/2/2023 for an 8 mm tracheostomy tube. Observations on 4/19/2024 at 10:03 am and 4/20/2024 at 7:45 am revealed tracheostomy supplies were in R14s room, including a 7.5 mm tracheostomy kit, 6.0 mm inner cannulas, gauze, tape, a resuscitator, sterile water, gloves, suction catheters, and tracheostomy cleaning kits. An interview on 4/20/2024 at 8:00 am with LPN EE revealed that R14's tracheostomy tube size was 7.5 mm, and the inner cannula size was 6 mm. She reviewed the physician's orders in the EMR and confirmed that the orders for tracheostomy sizes were dated 4/19/2024. LPN EE reviewed R14's discontinued physician's orders in the EMR and confirmed there were no previous orders for the tracheostomy tube size of 7.5 mm. An interview on 4/21/2024 at 8:40 am with the DON revealed that the RT changed R14's tracheostomy tube and inner cannula sizes on 4/17/2024. She stated the process for documenting orders for changes in tracheostomy tube and inner cannula sizes was for the RT to inform the nurse of the changes, and the nurse was responsible for putting the orders in the EMR. She further stated the change on 4/17/2024 was not put in as a physician's order and that she had put the order in on 4/19/2024. 45813 3. Review of the medical record revealed R4 had diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) and obesity. Review of the quarterly MDS assessment dated [DATE] revealed Section C (Cognition) documented a Brief Interview for Mental Status (BIMS) of 14 (indicating little to no cognitive impairment). Review of R4's Physician Orders dated April 2024 revealed orders for oxygen at 2 liters per minute via a mask or nasal cannula as needed for oxygen saturation (SPO2) less than 92 percent. If ineffective, notify physician as needed for shortness of breath (SOB), add humidification water bottle to oxygen concentrator for humidification, fill with distilled water, and check SP02 every shift, notify physician if less than 92 percent every shift related to chronic obstructive pulmonary disease. Review of the oxygen saturations in the EMR under the Vital Signs tab revealed no documented oxygen saturations less than 92 percent. Review of the April 2024 Medication Administration Record (MAR) revealed there was no documentation of R4 receiving oxygen. Further review of the MAR revealed all oxygen saturations documented were greater than 92 percent. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/19/2024 at 9:37 am revealed R4 with oxygen on via a nasal cannula at 3 liters per minute (LPM) via an oxygen concentrator. There was no humidification bottle attached to the concentrator. Observation revealed the oxygen concentrator filter had a white/light grey fuzzy substance on the vent covering the filter, and the concentrator had an accumulation of a light grey fuzzy substance and a white substance along both sides and the front. Observations on 4/20/2024 at 8:27 am and 12:20 pm revealed R4 with oxygen on via a nasal cannula at 2 LPM via an oxygen concentrator. Further observations revealed the concentrator still did not have a humidification container. The concentrator continued to be dirty, and the vent covering the concentrator's filter continued to have a white/light grey fuzzy substance. An interview on 4/20/2024 at 8:27 am with R4 revealed that she wears oxygen most of the time and only removes it during mealtimes. An interview on 4/20/2024 at 12:28 pm with Certified Nurse Aide (CNA) FF revealed that she ensures R4 is wearing the oxygen. CNA FF further stated R4 wears oxygen at all times and can't go without it. Interview and observation on 4/20/2024 at 12:48 pm with LPN GG verified that R4's oxygen concentrator did not have a humidification bottle and should have one since there was an order for one. LPN GG verified the dirty filters and the unclean concentrator. She further stated that R4 wears oxygen at all times, and she checks her oxygen saturation daily. LPN GG verified the current physician's order for oxygen was for it to be given as needed at 2 LPM if oxygen saturations were 92 percent or less. LPN GG stated that R4's oxygen saturation was 97 percent today when it was checked, and according to the current order, the resident should not be wearing the oxygen. LPN GG further stated she was unsure who was responsible for cleaning the concentrator and the filters. During an interview and walking rounds on 4/20/2024 at 1:04 pm with the DON, she verified the oxygen concentrator to be dirty, the filters were not clean, and the oxygen was not humidified. The DON further stated she was not sure who was responsible for cleaning the filters but thought maybe it was the Maintenance Director. The DON verified the current oxygen order was not being followed. She verified there were no documented oxygen saturations of 92 percent or below to indicate the use of the oxygen according to the current order. The DON stated that the nurses should check the orders to ensure they were correct and being followed. An interview on 4/20/2024 at 1:36 pm with the Maintenance Director revealed the oxygen concentrator filters were not cleaned on a routine basis and stated he only changes and cleans them if there is a work order for it. A follow-up interview on 4/21/2024 at 9:30 am with LPN GG revealed she was aware that as-needed (PRN) oxygen should be documented on the MAR. She further stated that she did not notice that it was not being documented because the oxygen saturations were being documented daily. A follow-up interview on 4/21/2024 at 9:34 am with the DON revealed the nurses are required to sign off oxygen use on the MAR for continuous and PRN use of the oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the medical record revealed R24 had diagnoses including, but not limited to, chronic combined systolic (congestive) and diastolic heart failure, cardiomyopathy, COPD, and presence of automatic (implantable) cardiac defibrillator. Review of the Quarterly MDS assessment dated [DATE] revealed Section C (Cognition) documented a BIMS of 15 (indicating little to no cognitive impairment). Review of R24's care plan, initiated on 2/1/2024, revealed that the resident had an altered respiratory status/difficulty breathing due to COPD with congestive heart failure (CHF). Interventions included checking oxygen saturations as ordered and providing oxygen as indicated. Review of the active Physician Orders dated 4/20/2024 revealed no order for oxygen therapy. Observations on 4/19/2024 at 8:52 am and on 4/20/2024 at 8:12 am and 12:56 pm revealed the filter vent on R24s oxygen concentrator had a large accumulation of light grey fuzzy substance and the concentrator was dirty. Further observation revealed the concentrator was turned on with oxygen flowing, and the nasal cannula was lying on the bedside table. An interview on 4/20/2024 at 1:12 pm with R24 revealed that he uses oxygen as needed due to having COPD and a pacemaker. R24 further stated he takes the oxygen off and on whenever he needs it. He stated that he had used the oxygen since admission to the facility. During walking rounds and interview on 4/20/2024 at 1:20 pm, the DON verified R24 had used oxygen in the last year. The DON verified the nasal cannula on the table, the dirty filter, and the dirty concentrator. She verified that R24 did not have a current physician's order for oxygen and stated there should be a physician's order if the resident is receiving oxygen. The DON further stated that R24 was recently sent to the hospital, and the oxygen order was not added back upon readmission to the facility. An interview on 4/20/2024 at 1:33 pm with CNA DD revealed she had observed R24 wearing oxygen. An interview on 4/20/2024 at 1:37 pm with LPN CC revealed that R24 uses oxygen as needed for shortness of breath. LPN CC further stated she was not sure who was responsible for cleaning the filters on the concentrators. She verified R24's oxygen order was discontinued on 4/10/2024 and there was no current physician's order for oxygen administration. Cross- reference F656