| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 115561 | A. Building<br>B. Wing | 05/08/2024 |

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| Meadowbrook Health and Rehab | 4608 Lawrenceville Highway<br>Tucker, GA 30084 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>47946<br><br>Based on observations and staff interviews, the facility failed to provide a safe, clean, and comfortable homelike environment for 27 rooms on five halls. These rooms contained dirty bathroom ceiling vent grills, oversized bathroom doors, damaged and missing drawer handles and doors on bedside nightstands and clothing chests, dirty damaged Packaged Terminal Air Conditioner (PTAC) units, damaged wall handrail, brown ceiling tiles, damaged bathtub, and damaged, unpainted walls.<br><br>1. Initial screening observation on 5/5/2024 at 1:23 pm and observation on 5/6/2024 at 9:58 am revealed room D-5's shared bathroom ceiling vent grill was dirty with gray substance. Further observation revealed the bathroom door was oversized and unable to be closed.<br><br>Initial screening observation on 5/5/2024 at 1:36 pm and observation on 5/6/2024 at 10:05 am revealed room D-7's bedside chest missing drawer handles. Further observations of clothes cabinet chest located underneath sink with broken and damaged front drawer doors.<br><br>Initial screening observation on 5/5/2024 at 2:07 pm and observation on 5/6/2024 at 10:07 am revealed room D-8's bathtub wall strip loose, ceiling tiles with brown stains, wall with two holes and exposed caulking and sheetrock material.<br><br>Initial screening observation on 5/5/2024 at 2:37 pm in Room C-22 revealed bathroom ceiling tiles with brown stains and leaking water.<br><br>Initial screening observation on 5/5/2024 at 3:15 pm and observation on 5/6/2024 at 10:11 am revealed room D-8's clothes cabinet chest located underneath the sink with broken front wooden drawers and chipped with sharp edges. The PTAC unit was unattached to the wall.<br><br>Initial screening observation on 5/5/2024 at 3:20 pm and observation on 5/6/2024 at 10:15 am revealed wall handrails outside of the sitting area with exposed, chipped wood and was unattached to the wall.<br><br>45811<br><br>2. During observation on 5/5/2024 at 1:15 pm in Room B-24 , it was revealed there was paint missing around the toilet paper holder in the bathroom.<br><br>(continued on next page) |

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

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

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During observation on 5/5/2024 at 1:20 pm in Room B-30, the wall behind the bed had three holes in the sheet rock.<br><br>46579<br><br>3. Observation on 5/05/2024 at 1:07 pm in Room A-19 revealed a bath basin and a urinal that were unlabeled and unbagged. There was a large amount of spider webs with leaves on the outside part of the window. The wall behind the B bed had a large number of dark scuff marks. The base board in the corner of the bathroom was found coming off the wall. The personal refrigerator in the room was dirty.<br><br>Observation on 5/5/2024 at 1:22pm in Room A-20 revealed scuff marks on the inside of the bathroom door and on the wall in front of B bed. There was also a hole in the wall plaster behind the towel rack in the bathroom.<br><br>Observation on 5/5/2024 at 1:26 pm in Room E-51 revealed there were three bath basins on the floor under the sink in the bathroom. They were not labeled and not in a bag. There was paint chipped off on the bathroom wall, and there were spider webs with leaves on the outside of the window.<br><br>Observation on 5/5/2024 at 1:36 pm in Room E-52 revealed the wall was dirty behind bed A.<br><br>Observation on 5/5/2024 at 1:45 pm revealed E-50 the bathroom toilet had a rounded lid, and the tank was rectangular, and there was an emesis basin not labeled or bagged. There was missing paint and a hole noted in the bathroom, and dirt, spider webs, and leaves noted on the area between the window and the screen.<br><br>Observation on 5/5/2024 at 1:58pm in Room E-45 revealed there was a bed pan and a urinal that were not labeled or bagged. The bathroom sink did not have any warm/hot water, and the sink was stopped up. A ceiling tile had a gap in it in the bathroom.<br><br>Observation on 5/5/2024 at 3:22 pm in Room D-1 revealed a hole in the outside bathroom door.<br><br>Observation on 5/5/2024 at 3:25 pm revealed the floor in the hallway between Rooms D-3 and D-1, D-2 and D-4 was noted to have chipped pieces from the floor tile.<br><br>49394<br><br>4. Observation on 5/5/2024 at 12:52 pm in Room B-35 revealed a gap in ceiling by the sprinkler head in the bathroom, and paint missing from the wall behind the bed on the right side.<br><br>Observation on 5/5/2024 at 2:00 pm in Room E-42 revealed three bath basins, rusty caulk around the toilet, and wheelchair leg rests in the bathroom.<br><br>Observation on 5/5/2024 at 2:07 pm in Room E-43 revealed water damage to ceiling tiles and a broken handle on the dresser.<br><br>Observation on 5/5/2024 at 2:15 pm in Room E-44-1 revealed missing hooks on the privacy curtain and a hole in the wall behind the door.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 5/6/2024 at 8:46 am in Room B-39 revealed no privacy curtain in front of the bed.<br><br>Observation on 5/6/2024 at 8:59 am in Room E-40 revealed scraped paint on the wall behind the bed, the toilet was running and did not flush, a missing grate on the PTAC unit, an electrical outlet out of the wall, a foot board hanging from Bed 1, and damage to the wall behind the head of the bed.<br><br>Observation on 5/6/2024 at 11:57 am in Room B-27 revealed damage to the wall behind the head of the bed, and water damage to ceiling tiles.<br><br>Observation on 5/6/2024 at 4:50 pm in Room B-39 revealed the privacy curtain for bed A was missing, scraped wall paint at the head of the bed, and the privacy curtain was off track for Bed B.<br><br>Observation on 5/6/2024 at 5:40 pm in Room E-44-2 revealed wheels were off the bed near the footboard on the left side, and a hole in the wall.<br><br>Observation on 5/7/2024 at 11:06 am in Room B-27 revealed damage to the wall at the head of the bed.<br><br>Interview during walking rounds on 5/8/2024 at 9:15 am with the Maintenance Director (MD) confirmed and stated the conditions of the rooms were unacceptable and needed attention of repairs and removal of damaged/stained unrepairable items. The MD mentioned he managed and tracked all facility maintenance work orders through the TELS computer system. He stated he will immediately correct and address the damaged items in each room. The MD stated he was not aware of any Maintenance policy in place. The Administrator confirmed the facility does not have an Environmental Maintenance policy but provided the Maintenance Work Orders Maintenance policy.<br><br>Interview on 5/8/2024 at 2:19 pm with Licensed Practical Nurse (LPN) DD revealed they do not keep maintenance work order books at any of the nursing stations. She stated the staff are required to report work orders on a (computer maintenance system). She stated this was more of a manageable tracking system for the nursing staff to use. She stated they have had issues in the past when they had to write work orders down in the nurse station's service requests binder. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49394<br><br>Based on staff interviews, record review, and review of the facility's policy titled, Pre-Admission Screening and Resident Review (PASARR) Program, the facility failed to ensure a Level II PASARR was conducted for one of five sampled residents (R) (R40) reviewed for PASARR.<br><br>Findings include:<br><br>Review of the facility's policy titled, Pre-Admission Screening and Resident Review (PASARR) Program dated 9/2023 under the Policy Statement revealed, This community will coordinate assessments with the preadmission screening and resident review (PASARR) program. Under Policy Interpretation and Implementation revealed, 1. Upon admission, the Social Worker or designee will, within the context of the established assessment process, the recommendations of the PASARR level II and the PASARR evaluation report with be incorporated into the resident's assessment, care planning and transition of care . 8. The Interdisciplinary Assessment Team must use the MDS from currently mandated by Federal and State regulations to conduct the resident assessment. Other assessment forms may be used in addition to the MDS form. 9. The assessment process will include: (a) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into the assessment, care planning and transitions of care.<br><br>Review of R40's Admission Record revealed he was admitted to the facility with diagnosis that included but not limited to schizoaffective disorder.<br><br>Review of R40's Annual Minimum Data Set (MDS) dated [DATE] revealed Section A- Identification Information, the question was asked, had the resident been evaluated by Level II PASRR and determined to have a serious mental Illness, and/or Mental Retardation or related condition? No, indication of PASSAR was checked; Section C-Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment at time of assessment look back period; Section D-Mood, no mood exhibited; Section I-Active Diagnosis, revealed a diagnosis of Schizophrenia; Section N-Medications, received antidepressants and antipsychotics.<br><br>Interview on 5/7/2024 at 3:15 pm with the Social Service Director (SSD) stated R40's Level I was to be completed prior to admission by the hospital. SSD revealed, Level I and Level II for all residents are completed on admission. She stated, if the residents had documented mental health issues, she would tell the MDS nurse to put in the diagnosis. She stated the business office manager was responsible for the referral and documentation in the electronic medical record. She revealed that she had not personally completed a PASARR. The SSD confirmed that the diagnosis of schizoaffective disorder and depression was not selected on the application. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811<br><br>Based on resident and staff interviews, record reviews, and review of the facility policy titled, F656, F657, F658 Comprehensive Care Plans, the facility failed to implement the care plan for one of six residents (R) (R58). This failure had the potential for R58 to not receive treatment and/or care according to their needs.<br><br>Findings include:<br><br>A review of the facility policy titled, F656, F657, F658 Comprehensive Care Plans, last approved 9/2023, revealed the Policy stated, An individualized comprehensive person centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural, and psychological needs is developed for each resident. The section titled Guidelines stated, 8. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas, b. Incorporate risk factors associated with identified problems, c. Build on the resident's strengths, d. Reflect the resident's expressed wishes regarding care and treatment goals if applicable, e. Reflect treatment goals, timetables and objectives in measurable outcomes, f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels, g. Enhance the optimal functioning of the resident.<br><br>A review of R58's diagnoses included, but was not limited to, multiple sclerosis, depression, and insomnia.<br><br>A review of the care plan revealed that R58 was at risk for falls and had gait/balance problems.<br><br>Interventions included: Resident will be evaluated for assist bars to aid in positioning in bed.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed under section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment.<br><br>During an interview on 5/7/2024 at 10:40 am with R58, revealed the resident requested side rails for his bed to prevent falls. R58 stated he had talked to everyone about the side rails, including the Social Worker and the nurses but his siderails had not been installed.<br><br>During an interview on 5/8/2024 at 2:25 pm, the Minimum Data Set (MDS) Coordinator reviewed R58's care plan and verified the care plan documented the resident was at risk for falls and had gait/balance problems. She further verified the interventions included for the residents to be evaluated for assist bars to aid in positioning in bed. The MDS Coordinator stated before the assist bars can be put on R58's bed, the rehabilitation staff must evaluate the resident, and there must be consent signed by the resident.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/8/2024 at 3:24 pm, the Director of Nursing (DON) revealed the MDS Coordinators initiate the care plan, the clinical team updates care plans as a team, and the nurse on the unit can update care plans as needed when changes occur. Further interview also revealed that the nursing staff is expected to follow the plan of care for each resident in the facility. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observations, resident and staff interviews, record review, and review of facility policy titled, Quality of Life-Activities of Daily Living (ADL), the facility failed to provide ADL care for three of seven residents (R) (R23, R87, and R70). Specifically, the facility failed to provide nailcare for R23 and R87 and failed to provide showers as scheduled for R70.<br><br>Findings included:<br><br>Review of the facility policy titled Quality of Life-Activities of Daily Living with a last revised date of November 2017 revealed under Policy Statement Residents who are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>1. Review of the electronic medical record (EMR) for R23 revealed that he was admitted to the facility with the following diagnoses but not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, unspecified symbolic dysfunctions, psychosis, and vascular dementia.<br><br>Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed that R23 had a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Section GG-Functional Abilities and Goals revealed that R23 had impairment on one side for upper and lower extremities and was dependent on staff for shower and personal hygiene.<br><br>Review of the care plan for R23 with a last review date of 4/16/2024 revealed that he has diabetes mellitus. An intervention in place for this problem is to refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. The care plan also revealed that he has an ADL self-care performance deficit related to dementia, hemiplegia, and sometimes refuses showers. An intervention in place for this problem is to assist him with ADLs as needed and he prefers showers on Tuesday, Thursday, and Saturdays on the evening shift after supper.<br><br>Observation and interview on 5/5/2024 at 3:33 pm, R23 was observed sitting up in his wheelchair, and noted to have extremely long fingernails. R23 stated that no one had offered to cut or trim his fingernails.<br><br>2. Review of the EMR for R87 revealed that he was admitted to the facility with diagnoses that included but were not limited to acute kidney failure, anxiety disorder, depression, insomnia, and dementia.<br><br>Review of the Quarterly MDS assessment dated [DATE] revealed that R87 had a BIMS score of 4, indicating severe cognitive impairment. Review of Section GG-Functional Abilities and Goals revealed that he required partial/moderate assistance with personal hygiene and was dependent on staff for showers and or bathing.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the care plan last reviewed on 3/28/2024 for R87 revealed that he was resistive to care related to dementia. An intervention in place for this problem was, if he resists with ADLS, reassure him, leave, and return 5 to 10 minutes later and try again. He also has an ADL self-care performance deficit related to dementia. An intervention included that he preferred shower days on Monday, Wednesday, and Fridays on day shift after breakfast. Staff is to check nail length and trim and clean on bath days and as necessary.<br><br>Observation on 5/5/2024 at 3:22 pm, R87 was observed sitting on his bed, and noted to have extremely long fingernails.<br><br>Interview on 5/8/2024 at 10:00 am with the Director of Nursing (DON), she stated that fingernail care should be done with ADL care and verified that R23 and R87 did have extremely long fingernails. Further interview also revealed that the CAN's are expected to perform all ADL care for each resident to include completing showers on the resident scheduled shower day.<br><br>3. Review of the EMR for R70 revealed that she was admitted to the facility with diagnoses that included but were not limited to activated protein C resistance, chronic kidney disease, type 2 diabetes, and adjustment disorder with depressed mood.<br><br>Review of the 5-day MDS assessment dated [DATE] revealed that R70 had a BIMS score of 15, indicating little or no cognitive impairment. Section GG-Functional Abilities and Goals revealed that she had impairment on one side in upper and lower extremities. It also revealed that she needed substantial/maximal assistance with showers and personal hygiene.<br><br>Review of the care plan for R70 revealed that she had an ADL self-care performance deficit. An intervention in place for bathing is that she is totally dependent on staff to provide a bath and that she requests to only have a bed bath 3 times a week on Monday, Wednesday and Fridays on the 3 to 11[3:00 pm to 11:00 pm] shift after supper.<br><br>Review of the Shower Sheets for April 2024 and May 2024 for R70 revealed that she received a bed bath on 4/5/2024, 4/6/2024, 4/8/2024, and 4/16/2024.<br><br>Observation and interview on 5/5/2024 at 2:55pm, R70 was noted sitting up in her bed. She stated that it had been two weeks since she had a bath.<br><br>Interview on 5/8/2024 at 3:55 pm, R70 was asked about her shower. She stated that she had not had her shower, and then stated that she was told by staff that it would be at least Monday before she would get one. She then stated that staff did not give her a reason for not getting one all week. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>45811<br><br>Based on observation, staff interviews, record review, and a review of the facility policies titled, Range of Motion Exercises and Goals and Objectives, Restorative Services, the facility failed to provide appropriate treatment and services to prevent further decrease in range of motion for one of nine Residents (R) (R22) receiving restorative care. This deficient practice had the probability to cause a further decline in range of motion for R22.<br><br>Findings include:<br><br>Review of the facility policy titled, Range of Motion Exercises last revision date 11/2016, revealed, Residents with limited range of motion will receive appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.<br><br>Review of the policy titled, Goals and Objectives, Restorative Services last approved date 9/2023, revealed under Policy interpretation and implementation, Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services.<br><br>Review of the medical record for R22 revealed the Quarterly Minimum Data Set (MDS) section C, the Resident has short- and long-term memory problems. Section GG indicates the upper and lower extremity has an impairment on one side. R22 needs supervision with eating. The medical diagnosis includes Dementia, Altered Mental Status, Adult Failure to Thrive, and adjustment disorder with Depressed Mood. The Care plan includes the Resident has a communication problem r/t Hearing deficit and cognitive deficit; Resident has Alteration in musculoskeletal status r/t contracture (Right hand).<br><br>During an observation on 5/6/2024 at 1:15 pm it was revealed R22 has contracture of her right hand; resident was asked to open her right hand but was unable to do so. During observation there was no splint noted being used for residents' contracture.<br><br>During an interview on 5/8/2024 at 9:41 am with Restorative Certified Nursing Assistant CNA EE it was revealed R22 was not on her list for Restorative care. Further interview revealed when new residents come into the facility they are evaluated and the MDS and Care Plan Team will make the decision for rehabilitative therapy services. Restorative CNA EE confirmed R22 was unable to open her right hand and there was not a brace or towel in the residents' hand at time of confirmation.<br><br>During an interview on 5/8/2024 at 9:55 am with Licensed Practical Nurse LPN DD, she revealed she was not sure if R22 receives restorative therapy; will need to ask the unit manager.<br><br>During an interview on 5/8/2024 at 10:16 am with LPN FF, it was revealed R22 does not have a brace; she is not aware if she has therapy; she feeds herself with the opposite hand; they make sure her nails are clipped so they will not dig into her skin.<br><br>During an interview on 5/8/2024 at 11:45 am with Certified Occupational Therapy Aide (COTA) GG; it was revealed the resident has not been on Therapy case load since 2022. The Resident was screened today 5/8/2024 because of a referral from nursing. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811<br><br>Based on observations, resident and staff interviews, record reviews, and a review of the facility policies titled Falls and Fall Risk, Managing F689 and Oxygen Administration, the facility failed to provide interventions to prevent falls for one of six residents (R) (R58) and failed to ensure an oxygen cylinder was stored and secured for one of 15 residents receiving oxygen (R15).<br><br>Findings include:<br><br>A review of the facility policy titled, Falls and Fall Risk, Managing F689, last approved 4/2024, revealed the Policy stated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.<br><br>A review of the facility policy titled Oxygen Administration, last approved 4/2023, revealed the section titled Equipment and Supplies documented 1. Portable oxygen cylinders should be strapped to the stand.<br><br>1. A review of R58s' Quarterly Minimum Data Set (MDS) dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment, section GG (Functional Abilities and Goals) documented upper and lower extremity impairment on both sides, section J (Health Conditions) documented two or more falls since prior assessment.<br><br>A review of R58's diagnoses included, but was not limited to, multiple sclerosis, depression, and insomnia.<br><br>A review of the Physician's Orders revealed there was not an order for assist rails prior to 5/8/2024.<br><br>A review of the Progress Notes revealed documentation of falls:<br><br>8/24/2023 Note Text: Resident observed on the floor approximately 12:15 am. Resident stated that he was trying to perform turns as instructed by the physical therapy.<br><br>1/21/2023 Resident was found on floor next to bed. Stated he was trying to move over and fell . 3/3/2024 Note Text: Resident observed on floor in supine position on right side of bed resident stated he was reaching for his computer and slid from bed.<br><br>3/13/2024 Resident states he was trying to reach something from his nightstand and rolled onto his mat.<br><br>3/26/2024 Patient was found on the floor next to his bed. His bed was at the lowest position, with legs across the end of the bed. Patient stated he was not in any pain. The patient stated he was reaching for something and that is how he ended up on the floor. Patient Resident Representative (RP)/Nurse Practitioner (NP) notified.<br><br>(continued on next page) |

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| | 115561 | A. Building<br>B. Wing | 05/08/2024 |

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| Meadowbrook Health and Rehab | 4608 Lawrenceville Highway<br>Tucker, GA 30084 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 5/7/2024 at 10:40 am with R58, it was revealed the resident requested side rails for his bed to prevent falls. R58 stated he had talked to everyone about the side rails, including the Social Worker and the nurses.<br><br>During an interview on 5/8/2024 at 1:35 pm, Licensed Practical Nurse (LPN) FF stated that R58 had not talked with her about his request for side rails and that the times he has fallen have been due to reaching for various items. She stated staff had moved the dresser and other items close to the bed and the bed was in the lowest position.<br><br>During an interview on 5/8/2024 at 1:40 pm, the Social Service Director (SSD) stated R58 had not talked with her about his request for side rails. The SSD stated that R58 would have to be evaluated before the side rails could be put on.<br><br>During an interview on 5/8/2024 at 2:15 pm, LPN CC revealed fall prevention interventions included checking the resident every two hours, positioning the resident, and placing fall mats in the room.<br><br>During an interview on 5/8/2024 at 2:17 pm, LPN DD revealed that R58's safety awareness was poor, and if something fell on the floor, he would try to pick it up and slip out of the bed. LPN DD stated in order to keep R58 safe, staff should keep the bed in the lowest position and the bed locked, re-educate, keep the call light within reach, and provide a high back chair. Further interview confirmed R58 does not have fall mats at the bedside because his table and dresser are close to the bed so he can reach items and did not have assist bars on the bed.<br><br>During an interview on 5/8/2024 at 4:00 pm, the Rehabilitation Director confirmed R58 did not have an evaluation for assist bars for his bed.<br><br>46579<br><br>2. Observation on 5/5/2024 at 1:15 pm revealed an unsecured oxygen cylinder sitting on the floor of R15's room. Observation revealed R15 was receiving oxygen via a nasal cannula.<br><br>A review of R15's Electronic Medical Record (EMR) revealed diagnoses included but were not limited to vascular dementia and generalized anxiety disorder.<br><br>A review of R15's Physician Orders revealed a current order for oxygen at two liters per minute continuously via nasal cannula.<br><br>In an interview on 5/8/2024 at 10:45 am, the Director of Nurses (DON) verified the unsecured oxygen cylinder and removed it. She stated that for the safety of residents, oxygen cylinders should not be left on the floor and should be secured in the oxygen cylinder cage. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observation, staff interviews, and record review, the facility failed to properly check for Gastric tube (G-tube) (tube in the stomach for nutrition) placement for one of four Residents (R) (R33) receiving nutrition through a G-tube.<br><br>Findings include:<br><br>Review of the Electronic Medical Record (EMR) for R33, revealed that he was admitted with diagnoses that included, but were not limited to end stage renal disease, adult failure to thrive, and aphasia following other cerebrovascular disease.<br><br>Review of the care plan for R33 dated [DATE] revealed that he requires tube feeding and is at risk for fluid balance fluctuation, alteration in nutrition and weight loss, and has a swallowing problem. An intervention that is in place for this problem is to check for tube placement and gastric contents/residual volume per facility protocol and record.<br><br>Review of the Physician Orders dated [DATE] for R33 revealed that the resident was to have continuous feeding of Nepro at 78 milliliters (ml)/ hour via the G-tube: at 12 noon down at 6:00 am or when total volume of 1404 ml's/24 hours have been infused. Continued review of the residents' orders revealed an order dated [DATE] indicating that the nurses are to check residual prior to feeding/medications two times a day.<br><br>Observation on [DATE] at 1:48 pm, Registered Nurse (RN) SS was initiating the tube feeding for R33. She primed the tubing using the feeding pump, after verifying that it was the correct feeding, and that bottle and bag were correctly labeled. She then opened a new syringe and listened for placement with her stethoscope by injecting air in the tube and proceeded to start the feeding.<br><br>Interview on [DATE] at 2:10 pm, RN SS revealed the procedure of checking for placement of the G-tube before starting the feeding was to both inject air and listen, as well as check for residual. RN SS verified that the residual was not checked during the procedure.<br><br>Interview on [DATE] at 10:05 am with the Director of Nursing (DON) revealed that the proper procedure for checking placement before starting a G-tube feeding was to verify orders, and make sure that the bottle of feeding has not expired. She further stated that the nurse was to listen to bowel sounds, inject air, listen to check for placement, and check residual. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44959<br><br>Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, Oxygen, Administration, the facility failed to obtain an order for oxygen therapy for one of 15 residents (R) (R32).<br><br>Findings include:<br><br>Review of the facility's policy titled, Oxygen Administration, dated April 2023 under the section titled, Purpose revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration. Under section titled, Preparation revealed, 1. Verify that there is a physician order for this procedure. Review the physician orders or facility protocol for oxygen administration.<br><br>Review of the clinical record revealed R32 was admitted to the facility with the diagnoses of but not limited to chronic obstructive pulmonary disease, unspecified, acute respiratory failure, unspecified whether with hypoxia or hypercapnia.<br><br>Review of R32's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment; Section O (Special Treatments and Programs) indicated oxygen use.<br><br>Review of R32's physicians order revealed there was no physician order for oxygen administration.<br><br>Observation on 5/5/2024 at 9:47 am revealed R32 in bed receiving oxygen via nasal cannula at four liters per minute.<br><br>Observation on 5/6/2024 at 9:37 am revealed R32 in bed receiving oxygen via nasal cannula at four liters per minute.<br><br>Interview on 5/7/2024 at 1:08 pm with the Director of Nursing (DON), she acknowledged that R32 Oxygen order was entered in the system on 5/7/2024 at 1900 (7:00 pm) and thought it was odd. Continued interview revealed R32 had been using oxygen since re- admission on 4/26/2024 and had always used oxygen as long as she had been in the facility, (initial admission 4/6/2023). When a resident is discharged the order is discontinued and when they return to the facility, the order is reactivated. During the interview it was revealed the unit manager completes audits on oxygen orders on Mondays and moving forward, she expects staff to continue with oxygen audits to ensure that the physician orders are entered into the system. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>49394<br><br>Based on staff interviews, record review, and review of the PBJ (Payroll Based Journal) [NAME] Report 1705D for the First Quarter (Q1) of Fiscal Year (FY) 2024, the facility triggered a One-Star staffing rating and triggered for Low Weekend Staffing. The facility census was 115 residents.<br><br>Findings include:<br><br>A review of the PBJ [NAME] Report for FY Q1 2024 (October 1 through December 31, 2023) revealed the facility reported data declaring one-star staffing ratings and triggered for Low Weekend Staffing.<br><br>In an interview on 5/8/2024 at 7:27 pm, the Director of Nursing (DON) revealed the Administrator reviews and discusses the PBJ reports during the Quality Assurance and Performance Improvement (QAPI) meetings. She stated she was newly employed during the period of 10/1/2023 through 12/31/2023. She further stated the facility was not utilizing agency staff, only had one unit manager, and the nursing staff was 60-70 percent staffed and extremely understaffed during the period of 10/21/2023 through 12/31/2023. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811<br><br>Based on observations, staff interviews, record reviews, and review of the facility's policy titled Administering Medications F760, the facility failed to ensure the medication error rate was less than five percent (5%). Specifically, the facility failed to obtain physician orders to crush medications prior to administration for two of four residents (R) (R37 and R90). There were 29 opportunities observed resulting in two medication errors. The medication error rate was 6.9%.<br><br>Findings include:<br><br>Review of the facility's policy titled, Administering Medications F760, last revised 10/2023 under the section titled, Guidelines revealed, 3. Medications must be administered in accordance with the orders, including any required time frame.<br><br>1. Review of R37's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, Section C (Cognitive Pattern), a Brief Interview for Mental Status (BIMS) of six which indicated severe cognitive impairment; Section I (Active Diagnoses) revealed, acute kidney failure, altered mental status, seizures, dysphagia, and cerebral infarction.<br><br>Observation on 5/6/2024 at 8:30 am revealed Licensed Practical Nurse (LPN) AA administering medications to R37. There was a total of nine medications crushed and given all together that included: hydralazine five milligrams (mg) three tablets, carbamazepine 200 mg one tablet, hydroxychloroquine 200 mg one tablet, levetiracetam 750 mg one tablet, amlodipine 10 mg one tablet, aspirin 81 mg enteric coated one tablet, buspirone five mg one tablet, multivitamin with minerals one tablet, and clonidine 0.1 mg one 1 tablet.<br><br>Review of R37's physician orders with last order review date of 3/14/2024 revealed there were no physician's order to crush medications prior to administration.<br><br>2. Review of R90's Quarterly MDS dated [DATE] revealed, Section C (Cognitive Pattern), a Brief Interview for Mental Status (BIMS) of nine which indicated moderate cognitive impairment. Section I (Active Diagnoses) revealed type 2 diabetes mellitus, Alzheimer's disease, asthma, essential hypertension, and unspecified convulsions.<br><br>Observation on 5/6/2024 at 9:30 am revealed LPN AA crushed R90 medications. There was a total of six medications crushed and given by mouth that included: zinc 50 mg four tablets, docusate 100 mg one tablet, senna 8.6 mg two tablets, quetiapine 25 mg one tablet, methadone five mg one tablet, and multivitamin with minerals one tablet.<br><br>Review of R90's physician orders with last order review date or 4/17/2024 revealed there were no physician's order to crush medications prior to administration.<br><br>During an interview on 5/6/2024 at 3:00 pm with LPN AA, the medical records for R90 and R37 were reviewed. LPN AA confirmed there was no order to crush the residents' medications.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/7/2024 at 12:41 pm with LPN BB revealed, the nurse would determine if the resident needed their medications crushed. LPN BB revealed, if there was a need to crush medications then the nurse would call the physician to get an order. LPN BB revealed, if the medication could not be crushed, an order for a liquid would be substituted for the oral medication.<br><br>During an interview on 5/7/2024 at 1:19 pm with the Director of Nursing (DON) confirmed there must be an order to crush medications. The DON revealed, residents must be evaluated by speech therapy if they are having difficulty swallowing medications. Further interview also revealed that enteric coated medication and, methadone are medications that should not be crushed and administered without a physicians order. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observations, staff interviews, record review, and review of the facility policies titled, Indwelling Urinary Catheters F690 and Handwashing/Hand Hygiene F 880, the facility failed to follow standard infection control practices for one of four residents (R) (R15) during catheter care observation. The facility also failed to ensure hand hygiene was performed during meal tray distribution. The deficient practice had the potential to affect all residents. The facility census was 115 residents.<br><br>Findings include:<br><br>1. Review of the facility policy titled Indwelling Urinary Catheters F690 with a revision date of 6/2022 revealed under Infection Control, 1. Use standard precautions when handling or manipulating the drainage system. 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.<br><br>Review of the facility policy titled Handwashing/Hand Hygiene F 880 with a revision date of 10/2022 revealed under Guidelines, 5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial soap and water or non-antimicrobial soap and water under the following conditions: . 7. Hand hygiene is always the final step after removing and disposing of personal protective equipment. 8. The use of gloves does not replace handwashing/hand hygiene . 10. Before performing an aseptic task (e.g. placing an indwelling device) or handling invasive medical devices, . immediately after glove removal.<br><br>Review of the electronic medical record (EMR) for R15 revealed she was admitted to the facility with diagnoses that included but were not limited to type 2 diabetes, transient cerebral ischemic attack, vascular dementia, and hemiplegia affecting left nondominant side.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed in Section H-Urinary and Bowel revealed R15 has an indwelling catheter. Section M-Skin Conditions revealed that the resident had a stage 4 pressure wound.<br><br>Review of the care plan for R15 that was last reviewed on 3/5/2024 revealed that she has an indwelling catheter related to her stage 4 pressure wound on her sacrum.<br><br>Observation on 5/7/2024 at 11:23 am, Certified Nursing Assistant (CNA) RR was observed performing catheter/incontinence care for R15. During observation CNA RR was observed not performing hand hygiene between glove changes while completing catheter care for R15.<br><br>Interview on 5/7/2024 at 12:05 pm with CNA RR, she was asked when hand hygiene should be performed. She stated that she needed to perform hand hygiene before she comes into the resident's room, before placing PPE (personal protective equipment), before, after, and during care, and after removing gloves. She confirmed that she did not perform hand hygiene each time she removed her gloves during catheter/incontinence care.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview during meal tray pass on 5/8/2024 at 5:52 pm, CNA HH was observed passing meal trays to residents without sanitizing hands between eat meal tray distributed. During the interview CNA HH stated that she was not aware that hand hygiene was to be completed between each resident tray served.<br><br>Interview on 5/8/2024 at 6:00 pm with the Director of Nursing (DON) revealed that hand hygiene should be conducted before resident contact, when you go to clean after unclean, and before and after applying gloves. |

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| F 0914<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide bedrooms that don't allow residents to see each other when privacy is needed.<br><br>49394<br><br>Based on observations and staff interviews, the facility failed to ensure that privacy curtains provided full visual privacy for three (3) of 63 shared resident bedrooms: (B39, E 44, D5).<br><br>Findings Include:<br><br>Observation on 5/5/2024 at 2:15 pm revealed that room E44 privacy curtain was missing several hooks causing the curtain to hang leaving a large gap in the curtain, and not providing full privacy for the resident in the B bed.<br><br>Observation on 5/6/2024 at 9:58 pm revealed room D5 privacy curtain had missing hooks and was unable to be drawn for full privacy while providing care for the resident.<br><br>Observation on 5/6/2024 at 8:46 am revealed that there were hooks noted on the curtain track, but no privacy curtain observed for room B39-1 to provide privacy for the resident during care.<br><br>Interview on 5/8/2024 at 2:19 pm with LPN DD revealed they do not keep maintenance work order books at any of the nursing stations. She stated there is a more manageable tracking system for the nursing staff to use electronically.<br><br>Interview walking rounds on 5/8/2024 at 9:15 am with the Maintenance Director (MD) confirmed and stated the conditions of the rooms were unacceptable and needed attention of repairs and removal of damaged/stained unrepairable items to include privacy curtains. He stated he will immediately correct and address the damaged items in each room. |