STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165351	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Griswold Rehabilitation & Health Care Center	106 Harrison St Griswold, IA 51535

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on the clinical record review, resident and family interview, policy review and staff interview the facility failed to provide a resident the right of self-determination related to consent or declination of vaccines and who he decided would be Power of Attorney (POA) for 1 of 3 one residents (Resident #28) reviewed. The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #28 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS documented Resident #28 had a diagnosis of Guillain Barre. On 9/30/24 at 3:31 PM Resident #28's emergency contact #2 / POA stated a voicemail was left requesting consent on giving the flu vaccine. She stated she contacted Resident #28's emergency contact #1 to inform the facility that Resident #28 could not have a flu shot related to a history of Guillain Barre. The resident's emergency contact #2 stated she was told the resident still got the flu shot. She stated she had never signed any paperwork to become the POA and she was not the POA. On 9/30/24 at 3:39 PM Resident #28's emergency contact #1 stated she was the power of attorney. The emergency contact #1 stated she called the facility and told them that both her and Resident #28's Emergency contact #2 did not want Resident #28 to receive the flu vaccine because of the history of Guillain Barre. The resident's emergency contact #1 stated the facility told her the resident received the flu vaccine. Review of Resident #28's EHR revealed emergency contact #2 as power of attorney. Review of the Progress Note dated 9/18/24 Staff F, Wound Care Nurse documented Resident #28's emergency contact #1, phoned the facility informing the last time Resident #28 had the flu vaccination he ended up with Guillain Barre. Staff F documented Resident #28's emergency contact #1 and #2 do not want him to have the vaccine again. Review of the Progress Note dated 9/23/24 Staff L, Director of Nursing (DON) documented influenza vaccination was given to Resident #28 in the left deltoid without incident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Griswold Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 106 Harrison St Griswold, IA 51535	

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 8:51 AM the ADON stated Resident #28 should not have received the influenza vaccine. The ADON stated she could not locate the consent or declination from POA for Resident #28. Stated when obtaining orders to give vaccines the facility expectation was the facility would get the consent from the family or POA, then would send a fax to the physician for an order to give the vaccine, and the facility would then administer the vaccine. On 10/3/24 at 2:52 PM the Assistant Director of Nursing (ADON) clarified over the phone with Resident #28's emergency contact #1 and #2 who had POA. The ADON stated emergency contact #1 has financial power of attorney but nobody has medical power of attorney. The DON acknowledged POA documentation was incorrect on Resident #28's electronic health records. On 10/3/24 at 2:58 PM the ADON stated that she spoke with Resident #28 and he wanted emergency contact #2 to be POA. The ADON stated the facility has no documentation on if there is a POA or who the POA is. On 10/3/24 at 2:56 PM the Administrator stated upon admission the facility would ask the resident if anyone had POA. The Administrator stated this should have been completed when Resident #28 entered the facility. The Administrator stated does not know if the facility has a policy for decision of POA. The Administrator stated the facility did not have a policy for documentation of POA. Review of document titled, Infection Prevention and Control Manual Resident Immunizations and Vaccinations Influenza Vaccine Program updated 9/22 documented the resident or the resident ' s representation has the opportunity to decline and refuse the influenza immunization. If immunization is declined, then document that education was provided and the refusal in the medical records. Prior to consent or administration, check to see if medical contraindications for the vaccine exist such as history of Guillain-Barre syndrome within 6 weeks of receipt of influenza vaccine.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, financial record review, family interview, staff interview and policy review the facility failed to provide access to personal funds managed by the facility or manage personal funds deposited at the facility for 1 resident (Resident #28) reviewed for personal funds. The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #24 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. On 9/30/24 at 2:35 PM Resident #24's power of attorney (POA) / daughter stated there is an issue with the resident trust account. The daughter stated that she spoke with Staff J, Private Pay Manager for Tuteral about the facility not paying the secondary health insurance for a while. The POA / daughter stated she had been asking since April about the secondary insurance if it had been paid, when the premium went up, and if that would be covered with the trust. The daughter stated she was told by Staff B, Business Office Manager the total in Resident #24's trust was about $1500.00. The daughter stated there was some money missing a few months ago and the facility paid the secondary insurance twice. The daughter stated Staff J had called when her mother wanted money from her account but Resident #24 only has access to money when staff is present, not on nights or on the weekends. Review of document titled, Resident #24 Trust Account documented trust account last paid secondary insurance 5/9/24 and payments were missed 12/23, 1/24, and 4/24. On 10/02/24 at 3:52 PM Staff B acknowledged she did not send any quarterly statements for resident trust amounts to the responsible party or the resident. Staff B stated there were things about the billing account that she did not understand. She acknowledged miss payments to Resident #24's secondary insurance. Staff B stated that occurred prior to her employment at the facility. She stated there were missed payments in December and January. Staff B stated she did not remember if the family had asked about the trust amount. She stated residents have not asked for money but the facility does not have money available when she is not at work. Staff B stated she normally worked 8:30 AM to 5:00 PM Monday through Friday and the residents do not have funds available when she is not at the facility. She stated she started in May and had not sent out any statements to resident or resident representative during her time of employment in this position. On 10/03/24 at 8:00 AM Staff J stated there was a change in personnel in the business office and was not receiving the payment. Staff J stated on 6/1/24 the premium was changed for resident #24. She stated the current premium was $324.62 and is that way until February of 2025. Staff J stated she would have been the one who spoke with Resident #24's daughter about the premium change. She stated she did not know why the secondary insurance was no longer covering Resident #24. Staff J stated she assumed that is related to lack of payment. She stated the statements for the secondary insurance were not being sent to the facility. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 4:42 PM the Administrator acknowledged the facility did not send out quarterly statements to any residents or POA from the facility and would follow federal regulations. The Administrator stated the facility's expectation was quarterly statements would be sent to residents and the residents power of attorney (POA). The Administrator acknowledged the facility did not have any resident funds available on the weekends or the evenings. The Administrator stated there had been discussion with the business office to have some money available when the business office was not open. Review of document titled, Facility Resident Trust Fund Policy revised 5/12 documented the facility was required to provide the funds to establish / start the petty cash box. The facility may maintain a minimum of cash on hand in a resident trust petty cash box for residents' spending needs.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on the clinical record review, financial record review, family interview, staff interview and policy review the facility failed to provide an individual financial record to the resident and / or power of attorney (POA) in the form of quarterly statements and upon request. The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #24 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. On 9/30/24 at 2:35 PM Resident #24's POA / daughter stated there is an issue with the resident trust account. The daughter stated she spoke to Staff B, Business Office Manager and requested an accurate statement about how much was in Resident #24's trust account. The daughter stated she was told by Staff B the total in Resident #24's trust was about $1500.00. The daughter stated there was some money missing a few months ago. She stated she had not received a quarterly statement from the facility. Review of document titled, Resident #24 Trust Account documented trust account had $3,877.19 as of 8/31/24. On 10/02/24 at 3:52 PM Staff B acknowledged she did not send any quarterly statements for resident trust amounts to the responsible party or the resident. Staff B stated there were things about the billing account that she did not understand. She stated she did not remember if the family had asked about the trust amount. She stated she started in May and had not sent out any statements to resident or resident representative during her time of employment in that position. On 10/2/24 at 4:42 PM the Administrator acknowledged the facility did not send out quarterly statements to any residents or POA from the facility and would follow federal regulations. The Administrator stated the facility's expectation was quarterly statements would be sent to residents and the residents power of attorney (POA). Review of document titled, Facility Resident Trust Fund Policy revised 5/12 documented a copy of the resident trust statements would also be available upon request to the resident or his / her legal representative during normal administrative business hours to allow review of entries and support documentation.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on the clinical record review, financial record review, family interview, staff interview and policy review the facility failed to notify a resident that receives Medicaid benefits when that resident's account reached $200.00 less than the social security income (SSI) resource limit for one person. The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #24 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. Review of document titled, Resident #24 Trust Account documented trust account had $3,877.19 as of 8/31/24 and had a balance above $2000.00 since 6/3/24 when the balance was $3,120.26. On 9/30/24 at 2:35 PM Resident #24's power of attorney (POA) / daughter stated she spoke to Staff B, Business Office Manager and requested an accurate statement about how much was in Resident #24's trust account. The daughter stated she was told by Staff B the total in the resident's trust was about $1500.00. The daughter stated she had not received a quarterly statement from the facility. On 10/2/24 at 3:52 PM Staff B stated there are things about the billing account that she did not understand. Staff B stated she did not remember if Resident #24's family had asked about the trust amount. Staff B acknowledged that Resident #24's trust has too much money in the account. She stated she started in May and had not sent out any statements to resident or resident representative during her time of employment in that position. She stated the resident's trust amount at the facility reached the limit for Medicaid of more than $2000.00 on 6-3-24. Staff B acknowledged Resident #24 a had to complete a spend down before the next review to ensure her trust was under $2000.00. She stated she had not notified the family, POA, resident representative, or the resident that the maximum SSI resource limit a Medicaid recipient can have. Staff B acknowledged notification to Resident #24 should have happened. On 10/2/24 at 4:42 PM the Administrator acknowledged Resident #24 had reached the maximum SSI resource limit a Medicaid recipient could have of more than 2000.00 on 6-3-24. The Administrator acknowledged Resident #24 had to complete a spend down before the next review. The Administrator stated he would contact the POA and say the resident is starting to get close to $1700.00. The Administrator stated the POA and Resident #24 should have been notified and were not. The Administrator stated he would ask the POA about burial trust and give options. The Administrator stated he would ask the POA how to spend the money. Review of document titled, Facility Resident Trust Fund Policy revised 5/12 documented that any individual resident trust account that was nearing the state specified maximum balance will require the following actions. Notification to the resident / responsible party as to balance and a discussion should include an inventory of resident material needs and make a comfort item purchase.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47673 Based on personnel document review, staff interview and policy review the facility failed to implement the abuse and neglect policy by not completing background checks prior to staff employment. The facility reported a census of 31 residents. Findings include: Review of a document titled, Employee List provided by the Administrator documented a hire date for Staff K, Certified medication Assistant (CMA) of 5/26/22. Review of documented titled, Single Contact License and Background Check documented check was completed 6/7/22. Review of Staff K's time clock hours revealed pay period 5/15/22 - 5/28/22 1 hour was work on 5/26/22 and pay period 5/29/22 - 6/11/22 7/75 hours worked 6/1/22. On 10/2/24 at 3:45 PM Staff B Business Office Manager stated the facility's expectation was that Staff K's background check would have been completed prior to working at the facility. On 10/2/24 at 5:59 PM the Administrator stated the facility's expectation was to follow the regulation and have the background check completed prior to staff working the floor with the residents. The Administrator acknowledged it did not appear that happened with Staff K. Review of policy titled, Abuse, Prevention, and Prohibition Policy revised 1/24 documented that all employees will have criminal background checks, stat, and federal required checks, employment reference checks, and license confirmation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, and staff interviews the facility failed to represent an accurate assessment of the resident's status during the observation period of the Minimum Data Set (MDS) by not accurately assessing need for an anticoagulant for 2 of 17 residents reviewed (Resident #5 and #24). The facility reported a census of 31 residents. Finding include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment. The MDS dated [DATE] documented no use of anticoagulant therapy by Resident #5. Review of Resident #5's Medication Administration Record (MAR) documented a physician's order for Apixaban oral tablet 2.5 mg to be given by mouth two times daily. Review of Resident #5's Care Plan documented no focus, goals or interventions for anticoagulant therapy. On 10/2/24 at 12:08 PM the Assistant Director of Nursing (ADON) acknowledged the MDS was miscoded when Apixaban was not documented as an anticoagulant. The ADON stated the facility's expectation was that an accurate assessment would be completed for Resident #5 and all residents at the facility. 2. The MDS dated [DATE] documented Resident #24 had a BIMS of 5 indicating severe cognitive impairment. Review of Resident #24's MDS dated [DATE] documented use of anticoagulant therapy. Review of Resident #24's MAR documented a physician's order for clopidogrel Bisulfate (Plavix) 75 mg given by mouth on time daily. Review of Resident #24's Care Plan documented a focus that the resident is on anticoagulant therapy plavix. On 10/2/24 at 12:08 PM the ADON acknowledged the MDS was miscoded when Plavix was documented as an anticoagulant. The ADON stated the facility's expectation was that an accurate assessment would be completed for Resident #24 and all residents at the facility. On 10/2/24 at 1:30 PM the Administrator stated he would expect an accurate assessment would be completed and documented in the MDS for all residents at the facility. The Administrator stated the facility did not have a policy on accuracy of MDS assessments.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review and staff interviews the facility failed to provide a comprehensive care plan that included goals or interventions for anticoagulant therapy for 1 of 5 residents reviewed (Resident #5). The facility reported a census of 31 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment. Review of Resident #5's MDS dated [DATE] documented no use of anticoagulant therapy. Review of Resident #5's Medication Administration Record documented a physician's order for Apixaban oral tablet 2.5 mg to be given by mouth two times daily. Review of Resident #5's Care Plan documented no focus, goals or interventions for anticoagulant therapy. On 10/2/24 at 12:08 PM the Director Of Nursing acknowledged Resident #5 was on anticoagulant therapy and her expectation was a care plan with focus, goals, and interventions would have been created for Resident #5. On 10/2/24 at 1:30 PM the Administrator stated the facility would expect that anticoagulant therapy would have been on the care plan for Resident #5. The Administrator stated the facility had no policy on development of care plans.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical record review, observations, resident and staff interviews, the facility failed to follow physician orders by not applying edema wear as ordered for 1 of 1 residents (Resident #15) reviewed. The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #15 documented the resident had a Brief Interview for a Mental Status score (BIMS) of 09, indicating moderately impaired cognition. The MDS also showed Resident #15 required total staff assistance with lower body dressing and when applying or removing footwear. The October 2024 Treatment Administration Record (TAR) for Resident #15 revealed an order for tubi grips two times a day to apply in am and remove in pm starting on 3/12/24. Documentation revealed the order was administered on 10/1 morning and bedtime, 10/2 blank for morning and completed at bedtime, 10/3 morning completed. During an interview on 10/02/24 at 10:38 am Resident #15 stated they don't put tubi grips on her every day but she liked it when they did put them on her. During an interview on 10/03/24 at 10:28 am Resident #15 stated staff did not put tubi grips on her and she preferred to have them on. Observations during both interviews with Resident #15 revealed the tubi grips were not applied to the lower extremities. In an interview on 10/2/24 at 10:50 am, Staff N, Certified Nursing Assistant (CNA), reported Resident #15 had tubi grips but did not like to wear tubi grips and often removed them on her own. A review of the Electronic Health Record did not reveal a documentation of refusal to wear tubi grips. A review of the care plan did not document tubi grips or a history of refusal with interventions. During an interview on 10/3/24 at 10:44 am, Assistant Director of Nursing (DON) reviewed TAR documentation and stated the tubi grip treatment was documented as completed. She further stated her expectation was for staff to document any refusals of treatments as refused and not as completed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical record review, observation, and staff interviews the facility failed to ensure resident's (Resident #20) activities of daily living abilities were maintained or improved. The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was admitted on [DATE] with diagnoses of dementia, diabetes, stroke and a history of repeated falls. The MDS revealed Resident #20 required setup or clean-up assistance with eating, supervision or touching assistance with toileting hygiene, and supervision or touching assistance with walking 10 feet. The MDS recorded the resident's range of motion (ROM) not impaired. The quarterly MDS assessment dated [DATE] revealed Resident #20 required supervision or touching assistance with eating, substantial/maximal assistance with toileting hygiene, and ambulation was not attempted due to medical condition or safety concerns. The MDS recorded the resident's upper and lower extremities range of motion (ROM) impaired on both sides and restorative nursing program (RNP) for 0 days during the 7 day look-back period. The Care Plan initiated 7/8/24 revealed Resident #20 had ADL (activities of daily living) deficit associated with a diagnosis of dementia and stroke. The resident required assistance with ADL's and transfers of one staff. During observations of noon meals on 10/1, 10/2, and 10/3 of 2024, Resident #20 received hands-on staff assistance with transfers and meals. During an interview on 10/2/24 at 9:10 am, Staff G, Therapy Services, stated Resident #20 did not attend therapy since admission to the facility and she did not have a Restorative Program evaluation request for him from the Nursing Department. She further stated Resident #20 would benefit from a restorative program and the nursing department could write a plan for him without prior services from therapy. During an interview on 10/2/24 at 2:15 pm, the Business Office Manager (BOM) revealed Resident #20 had a decline in ADL's since admission. She further stated that he walked with staff assistance upon admission and fed himself but now due to cognition she didn't believe he remembered how to walk. During an interview on 10/3/24 at 12:00 pm, Assistant Director of Nursing (DON) stated the facility did not offer a Restorative Program to the residents at this time and she will be working on developing a RNP. She further stated Resident #20 would be a candidate for the program.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical document review, and staff interviews, the facility failed to provide restorative cares to promote range of motion to 2 out of 2 (Residents #2 and #8) residents reviewed. The facility reported a census of 31 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnosis of cerebral palsy, quadriplegia, and seizure disorder. The MDS also documented upper and lower extremities limitation in range of motion and restorative nursing program (RNP) for 0 days during the 7 day look-back period. The Care Plan revised 2/19/24 revealed Resident #2 had an ADL (activities of daily living) self care deficit related to cerebral palsy/quadriplegia. Interventions dated 7/8/24 included restorative program; passive range of motion (PROM) - gentle PROM exercises to upper and lower extremities as resident tolerated. 2. The MDS dated [DATE] for Resident #8 documented physical therapy end date of 2/19/24. The Care Plan initiated 1/12/23 revealed Resident #8 had an ADL self care deficit. Interventions included a restorative program for grooming. No further updates were documented after the physical therapy ended on 2/19/24. During an interview on 10/2/24 at 9:15 am, Staff G, Therapy Services, stated Resident #2 did not participate in their services due to his diagnoses but he would benefit from PROM RNP . She also stated Resident #8 attended physical therapy not too long ago due to decline with transfers and ambulation but the resident didn't improve and they discontinued therapy service with a recommendation for RNP. To her knowledge, the facility recently discussed a plan to revamp their RNP. She agreed that the facility RNP needed to be ongoing. During an interview on 10/3/24 at 12:00 pm, the Assistant Director of Nursing (ADON) stated the facility did not offer a Restorative Program to the residents at this time and she will be working on developing a RNP. A request to review the facility RNP policy revealed the facility did not have a policy but ADON had one in the works.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, resident interview, and staff interviews the facility failed to provide sufficient nursing staff to meet the needs for 1 of 5 resident reviewed (Resident #11). The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #11 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS indicated Resident #9 was frequently incontinent of urine and occasionally incontinent of bowel. The Care Plan revised 2/20/24 documented the resident had a potential impairment for skin integrity. Interventions included to keep body parts from excessive moisture. On 9/30/24 at 1:29 PM Resident #11 stated there is not enough staff at the facility. Resident #11 stated she asked for her brief to be changed and they will return 4 or 5 hours later. Resident #11 stated she stays in her bed most of the time. Resident #11 stated she was sitting in her room for 4 hours this morning in a soiled brief. Resident #11 stated Staff M was the staff that morning. Resident #11 stated all the staff at the facility come into the room to shut the light off and then do not return for a long time. Resident #11 stated she can read the clock in her room. Resident #11 stated Staff M entered and shut the light off around 6:30 AM. Resident #11 stated Staff M returned at 10:30 am. On 10/2/24 at 10:35 AM Staff N, Certified Nursing Assistant (CNA) stated she was familiar with Resident #11. Staff N stated her first day was August 5th. Staff N stated she cared for Resident #11 on 10/3/24. Staff N stated she did not get out of bed yesterday on her shift. Staff N stated she worked 6am - 2 pm. Staff N stated Resident #11 supposed to be every 2 hours but does not always check for incontinent. Staff N stated she did not think that there is enough staff at the facility. Staff N stated once in a while it is just one CNA on the floor in the front. Staff N stated she had not worked with one CNA on the floor last week but definitely in the last month. On 10/2/24 at 11:04 AM Staff I, CNA stated she was familiar with resident #11. Staff I stated incontinence cares are only provided to Resident #11 when she turns on her call light. Staff I stated she believed Resident #11 could tell when she was incontinent. Staff I stated one time she was the only staff working 9/29/30. Staff I stated she worked with another staff that went home early because she hurt her back. Staff I stated the staff hurt her back when getting people up for breakfast. Staff I stated the nurse and the medication aide both equally helped get residents up. Staff I stated she did not feel there was enough staff to provide care to residents appropriately that day because of the lack of staff. Staff I stated was doing the best they could. Staff I stated they did not have a break that day. Staff I stated Staff O, CNA came in to the facility around 12pm and helped out until around 2pm. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/2/24 at 12:13 PM Staff M, CNA stated she worked for an agency. Staff M stated she took care of Resident #11 on 10/1/24 and 10/2/24. Staff M stated she had provided care to Resident #11 that morning. Staff M stated there had been times at the facility that she was the only CNA on the floor in the front. Staff M stated if it was only her working it would take longer than 15 minutes to answer call lights and this has happened in the past. Staff M stated on 10/1/24 when the survey team entered the facility she was working by herself. Staff M stated sometimes she will work with Staff P, Resident Assistant (RA) and a dietary aide who is not certified. Staff M stated on 10/1/24 she answered Resident #11's call light before breakfast and told her to give her a minute. Staff M stated it is very frustrating to be the only staff and being paged by everyone to change. Staff M stated that was why on 10/1/24 it took longer than 15 minutes to get to everyone. Staff M stated on 10/1/24 she did tell Resident #11 that she would be back. Staff M stated she fed the other residents breakfast and returned to Resident #11 after breakfast and changed Resident #11 then. On 10/3/24 at 11:48 AM the ADON stated the Staff P can not do any hands on work. The ADON stated on 9/30/24 Staff P helped on the floor that morning. The ADON stated it would have been an accurate description that the CMA came to the floor after breakfast. The ADON stated there was no help requested by the staff on 9/30/24. The ADON stated she would have expected the CNA would shut the light off, obtained help, and the CNA should have told the resident that she would be right back for help. The ADON stated she did not know how the staffing levels were determined at the facility. The ADON stated the minimum was 3 CNA's up front and 1 in the back. The ADON acknowledged the facility was running under the minimum staffing on 9/30/24 and 10/1/24. On 10/3/24 at 11:57 AM the ADON stated the facility would run with 2 CNA's in the front and 1 in the back on the weekends. The ADON stated the census does impact staffing if there were more residents this would increase staffing levels. The ADON stated if there was a call in they would try to cover with their own staff, then would reach out to the staffing agencies, and if there was no agency the ADON or DON would work the floor. On 10/3/24 at 1:38 PM the Administrator stated on 9/29/24 Staff P came from the kitchen to work the floor. The Administrator stated a resident assistant was non-certified. The Administrator stated Staff P could not work with any resident alone. The Administrator stated he felt there was adequate staffing once Staff P arrived from the kitchen. The Administrator stated Sunday 9/29/24 schedule was not available for the survey team. The Administrator stated the facility did not have a policy on answering call lights or staffing the floor.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47582 Based on observation, staff interview, document review and a facility policy review, the facility failed to provide a well balanced diet that meets nutritional and special dietary needs by use of incorrect serving size portions for meals for 1 of 31 residents reviewed. The facility reported a census of 31 residents. Findings include: During a continuous observation on 10/2/24 from 11:30 AM through 12:30 PM Staff H, [NAME] served lunch. Pureed diet was served to 1 out of 31 residents. Staff H, Cook, used a 4 oz ladle to serve pureed braised beef tips with gravy, 4 oz ladle of green beans and followed a regular diet portion size menu located near the prep table. Staff H stated she has not followed a chart for special diets after the meat was altered to meet a specific diet to reference what scoop size to use for serving size. She further stated that the portion sizes were correct because they were the same as for the regular diet but failed to realize the menu she was looking at was not for pureed portion sizes but for a regular menu. Upon further inquiry and reviewing the Diet Spreadsheet for Day: 11-Wednesday Regular, Staff H confirmed regular diet portion size was 6 oz for braised beef tips with gravy and she stated she usually adds a little extra food to the food processor but did not measure the portion size after the food was pureed. During this process the Dietary Manager observed Staff H complete the pureed diet. The Dietary Manager revealed the displayed chart for measuring portion sizes for special/altered diets was not utilized and she will seek further clarification and training from the facilities Registered Dietician who was scheduled to come to the facility at the end of the week. During an interview with the Dietary Manager on 10/2/24 at 2:51 PM she confirmed dietary staff didn't have the knowledge needed for scoop sizes chart posted to know how much food to serve for pureed diets. She further confirmed that Staff H was not reading the menu correctly and did not reference pureed portion sizes while following the menu and followed regular menu portion sizes. A review of the facility provided document, titled Therapeutic Diets revised January 2017, documented the facility diets will be determined in accordance with the resident ' s informed choices, preferences, treatment goals and wishes and the physician's diet order should match the terminology used by Food Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47582 Based on observations, staff interview, and facility policy review, the facility failed to serve food within appropriate temperature ranges and in an attractive and palatable manner for 1 out 31 residents reviewed. The facility reported a census of 31 residents. Findings include: During a continuous observation on 10/2/24 from 11:30 AM through 12:30 PM, the Dietary Manager was prepared to serve 1 plated pureed diet to a resident without documenting the serving temperature of each food item on the plate. Upon further inquiry, the Dietary Manager placed the plated food in a microwave, mixing each food item around on the plate then placing it back in the microwave several times. No documentation of food temperatures were noted prior to serving the food to a resident and the food items on the plate were notably unappealing after being stirred around during the microwave process. During an interview with the Dietary Manager on 10/2/24 at 2:51 PM, she confirmed there was no documentation of temperatures prior to the food being served to a resident. A review of the facility provided policy titled Monitoring Food Temperatures for Meal Service undated, documented prior to serving a meal, food temperatures will be taken and documented for all hot and cold foods to ensure proper serving temperatures.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47673 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (April 1 - June 30), facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 31 residents. Findings include: The PBJ Staffing Data Report run date 9/26/24 triggered for failure to have licensed nursing coverage 24 hours a day on 5/28, 6/14, 6/15, 6/16, 6/19, 6/20, and 6/28/24. Review of Facility Daily Assignment Sheets for 5/28, 6/14, 6/15, 6/16, 6/19, 6/20, and 6/28/24 revealed staffing for licensed nursing coverage revealed 24 hour nursing coverage present on those days. On 10/03/24 at 1:38 PM the Administrator stated the facility's expectation was the PBJ would have been submitted with an accurate description of the facilities staffing. The Administrator acknowledged the PBJ must have been submitted inaccurately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, clinical record review, policy review, and staff interview the facility failed to provide appropriate infection prevention practices with personal care by failing to provide hand hygiene for 1 of 3 (Resident #17) reviewed. The facility reported a census of 31 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documented the utilization of an indwelling catheter. Review of Resident #17's Medication Administration Record for October 2024 revealed a physician order to change 16 FR 10cc Foley catheter every night shift every 1 month(s) starting on the 28th for 1 day(s) AND as needed for clogging. On 10/02/24 at 5:13 PM Staff N and Staff O transferred Resident #17 to the bed without difficulties. Staff N and Staff O removed Resident #17's pants, removed his brief, provided peri care, and the catheter was cleaned about 6 inches down from the penis. Staff N and Staff O assisted Resident #17 to turn to the left side. Staff N had feces on their gloves. Staff N and Staff O removed their gloves, no hand hygiene completed, and new gloves applied. Staff N cleansed Resident #17's buttocks and right hip using one wipe with one swipe. Staff N cleansed feces off Resident #17's buttocks then returned Resident #17 to his back. Both CNA's removed their gloves, no hand hygiene completed, and gloves reapplied. Staff O obtained the graduated cylinder and placed it in a basin. Staff N cleansed the catheter tip with alcohol wipe and replaced the catheter tip. Staff N removed gloves and then applied a dignity bag. Staff N pulled a blanket up over Resident #17. Gloves removed by both staff, gowns, and masks removed. Hand hygiene completed by both staff prior to exiting the room. The ADON was present during care through all observations. On 10/2/24 at 5:20 PM the ADON stated hand hygiene should have been completed between all glove changes, when going from dirty to clean, and from the resident cares to the catheter care / emptying. The ADON acknowledged missed opportunities for hand hygiene during the cares with Resident #17. The document dated 2019 titled, Infection Prevention and Control Manual Standard Precautions Hand Hygiene, documented the purpose was to prevent the spread of potentially deadly infections, provide a clean and healthy environment for residents, staff, and visitors, and to reduce the risk to the health care provider of colonization or infections acquired from a resident. Hand hygiene continues to be the primary means of preventing the transmission of infections. According to the CDC, strict adherence to glove use is the most effective means of preventing hand contamination with C. difficile spores as spores are not killed by ABHR and may be difficult to remove even with thorough hand washing. Staff must perform hand hygiene even if gloves are utilized.

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F 0883

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement policies and procedures for flu and pneumonia vaccinations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47673

Based on electronic record review, resident power of attorney interview, and staff interview the facility failed to implement policies and procedures, to ensure a resident did not receive influenza immunizations when declined for 1 of 5 residents reviewed (Resident #28). The facility reported a census of 31 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #28 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS documented Resident #28 had a diagnosis of Guillain Barre.

On 9/30/24 at 3:31 PM Resident #28's emergency contact #2 / POA stated a voicemail was left requesting consent on giving the flu vaccine. Resident #28's emergency contact #2 / POA stated she contacted Resident #28's emergency contact #1 to inform the facility that Resident #28 could not have a flu shot related to a history of Guillain Barre. Resident #28's emergency contact #2 stated she was told Resident #28 still got the flu shot.

On 9/30/24 at 3:39 PM Resident #28's emergency contact #1 stated she was the power of attorney. Resident #28's emergency contact #1 stated she called the facility and told them that both her and Resident #28's Emergency contact #2 did not want Resident #28 to receive the flu vaccine because of the history of Guillain Barre. Resident #28's emergency contact #1 stated the facility told her that Resident #28 received the flu vaccine.

Review of Resident #28's EHR revealed emergency contact #2 as Power of Attorney (POA).

The Progress Note dated 9/18/24 by Staff F, Wound Care Nurse documented Resident #28's emergency contact #1, phoned the facility informing the last time Resident #28 had the flu vaccination he ended up with Guillain Barre. Staff F documented Resident #28's emergency contact #1 and #2 do not want him to have the vaccine again.

The Progress Note dated 9/23/24 by Staff L, Director of Nursing (DON) documented influenza vaccination was given to Resident #28 in the left deltoid without incident.

On 10/3/24 at 8:51 AM the ADON stated Resident #28 should not have received the influenza vaccine. The ADON stated she could not locate the consent or declination from POA for Resident #28. She stated when obtaining orders to give vaccines the facility expectation was the facility would get the consent from the family or POA, then would send a fax to the physician for an order to give the vaccine, and the facility would then administer the vaccine.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of document titled, Infection Prevention and Control Manual Resident Immunizations and Vaccinations Influenza Vaccine Program updated 9/22 documented the resident or the resident's representation has the opportunity to decline and refuse the influenza immunization. If immunization is declined, then document that education was provided and the refusal in the medical records. Prior to consent or administration, check to see if medical contraindications for the vaccine exist such as history of Guillain-Barre syndrome within 6 weeks of receipt of influenza vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on electronic record review, policy review, and staff interview the facility failed to develop and implement policies and procedures, to ensure the resident's medical record included documentation of consent to receive COVID-19 immunizations for 2 of 5 residents reviewed (Resident #2 and Resident #24). The facility reported a census of 31 residents. Findings included: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented that the resident was rarely / never understood. Review of electronic health records documented Resident #2 had no electronic documentation consent for the COVID-19 immunization. 2. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #24 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. Review of electronic health records documented Resident #24 had no electronic documentation consent for the COVID-19 immunization. On 10/3/24 at 10:45 AM the ADON stated she can not find any consent related to the Covid-19 vaccine administration for Resident #2, and #24. The ADON stated she was not able to obtain a policy with administration guidelines for Covid-19 vaccination. Review of document titled, SARS-CoV-2 Infection Policy dated 8/22/24 documented residents should be offered resources and counseled about the importance of receiving the COVID-19 vaccine.