STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265463	A. Building B. Wing	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare	128 North Hardesty Kansas City, MO 64123

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on interview and record review, the facility failed to ensure appropriate weight management for two sampled residents (Resident #8 and Resident #10), who had Percutaneous Endoscopic Gastrostomy (PEG) tubes (a tube that is passed into a person through the abdominal wall, commonly used to provide a means of feeding when oral intake is not adequate), with weight discrepancies out of 10 sampled residents. The facility census was 101 residents. Review of the facility's policy titled Weight Assessment and Intervention dated March 2022 showed: -Residents are weighed upon admission and at intervals established by the interdisciplinary team. -Any weight change of five percent or more since the last weight assessment is retaken the next day for confirmation. -If the weight is verified, nursing will immediately notify the dietician in writing. -Unless notified of significant weight change, the dietician will review the unit weight record monthly to follow individual weight trends over time. 1. Review of Resident #8's Face Sheet showed he/she admitted to the facility with the following diagnoses: -Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors). -Dysphagia (difficulty or discomfort in swallowing). -Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin). Review of the resident's weights and vitals summary dated 12/12/23 showed the resident weighed 171 pounds (lbs.). Review of the resident's weights and vitals summary dated 1/15/24 showed the resident weighed 150 lbs, which is a 21 lbs weight loss in 34 days. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan dated 1/30/24 showed: -The resident was at potential nutritional risk due to Parkinson's and DM II diagnoses, difficulty swallowing, and now used a PEG tube with a history of significant weight loss with the following interventions: --Registered Dietician (RD) to evaluate and make diet change recommendations as needed (PRN). --RD would monitor weight, labs, wound healing, hydration, and nutritional status monthly or PRN. --Weights per facility protocol. Review of the resident's weights and vitals summary dated 2/7/24 showed the resident weighed 154 lbs, which was weight gain of four pounds in 23 days Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 2/20/24 showed: -The resident was cognitively intact. -The resident did not have a swallowing disorder. -The resident did not have any weight loss. -The resident only received tube feeding. - The resident received 51% of his/her proportion of calories through a feeding tube. -The resident received 500 cubic centimeters (cc- also equivalent to milliliters (ml)) average fluid intake via tube feeding. Review of the resident's March 2024 Physician Order Sheet (POS) showed: -A physician's order for a full liquid diet (made up of only fluids) with regular texture, nectar-thick (easily pourable and comparable to heavy syrup), juices only at nectar thick 1/2 teaspoons (tsp) sips, give sips slowly, allow to do hard swallows in between, to be done by charge nurse or restoration aide (RA) only for diet. - A physician's order for Jevity (a fiber-fortified tube feeding formula) 1.5, give one can via PEG tube [NAME] times a day for nutritional supplement. NOTE: No order was found related to the resident being weighed more frequently due to weight changes. 2. Review of Resident #10's Face Sheet showed he/she was first admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: -Paraplegia (paralysis of the legs and lower body). (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses). -Unspecified Severe Protein-Calorie Malnutrition. -Dysphagia. Review of the resident's weights and vitals summary dated 9/7/23 showed the resident weighed 146.2 lbs. Review of a nutrition/dietary noted dated 12/3/23 completed by the facility's RD showed: -The resident had not been weighed since September 2023. -The resident needed to be weighed at least monthly. Review of a nutrition/dietary note dated 12/6/23 completed by the facility's RD did not indicate if the resident's weight was stable. Review of the resident's care plan dated 12/12/23 showed: -The resident required tube feeding related to dysphagia with an intervention to see MD orders for current feeding orders. NOTE: No care plan focus or intervention was found related to weight management. Review of the resident's weights and vitals summary dated 12/12/23 showed the resident weighed 130 lbs. NOTE: The resident was not weighed in October or November. Review of the resident's quarterly MDS dated [DATE] showed: -The resident had moderately impaired cognition. -The resident did not have a swallowing disorder. -The resident did not have any weight loss. -The resident had a mechanically altered diet. -The resident received 51% of his/her proportion of calories through a feeding tube. -The resident received 500 cc average fluid intake via tube feeding. Review of the resident's weights and vitals summary dated 1/15/24 showed the resident weighed 133 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's weights and vitals summary dated 2/7/24 showed the resident weighed 133 lbs. Review of a nutrition/dietary note dated 2/20/24 completed by the facility's RD showed the resident's weight was stable. Review of the resident's March 2024 POS showed: -A physician's order for a regular diet with mechanical soft texture (any foods that can be blended, mashed, pureed, or chopped using a kitchen tool), thin liquids (un-thickened liquids like water or juice) consistency, *Per Os (PO- by mouth) feedings at the resident request* thin liquids, soft/moist, easy-chew solids. -An order for Jevity 1.5 at 55 ml per hour by pump. NOTE: No order was found related to the resident being weighed more frequently. During an interview of 3/5/24 at 10:50 A.M. the resident said: -He/She was unsure if he/she had lost any weight. -He/She was unsure how the facility was maintaining his/her weight. 3. During an interview on 3/5/24 at 10:34 A.M. Certified Nursing Assistant (CNA) B said: -He/She did not think Resident #8 had any weight loss. -Resident #8 was weighed monthly. -Therapy was in charge of weighing the residents. -Resident #8 had not complained of losing weight. -If any resident reported any weight loss or gain to him/her, then he/she would report it to the charge nurse. -Therapy would let the CNAs know if the resident had lost weight or if they could not obtain the weight at that time. -All residents were weighed once a month. -An order would be needed for weights to be done more frequently. -He/She was able to see weights within the residents' charts. During an interview on 3/5/24 at 10:55 A.M. CNA C said: -He/She did not think that Resident #10 had lost any weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The RA completed the monthly weights. -If a resident were to tell him/her that they were losing weight then he/she would weigh the resident and report the weight to the charge nurse. -He/She was able to see weights within the residents' charts. -Resident #10 had a recent diet change and thought the resident was now on a mechanical soft diet. During an interview on 3/2/24 at 11:13 A.M. Licensed Practical Nurse (LPN) A said: -All residents in the facility were weighed once a month unless there was a more specific order. -He/She had only worked at the facility for a month, so he/she was unsure of Resident #8 or Resident #10 had lost weight. -If a resident was losing weight there would be a detailed nurse's note related to the weight loss and weight management. -If he/she saw more than a three-pound weight difference for any resident, then he/she would notify the physician. -For residents with weight loss their intake and output were recorded by the nurse during the shift. During an interview on 3/5/24 at 11:22 A.M. Registered Nurse (RN) A said: -He/She did not know if Resident #8 had lost weight. -He/She did not think that Resident #10 had any weight loss. -The Assistant Director of Nursing (ADON) and Director of Nursing (DON) monitored the residents for weight loss. -He/She was unsure if there was a weight loss alert within the facility's electronic charting system. -The facility's RD also looked at resident weights. -Resident #10 was currently on monthly weights. During an interview on 3/5/24 at 11:57 A.M. the ADON said: -He/She had noticed that Resident #8 had lost weight. -Resident #10 had been on a trial diet of pureed food, but he/she had been placed back onto tube feeding with pleasure feeding. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #10's trial diet could have caused the resident to lose weight. -It was the nurses responsibility to document resident intake and output. -The RA was responsible for weighing the residents. -The RA was responsible for telling management about weight loss. -Resident weights were discussed monthly during the facility's Quality Assurance and Performance Improvement (QAPI- a data driven and proactive approach to quality improvement) meeting. -There had been an issue with the calibration of the facility's scale in the past. -If a resident had a significant change in weight, then the resident needed to be re-weighed to ensure accuracy of the weight. -Resident #8 and Resident #10 should have been re-weighed due to the significant difference in weight. -If it was determined that a resident was losing weight, then he/she would inform the doctor, inform the RD, and put the weight loss and interventions on the resident's care plan. During a phone interview on 3/7/24 at 8:33 A.M. the facility's RD said: -He/She thought that Resident #8 and Resident #10 had weight discrepancies and not actual weight loss. -He/She had told the facility that all residents needed to be re-weighed to get a new baseline weight for each resident due to the inconsistency in weights. -He/She would have expected the facility to re-weigh Resident #8 and Resident #10 after noticing the significant change in weight. -He/She remembered when Resident #10 admitted to the facility and had to remind the staff multiple times that the resident needed to be weighed. -He/She expected the residents to be weighed monthly and was unsure why Resident #10 did not have weights documented in October or November 2023. During a phone interview on 3/8/24 at 8:24 A.M. the facility's physician said: -He/She had a hard time with weights in general at the facility due to the inconsistency. -He/She thought Resident #10 had been at the hospital at the times when the facility would have done the monthly weights. -He/She did not think that Resident #8 had lost any weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #10 could have lost weight while in the hospital and weight loss at that time would have been expected with the resident's current state and disease process. -Resident #8 had been morbidly obese, so if the resident had lost weight, it would have been appropriate. -He/She would have expected the facility the re-weigh Resident #8 and Resident #10 when there had been a significant drop in weight. -The monthly QAPI meetings seemed to be when the facility discussed weights, but the facility's management might also be having daily Person at Risk (PAR) meetings. -He/She would not change the treatment plan for either resident. -When looking at resident weight loss he/she usually looked at the graph in the facility's charting system. -If the graph showed a steep drop in weight, then he/she would not think the weight was accurate. -He/She would discuss with management about the inconsistent weights. MO00231857

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46519 Based on observation, interview and record review, the facility failed to obtain physician's orders to ensure the intake of tube feeding and fluids was completed, failed to ensure the flush bag was dated and labeled, and failed to ensure the tube feeding bag and flush bag were changed every 24 hours, for one sampled resident (Resident #10) with a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube that is passed into a person through the abdominal wall, commonly used to provide a means of feeding when oral intake is not adequate) out of 10 sampled residents. The facility census was 101 residents. Review of the facility's policy titled Enteral (passing through the intestine) Feeding via Continuous Pump dated November 2018 showed: -In preparation staff would need to verify that there is a physician's order for this procedure. -The person performing this procedure should record the following information: --The date and time the procedure was performed. --Verification of tube placement. --Amount and type of enteral feeding. --The average fluid intake per day. --The name and title of the individual(s) who performed the procedure. --All assessment data obtained during the procedure. --How the resident tolerated the procedure. --If the resident refused the procedure, the reason(s) why and the interventions taken. -The signature and title of the person recording the data. NOTE: There was no part in the policy that indicated the flush bag (bag containing water) for water boluses (used as a way for the person receiving tube feeding hydration) needed to be dated/labeled. 1. Review of Resident #10's Face Sheet showed he/she was first admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: -Paraplegia (paralysis of the legs and lower body). (continued on next page)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses). -Unspecified Severe Protein-Calorie Malnutrition. -Dysphagia (difficulty or discomfort in swallowing). Review of the resident's Physician Order Sheet (POS) dated 8/30/23 showed: -An order for Jevity (a fiber-fortified tube feeding formula) 1.5, 55 ml per hour by pump. -Flush PEG tube with 150 ml of water every six hours. Review of the resident's POS dated 12/21/23 showed an order for a regular diet with mechanical soft texture (any foods that can be blended, mashed, pureed, or chopped using a kitchen tool), thin liquids (un-thickened liquids like water or juice) consistency, *Per Os (PO- by mouth) feedings at the resident request* thin liquids, soft/moist, easy-chew solids. Review of the resident's Care Plan dated 12/12/23 showed the resident required tube feeding related to dysphagia with an intervention to see physician's orders for current feeding orders. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 12/13/23 showed: -The resident had moderately impaired cognition. -The resident did not have a swallowing disorder. -The resident received 51% or more of his/her proportion of total calories needed received through a feeding tube. -The resident received 500 cubic centimeters (cc- also equivalent to a milliter (ml)) a day or more of average fluid intake by feeding tube. Review of the resident's Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated February 2024 showed no documentation related to the resident receiving his/her tube feeding. Review of the resident's MAR/TAR dated March 2024 showed no documentation related to the resident receiving his/her tube feeding. Observation on 3/4/24 at 11:03 A.M., of the resident's tube feeding showed: -It was labeled as hung at 3/4/24 at 10:46 A.M. -It was running at 55 ml an hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The flush bag was not labeled. Observation on 3/5/24 at 10:50 A.M., of the resident's tube feeding showed: -It was the same bottle from the day before as it was labeled as hung on 3/4/24 at 10:46 A.M. -It was running at 55 ml an hour. -The flush bag was not labeled. During an interview on 3/5/24 at 11:13 A.M., Licensed Practical Nurse (LPN) A said: -He/She would not expect the resident's tube feeding administration to show up on the TAR because it was a continuous order. -He/She had only worked with the resident once before and was not sure about his/her specific orders. During an interview on 3/5/24 at 11:22 A.M., Registered Nurse (RN) A said: -The resident's tube feeding administration should show up on the resident's MAR/TAR. -There was a place to document the resident's water flushes on the MAR/TAR. -The resident was on a continuous feed, so he/she knew that it needed to be hung every 24 hours. -The resident needed a new bottle about once a day. -He/She just monitored the tube feeding and did not need the TAR notification for the bottle to be changed out. -The resident's flush bag did not need to be labeled because it would be changed out with the rest of the tube feeding administration tubing. During an interview on 3/5/24 at 11:57 A.M., the Assistant Director of Nursing (ADON) said: -Tube feeding bottles should only be hung for a maximum of 24 hours. -He/She expected staff date and label the tube feeding bottle and flush bag. -There should be an order in place for the resident to receive tube feeding. -There should be a place on the TAR for the nurses to document that the resident's tube feeding was given. -He/She was unsure why there was not a place on the TAR for the nurses to document the tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She thought that due to a recent diet change the resident's tube feeding order may have dropped from the resident's original POS and when it was re-ordered the order was not given a schedule for the TAR. -He/She expected staff to document when tube feeding was given. MO00231857

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to ensure the call light system was operable and within reach for one sampled resident (Resident #1), who was bedbound and needed total assistance from staff for care, out of 10 sampled residents. The facility census was 101 residents. Review of the facility's Call light policy and procedure dated March 2021, showed: -The purpose was to ensure timely responses to the resident's requests and needs. -Be sure the call light is plugged in and functioning at all times. -When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. -Some residents may not be able to use their call light. Be sure you check these residents frequently. 1. Review of Resident #1's Face Sheet showed he/she was admitted to the facility on [DATE] with diagnoses of quadriplegia (a form of paralysis that affects all four limbs, plus the torso), stroke (when blood flow to the brain is blocked or there is sudden bleeding in the brain), diabetes, morbid obesity (weight is more than 80 to 100 pounds above their ideal body weight), adjustment disorder (an emotional or behavioral reaction to a stressful event or change in a person's life), bipolar disorder (a mental health condition that causes extreme mood swings), high blood pressure, muscle spasm, depression, asthma (a condition in which the airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe) and rapid heart rate. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 12/25/23, showed the resident: -Was alert, oriented and had no cognitive incapacities. -Had upper and lower range of motion impairment on both sides of his/her body. -Was totally dependent on nursing staff for bed mobility, transfers, mobility, eating, bathing, dressing, toileting and did not walk or stand. Review of the resident's Care Plan updated 2/17/24, showed the resident required maximum assistance of two to three staff for turning and bed mobility, transfers, bathing and needed the assistance of one to two staff for toileting and hygiene. It showed: -The resident was at risk for falls and staff were to keep the resident's call light within reach and encourage the resident to use it. The resident needed prompt response to all requests for assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The care plan did not show the resident refused to use his/her call light or that he/she was unable to use a call light. There was no documentation showing the facility had an alternate method for the resident in place of call light usage. Observation and interview on 3/4/24 at 12:00 P.M., showed the resident was in a room by himself/herself. He/She was laying in a bariatric bed, on his/her back. The resident had a tray table with a small speaker on top of it that was beside the resident's bed. There was also a cell phone on the tray table. There was no call light within the resident's reach. It was not on the floor or wedged between the resident's bed and the wall. Further observation showed that there was no call light plugged into the wall for the resident. There was a pad call light that was unplugged and sitting on another bed that was behind the resident. The resident said: -Usually his/her call light was on the floor and was rarely within his/her reach. -He/She was unable to move himself/herself in bed so he/she was unable to see where his/her call light was. -Nursing staff had to place the call light within reach of his/her right hand in order for him/her to use it. -He/She used the [NAME] (a virtual assistant technology using voice activation) speaker to call for assistance by asking it to call the facility phone and then when someone answers the telephone he would let them know he/she needs assistance. -[NAME] rang the telephone 10 times before it hung up the telephone call. -Sometimes he/she had to call several times when no one answered the telephone. -At this time, the resident asked [NAME] to call the facility. The telephone called the facility telephone and the telephone rang 10 times before the call was disconnected. The resident said he/she would normally call again until someone answered. Observation and interview on 3/4/24 at 12:11 P.M., Certified Medication Technician (CMT) A came into the resident's room and began to look for the resident's call light. CMT A said: -He/She did not see that the resident had a call light and was not able to find it. -The resident usually called the facility using [NAME] to request assistance, but he/she should not have to call on the telephone line to notify someone that he/she needed help. -The resident should have his call light available to use in addition to [NAME]. -The current call light system functions this way: the resident will push the call light and information showing the date, room and time the call light was pushed will display on the monitor at the nursing station. -There was no longer a light that came on over the resident's door that notified staff that the call light was on and there was no sound to identify a call light was on anymore. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265463	A. Building B. Wing	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare	128 North Hardesty Kansas City, MO 64123

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing staff had to go to the nursing station to know if someone had turned their call light on now. Observation and interview on 3/4/24 at 12:28 P.M., Certified Nursing Assistant (CNA) A came into the resident's room and began to look for the resident's call light. CNA A saw the pad call light on the bed behind the resident, picked it up and sanitized it, then plugged it into the wall and placed it beside the resident's right arm. CNA A said: -The resident did not really use his/her call light and rather used the [NAME] to call the facility for assistance. -He/She did not know why the resident's call light was not plugged in or available for the resident. -The resident was not able to move in bed without assistance and had limited mobility in his/her arm. -He/She usually checked on the resident more frequently during the day and anticipated his/her needs. Observation on 3/4/24 at 12:30 P.M., showed when CNA A left the resident's room, the resident used his/her right hand to push the pad alarm, which showed that it was on at the wall (plug in) in his/her room. Observation at the nursing station showed there was a monitor at the nursing station that showed the resident had turned his/her call light on and showed the date, room number and time the call light was turned on. During an interview on 3/5/24 at 10:39 A.M., Registered Nurse (RN) A said: -The resident had limited movement in his/her hands and arms which is why he/she did not use a call light. -The resident had a pad call light because he/she was unable to use the standard call light, but he/she did not use it either and would throw it on the floor. -The resident preferred to use [NAME] to call the staff when he/she needed assistance. -The [NAME] called the facility and the call rang in the front administrative area as well as at the nursing stations. -This was his/her only means of letting them know when he/she needed assistance. -The resident called several times daily for assistance. -If there was no one at the nursing station or in the offices, then the resident would have to wait until someone got to the telephone to answer it to find out that he needed assistance. -The call light system was their standard system for notifying staff that a resident needed assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's call light should be plugged in and available for the resident to use if he/she chose to use it. -Their new current call light system did not sound or light up above the resident's door when the call light was activated. The nursing staff would have to check the monitor at the nursing station to know if a call light was on. -The nursing aides should check the monitor at the nursing station frequently to see if there were call lights activated. If they answer a call light, when they are done assisting a resident they are expected to check the monitor to see if there were other call lights activated. During an interview on 3/5/24 at 11:00 A.M., the Administrator said: -They are implementing a new call light system and when the resident activates the call light, the monitor at the nursing station will display the date, room, time the call light was activated and how long it had been on. -There was a beeping sound that is also activated at the nursing station when a call light has been activated and it will stop when the call light has been answered. -The sound can be also be deactivated at the nursing station if someone turned the sound off. -The pagers (like a cell phone) that are paired to the call light system will also activate when a call light is activated. The nursing staff are going to have the cell phones so they will know when the call light is activated and the pagers will tell them where the light is activated. -The staff will also be able to use the pagers like a cell phone to communicate with each other. -He/She had not yet distributed the pagers so this part of the call light system was not yet operating-he/she was going to do this with training within the week. -In the meantime, he/she expected staff to check on the residents frequently and check the monitors frequently. The sound on the monitor should not be turned off. -Regarding the resident, he/she used [NAME] to call the facility to notify them is he/she needed assistance, however his/her call light should have been plugged up and within his/her reach. -The resident was able to use his/her right arm to activate the pad and they obtained the pad call light specially for him/her for this reason. -Nursing staff should be checking the resident more frequently, which was why they placed him/her closer to the nursing station. During an interview on 3/5/24 at 3:00 P.M., the Assistant Director of Nursing (ADON) said: -He/She expected resident call lights to be plugged in and accessible to the resident at all times. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing staff should check on the residents every two hours and they should be checking to ensure call lights are available and within reach. -The new call light system they are using does not have lights that identify which rooms have call lights activated or a sound that is audible. -The monitor at the nursing station was how the nursing staff know there was a call light on and the expectation was that nursing staff was checking the monitor frequently to know whether a call light had been activated. -The resident had been using his/her [NAME] to call the facility to let them know he/she needs assistance, but this was not the protocol for the facility. -They ordered a pad alarm for the resident to use because he/she was unable to use the standard call light, but the resident chose to use [NAME]. -The call light should be accessible to the resident whether he/she used [NAME] or not. MO00231895 MO00232373