STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265759	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort St Marys LLC	111 Mock Avenue Blue Springs, MO 64014

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51150 Based on observation, interview and record review, the facility failed to provide dignity and privacy while completing Activities of Daily Living (ADL-A collective term for all basic skills you need in regular daily life) and performing perineal care (care to the area between the anus and the exterior genitalia) for one sampled resident (Resident #62) out of 18 sampled residents. The facility census was 84 residents. Review of the facility's Dignity policy and procedure updated in July 2024, showed: -The facility will promote care for residents of the facility in a manner and in an environment that maintains and enhances each resident ' s dignity and respect. -All staff will provide dignity to each resident by maintaining the resident ' s privacy of body. -All staff will refrain from any practice which could be considered demeaning to an elder. 1. Review of Resident #62's Face Sheet showed the resident was admitted to the facility with the following diagnoses: -Difficulty in walking. -Muscle weakness. -Need for assistance with personal cares. -Cerebral Infarction (ischemic stroke, a cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). -Major Depressive Disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). Review of the resident's Care Plan dated 11/28/23 showed the resident: -Had a communication problem. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had ADL self-care performance deficits and limitations in physical mobility. -Had incontinence (having no or insufficient control over urination or defecation). -Had the potential for alterations in psychosocial well-being. -Had depression. Review of the resident's annual Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 6/3/24 showed the resident: -Had cognitive impairment. -Had functional limitation in Range Of Motion (ROM the extent or limit to which a part of the body can be moved around a joint or a fixed point; the totality of movement a joint was capable of doing). -Needed partial/moderate assistance with ADL's. -Had an indwelling urinary catheter (a tube passed through the urethra into the bladder to drain urine) -Had frequent incontinence. -Had a history of stroke. -Had depression. Observation on 8/21/24 at 12:24 P.M., showed: -The resident received wound care on his/her right ankle by Nurse Practitioner (NP) A and Assistant Director of Nursing (ADON) A. -The window curtains were open during wound care. -A bystander was outside of resident's window during cares. Observation on 8/22/24 at 10:44 A.M., showed: -ADON A and Certified Nurse Assistant (CNA) J performed perineal care on the resident. -The window curtains were left open during perineal care. -Several bystanders (approximately seven) were observed and seen outside of the resident ' s window during resident care. -The resident was fully exposed to outside bystanders during resident cares. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24 at 1:22 P.M., CNA B said: -He/She would promote dignity and privacy by knocking on the resident's door before entering, introduce self, and pulling the resident's curtain for privacy. -He/She would close window blinds/curtains if a resident was next to a window during resident cares. During an interview on 8/22/24 at 1:40 P.M., CNA J said: -He/She would shut a resident door and pull their curtains to promote dignity and privacy during cares. -He/She forgot to pull resident's window curtains during cares, but he/she normally would have. During an interview on 8/23/24 at 8:59 A.M., Licensed Practical Nurse (LPN) B said: -All residents should be given privacy and dignity during personal cares. -He/She would expect window curtains/blinds to be shut if a resident was receiving cares next to a window. -He/She would expect curtains between two residents in the same room would also be closed during resident cares. During an interview on 8/23/24 at 11:35 A.M., ADON A said: -He/She would expect privacy and dignity to be given to each resident in the facility during resident cares. -He/She would expect all curtains in a resident room to be closed during resident cares, including window curtains. -He/She should have made sure the window curtain was closed while providing Resident #62 personal care. During an interview on 8/23/24 at 1:09 P.M., the Director of Nursing (DON) said: -He/She would expect privacy and dignity to be given to each resident in the facility. -He/She would expect staff to close all doors, blinds, and curtains in a resident room, while a resident was receiving personal cares.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409 Based on observation, interview and record review, the facility failed to obtain a physician order for self administration of medication at bedside and failed to evaluate and document the ability to self-administer medication for two sampled residents (Resident #343 and #345) out 18 sampled residents. Facility's resident census of 84 residents. The facility did not provided a policy for Resident Self-administration of medication at time of exit. 1. Review of Resident #343's Admission Face Sheet showed the resident admitted to the facility on [DATE], had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation). Review of the resident's Electronic Medical Record from 8/7/24 to 8/18/24 showed the resident did not have physician order for self administration of medication at bedside and did not have Self Administration of Medication Evaluation completed prior to 8/18/24. Review of the resident's Physician Order Sheet (POS) dated 8/7/24 to 8/18/24 showed: -ProAir HFA (Ventolin) Inhalation Aerosol Solution 108 (90 Base) microgram (mcg)/ACT (Albuterol Sulfate) 2 puff inhale orally every four hours as needed for shortness of breath. -Breo Ellipta Inhalation Aerosol Powder Breath Activated 200-25 mcg/ACT (Fluticasone Furoate-Vilanterol) one puff inhale orally one time a day for shortness of breath. -The resident did not have a physician's order to keep medication at bedside. -The resident did not have a physician's order to self administer the medication by himself/herself. -The resident did not have a physician's order for evaluation by nursing staff to assess the residents ability to be able to provide his/her own breathing treatment. Review of the resident's Medication Administration Record (MAR) dated 8/1/24 to 8/18/24 showed: -A physician's order for ProAir HFA (Ventolin) Inhalation Aerosol Solution 108 (90 Base) mcg/ACT (Albuterol Sulfate) two puff inhale orally every four hours as needed for shortness of breath dated 8/8/24. -There was no documentation the resident had administered the inhaler by himself/herself. -There was no monitoring of the use of the inhaler medication by the Certified Medication Technician (CMT) or nursing staff. Observation on 8/19/24 at 11:09 A.M. and 11:47 A.M., of the resident's room showed: (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was in private room. -He/She had Ventolin inhaler on his/her bedside table, unattended. Observation and interview on 8/19/24 at 3:03 P.M., of the resident showed: -He/She had a left arm amputation. -He/She administered the Ventolin inhaler medication as needed for shortness of breath. -The resident took the inhaler medication in his/her right hand. He/she shook the Ventolin inhaler then removed the cap with his/her teeth. -Placed his/her lips around the mouth piece, pushed the vial, while he/she inhaled. -He/She held his/her breath for a few seconds and then exhaled. -He/She then placed the cap back on the medication and laid it on the bedside table. -He/She was not aware if staff monitored when he/she took the inhaler medication or if nursing staff documented on the resident's MAR the medication was given. -He/She could not remember if nursing staff evaluated his/her ability to administer the inhaled medication. Review of the resident's Health Status Note dated 8/19/24 at 4:41 P. M. showed: -The resident had complaints of shortness of breath. -The resident provided breathing treatment by the nurse with some relief. -The resident's heart rate elevated to 133 beats per minute. -The resident again said he/she was having difficulty breathing at 3:30 P.M. The resident's oxygen level was at 99% and heart rate was 127 beats per minute. -The resident said he/she may be anxious (experiencing worry, unease, or nervousness, typically about an imminent event or something with an uncertain outcome). Anxiety medication was given for possible anxiety episode. -The resident again said he/she was having shortness of breath at 4:00 P.M. and the medication did not help. -Breathing treatment administered with no relief and heart rate was 142 beats per minute. -Attempted to call the resident's emergency contact with no answer. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse Practitioner (NP) on unit and ordered to send the resident to hospital for evaluation and treatment. Nurse called second contact listed and notified of condition. Emergency Medical Services arrived and transported to hospital. During an interview on 8/20/24 at 1:55 P.M., CMT D said: -Self administration of medication for Resident #343, should be on the resident MAR, and pop up on the MAR when needed to be given. -He/she would observe the resident while the medication was being taken and document on the MAR. -He/she did not see a physician order at that time for self administration of any medication. -The resident's Ventolin inhaler would require a physician's order to be kept at bedside and to be self administered. -The resident would be assessed by the charge nurse, respiratory staff to assess for the resident's ability and knowledge to self administer the inhaler medication. 2. Review of Resident #345's Admission Face sheet showed the resident admitted to the facility on [DATE] with diagnoses of Pneumonia (an infection in your lungs caused by bacteria, viruses or fungi) and COPD. Review of the resident's POS dated 8/8/24 to 8/19/24 showed the resident: -Was admitted to skilled nursing on 8/8/24 for rehabilitation. -Had an order for Trelegy Ellipta (works to lower inflammation in your lungs and open up and relax your airways over time, while Albuterol works over a short period of time) inhaler one puff, one time a day for COPD. Review of the resident's Care Plan dated 8/8/24 to 8/19/24 showed: -No care plan for self administration of medication or evaluation to self administer medication. Observation 8/20/24 at 12:29 P.M., of the resident showed: -He/She had a Tregely inhaler at his/her bedside. During an interview on 8/20/24 at 12:29 P.M. the resident said: -He/She used the inhaler on his/her own once a day. Observation on 8/21/24 at 7:15 A.M., of medication administration with CMT C showed: -CMT C looked for Resident #345's Trelegy Ellipta inhaler in the medication cart. -CMT C did not find the resident's inhaler in the medication cart. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The inhaler was on the resident's bedside table and was labeled with the resident's name. During an interview on 8/21/24 at 7:25 A.M., the resident said: -He/she had already taken the inhaler medication that morning. During an interview on 8/21/24 at 7:27 A.M., CMT C said: -He/she did not see a physician's order for the inhaler medication to be left at bedside for Resident #345. -He/she normally would not leave an inhaler at bedside and would setup medications for the resident to administer and observe the use. Observation on 8/21/24 at 7:30 A.M. showed CMT C placed the resident's inhaler back into the CMT medication cart. 3. During an interview on 8/23/24 at 9:21 A.M., Licensed Practical Nurse (LPN) A said: -He/she would expect to have a physician's order for self administration and have a self administration assessment completed for residents that had medications at bedside. -He/she was not aware that Resident #343 and #345 had inhalers left at bedside. -The CMT or nursing should verify the resident had an order and if an assessment for self-medication had been done. -The CMT or nursing would still be required to document and monitor medications self administered by the resident. -On the MAR the medication /inhaler would still pop up to be self administered and monitored. -Nursing staff would document if reviewed or given. During an interview on 8/23/24 at 11:36 A.M., Assistant Director of Nursing (ADON) A and ADON B said: -Nursing staff would be expected to complete a resident self-administration medication evaluation and obtain a physician's order to keep medication at bedside and self-administer medication. -ADON A was not aware Resident #343 and Resident #345 had medications left at bedside until it was brought to their attention. During an interview on 8/23/24 at 1:31 P.M., the Director of Nursing (DON) said: -He/She would expect there to be a phsycian's order and nursing evaluation for self-administration of medication completed to keep medication at bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nursing should verify the resident had an order and if an assessment for self-medication was completed. -The CMT or nursing staff would be required to monitor resident self-administration of medication and document the medication as being monitored by nursing and taken by the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm 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. 19916 Based on observation and interview, the facility failed to maintain commode risers (assistive devices to improve the accessibility of toilets to older people or those with disabilities. They can aid in transfer from wheelchairs and may help prevent falls) in resident rooms A110, A105, A102, B104, C106, C104, C102, E107, E108, G104, D107 free from areas that were not easily cleanable; failed to maintain the fan in resident rooms B105, free from a buildup of dust; failed to maintain the ceiling vent in in resident room A101; failed to ensure the floor was maintained clean in resident rooms A105 and C109; failed to ensure the countertop in the A Hall shower room was in good repair; failed to ensure the grab bar was firmly attached to the wall in the restroom of B105; and failed to ensure the shower chair in D105 was in good repair. This practice potentially affected at least 30 residents who resided in or used those areas. The facility census was 84 residents. 1. Observation on 8/21/24 with the Environmental Services Director (EVS) Director showed the areas that were not easily cleanable on commode risers in the following rooms: -At 10:23 A.M., the commode riser in resident room A110 was not easily cleanable. -At 10:25 A.M., the commode riser in resident room A105 was not easily cleanable. -At 10:59 A.M., the commode riser in Resident room A102 was not easily cleanable. -At 11:28 A.M., the commode riser in Resident room B112 was not easily cleanable. -At 11:36 A.M., the commode riser in Resident room B107 was not easily cleanable. -At 11:50 A.M., the commode riser in Resident room B103 was not easily cleanable. During an interview on 8/21/24 at 11:51 A.M., the EVS Director said there were many commode risers which needed to be replaced and he/she would order the replacements. Observation on 8/21/24 with the EVS Director showed the areas that were not easily cleanable on commode risers in the following rooms: -At 12:17 P.M., the commode riser in Resident room C104 was not easily cleanable. -At 12:19 P.M., the commode riser in resident room C105, was not easily cleanable. -At 1:44 P.M., the commode riser in resident room E107 was not easily cleanable. -At 2:25 P.M., the commode riser in Resident room G104 was not easily cleanable. -At 2:44 P.M., the commode riser in Resident room D107 was not easily cleanable. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 8/21/24 at 11:40 with the EVS Director showed a buildup of dust on the fan blades of the fan in resident room B105. During an interview on 8/26/24 at 9:43 A.M. Housekeeper B said the following observing the fan in resident room B105: -They were told not to clean the fans and he/she did not know how the fans got cleaned. 3. Observation on 8/21/24 at 10:46 A.M., showed a heavy buildup of dust inside the ceiling vent in resident room A101. During an interview on 8/21/24 at 10:48 A.M., the EVS Director said: -He/she noticed the heavy dust buildup in that ceiling vent and he/she would identify other ceiling vents with a heavy dust buildup. 4. Observation on 8/21/24 at 10:30 A.M., showed an old spill on the floor behind the door in resident room A105. During an interview on 8/21/24 at 10:32 A.M., the EVS Director said he/she was unaware of that spill. Further observation showed he/she notified a Housekeeper to go to that room and clean that spill. 5. Observation on 8/21/24 at 12:09 A.M., showed a buildup of dust and powder on the floor in resident room C109. During an interview on 8/26/24 at 9:44 A.M., Housekeeper B said the housekeepers needed to use the swivel tool to get under the beds and get the powder and dust up and off the floor. 6. Observation on 8/21/24 at 10:51 A.M., showed two areas of missing tile pieces from the countertop in the A Hall shower room which caused an area that could potentially cause skin damage. One area was 12 inches (in.) long. The other area was eight in. long. During an interview on 8/21/24 at 10:52 A.M., the EVS director said: -Those areas needed to be repaired. -He/she was not sure how long those pieces of tile were missing. 7. Observation on 8/21/24 at 11:44 A.M., showed the grab bar was not securely affixed to the wall in the restroom of resident room B106. During an interview on 8/21/24 at 11:46 A.M. the EVS director said: -He/she needed to repair that grab bar. -He/she was unaware that grab bar was not secured to the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/26/24 at 9:39 A.M., Housekeeper B said he/she reported the loose grab bar in B106 to the EVS Director less than a month ago. 8. Observation on 8/21/24 at 2:45 P.M., showed the shower chair in the restroom of D105 was broken. During an interview on 8/21/24 at 2:46 P.M., the EVS director said: -The shower chair in D105 needed to be discarded. -He/she found out that day that the shower chair was broken.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to ensure the skin issues that were identified in the initial skin assessment were acted upon timely for one sampled resident (Resident #47); failed to obtain treatment orders timely for one sampled resident (Resident #47); and failed to ensure documentation of the weekly skin assessments were completed for one sampled resident (Resident #47) who was admitted with skin issues and was at risk for developing pressure wounds (areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body) and failed to complete and document weekly skin assessment orders and failed to follow up on a change in condition in skin for one sampled resident (Resident #62) out of 18 sampled residents. The facility census was 84 residents. Review of the facility policy titled Skin Integrity, updated 5/2024, showed: -Staff would ensure a resident who entered the facility without a pressure sore/ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) would not develop one unless unavoidable (hospice, end of life skin failure). -A nurse would perform a full body skin assessment within two to six hours after admission and weekly thereafter (identification on admission of the presence of a pressure ulcer or the presence of a deep tissue injury or skin areas at risk for breakdown). -The nurse will conduct a full body skin assessment for each resident weekly to ensure no risks have developed. -If the resident is determined to be at risk or has developed any skin integrity abnormalities, the nurse will implement action according to the specific skin issue identified per protocol. -The nurse and interdisciplinary team will plan and implement preventive care to avoid complications resulting from a resident's inactivity. 1. Review of Resident #47's face sheet showed the resident was admitted to the facility on [DATE], with diagnoses including obesity, difficulty walking, need for assistance with personal care, kidney disease (damage to or disease of a kidney with gradual loss of kidney function), and lymphedema (swelling that generally occurs in an arm or leg, but can also occur in the chest wall, abdomen, neck and genitals. The condition is caused by a blockage in the lymphatic system). Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 7/22/24 showed the resident: -Was alert and oriented without confusion. -Had incontinence and needed some assistance with toileting. -Had moisture associated skin damage (MASD areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Did not have any pressure ulcers. -Had ointments/treatments and devices to reduce pressure. Review of the resident's initial Nursing Evaluation Note dated 7/17/24 showed: -The resident had skin integrity concerns. -The resident had redness under both breasts, abdominal folds, genital area, lower extremities were red and inflamed, there was an open area (undefined) on his/her coccyx (a small triangular bone at the base of the spinal column) and shearing (shearing wound damages the skin on a deeper level-shearing occurs when tissue layers laterally shift in relation to each other; as when bone and deep tissue layers move in opposite directions) on bilateral (both) gluteal folds (the horizontal skin crease that forms below the buttocks, separating the upper thigh from the buttocks). -There were no physician's orders for treatment to the resident's skin documented. Review of the resident's admission Skin Observation assessment dated [DATE] showed: -The resident's skin color to his/her left and right upper extremities were normal. The resident's skin temperature on his/her upper extremities was warm and dry. -The resident's skin color to his/her left and right lower extremities were normal. The resident's skin temperature was warm and equal on bilateral sides. Lower extremity skin was moist. -The resident had skin integrity concerns. -The resident had redness under both breasts, abdominal fold, genital area, bilateral lower extremities area was red and inflamed, there was an open area (undefined) on his/her coccyx and shearing on bilateral gluteal folds. -There were no physician's orders for treatment to the resident's skin documented. Review of the resident's Medical Record showed there were no physician's orders for treatment to the resident's left and right lower extremities (shearing). Review of the resident's Skilled Nursing Note dated 7/18/24 showed: -The resident was receiving skilled services for physical therapy, occupational therapy, respiratory therapy and wound care. -The resident's existing skin alterations included skin tear, and pressure wound with no concerns noted related to his/her skin alteration evaluation. Review of the resident's Nurse Practitioner (NP) Note dated 7/19/24 showed: -He/She visited the resident and examined him/her for initial consultation. He/She reviewed the resident's transfer notes and physician's orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265759	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort St Marys LLC	111 Mock Avenue Blue Springs, MO 64014

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She discussed the purpose of the consultation and encouraged participation in therapy. -The resident had impairment with his/her mobility, balance, transfers, self-care and safety awareness. -The resident's skin color was appropriate for his/her race, warm, visible skin was intact, discoloration was noted to his/her bilateral lower extremities and had dry skin. -Recommendations addressed the resident's medication, comorbidities (diagnoses), rehabilitation and pain management, but did not address the resident's skin issues or treatment for the skin on both the resident's bilateral lower extremities. Review of the resident's Physician's Note dated 7/21/24 showed the resident was admitted to the facility for skilled rehabilitation services and pain management. It showed: -The resident was admitted to the facility from the hospital after having increased shortness of air and worsening back pain. His/Her pain had limited him/her to the point of immobility and inability to care for himself/herself despite using routine pain medications. -The resident was stabilized and was admitted to the facility for rehabilitation. -The physician reviewed the resident's symptoms and conducted a physical examination. -The physician reported the resident had no skin rash or lesions. There was no documentation showing the resident had any skin issues. Review of the resident's Wound assessment dated [DATE] showed a score of 17 (a score of 17 meant the resident was at risk for developing pressure ulcers). Review of the resident's Physician's Telephone Orders showed: -Wound Care left thigh back: cleanse with normal saline, pat dry, apply skin prep (a moisture barrier cream) to the skin around the wound, apply hydrafera blue (an antibacterial wound dressing) to the wound bed (the tissues at the base of the wound) and cover with a dry dressing every day shift for wound care. The order was dated 7/24/24. -Wound care right thigh back: cleanse with normal saline, pat dry, apply skin prep to the skin around the wound, apply hydrafera blue to the wound bed and cover with a dry dressing every day shift for wound care. The order was dated 7/24/24. -Low air loss mattress to bed for pressure reduction every shift for skin prevention low air loss mattress to bed for pressure reduction was dated 7/25/2024. Review of the resident's Medication Administration Record (MAR) dated July 2024, showed wound care treatment to the resident's bilateral thighs started on 7/24/24. Review of the resident's Skin Observation Assessments showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/26/24, showed the resident's left gluteal fold had shearing to fold, the resident's right gluteal fold had shearing to fold, there was redness to the resident's sacrum (a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis). -There were no additional skin assessments documented fin the resident's electronic medical record for two weeks from 7/26/24 to 8/14/24. Review of the resident's Wound Report dated 7/29/24 showed: -The resident's coccyx was healed. -The area to the resident's left thigh was MASD due to incontinence. The measurement was 1.0 centimeters (cm) length (L) by 1.5 cm width (W) by 0.0 cm depth (D). The documentation showed the area was closed and the tissue had partial thickness and intact skin was 40 percent, epithelial (pale, pink, red skin) skin was 10 percent, non-granulating skin (the wound surface appeared smooth and red as opposed to berry-like) was 50 percent, without exudate (fluid that leaks out of blood vessels into nearby tissues). -The area to the resident's right thigh was MASD due to incontinence. The measurement was 1.5cm (L) by 2. 0 cm (W) by .10 cm (D). The documentation showed the area was closed, and the tissue had partial thickness, intact skin was 40 percent, epithelial tissue was 10 percent, non granulating tissue was 50 percent, without exudate. Review of the resident's Skin Observation Assessments showed: - 8/14/24, showed there was redness to the resident's coccyx, the resident's left gluteal fold showed redness and open area, that resembled shearing, the resident's right gluteal fold showed redness and an open area, that resembled shearing. The nurse notified the resident's family and the wound team of the new area on 8/14/24. Review of the resident's Physician's Order Sheet (POS) dated August 2024, showed physician's orders for: -Wound care right thigh back: cleanse with ns, pat dry, skin prep to the peri wound, apply silver sulfadiazine cream to wound bed, cover with dry dressing every shift for wound care and as needed for missing or soiled dressing. The order was dated 8/7/2024. -Wound care left thigh back: cleanse with ns, pat dry, skin prep peri wound, apply silver sulfadiazine cream to wound bed, cover with dry dressing every shift for wound care and as needed for missing or soiled dressing. The order was dated 8/7/2024. -Low air loss mattress to bed for pressure reduction every shift for skin prevention low air loss mattress to bed for pressure reduction was dated 7/25/2024. Review of the resident's comprehensive undated care plan showed the resident was at risk for alteration in skin integrity and had MASD to his/her bilateral posterior thighs. Interventions showed staff would: (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Apply barrier cream per facility protocol to help protect skin from excess moisture. -Encourage/assist with turning and repositioning every 2-3 hours. -Provide skin/wound treatments as ordered. -Encourage the resident to avoid scratching and keep hands and body parts from excessive moisture and keep his/her fingernails short. -Educate resident/family/caregivers of causative factors and measures to prevent skin injury. -Encourage good nutrition and hydration in order to promote healthier skin. -Evaluate and treat per physician's orders. -Evaluate resident for signs and symptoms of possible infections. -Keep the resident's skin clean and dry. Use lotion on dry skin. -Obtain blood work, labs and laboratory cultures of any open wounds as ordered by the physician. -Complete weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, by the wound nurse or provider. -Documentation showed the resident declined treatments to wounds at times. Observation and interview on 8/20/24 at 9:13 A.M., showed the resident was sitting in his/her recliner, fully dressed for the weather with glasses on watching television (tv). He/She was alert and oriented and said: -He/She was in the facility for rehabilitation and treatment of pain and had been in the facility about three weeks. -He/She stayed in his/her room for most of the day by choice. -Nursing staff needed to assist him/her with all of his/her cares and he/she did have some incontinence. -He/She was admitted to the facility with wounds to his/her bottom and legs, but the nurses treated them daily and the wound care team also came in to assess and treat them. -They recently changed the medications they were using to treat the wounds and since then they had been healing well and he/she was pleased with that. During an interview on 8/20/24 at 4:00 P.M., the Administrator said: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The former NP completed their wound assessments, treatments and monitoring of all wounds. After he/she left the facility, the NP that was working with him/her at the time wanted to continue providing this service in house. -The current NP was taking classes for wound certification but had not completed the classes yet. -They began to notice that the wounds were not being followed as they should have been and the documentation was not being completed as it should and so they decided to hire a wound care consultant which would start on September 1, 2024 (the contract with the wound consultant was signed July 2024). During an interview on 8/22/24 at 1:50 P.M., Certified Nursing Assistant (CNA) C said: -When they completed any cares they looked at the resident's skin to see if there were any issues, red areas and any bruises. -They also gave resident baths and document any skin issues they saw on the resident's bath sheets that they provided to the charge nurse. -If they saw any skin issues, they notified the charge nurse and the nurse would assess the resident's skin. -He/She was familiar with the resident and noticed the areas on the back of his/her upper thighs. -The resident's thighs looked like really irritated, macerated skin. -He/She had not seen an open area or torn skin on the resident's thighs or bottom, but the nurse completed treatments on the areas daily. During an interview on 8/23/24 at 11:36 A.M., with Assistant Director of Nursing (ADON) A and ADON B, ADON A said: -Skin assessments populate weekly. -The floor nurse was responsible for completing the skin assessments. They documented what they saw and if they saw a skin issue, they were responsible for contacting him/her or the Nurse Practitioner. -Any nurse could assess the resident's skin, they don't typically document measurements, any skin issue that could heal within two weeks he/she did not necessarily track, but he/she would assess it and implement preventive measures. -All skin assessments should be documented on the skin assessment document in the electronic record. -He/She would expect the charge nurse, once notified that there was a skin issue, to notify him/her or the NP of the skin issue and they completed a full assessment of the wound and would obtain the order for treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The charge nurse documented the initial assessment of skin upon admission. If there were orders from the hospital, they should document those and they should document what the skin looked like. Treatment for the resident's skin/wound should begin immediately. -If there was already an identified area then there should be preventative measures, treatment in place and he/she would expect the nurses to implement the treatments upon seeing them. -The nurses should document skin assessment weekly and follow up on the skin areas weekly. If the resident refused to allow them to assess there should be documentation showing that. -Wound assessments were completed weekly on Wednesdays. If the bath aide noticed anything abnormal, they should notify the charge nurse -He/She completed the wound risk assessments upon admission, and they automatically populate during the wound rounds weekly. -For non pressure wounds he/she could put a treatment order in place but the nurses were responsible for providing the treatments and monitoring. He/She would also ask the Nurse Practitioner if they wanted him/her to track the wound and would follow whatever they advised him/her to do. -He/She was tracking and monitoring the resident's wound weekly and completed rounds with the NP. During an interview on 8/23/24 at 1:31 P.M., the Director of Nursing (DON) said: -Upon admission the charge nurse was expected to complete a full skin assessment on the resident. -The nurse's documentation should be a detailed description of the skin/wound to include shearing. -If the resident had skin issues/wounds, the nurse should make an initial description of the wound/skin and would start an initial treatment or would get an order from the physician for treatment orders and implement them immediately or within the first 48 hours. -The charge nurse should then notify the Wound Nurse and he/she would start the resident on wound rounds and would complete a skin assessment on the resident. -If the Wound Nurse assessed the skin and determined it was not something he/she needed to follow, the nursing staff would continue the treatments and monitoring. -If the Wound Nurse assessed the skin and determined that the treatment orders were not adequate, he/she would change the treatment with the notification of the NP. -If the Wound Nurse assessed the skin and determined he/she would start wound rounds, he/she would also start treatment orders on the wound with notification of the NP. -Wound rounds were weekly and should be completed and documented every seven days. The NP staged the wounds during wound rounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin assessments were completed weekly by the nurses and they should be documented in the evaluations section of the resident's medical record. -He/She expected the skin assessment to be completed and documented at the time the form was opened in the electronic record system. -Staff should report any observed skin areas to the nurse. If there were missing skin assessments, wound assessments or other wound documentation then it was not completed. During an interview on 8/21/24 at 10:31 A.M., NP A said: -When he/she came in to complete dedicated rounds they completed a full assessment for all wounds. -The facility nursing staff were supposed to complete the initial skin assessment (upon admission) and then skin assessments weekly thereafter. -If the nurses saw a skin issue, they would notify the Wound Nurse and he/she would put the resident on the list to be seen if he/she felt it was necessary. -He/She would then come and complete a full wound assessment on the resident, measure and identify the wound and order treatment for the wound. -He/She would see the resident weekly and monitor the resident's wound (he/she has wound round documentation that was provided to the facility every week). -He/She would expect the nurse or wound nurse to notify him/her immediately if a resident came in with wounds or skin issues to include MASD. -Treatment for wounds should be implemented immediately or as soon as the order was obtained. -Resident #47 had an open area prior to admission that was more of a friction wound from wiping. It looked like scraping from excessive wiping. -The resident's primary care physician was monitoring the resident's skin prior to him/her admitting to the facility, but he/she was now reviewing and assessing it weekly. -He/She was referred for wound assessment and he/she observed and documented the assessment of the resident's wounds on his/her initial rounds (on 7/24/24) and he/she had seen and updated the resident's progress weekly during weekly wound rounds. -The resident's wounds may have been staged as a Stage I injury (observable, pressure-related alteration of intact skin with non-blanchable redness of a localized area usually over a bony prominence), but there was no blister just blood from friction. -He/She determined the resident had MASD (documented on the wound report). -The resident should have had a treatment order for his/her wound upon admission and if not, the nurse should have obtained it upon admission and began implementing treatments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-They were currently putting silver silvadene (a topical antibiotic used in partial thickness and full thickness burns to prevent infection) on the areas. -Now the injury was just friction from incontinence and excessive wiping. 51150 2. Review of Resident #62's POS dated 11/27/23 showed the following physician's orders: -Skin checks weekly. Every day shift, every Friday. Must open and document skin evaluations for each assessment (including no new areas found). Review of the resident's Care Plan dated 11/28/23 showed: -The resident was at risk for alteration in skin integrity. -The resident would remain free of new skin impairment through the review date of 8/2/24. -The resident would receive skin/wound treatments as ordered. Review of the resident's quarterly MDS dated [DATE] showed: -The resident was at risk for developing pressure ulcers. -The resident did not have any other ulcers, wounds, or skin problems. Review of the resident's POS dated 7/24/24 showed the following physician's orders: -Skin checks weekly. Every day shift, every Wednesday. Must open and document skin evaluations for each assessment (including no new areas found). Review of the resident's Treatment Administration Record (TAR) dated July 2024 showed the resident's weekly skin check to be completed on 7/5/24 had no nursing initial or check mark. Review of the resident's communication log with hospice (end of life care) dated 8/14/24 showed the resident was getting an open wound on his/her left buttock cheek. Review of the resident's bath sheet dated 8/14/24 showed the resident had an abnormal color on an area on his/her bottom. Review of the resident's skin observation documentation dated 8/14/24 showed: -The resident had skin issues observed. -There was a small open area, no bleeding, on the left gluteal fold. Review of the resident's bath sheet dated 8/17/24 showed: (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had an excoriated area. -A staff member wrote, butt red. -No explanation of excoriated area on body diagram. -No explanation of butt red on body diagram. -No staff signature. Review of the resident's Electronic Medical Record (EMR) on 8/20/24 showed: -No skin observations were documented from 3/27/24 to 5/9/24. -No skin observations were documented from 5/10/24 to 6/6/24. Observation on 8/20/24 at 11:43 A.M. of the resident's perineal care showed: -An open wound was noted on the residents left buttock. -During cares, the open wound was not treated. Review of the facility wound report dated 8/21/24 showed: -The resident had a pressure wound on his/her right outer ankle. -The resident had no other skin wounds listed. Observation on 8/21/24 at 10:06 A.M. of wound rounds showed: -NP A and ADON A assessed the residents ankle wound. -NP A and ADON A both said that the ankle wound was the only wound that the resident had. During an interview on 8/21/24 at 10:31 A.M. NP A said: -Skin assessments should be completed and documented weekly by the nurses. -Once a wound was found during weekly assessments, the resident was added to the NP's weekly wound round schedule. -He/She was unaware of a wound on residents buttocks. -He/She would expect to be notified by nursing staff if an area of concern was found on a residents skin. Observation and interview on 8/21/24 at 12:24 P.M. of perineal care showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-ADON A said that he/she did not see any wounds on the buttocks before barrier cream was applied. -ADON A wiped some of the barrier cream off the buttocks and looked again. -ADON A then said that he/she saw an open wound after assessing the area a second time. Review of the resident's wound assessment details report dated 8/22/24 at 7:15 A.M. showed: -MASD wound on resident buttocks. -The wound was facility acquired. -The wound was 0.30 cm (L) x 0.40 cm (W) x 0.10 cm (D). During an interview on 8/23/24 at 8:59 A.M. LPN B said: -Charge nurses were responsible for weekly skin assessment and documentation of those assessments. -He/She was not aware that the resident had a wound on his/her buttocks. During an interview on 8/23/24 at 12:47 P.M. ADON A said: -Floor nurses were responsible for weekly skin assessment and documentation of assessments. -Floor nurses reported to the facility wound nurse when a wound was noted in an assessment. -He/She was the current facility wound nurse. -He/She was not aware of the resident having a wound on the buttocks. During an interview on 8/23/24 at 1:09 P.M. the DON said: -Floor nurses should be completing and documenting skin assessments weekly. -Weekly skin assessments should reflect all skin conditions. -He/She would expect nursing staff to read and follow up on all hospice notes.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579 Based on observation, interview, and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent the development of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) which resulted in the development of a pressure ulcer; failed to implement ordered interventions to promote healing of developed ulcers for one sampled resident (Resident #74) which resulted in the worsening of the pressure ulcer; and failed to accurately assess resident's skin for the monitoring of pressure ulcer development and progression for three sampled residents, (Residents #74, #1 and #62) out of 18 sampled residents. The facility census was 84 residents. Review of the facility policy titled Skin Integrity, dated 11/2019, showed: -Staff would ensure a resident who entered the facility without a pressure sore [pressure ulcer] would not develop one unless unavoidable (hospice, end of life skin failure). -A nurse would perform a full body skin assessment within two to six hours after admission and weekly thereafter. -Preventative measures would be put into place for residents at risk of developing a pressure ulcer. -A resident who had or developed a pressure ulcer would receive treatment to promote healing and prevent further development. -Staff would ensure pressure relieving devices were placed on the resident's bed. 1. Review of Resident #74's after visit summary (discharge orders) from the resident's hospital stay, dated 7/19/24, showed instruction to facility staff to monitor an ulcer to his/her left heel and change the wound dressing daily as needed. Review of the resident's Care Plan, dated 7/20/24, showed: -He/She was at risk for alteration in skin integrity. -An addendum on 8/1/24 showed he/she had an actual impairment to skin integrity related to a suspected deep tissue injury to the left heel with a goal of showing signs of healing. Review of the resident's Admission Minimum Data Set (MDS-a federally mandated comprehensive assessment completed by facility staff for care planning), dated 7/26/24, showed: -Diagnoses of high blood pressure, renal failure (inability of the kidneys to adequately filter blood), chronic lung disease and pneumonia (an infection in the lungs) and malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident had a Stage I pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) but lacked indication of the location. -The resident was cognitively intact. -The resident did not reject cares within the seven-day look-back period (a period in which staff observe a resident to document MDS data). -The resident needed substantial assistance with lower body dressing including putting on and taking off footwear. Review of the resident's pressure ulcer Care Area Assessment (CAA, a focused worksheet in the MDS assessment), dated 7/26/24, showed: -The resident admitted with a Stage I pressure ulcer to the coccyx (area just above the buttock). -The resident had a pressure relieving mattress on his/her bed. -The resident was a high risk for pressure ulcer development. -No other documented pressure ulcers. Review of the resident's Physician Order Summary, dated 8/19/24, showed orders for: -Weekly skin assessments dated 7/19/24. -A low air loss mattress (a pressure relieving air mattress that reduces the risk of pressure injury development) dated 7/22/24. -Prevalon boots (a pressure reducing boot) when in bed every shift for skin injury prevention dated 7/22/24. -Encouragement of turning and repositioning, beginning 8/8/24. -Wound care to the left heel, cleansing with normal saline, pat dry, apply skin prep and cover with a dry dressing, beginning 8/14/24. --A discontinued order for cleansing bilateral heels with normal saline, pat dry, apply skin prep and leave open to air twice daily, valid from 7/22/24 to 8/14/24. Review of the resident's Treatment Administration Record (TAR) dated July 2024 showed: -Administration of an order for cleansing bilateral heels with normal saline, pat dry, apply skin prep and leave open to air twice daily with missing documentation on 7/23/24's day shift. -Administration of a low air loss mattress with no documentation of resident refusal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265759	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort St Marys LLC	111 Mock Avenue Blue Springs, MO 64014

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Administration of Prevalon boots with missing documentation on 7/23/24 and no documentation of resident refusal. Review of the resident's TAR dated August 2024 showed: -Administration of an order for cleansing bilateral heels with normal saline, pat dry, apply skin prep and leave open to air twice daily with missing documentation on 8/7/24 and 8/8/24 day shift. -Encouragement of turning and repositioning, beginning 8/8/24, with missing documentation on day shift 8/18/24. -Administration of a low air loss mattress with no documentation of resident refusal. -Administration of Prevalon boots with missing documentation on day shifts for 8/8/24 and 8/18/24, and no documentation of resident refusal. -Administration of wound care to the left heel, cleansing with normal saline, pat dry, apply skin prep and cover with a dry dressing, beginning 8/14/24, with missing documentation on day shift 8/18/24, night shift 8/21/24 and omission of the administration on night shift of 8/17/24 due to resident sleeping. Review of the resident's weekly skin assessments showed: -An admission skin assessment on 7/19/24 showed non-blanchable redness to the coccyx and genital area as well as blanchable redness to the left heel. -A skin assessment on 7/27/24 showed swelling to both legs but no other skin issues. -A skin assessment on 8/4/24 showed swelling and no other skin issues. -A skin assessment on 8/10/24 showed a blister with drainage on the left heel. --No further nursing skin assessments were documented as of 8/19/24. Review of the resident's wound rounds documentation (documentation from weekly Nurse Practitioner (NP) wound rounds with the facility wound nurse) showed: -The first visit on 8/1/24 showed a wound to the left heel measuring 3.2 centimeters (cm) long, 5.1cm wide, and an unknown depth. The wound was 80% deep maroon and 20% blanchable redness and marked present on admission. A low air loss mattress was part of the treatment plan. No staging was provided by the NP during this visit and no progress note was provided by the facility on this date. All documentation was performed by the facility wound nurse. -No provider notes or assessments provided by the facility documented an assessment of the wound to the resident's left heel until 8/14/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-On 8/14/24 a visit showed the pressure ulcer to the left heel measuring 3.2cm long, 4.2cm wide and an unknown depth. The wound was 100% hard necrotic tissue and marked present on admission. Review of an attached progress note by NP A showed the wound was an unstageable pressure ulcer (a wound that is covered in necrotic tissue that prevents the assessment of the wound depth, but if the tissue was removed would reveal a Stage III pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) or IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) Observation on 8/19/24 at 9:34 A.M., showed the resident was lying in bed without a low air loss mattress in place and with no Prevalon boots. Observation on 8/21/24 at 9:52 A.M., of wound rounds with NP A and Assistant Director of Nursing (ADON) A showed: -NP A and ADON A assessed the resident's wound. At this time, the wound measured 4.3cm long (an increase of 0.9cm), 6.5cm wide (an increase of 2.3cm) and an unknown depth. The wound was 85% hard necrotic tissue, but now had a surrounding border of broken-down skin appearing red (10%) and with 5% slough (a yellow material made up of dead cells). The resident did not have a low air loss mattress at this time. During an interview on 8/21/24 at 9:53 A.M., NP A said the resident's wound was worsening. During an interview on 8/21/24 at 10:30 A.M., NP A said: -Wound rounds were a focused assessment, not all skin was evaluated. -He/She and other NPs make progress notes each time they see a resident for wounds. -Skin assessments should have been completed at least once per week. -All wound assessments should have measurements and a full description of the wound. -He/She believed Resident #74's wound was present on admission. -He/She would expect documentation of the wound with a full assessment as soon as the wound was noted. -He/She would expect orders for prevention and treatment to be implemented immediately after the identification of a skin integrity impairment. -He/She would expect all physician orders to be carried out by staff including the implementation of a low air loss mattress. During an interview on 8/22/24 at 8:22 A.M., the Director of Nursing (DON) said Resident #74: -Did not have a low air loss mattress in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Should have had one on the bed. During an interview on 8/23/24 at 8:54 A.M., Certified Nursing Aide (CNA) F said: -He/She was aware the resident had a pressure ulcer. -Nurses did wound treatments to the resident's foot daily. -CNA's and other staff tried to ensure the resident's heels were elevated off the bed. -He/She was unaware of a low air loss mattress for the resident. During an interview on 8/23/24 at 11:38 A.M., ADON A said: -He/She was responsible for the wound care in the facility. -Skin assessments populated weekly, and the floor nurses were responsible for doing them. -Weekly skin assessments should have listed every skin condition the resident had along with a full assessment including wound measurements. -Stage I pressure ulcers and other identified redness were not monitored by the facility because they could heal within a few weeks and would take too long to document on. -He/She was not wound care certified. -If a wound was identified by nursing staff, orders for prevention and treatment would have been put in up to 72 hours after identification when he/she had a chance to evaluate the wound. -No skin or pressure ulcer treatments should lack documentation. -A lack of documentation on an order in the medical record indicated the treatment was not done. -There should have been a low air loss mattress in place for Resident #74, and any refusals of interventions should have been documented. -Since redness was documented on Resident #74 on admission, the unstageable pressure ulcer to the left heel would be either recurring or worsening, not a facility acquired ulcer. 33409 2. Review of Resident #1's face sheet showed the resident admitted with the following diagnoses: -Quadriplegia (paralysis of all four extremities and usually the trunk). -Osteomyelitis (an infection in a bone) of right upper arm. -Pressure injury/ulcer right elbow. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Hospital Discharge Summary dated 8/1/24 at 4:24 P.M., showed: -The resident had documentation that he/she had wounds noted on 6/14/24 while in the community and was admitted to the hospital with worsening wounds on 7/18/24. -The resident was discharged from the hospital on 8/1/24 and admitted to the facility with pressure wounds. -Wound #1, was unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) on the left buttocks. The wound measurements at that time were length (L) of 3.5 cm by width (W) of 2.0 cm by depth (D) of 0.5 cm. The wound bed was moist, yellow, slough and pale pink in color. -Wound #2 was a Stage IV pressure injury (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) on the left hip. The wound bed was moist with yellow slough and was the shape of an oval. The wound measurements were L of 1.5 cm by W of 2 cm by D of 0.8 cm. -Wound #3, was a Stage IV pressure injury on the right buttocks, The wound bed was moist, with yellow slough, and pale pink in color. The wound measurements were L of 4.0 cm by W of 2.5 cm by D of 2 cm. -Wound #4 on the right elbow presented as a pressure injury. The resident had surgery on the elbow area which made it a new surgical wound. Review of the resident's nursing evaluation for admitted d 8/2/24 at 12:29 A.M. showed: -The resident admitted to the facility on [DATE] at 4:30 P.M. -Staff should document the impairment site and the initial wound measurements. -Documentation of a large wound to right buttocks, left buttocks, and left hip, a surgical wound to the right elbow wound where he/she underwent debridement (the removal of dead tissue) and was closed with sutures. -There were no initial wound measurements transcribed to the initial skin assessment form or in the comments note. Review of the resident's Physician Order Sheet (POS) dated 8/2/24 at 3:12 P.M. showed: -Wound care to the resident's right and left buttocks and left hip: cleanse with normal saline, pat dry, apply Dakin's solution (used to kill germs and prevent germ growth in wounds) soaked gauze, cover with an Abdominal (ABD, is a gauze dressing that absorbs fluid from large or heavily draining wounds) dressing pad and secure with tape, every shift for wound care and as needed for missing or soiled dressing. Review of the resident's wound care plan initiated on 8/2/24 showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident was at risk for alteration in skin integrity. --Provide skin/wound treatments as ordered. Review of the resident's TAR dated 8/1/24 to 8/23/24 showed: -Order dated 8/2/24 at 3:12 P.M., for wound care treatment to the resident's right buttocks, left buttocks and left hip: nursing staff were to cleanse wounds with normal saline, pat dry, apply Dakin's-soaked gauze, cover with ABD and secure with tape, every shift for wound care and as needed for missing or soiled dressing. --No documentation of wound care treatment completed on admission and 8/2/24. Review of the resident's medical record dated 8/1/24 to 8/7/24 showed there was no documentation of a comprehensive wound assessment that included wound measurements and detailed descriptions of the wounds upon admission to the facility. Review of the resident's wound care plan initiated on 8/7/24 showed the resident had an actual impairment to skin integrity related to pressure injury to the left buttock, left hip, right buttock, and right elbow. Review of the resident's POS dated 8/8/24 showed the resident was to have weekly skin checks on Thursday during the day shift. Must open and document the skin evaluation for each resident assessment (including no new areas found). Review of the resident's TAR dated 8/8/24 showed the resident's weekly skin observation/assessment to be completed on 8/8/24 had no nursing initial or check mark documented to indicate the assessment was completed. Review of the resident's weekly skin observation/assessment dated [DATE] showed: -Nursing documented the resident had pressure wounds to bilateral buttocks, left hip, and a surgical wound on his/her right elbow. -Did not have a comprehensive wound assessment of the resident's wound to include wound measurements and detail description of the wounds. Review of the resident's NP wound encounter note dated 8/14/24 at 3:37 P.M., showed: -The resident had a diagnosis that included infection, irrigation debridement of right upper extremity. -Was seen for wound rounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	--The resident who was recently admitted to Hospital on 7/16/24 for worsening wound infections from community. He/she did have a medical history of quadriplegia secondary to driving accident many years ago and was wheelchair-bound with muscle spasms. He/she also presented with complaints of chills and not feeling well and drainage from his/her right elbow. Patient was found to have a wound of his/her right elbow as well as three separate wounds on his/her buttocks and coccyx. His/her elbow wound did require surgical debridement by an orthopedist while at the hospital. Patient was initially started on antibiotic for elbow wound. No surgical interventions were necessitated on resident's buttock and coccyx wounds. Patient was ultimately started on Intravenous (IV) antibiotic daily and would continue this through 9/7/24. The resident was ultimately stabilized and deemed appropriate for discharge to a skilled nursing care facility on 8/1/24. -The resident had three pressure injuries on his/her left and right buttocks and coccyx region. Furthermore, he/she had a new surgical wound to his/her right elbow. The pressure injury of his/her left and right buttocks and coccyx regions were deep with undermining (the destruction of tissue or ulceration extending under the skin edges so that the pressure is larger at its base than at the skin surface. Undermining often develops from shearing forces and is differentiated from tunneling by the larger extent of the wound edge involved in undermining and the absence of a channel or tract extending from the pressure ulcer under the adjacent intact skin). They did not have heavy exudate however the current treatment included Dakin's solution they are considered to be wet. There was slough within the wound beds however there did not appear to be a concern for infection at that time. The resident did not endorse significant pain to any of the sites. -The resident's skin included three pressure injury/wounds to his/her left and right buttocks and coccyx regions, with a new surgical wound to the right elbow. -Wound #1 Stage IV pressure injury on his/her left buttock, measured Length of 5.30 cm by Width of 4.00 cm By Depth of 0.50 cm. --Base: Epithelial (Pale Pink or Red) at 70% and Slough Loosely Adherent at 30%. Had clear serous drainage. -Wound #2 Stage IV pressure injury on left hip measured L of 2.50 cm by W of 4.00 cm and D of 0.90 cm. --Had Undermining at 9 o'clock to 1 o'clock with a depth of 3.90 cm. --Base epithelial (pale pink or red) at 20%, Bright Pink or Red at 30% and Slough Loosely Adherent at 50%. Had clear serous drainage. -Wound #3 right buttock stage IV pressure injury. Measurement of L of 3.00 cm by W of 2.60 cm and D of 2. 10 cm. Had undermining at 9 o'clock to 1 o'clock and d of 6.60 cm. --Base of wound had epithelial at 10%, bright pink or red at 5% and slough loosely adherent at 85%. Had clear serous drainage. -Cleanse the wounds with normal saline and primary dressing: Cleanse with normal saline, pat dry, skin prep peri wound, pack with Dakin's soaked gauze, cover with ABD and secure with tape. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound #4 now a surgical wound on right elbow. --Closed well-approximated at 100%. --Measurement of size L at 7.00 cm by W of 0.20 cm and D of 0.00 cm --Intact Skin: 100% --Cleanse with normal saline, pat dry, apply Xeroform (sterile, non-adherent gauze dressing that's used to cover and protect wounds, abrasions, and burns), cover with ABD Kerlix, and secure with Ace wrap. -Plan: Surgical wound right elbow: Cleanse with normal saline, pat dry, apply xeroform, cover with ABD Kerlix, and secure with Ace. Three pressure ulcers of left and right buttocks and coccyx region: Cleanse with normal saline, pat dry, skin prep peri wound, pack with Dakin's soaked gauze, cover with ABD and secure with tape. Continue Intravenous (IV) Daptomycin (antibiotic) 500 milligram (mg) per IV daily. Review of the resident's wound round documentation written by the wound nurse dated 8/21/2024 at 7:32 A. M., showed: -Wound #1 Stage IV pressure injury on left buttock, measured Length of 5.30 cm by Width of 4.00 cm By Depth of 0.50 cm --Base: Epithelial (Pale Pink or Red) at 70% and Slough Loosely Adherent at 30%. Had clear serous drainage. -Wound #2 Stage IV pressure injury on left hip measured Length of 2.50 cm by Width of 4.00 cm and Depth of 0.90 cm --Had Undermining at 9 o'clock to 1 o'clock /with depth of 3.90 cm --Base Epithelial (Pale Pink or Red) at 20%, Bright Pink or Red at 30% and Slough Loosely Adherent at 50%. Had clear serous drainage. -Wound #3 stage IV pressure injury on right buttock, Measure Length of 3.00 cm by Width of 2.60 cm and Depth of 2.10 cm. Had undermining at 9 o'clock to 1 o'clock and depth of 6.60 cm --Base of wound had Epithelial (Pale Pink or Red) at 10%, Bright Pink or Red at 5% and Slough Loosely Adherent at 85%. Had clear serous drainage. -NOTE: the documentation had the same measurements and descriptions the resident's NP wound note dated 8/14/24. During an interview on 8/21/24 at 11:47 A.M., the resident said: -He/she did not have wound care treatment completed on the morning of 8/21/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-He/she was informed the wound nurses would complete treatment after lunch time that day. -He/she thought nursing reported his/her wounds were improving. -Nursing staff were completing wound care twice a day or as needed. Observation on 8/21/24 at 1:45 P.M., of the resident's wound care showed: -Wound nurse and NP provided assessment and care of the resident wounds. -Had barrier for supplies, staff washed hands and applied gown and gloves for wound care. -NP removed old dressing dated 8/20/24 and measured each wound area. -The resident's right buttock wound was size of a golf ball and measured L 2.5 cm by W of 3.7 cm by D of 1.3 cm. Had undermining from 11 o'clock to 1 o'clock with tunneling of 4.4 cm at deepest area. -The left hip wound was about golf ball size, and measured L of 2.5 by W of 3.7 by D of 0.8, had undermining from 9 o'clock to 12 o'clock with tunneling of 2.2 cm at the deepest area. -The left buttock wound was about [NAME] size, and measured L of 5.3 by W of 4.0 by D of 0.6, had undermining from 12 o'clock to 3 o'clock, with tunneling of 0.9 at deepest area. The wound had white outer edges, inner edges pink, cream color inner wound and was healing muscle base. -NP said all wounds appeared to be improving and had no excessive drainage noted. -The resident's right elbow was a healed surgical wound. Preventive treatment with padding noted. -Wound Nurse took pictures of each of the wounds and recorded measurements to be uploaded into the resident's electronic record under wound rounds. -Wound nurse cleansed each wound with normal saline, pat dry, then applied Dakin's soaked gauze pad in wounds, covered with ABD and secured with dressing. Review of resident's wound documentation showed: - On 8/22/24 at 9:04 A.M., the facility provided wound care documentation and pictures of the resident's wounds dated 8/7/24, 8/14/24 and 8/21/24 that were not accessible to surveyor. -The resident did not have documentation upon admission of a comprehensive initial wound assessment that included measurements and descriptions of all the wounds by facility nursing staff or wound nurse. During an interview on 8/21/24 at 10:31 A.M., NP A said: -The facility had a dedicated wound round documentation section. The NP and physician were able to review wound rounds for monitoring active wounds or reoccurring wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-He/she would do wound rounds only for open active wounds. -The facility had just completed a facility wide wound and skin assessment for all residents at the facility. -The NP and physician wound round templates flowed into the NP/physician progress notes. -Wound rounds included measurements of the wound by the NP and the wound nurse transcribed the wound measurements and descriptions of the wounds in the wound rounds report. -Weekly skin assessments were to be completed by nursing staff for those residents who were at high risk for skin issues. -The charge nurse would be responsible for completing the resident's weekly skin observations and documenting them in the electronic record. -He/she had not seen Resident #1 related to his/her wounds. His/her partner had seen the resident on 8/14/24. -He/she would expect to have detailed descriptions and measurements by nursing staffing for new wounds or wounds upon admission. -The wound nurse would be responsible for completing the resident's initial wound evaluation/assessment. -The resident would only be seen by the wound NP when there was a referral due to a new or worsening wound, and they had open active wounds. -The facility wound nurse did the initial nursing staging of the wound then it was verified by the NP. -The wound NP or physician would be responsible for final staging of all wounds at the facility. During an interview on 8/22/24 at 9:22 A.M., the wound nurse said: -Admission skin evaluations should be documented in the section under general skin areas for all residents. -He/she would not expect the admitting nurse to have a detailed comprehensive description of each wound and would not expect the admission nurse to measure the wounds upon admission. -He/she would expect to have a general review of the placement of the wounds. -the admitting nurse would be expected to notify the wound nurse and physician when a resident was admitted to the facility with something big or with severe wounds. He/she would review the resident's hospital orders, observe the skin and obtain a physician's order for wound care and treatments at that time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort St Marys LLC	111 Mock Avenue Blue Springs, MO 64014

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident's weekly wound rounds and treatments were to be completed by the facility wound nurse. -The wound nurse would document in the wound rounds tab. -Licensed nursing staff would document any wound/skin changes and should notify the wound nurse and physician of any changes. -His/her wound documentation would include complete wound care with a general description of the wound. During an interview on 8/22/24 at 1:56 P.M., CNA C said: -He/she would notify the charge nurse of any resident skin changes. -CNA's were responsible for charting under the tasks area and should make note of any skin issues. -The bath sheets were to be completed by the CNA's and should include documentation of any new skin issues or changes in the residents skin. 51150 3. Review of Resident #62's POS dated 11/27/23 showed the following physician's orders: -Skin checks weekly. Every day shift, every Friday. Must open and document skin evaluations for each assessment (including no new areas found). Review of the resident's care plan dated 11/28/23 showed: -The resident was at risk for alteration in skin integrity. -The resident would remain free of new skin impairment through the review date of 8/2/2024. -The resident would receive skin/wound treatments as ordered. Review of the resident's quarterly MDS dated [DATE] showed: -The resident was at risk for developing pressure ulcers. -The resident did not have one or more unhealed pressure ulcer(s) at stage I or higher. -The resident did not have any other ulcers, wounds, or skin problems. Review of the resident's POS dated 6/11/24 showed the following physician's orders: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound Care: Right Ankle: Cleanse with normal saline (NS), pat dry, Skin Prep (A topical barrier between skin and adhesives) to the peri wound, apply Silver Alginate (Silver Alginate contains silver ions. It is typically used on infected wounds or wounds that are at a high risk of infection. Silver has antimicrobial properties that can help to prevent and treat wound infections) to the wound bed, cover with dry dressing. Every day shift for wound care. Review of the resident's TAR dated June 2024 showed the resident's daily wound care to be completed on 6/27/24 had no nursing initial or check mark. Review of the resident's care plan revision dated 7/8/24 showed: -The resident had actual impairment to skin integrity related to a Stage III pressure ulcer on the right ankle. -The resident's pressure ulcer will show signs of healing and remain free from infection through review date. -Facility protocols would be followed for treatment of injury. Review of the resident's POS dated 7/9/24 showed the following physician's orders: -Wound Care: Right Outer Ankle: Cleanse with wound cleanser, pat dry, Skin Prep to the peri wound, apply Hydrafera Blue (Hydrofera Blue's capillary action continuously pulls harmful bacteria- laden slough, exudate, and debris away from the wound bed) to the wound bed, cover with dry dressing. Every day shift for wound care. Review of the resident's POS dated 7/17/24 showed the following physician's orders: -Wound Care: Right Outer Ankle: Cleanse with wound cleanser or NS, pat dry, Skin Prep to the peri wound, apply Hydrogel (Hydrophilic starch polymers (predominately composed of water). These are available in sheets, amorphous gels, or gauze) to the wound bed, cover with dry dressing. Every day shift for wound care. Review of the resident's POS dated 7/24/24 showed physician's orders for skin checks weekly. Every day shift, every Wednesday. Must open and document skin evaluations for each assessment (including no new areas found). Review of the resident's significant change MDS dated [DATE] showed: -The resident was at risk for developing pressure ulcers. -The resident did have one or more unhealed pressure ulcer(s) at stage 1 or greater. -The resident did have one Stage III pressure ulcer. -The resident did have pressure ulcer care. Review of the resident's TAR dated July 2024 showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident's daily wound care

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409 Based on observation, interview and record review, the facility failed to ensure indwelling Foley catheter (a urinary bladder catheter inserted through urethra, is a external opening of the urinary tract, into the bladder to drain urine) care was preformed to include cleaning of insertion site and surrounding skin area for one sampled resident (Resident #1) who was at risk for Urinary Tack Infections (UTI - an infection of one or more structures in the urinary system), and failed to transcribe and implement hospital discharge orders to attempt a voiding trial to remove the urinary catheter in one week (7/26/24) for one sampled resident (Resident #74) out of 18 sampled residents. The facility census was 84 residents. Review of the facility's Foley Catheter Care Policy revised on 4/2024 showed: -Foley Catheter care will be provided to all resident with indwelling catheter as least every shift and more often as needed. -The purpose of catheter care was to prevent possible urinary tract infections from bacteria spreading from perineal area (Peri-care, to the area between the anus and the exterior genitalia) and external catheter into the bladder. -Physician order for catechization should include the reason /indication for catheterization. -Begin catheter cleaning starting at the urethra meatus and wiping away from the body. -Drainage bag is to be emptied at the end of each shift (or more often as needed) by emptying into a labeled, measured graduate with the total documented in the clinical record. 1. Review Resident #1's Admission Face sheet showed the resident admitted with following diagnosis include: -Quadriplegia (paralysis of all four extremities and usually the trunk) -Neurogenic bladder (a disorder of urinary bladder control due to damage to the spinal cord or to the nerves supplying the bladder). -Pressure injury/ulcer (is localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) on the right and left buttocks. Review of the resident's Physician Order Sheet (POS) dated 8/2/24 showed: -Foley Catheter care was to include anchoring tubing and checking skin integrity every shift and as needed every shift. -Record urine output for every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Change Foley Drainage Bag as needed. Review of the resident's Care Plan dated 8/2/24 showed: -The resident had a Foley catheter. -Check placement of catheter tubing every shift. -No intervention related to the process of the care of a Foley catheter. Review of the resident's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment conducted by facility staff) dated 8/3/24, showed: -Diagnoses of Neurogenic Bladder, Pressure injuries. -The resident was cognitively intact. -The resident had an indwelling urinary catheter. -The resident required total assistance from staff for toileting. Observation on 8/20/24 at 10:21 A.M., of the resident's catheter care showed: -Certified Nursing Assistant (CNA) D and CNA E provided care for the resident. -The resident was on enhanced barrier precaution due to a risk for infection related to catheter and wounds. -The resident had an indwelling Foley catheter with drainage bag. -CNA D provided catheter care for the resident. -CNA D cleaned the Foley catheter tubing by holding the top of the tubing with one hand and wiped downward toward the drainage bag tubing. -CNA D, did not clean around opening of the catheter insertion site and the surrounding area as part of perineal area care and catheter care. -CNA D used a bleach wipe and cleaned the outside of the drainage bag. -The resident's drainage bag tubing had white/yellowish thick substance and the drainage bag had about a 100 cubic centimeters (cc) of dark tea color urine. -CNA D and CNA E removed gloves and washed hands between the dirty to clean process. During an interview on 8/20/24 at 10:25 A.M. CNA D and CNA E said: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-They did not empty the resident's drainage bag at that time since it did not have much urine output. During an interview on 8/22/24 at 1:56 P.M., CNA C said: -Part of resident catheter care would be to clean around the catheter insertion site and surrounding skin. -The drainage bag was to be emptied every shift and the amount of urine output recorded. During an interview on 8/23/24 at 9:13 A.M., CNA D said: -Catheter care use one wipe at a time down catheter tubing and clean the bag with bleach wipes. -He/she did not clean the resident's catheter insertion site and surrounding skin area as part of the catheter care and peri care provided. -He/she should have cleaned the catheter insertion site around the urethra first and then completed full peri care as part of the catheter care process. -He/She had facility in-service related to catheter care and peri care in the past. During an interview on 8/23/24 at 9:21 A.M., Licensed Practical Nurse (LPN) A said: -He/she would expect CNA's to complete full catheter care to include cleaning of the insertion site and surrounding skin area. During an interview on 8/23/24 at 11:36 A.M., Assistant Director of Nursing (ADON) B said: -He/she would expect CNA's to perform catheter and peri-care to include cleaning the insertion site and surrounding skin. During an interview on 8/23/24 at 1:08 P.M., the Director of Nursing (DON) said: -He/she would expect care staff to ensure to clean catheter insertion site and peri area as part of the residents catheter care process. 50579 2. Review of Resident #74's After Visit Summary (discharge orders) from the resident's hospital stay, dated 7/19/24, showed an instruction to facility staff to attempt a voiding trial to remove the urinary catheter in one week (7/26/24) and, if unsuccessful, consult with a urologist. Review of the resident's Care Plan, dated 7/20/24, showed he/she had a urinary catheter in place. Review of the resident's admission MDS dated [DATE], showed: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of high blood pressure, renal failure (inability of the kidneys to adequately filter blood), benign prostatic hyperplasia (BPH, an enlarged prostate). -The resident had an indwelling urinary catheter. -The resident was not evaluated for urinary continence. -The resident was cognitively intact. -The resident required moderate assistance from staff for toileting. An admission progress note, dated 7/22/24, showed Nurse Practitioner (NP) A instructed facility staff to Continue Foley catheter, consider trial for DC. Review of the resident's medical record showed a lack of assessment for foley catheter removal and a lack of attempted voiding trials. Observation on 8/19/24 at 9:34 A.M., showed the resident had an intact foley catheter in place. During an interview on 8/23/24 at 11:12 A.M., LPN B said: -He/She had been responsible for admission order entry in the past. -He/She would have expected a nurse to enter orders for the foley catheter voiding trial based on the hospital discharge orders on 7/19/24. -He/She would have expected a nurse to obtain clarification on the NP progress note on when to start the voiding trial, but stated the note implied the NP agreed to the voiding trial per the discharge orders. During an interview on 8/23/24 at 11:38 A.M., ADON A said: -The hospital gave admission orders to attempt a foley catheter voiding trial to remove the catheter in seven days of discharge from the hospital. -NP A's progress note indicated that he/she was ordering the foley catheter trial be done upon the patients discharge home. - DC referred to discharge home, not discontinue. -The facility did not assess the resident's current urinary continence status or the status prior to insertion of the urinary catheter. -The facility had not consulted with a urologist for the resident. -The reason the catheter was still in place was the diagnosis of BPH. -He/She was unsure of the facilities role in assessing the resident for removal of the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/23/24 at 1:09 P.M., the DON said: -The hospital gave admission orders to attempt a foley catheter voiding trial to remove the catheter in seven days of discharge from the hospital. -NP A's progress note indicated that he/she was ordering the foley catheter trial be done upon the patients discharge home. - DC referred to discharge home, not discontinue. -The facility did not assess the resident's current urinary continence status or the status prior to insertion of the urinary catheter. -The reason the catheter was still in place was the diagnosis of BPH. -The facility only assessed removal of catheters based on physician orders. -It was up to the provider to determine if a foley catheter should remain and he/she did not expect staff to assess the resident for removal of the foley catheter if a provider had ordered the catheter. -It was the responsibility of the physician or nurse practitioner to assess the resident for foley catheter removal, not facility staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46519 Based on observation, interview and record review, the facility failed to ensure oxygen equipment was stored using the proper infection control practices when not in use for one sampled resident (Resident #37) out of 18 sampled residents. The facility census was 84 residents. Review of the facility's policy titled Oxygen Handling and Transport dated January 2024 showed oxygen concentrators, cylinders, and equipment would be kept and maintained in such a way as to be compliant with all relevant health and safety guidelines. 1. Review of Resident #37's face sheet showed he/she admitted to the facility with the following diagnoses: -Chronic Obstructive Pulmonary Disease (COPD- a disease process that decreases the ability of the lungs to perform ventilation). -Unspecified Chronic (persisting for a long time) Bronchitis (inflammation of the lining of bronchial tubes, which carry air to and from the lungs. -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). Review of the resident's undated care plan showed the resident had the potential for altered respiratory status/difficulty breathing related to non-compliance with oxygen history of COPD, and chronic bronchitis with the goal of the resident's oxygen saturation level would remain above 90% but did not indicate the route or amount of oxygen used. Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 5/28/24 showed: -The resident had moderately impaired cognition. -It did not indicate the resident was on oxygen. Review of the resident's Physician Order Sheet (POS) dated August 2024 showed an order for oxygen Pro Re Nata (PRN- as needed) via nasal cannula (a device that delivers extra oxygen through a tube into your nose) flow at 2 Liters (L) per minute to keep saturation (measures how much oxygen is in the blood) greater than 90%. Observation on 8/19/24 at 9:51 A.M. showed: -The resident was asleep in his/her bed. -He/She had an oxygen concentrator next to his/her bed, on, and the oxygen tubing was on the floor. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/21/24 at 8:59 A.M. showed: -The resident was asleep in his/her bed. -He/She had an oxygen concentrator next to his/her bed, on, and the oxygen tubing was on the floor. Observation on 8/21/24 at 11:36 A.M. showed: -The resident was not in his/her room. -He/She had an oxygen concentrator next to his/her bed, on, and the oxygen tubing was on the floor. Observation on 8/22/24 at 12:54 P.M. showed the oxygen tubing remained on the ground in the same spot as the day before, 8/21/24. During an interview on 8/22/24 at 1:07 P.M. Certified Nursing Assistant (CNA) A said: -Oxygen tubing should be stored in a bag and labeled with the resident's name, room number, and date. -If he/she were to see oxygen tubing laying on the floor, then he/she would get new tubing for the resident. -He/She thought the resident only used his/her oxygen during the night. -The resident was mostly independent with his/her care, so the nursing staff weren't usually on his/her side of the room. -He/she was unaware that the oxygen tubing in the resident's room was on the floor. During an interview on 8/22/24 at 1:56 P.M. Assistant Director of Nursing (ADON) B and the Director of Nursing (DON) said: -Oxygen tubing needed to be stored in a bag. -The bag should be labeled with a date and the initials of the resident. -If either of them were to see oxygen tubing on the floor then they would dispose of it. -The resident very rarely used oxygen. -They expected the CNA's to have noticed that the oxygen tubing was on the floor in the resident's room and get the resident new oxygen tubing. During an interview on 8/22/24 at 2:43 P.M. the MDS Coordinator said: -Oxygen tubing needed to be stored in a bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The bag should be labeled with the resident's name and date. -Oxygen tubing should not be stored on the floor. During an interview on 8/23/24 at 9:49 A.M. Licensed Practical Nurse (LPN) B said: -There should be a bag in the resident's room for staff to store the oxygen tubing. -The bag should be labeled with the resident's name and date. -Oxygen tubing was not ever to be stored on the floor. -He/She would have expected the CNA's to have noticed the oxygen tubing on the resident's floor. -He/She expected for the CNAs to tell him/her if the oxygen tubing needed to be replaced, so he/she could provide the resident with new tubing.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 46519 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #8) who had a diagnoses of Post-Traumatic Stress Disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) received trauma based interventions or developed a care plan that showed interventions for the staff to provide care to protect the resident and prevent trauma from recurring out of 18 sampled residents. The facility census was 84 residents. Review of the facility's policy titled Trauma Informed Care dated May 2024 showed: -The facility ensured that residents who were trauma survivors received culturally competent, trauma-informed care (a framework for relating to and helping people who have experienced negative consequences after exposure to dangerous experiences) in accordance with professional standards of practice and accounting for each resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. -The facility would assist the resident in locating and arranging to attend support groups. -The facility would offer to host support meetings as appropriate. -All facility staff, in all departments involved in resident care would partner with resident/representative to develop a comprehensive, individualized, person-centered care plan related to recognition that healing happens in relationships and meaningful sharing of power and decision-making. -Trauma informed care was an important component of integration to person-centered care through which the staff offer individualized support and services that were responsive to the resident's wishes and goals. -The facility would involve residents and family members as well as staff members and community partners related to trauma informed care through education and opportunities to provide input. -The symptoms of trauma varied greatly. -Upon admission, an initial screening for history of trauma would be completed and would determine if residents had trauma-related symptoms. 1. Review of Resident #8's face sheet showed he/she admitted to the facility with the following diagnoses: -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). -Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-PTSD. -Insomnia (persistent problems falling and staying asleep). -Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats. -Borderline Personality Disorder (a personality disorder characterized by severe mood swings, impulsive behavior, and difficulty forming stable personal relationships). Review of a Psychiatric Evaluation dated 6/27/24 completed by Nurse Practitioner (NP) D showed the nursing staff had reported impulsiveness and anxiousness behaviors to NP D. Review of the resident's Admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/29/24 showed: -The resident had moderately impaired cognition. -The resident had an active diagnosis of PTSD. -The resident had felt down, depressed, or hopeless 12-14 days (nearly every day) during the look back period. -The resident had trouble falling or staying asleep or slept too much 12-14 days during the look back period. -The resident felt tired or had little energy 12-14 days during the look back period. -The resident exhibited no behaviors during the look back period. Review of the resident's care plan dated 7/8/24 showed the resident had no focus or interventions related to his/her diagnosis of PTSD or trauma informed care. Observation on 8/20/24 at 11:15 A.M. showed the resident sitting in the dining room and verbalized he/she was not feeling well that day. Observation on 8/20/24 at 11:47 A.M. of the resident showed: -He/She seemed to be upset by something. -He/She was taking sharp, quick, heavy breaths at the dining table and then left the dining room. Review of the resident's Electronic Medical Record (EMR) on 8/22/24 showed no trauma assessment could be found. Observation on 8/22/24 at 8:23 A.M. showed the resident was angry and worried about not receiving his/her medications yet. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24 at 8:37 A.M. the resident said: -He/She had been upset that morning. -He/She was upset because the staff around him/her were moving too fast. -He/She was also worried because he/she had not received his/her morning medication yet. -He/She had not seen a therapist since admitting to the facility. -He/She did not think the facility had offered him/her therapy. -He/She thought therapy would be beneficial because it would help him/her with fast-talking and worry. -He/She was unsure of anything else that would help him/her with his/her diagnosis of PTSD. During an interview on 8/22/24 at 10:05 A.M. Social Services Designee (SSD) A said: -He/She was unaware of the resident's PTSD diagnosis. -He/She had not completed an initial screening for history of trauma with the resident or the resident's representative. -He/She knew the resident had been seen by NP D and was not sure if NP D had offered or recommended any services. -He/She was unsure of any triggers to the resident's behaviors. -He/She thought he/she would be the staff person most likely to complete the trauma informed care assessments. -The resident should have been offered services related to his/her diagnosis of PTSD. During an interview on 8/22/24 at 10:17 A.M. Family Member A said: -He/She was the resident's health care Durable Power of Attorney (DPOA- a legal document that gives another person the authority to make a medical decision for an individual). -The resident had grown-up in an abusive household. -The resident had been mentally ill for a long time. -The resident was frequently anxious and that was his/her main behavior. -The facility had not discussed any psychiatric services to him/her or the resident. -He/She thought the resident would benefit from seeing a therapist. (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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Ignite Medical Resort St Marys LLC	111 Mock Avenue Blue Springs, MO 64014

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was willing to do anything that would bring any peace and happiness to the resident. During an interview on 8/22/24 at 1:03 P.M. Certified Nursing Assistant (CNA) A said: -He/She was unaware of the resident's diagnosis of PTSD. -He/She was unsure if the resident had any triggers related to his/her psychiatric disorders. -He/She was unsure if the resident received any psychiatric services. -He/She was unsure if CNAs had access to residents' care plans. -The CNAs would go over resident behaviors during report. -Services should have been offered to the resident. -He/She was unsure of who would be responsible for setting up the services. During an interview on 8/22/24 at 1:51 P.M. Assistant Director of Nursing (ADON) B and the Director of Nursing (DON) said: -They were both aware of the resident's diagnosis of PTSD. -The DON would not expect the CNAs to know that the resident had PTSD. -The resident only had behaviors related to his/her diagnosis of Dementia and not PTSD. -The resident did not receive any psychiatric services at that point in time. -The resident's family declined therapy services. -The resident's family just dumped the resident at the facility. -Social Services would be the one to offer any services that might be beneficial to the resident. -Social Services would also be responsible for the trauma informed care assessment and any related documentation to the services that were offered. -Per the DON, No one wants to talk about it, it was in her childhood or something. During an interview on 8/22/24 at 2:33 P.M. the MDS Coordinator said: -He/She was aware of the resident's diagnosis of PTSD. -He/She was unsure if the resident had received any services related to his/her diagnosis of PTSD. -The staff would only know about the resident's PTSD diagnosis if they had access to the resident's diagnosis list. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She thought the nurses would be responsible for informing care staff about any pertinent diagnoses including PTSD. -A focus on PTSD should be on the resident's care plan. -He/She was unsure of any triggers that the resident had related to his/her PTSD. -He/She was unsure if there was a designated staff person to perform a trauma assessment and assess for any triggers. During an interview on 8/23/24 at 9:45 A.M. Licensed Practical Nurse (LPN) B said: -Any CNAs that cared for the resident should know about his/her diagnosis of PTSD. -He/She thought therapy services should be offered to resident/resident's representative regardless of the resident's dementia diagnosis. -He/She was unsure of who was responsible for completing the trauma assessments. -He/She thought that any services offered to a resident should be documented somewhere in the resident's chart. During an interview on 8/23/24 at 1:09 P.M. the DON said: -The MDS Coordinators and the nurses could update care plans. -Nurses were responsible for initiating care plans upon admission and then the MDS Coordinators were responsible for the care plans afterwards. -He/She expected care plans to be individualized and reflect the residents' current status. -The resident's diagnosis should be on the resident's care plan.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility's physician failed to visit one sampled resident (Resident #8) at least once every 30 days for the first 90 days after admission and the facility failed to ensure the physician visited the resident every 60 days for five sampled residents (Resident's #25, #38, #41, #62, and #15) out of 18 sampled residents. The facility census was 84 residents. Review of the facility Physician's Visits Frequency, Timeliness and Alternates policy and procedure updated 5/2024, showed: -The Physician or Nurse Practitioner must make actual face to face contact with the resident and at the same physical location, not via a telehealth arrangement. -Residents must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. -Physician visits are considered timely if it occurs no later than 10 days after the date the visit was required. -All required physician visits must be made by the physician personally. -At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician's assistant, nurse practitioner and clinical nurse specialist. 1. Review of Resident #25's Face Sheet showed the resident was admitted on [DATE], with diagnoses including dementia (a chronic condition that causes a loss of cognitive functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life), psychosis (a mental disorder that causes people to lose touch with reality and have difficulty relating to others), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), depression (a common mental health condition that can affect anyone, and is characterized by a persistent low mood or loss of interest in activities for long periods of time), repeated falls, diabetes, high cholesterol, protein calorie malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), muscle weakness, anemia (low iron), kidney disease, high blood pressure, heart disease, and history of urinary tract infection (UTI). Review of the resident's quarterly Minimum date Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 6/24/24, showed the resident: -Was alert with significant cognitive impairment and memory loss. -Needed set up assistance and supervision with eating. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Needed moderate to maximum staff assistance with transfers, bathing, dressing, toileting and hygiene. -Used a wheelchair for mobility. Review of the resident's Physician's Order Sheet (POS) dated August 2024, showed physician's orders for: -Bupropion (an antidepressant) extended release 300 milligrams (mg) daily for depression. -Cholecalciferol (Vitamin D3) 1000 units daily for supplement. -Duloxetine (used to treat depression) 60 mg daily for depression. -Famotidine 20 mg daily for indigestion. -Hydrocodone -Acetaminophen 5-325 mg every four hours as needed for pain. -Hydroxyzine Pamoate (an anti-anxiety) 25 mg twice daily for anxiety. -Metformin 500 mg twice daily for diabetes. -Rosuvastatin Calcium 20 mg daily for lipid control. -Sertraline (an antidepressant) 100 mg every evening for depression. -Aspirin 81 mg daily for heart health. Review of the resident's Medical Record from 9/8/2023 to 8/9/2024 showed: -From 9/8/23 to 12/31/23 the resident was seen by the Nurse Practitioner (NP) every month. -The physician documented he/she visited on 10/30/23. This was the most recent physician's note that was documented in the resident's medical record. -The physician had not visited the resident in 10 months. 46519 2. Review of Resident #8's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -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). -Coronary Artery Disease (CAD- plaque build-up in the wall of the arteries that supply blood to the heart). (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life. -Post-Traumatic Stress Disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). -Chronic Kidney Disease (CKD- a long standing kidney disease based on kidney damage or decreased kidney function for three or more months). Review of the resident's undated care plan showed: -The resident had impaired cognitive function and/or thought processes related to dementia. -The resident had impaired visual function. -The resident had an Activities of Daily Living (ADL) self-care performance deficits and limitations in physical mobility. -The resident had the potential for alterations in psychosocial well-being. Review of the resident's NP encounter note dated 6/26/24 showed the resident was seen by NP A and not by the facility's physician. Review of the resident's NP encounter note dated 6/27/24 showed the resident was seen by NP A and not the facility's physician. NOTE: This indicated the resident had not been seen by the facility's physician since admission. Review of the resident's admission MDS dated [DATE] showed the resident had moderately impaired cognition. 3. Review of Resident #41's face sheet showed he/she admitted to the facility with the following diagnoses: -Personal History of Transient Ischemic Attack (TIA- a stroke like attack which may be a warning sign of a future stroke) and Cerebral Infarction (ischemic stroke- occurs as a result of disrupted blood flow and restricted oxygen to the brain). -Congenital (a condition or trait that exists at birth) Hydrocephalus (a condition in which fluid accumulates in the brain and can cause brain damage). -Seizures (a sudden, uncontrolled burst of electrical activity in the brain causing changes in behavior, movements, feelings, and level of consciousness). -Hemiplegia (paralysis of one side of the body) following Cerebral Infarction Affecting the Left Dominant Side. -MDD. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's NP encounter note dated 9/11/23 showed the resident was seen by NP B and not the facility's physician. Review of the resident's NP encounter note dated 11/1/23 showed the resident was seen by NP B and not the facility's physician. Review of the resident's NP encounter note dated 1/5/24 showed the resident was seen by the facility's physician. Review of the resident's NP encounter note dated 4/16/24 showed the resident was seen by NP C and not the facility's physician. Review of the resident's NP encounter note dated 5/31/24 showed the resident was seen by NP A and not the facility's physician. Review of the resident's NP encounter note dated 6/17/24 showed the resident was seen by NP C and not the facility's physician. Review of the resident's Quarterly MDS dated [DATE] showed the resident was cognitively intact. Review of the resident's NP encounter note dated 8/13/24 showed the resident was seen by NP A and not the facility's physician. NOTE: This indicated the resident was only seen by the facility's physician once in 11 months. Review of the resident's care plan dated 8/18/24 showed: -The resident had impaired cognitive function or impaired thought processes. -The resident had an ADL self-care performance deficit. -The resident had depression. -The resident had the potential for nutritional deficit. -The resident had a seizure disorder. 4. During an interview on 8/23/24 at 9:48 A.M. Licensed Practical Nurse (LPN) B said he/she had not normally worked on the Long-Term Care (LTC) side of the facility and was unsure of the physician visit schedule. 26996 5. Review of Resident #62's quarterly MDS dated [DATE] showed the resident: -Was cognitively intact. -Had the following diagnoses: (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--High blood pressure. --Stroke. --Diabetes Mellitus (DM-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). --Seizure disorder (a hyperexcitation of neurons in the brain leading to a sudden, violent involuntary series of contractions of a group of muscles). Review of the resident's physician/nurse practitioner notes showed: -On 4/17/24 the resident was seen by the nurse practitioner. -On 4/19/24 the resident was seen by the nurse practitioner. -On 5/15/24 the resident was seen by the nurse practitioner. -On 6/6/24 the resident was seen by the nurse practitioner. -On 7/10/24 the resident was seen by the nurse practitioner. -On 7/17/24 the resident was seen by the nurse practitioner. -On 7/24/24 the resident was seen by the nurse practitioner. -On 8/1/24 the resident was seen by the nurse practitioner. -On 8/7/24 the resident was seen by the nurse practitioner. -On 8/14/24 the resident was seen by the nurse practitioner. -On 8/21/24 the resident was seen by the nurse practitioner. -There was no documentation that showed the residents physician saw the resident face to face alternating with the nurse practitioner every 60 days. During an interview on 8/23/24 at 9:00 A.M. LPN B said he/she was not aware how often the nurse practitioner and/or physician were required to see the resident. 33409 6. Review of Resident #38's Admission Face Sheet showed he/she was readmitted on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD, difficulty breathing) and Atrial fibrillation (A-Fib irregular heart beat). Review of the resident's Electronic Medical Record dated 8/25/23 to 8/23/24 showed: (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She had one Physician visit documented on 4/17/24, as the resident's Initial History and Physical and was electronically signed by the physician on 4/19/24. -That was the most recent physician's note documented in the resident's medical record. -There was no other documentation to show the physician had visited the resident in four months. -The facility could not provide documentation of physician visit every 60 days for the resident. Review of the resident's Annual MDS dated [DATE], showed the resident: -Was alert and cognitively intact. -Needed moderate to maximum staff assistance with transfers, bathing, dressing, toileting and hygiene. -Used a wheelchair and walker for mobility. Review of the resident's POS dated August 2024, showed physician's orders to include not limited to: -admitted to skilled nursing on 7/22/24 for rehabilitation. -Welbutrin XL extended release 24 hours 300 mg one tablet daily for depression. -Lovenox Injection 150 mg/ml subcutaneously one time a day for preventive for Deep Vein Thrombosis (DVT). -Oxycodone hydrochloride (HCl) 15 mg one tablet by mouth every four hours as needed for pain. -Tramadol HCl 50 mg give two tablets every four hours as needed for pain. 50579 7. Review of Resident #15's Quarterly MDS dated [DATE] showed the resident: -Was moderately cognitively impaired. -Had high blood pressure, A urinary tract infection within the previous 30 days, high cholesterol, Diabetes Mellitus type II, stroke, and Dementia. Review of the resident's physician/nurse practitioner notes dated 1/3/24 to 8/19/24 showed: -The resident was seen by a nurse practitioner every month. -The physician documented he/she saw the resident on 2/22/24. -The physician had not seen the resident in six months. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. During an interview on 8/23/24 at 11:36 A.M. Assistant Director of Nursing (ADON) A and ADON B, both said: -The Nurse Practitioner would visit the residents daily if needed, but they usually visited each resident at least weekly. -They saw the physician in the building at least monthly, but they don't round with him/her so they don't know who he/she visited with when he/she was in the building. -They did not know how frequently the residents physicians were supposed to visit the resident between Nurse Practitioner visits. -The physician had a set patient list upon each visit and he/she determined who he/she needed to see according to that list. -They did not know how frequently the physician was supposed to visit Resident #8, #25, #41, #62, #38, and #15 between Nurse Practitioner visits. During an interview on 8/23/24 at 1:08 P.M., the DON said: -He/she would expect to have physician visit progress notes in the resident's medical record. -The Physicians should visit each resident every 60 days. -They could alternate every 60 days with the Nurse Practitioner visits. -He/she did not know who monitored to ensure the Physician saw each resident every 60 days. -He/she was unsure when Resident #8, #25, #41, #62, #38, and #15 were last seen by the facility's physician.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26996 Based on observation, interview and record review, the facility failed to provide medically related social services for one sampled resident (Resident #62) who had major depressive disorder (a mental disorder characterized by a feeling of profound and persistent sadness or despair and was frequently accompanied by a loss of interest in things that were once pleasurable) out of 18 sampled residents. The facility census was 84 residents. A policy was requested related to social services and no policy was received. 1. Review of Resident #62's Admission Record showed the resident was admitted to the facility on [DATE]. Review of the resident's Care Plan dated of 11/28/23 showed: -The resident had the potential for altercations in psychosocial well-being. -The staff needed to allow the resident time to answer questions, verbalize feelings, perceptions and fears. -Initiate referrals as needed for counseling and psychiatric services as needed. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) dated 3/4/24 showed the resident: -Was cognitively intact. -Felt down, depressed and hopeless nearly every day. -Had trouble sleeping nearly every day. -Felt tired and had little energy nearly every day. -Had a diagnosis of depression disorder (a common mental health condition that can affect anyone, and is characterized by a persistent low mood or loss of interest in activities for long periods of time) . -Took medications for depression and anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus). Review of the resident's Psychiatric Evaluation dated 4/4/24 showed: -The resident had a past psychiatric history of depression and anxiety. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was seen today due to staff reporting increased depressive features, being withdrawn and staying in his/her room. -The resident reported he/she wanted to go home and felt frustrated he/he was in a long-term care facility. -If he/she could go back home he/she would be happy. -Monitor the resident closely for safety. -Monitor for changes in mood and behaviors. -When necessary, continue being flexible with the resident's mood and validate concerns and feelings. -Continue offering one-on-one time as staffing allows. Review of the resident's Psychiatric Evaluation dated 6/10/24 showed: -The resident was seen today for a monthly routine evaluation. -The resident denied mood concerns today. -Monitor the resident closely for safety. -Monitor for changes in mood and behaviors. -When necessary, continue being flexible with the resident's mood and validate concerns and feelings. -Continue offering one-on-one time as staffing allows. During an interview on 8/19/24 at 9:15 A.M. the resident said: -This is all I do. -He/she never would get out of bed and wanted to go home. -The resident was observed lying in his/her bed at the time of the interview. The resident appeared to have depressive indicators including looking away, depressed facial expressions, and a sad tone of voice. Review of the resident's Electronic Medical Record (EMR) on 8/20/24 showed no documentation of social services supportive visits or counseling services. During an interview on 8/22/24 at 1:33 P.M. Certified Nurses Assistant (CNA) B said: -He/she did not work with the resident often. (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The SSD's should be making supportive visits and arrange counseling services for the resident due to his/her mood. During an interview on 8/23/24 at 1:09 P.M. the Director of Nursing (DON) said: -The staff should be monitoring the residents for mood/behavior. -The resident had called him/her curse words in the past, would state he/she wanted to die or wanted to go home. -When the staff offered to get the resident out of bed, he/she would get very angry. -He/she expected the SSD's to offer supportive visits and offer counseling services to the resident. -The SSD should try talk therapy, dog therapy and supportive visits. -He/she expected these supportive visits to be documented to monitor the resident's mood.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265759	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on interview and record review, the facility failed to ensure the physician documented a rationale for why he/she disagreed with the pharmacist's recommendation in a timely manner for two sampled residents (Resident #25 and #62) out of 18 sampled residents. The facility census was 84 residents. Review of the facility's Pharmacy Services policy and procedure updated 5/2024, showed: -Medication Regimen Review-Reviews will be conducted in accordance with all state and federal requirements. Pharmacist medication reviews to the physician and nursing will be completed in a timely manner, but not later than five days from receiving. -The policy did not address the physician's response to recommendations. 1. Review of Resident #25's Face Sheet showed the resident was admitted on [DATE], with diagnoses including dementia (a chronic condition that causes a loss of cognitive functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life), psychosis (a mental disorder that causes people to lose touch with reality and have difficulty relating to others), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), depression (a common mental health condition that can affect anyone, and is characterized by a persistent low mood or loss of interest in activities for long periods of time), repeated falls, diabetes, high cholesterol, protein calorie malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), muscle weakness, anemia (low iron), kidney disease, high blood pressure, heart disease, and history of urinary tract infection (UTI). Review of the resident's Medication Regimen Review (MRR) dated 4/17/24, showed: -Nystatin-Triamcinolone Ointment apply every six hours as needed for yeast/redness was ordered since 3/18/22. The pharmacist documented this was not appropriate for as needed use. -The recommendation was to please evaluate if it should be changed to routine. -The physician's response showed the physician disagreed with this recommendation, but he/she did not show a rationale for why the resident should continue using the medication or why he/she did not agree with the recommendation. Review of the resident's MRR completed on 5/15/24, 6/14/24 and 7/13/24 showed the pharmacist did not continue to address the recommendation to change the order for Nystatin- Ointment apply every six hours as needed for yeast/redness. Review of the resident's quarterly Minimum date Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 6/24/24, showed the resident: -Was alert with significant cognitive impairment and memory loss. (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Needed set up assistance and supervision with eating. -Needed moderate to maximum staff assistance with transfers, bathing, dressing, toileting and hygiene. -Was incontinent and used a wheelchair for mobility. Review of the resident's Physician's Order Sheet (POS) dated 5/2024, 6/2024, 7/2024 and 8/2024, showed physician's orders for Nystatin-Triamcinolone Ointment 100000-0.1 grams(gm) apply to red/yeasty areas every six hours as needed for yeasty area. The order was dated 3/18/22. Review of the resident's Medical Record showed the resident had no documentation showing the resident was currently being treated for yeast or redness. Review of the resident's MRR dated 8/16/24, showed: -Nystatin-Triamcinolone Ointment apply every six hours as needed was ordered since 3/18/22. -The pharmacist's recommendation showed the medication was not appropriate for as needed use. Please evaluate if it should be changed to routine. -The document showed the physician responded and agreed with the pharmacist's recommendation. During an interview on 8/22/24 at 1:59 P.M., Assistant Director of Nursing (ADON) A said: -Regarding the MRR, when they received pharmacy recommendations, they provided the recommendation to the physician or Nurse Practitioner (NP) within 48 hours of receiving it. -If there was a recommended change in dosage or other medications, they would get a verbal order from the physician and then they could change the order to reflect the new physician's order. -The former NP used to document why they did not agree with the recommendations on the MRR form or in the notes, and then the nurse would send the documentation back to the pharmacist. -He/She was not sure if the current NP was aware that he/she was supposed to document rationale for not following the recommendation of the pharmacist and may need additional education. -The expectation was that the physician would respond to the recommendation and document why they were not agreeing with the recommendation. 51150 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265759	A. Building B. Wing	08/27/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #62's Face Sheet showed the resident was admitted with diagnoses including cerebral infarction (also called ischemic stroke, a cerebral infarction occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), Gastro Esophageal Reflux Disease (GERD-backup of stomach acid/heartburn), major depressive disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living), hypertensive [NAME] disease (heart problems that occur because of high blood pressure), and occlusion and stenosis of the right vertebral artery (medical condition characterized by the narrowing of one or both vertebral arteries, which supply blood to the brainstem and cerebellum. This narrowing may lead to reduced blood flow and an increased risk of stroke). Review of the resident's MRR dated 12/14/23 showed: -The resident was receiving a Proton Pump Inhibitor-Omeprazole (PPI- Proton-pump inhibitors were a class of medications that caused a profound and prolonged reduction of stomach acid production) and Clopidogrel (Plavix antiplatelet drug) concurrently. -There was potential of PPI's decreasing the effectiveness of Plavix and an increased risk of major adverse cardiovascular events. -Administration of Omeprazole and Clopidogrel together should be avoided. -The pharmacist recommended replacing the residents Omeprazole with Pepcid (a histamine-2 blocker (H2 blocker) with the active ingredient Famotidine that helped relieve heartburn by reducing the amount of acid in the stomach) 20 milligrams (mg) daily (QD). -The pharmacist recommended that if PPI therapy was necessary, to please consider Rabeprazole instead of Omeprazole. -The physician's response showed the physician disagreed with the recommendation, but he/she did not show a rationale for why the resident should continue using the medication or why he/she did not agree with the recommendation. Review of the resident's MRR dated 12/14/23 showed: -The resident was receiving Esomeprazole (PPI-used to treat GERD) 40 mg twice per day (BID) for acid indigestion. -Maximum daily dose recommended was 40 mg once per day. -Recommendation from pharmacist was to reduce the dose to once daily to minimize adverse drug reactions. -The physician's response was to continue medication as ordered. -The physician did not show a rationale for why he/she did not agree with the pharmacist's recommendation. (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's MRR dated 2/20/24 showed: -A recommended Gradual Dose Reduction (GDR) for Lorazepam (anti-anxiety) 0.25 mg BID. --The physician's response was Lorazepam 0.5 mg BID. --The physician did not show a rationale for why he/she did not agree with the pharmacist's recommendation. --The physician did not show a rationale for why he/she increased the medication. -A recommended GDR for Sertraline (anti-depressant) 25 mg QD. --The physician did not show a rationale for why he/she did not agree with the pharmacist's recommendation. -The resident was receiving Omeprazole and Clopidogrel concurrently. --There was potential of PPI's decreasing the effectiveness of Plavix and an increased risk of major adverse cardiovascular events. --Administration of Omeprazole and Clopidogrel together should be avoided. --The pharmacist recommended replacing the residents Omeprazole with Pepcid 20 mg QD. --The pharmacist recommended that if PPI therapy was necessary, to please consider Rabeprazole instead of Omeprazole. --The physician's response was continue with medication as ordered. --The physician did not show a rationale for why he/she did not agree with the pharmacist's recommendation. -The resident was receiving Pantoprazole 40 mg BID for acid indigestion. --Maximum daily dose recommended was 40 mg once per day. --Recommendation from the pharmacist was to reduce the dose to once daily to minimize adverse drug reactions. --The physician's response was continue medication as ordered. -The physician did not show a rationale for why he/she did not agree with the pharmacist's recommendation. Review of the pharmacy note in the Electronic Medical Record (EMR) dated 3/20/24 showed: -No irregularities noted. (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The pharmacist did not address previous recommendations. Review of the pharmacy note in the EMR dated 4/17/24 showed: -No irregularities noted. -The pharmacist did not address previous recommendations. Review of the resident's annual MDS dated [DATE] showed the resident: -Had high blood pressure. -Had a history of stroke. -Had depression. -Had no GERD. -Was taking an anti-anxiety medication. -Was taking an anti-depressant medication. -Was taking an anti-platelet medication. -GDR had not been attempted. Review of the resident's pharmacy note dated 6/13/24 showed: -No irregularities noted. -The pharmacist did not address previous recommendations. Review of the resident's pharmacy note dated 7/14/24 showed: -No irregularities noted. -The pharmacist did not address previous recommendations. Review of the resident's significant change MDS dated [DATE] showed the resident: -Had high blood pressure. -Had a history of stroke. -Had depression. -Had GERD. (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was taking an anti-anxiety medication. -Was taking an anti-depressant medication. -Was taking an anti-platelet medication. -GDR had not been attempted. Review of the resident's pharmacy note dated 8/16/24 showed: -No irregularities noted. -The pharmacist did not address previous recommendations. Review of the resident's POS dated 8/20/24 showed: -Pantoprazole Sodium (PPI) Oral Tablet Delayed Release 40 mg give 1 tablet by mouth two times a day for GERD. -Clopidogrel Bisulfate (anti-platelet) oral tablet 75 mg give one tablet by mouth one time a day for blood clot prevention. -Sertraline HCL (anti-depressant) Oral Tablet 25 mg give 25 mg by mouth one time a day for depression. -Lorazepam (anti-anxiety) Oral Tablet 0.5 mg give 0.25 mg by mouth two times a day for anxiety. -Lorazepam (anti-anxiety) Tablet 0.5 mg give 1 tablet by mouth two times a day for anxiety. During an interview on 8/23/24 at 11:35 A.M. ADON A said: -If there was a recommended change in a medication dosage or other medication recommendations, either he/she or ADON B would get a verbal order from the physician and then they would change the order to reflect the new physician's order. -There should be a rationale from the physician on all GDR recommendations or any additional medication recommendations from the pharmacist. -He/She was not sure why the physician would not write a rationale on a recommended GDR or recommended change in medication. -He/She would expect the physician would have written a rationale for not initiating a GDR recommendation or change of medication recommendation. During an interview on 8/23/24 at 1:31 P.M. the Director of Nursing (DON) said: -When the pharmacist had a recommendation, he/she would put it in the physician's box and the NP or physician would get the information. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-They usually tried to get the MRR recommendations to the physician and returned from the physician within a week.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on interview and record review, the facility failed to ensure the physician responded to the pharmacist's recommendation for Gradual Dose Reduction (GDR) for psychotropic (relating to or denoting drugs that affect a person's mental state) medication in a timely manner for two sampled residents (Resident #25 and #62), failed to follow up on a physicians response to the pharmacist's Medication Regimen Review (MRR), failed to follow a physician dose recommendation, and failed to ensure appropriate indication for antipsychotic medication dose increases for one sampled resident (Resident #50) out of 18 residents. The facility census was 84 residents. Review of the facility's Pharmacy Services policy and procedure updated 5/2024, showed: -Medication Regimen Review-Reviews will be conducted in accordance with all state and federal requirements. Pharmacist medication reviews to the physician and nursing will be completed in a timely manner, but not later than five days from receiving. Review of the facility's Psychotropic Medications policy and procedure updated 5/2024, showed: -The physician's order for a psychotropic medication will include both a qualifying diagnosis for the drug and a list of behaviors which the staff will monitor during the drug administration. -The attending physician must certify that a psychotropic medication is necessary to treat a specific condition/behavior. -The drug dosage must be periodically reduced with a goal of discontinuing it, or replacing it with another less potent prescription. -All antipsychotic's will be tapered as a gradual dose reduction unless clinically contraindicated. -The continued use is in accordance with current standards of practice and they physician has documented rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating and underlying medical or psychiatric disorder. 1. Review of Resident #25's Face Sheet showed the resident was admitted on [DATE], with diagnoses including dementia (a chronic condition that causes a loss of cognitive functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life), psychosis (a mental disorder that causes people to lose touch with reality and have difficulty relating to others), anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome), depression (a common mental health condition that can affect anyone, and is characterized by a persistent low mood or loss of interest in activities for long periods of time), repeated falls, diabetes, high cholesterol, protein calorie malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat), muscle weakness, anemia (low iron), kidney disease, high blood pressure, heart disease, and history of urinary tract infection (UTI). (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Drug Regimen Review dated 5/15/24, showed the pharmacist review listed three medications for GDR: -Bupropion (an antidepressant) 300 milligram (mg) daily since 8/19/22 -the pharmacist's recommendation was to review for GDR. -Duloxetine (used to treat depression) 60 mg daily since 8/19/22 - they recommendation was to review for GDR. -Quetiapine (Seroquel an antipsychotic) 25 mg take a half tablet twice daily since 11/27/22 -the pharmacist's recommendation was to review for GDR. -The physician's response showed Quetiapine was discontinued, but there was no documented response to the recommendation for a gradual dose reduction for Bupropion or Duloxetine to show if the physician agreed or disagreed with the pharmacist's recommendation and there was no rationale for why the physician disagreed with the recommendation. Review of the resident's Physician's Psychiatric Note dated 6/10/24, showed: -The Psychiatrist was seeing the resident for a psych follow-up and GDR medication management. -Seroquel was discontinued. Continue to monitor the resident's response. Resident appeared to be in a good mood. Nursing staff reported no behaviors today. No other acute psychiatry concerns noted today. -The Psychiatrist documented he/she reviewed the resident's Medication Administration Records (MARS) for compliance with medications. -The Psychiatrist documented he/she reviewed the resident's current psychiatric medication regimen and that a GDR was completed on Seroquel. He/She documented that the resident was currently taking Bupropion 300mg daily and Duloxetine 60mg once daily. -They Psychiatrist did not address the Pharmacist's recommendation for trying a GDR with Bupropion or Duloxetine. 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 6/24/24, showed the resident: -Was alert with significant cognitive impairment and memory loss. -Needed set up assistance and supervision with eating. -Needed moderate to maximum staff assistance with transfers, bathing, dressing, toileting and hygiene. -Used a wheelchair for mobility. (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Had symptoms of depression but did not have behaviors (hallucinations or psychosis) during the lookback period. Review of the resident's Medical Record showed there was no documentation showing a GDR was completed on Bupropion 300 mg once daily and Duloxetine 60 mg once daily or that the Physician/Psychiatrist did not agree with the Pharmacist's recommendation. There was no documentation showing any rationale for why a GDR was not appropriate for the resident in the resident's medical record. Review of the resident's Physician's Order Sheet (POS) dated 6/2024, 7/2024 and 8/2024 showed physician's orders for: -Bupropion 300mg daily for depression (ordered 3/18/22). -Duloxetine 60mg daily for depression (ordered 11/29/22). Review of the resident's Drug Regimen Reviews dated 6/14/24 and 7/13/24, did not show documentation that the Pharmacist continued to address the recommendation for GDR of Bupropion 300mg once daily and Duloxetine 60mg once daily. Review of the resident's Physician's Psychiatric Note dated 8/9/24, showed: -The Psychiatrist visited the resident for follow up for mental/psychiatric management and documented the staff was reporting the resident had tearfulness, agitation and was combative toward staff since the reduction of Seroquel. He/She documented he/she was performing a mental/psychiatric medication check and follow up. -The Psychiatrist documented the resident reported feelings of anxiety and agitation. -The Psychiatrist reviewed the resident's Medication Administration Record (MAR) and complete list of medications. To include his/her current psychiatric medication regimen. -The Psychiatrist documented the plan was to continue psychotropic medication(s) as presently prescribed. Patient currently benefited psychiatrically and behaviorally at current dose(s). Dose reduction attempt at this time would risk decompensation of patient. During an interview on 8/22/24 at 1:59 P.M., Assistant Director of Nursing (ADON) A said: -Regarding the Drug Regimen Reviews, when they received pharmacy recommendations, they provided the recommendation to the physician or Nurse Practitioner within 48 hours of receiving it. -If there was a recommended change in dosage or other medications, they would get a verbal order from the physician and then they could change the order to reflect the new physician's order. -The GDR had to be responded to by the prescribing physician or Nurse Practitioner (NP) and if the physician was not in agreement with the recommendation they should document why they were not going to try a gradual dose reduction. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The former NP used to document why they did not agree with the recommendations on the drug Regimen Review form or in the notes, and then the nurse would send the documentation back to the pharmacist. -He/She did not know why the physician or NP would not have responded for each of the resident's medications but maybe they thought that discontinuing Seroquel was what was needed at the time. -He/She was not sure if the current NP was aware that he/she was supposed to document rationale for not following the recommendation of the pharmacist and may need additional education. -The expectation was that the physician would respond to the recommendation and document why they were not agreeing with the recommendation. During an interview on 8/23/24 at 1:31 P.M. the Director of Nursing (DON) said: -When the pharmacist had a recommendation, he/she would put it in the physician's box and the NP or physician would get the information. -if the physician recommended a gradual dose reduction of psychotropic medications and the physician did not agree with the recommendation, the physician should document a rationale for why they did not agree. -They usually tried to get the Drug Regimen Review recommendations to the physician and returned from the physician within a week. 50579 2. Review of Resident 50's behavior progress notes dated 1/1/24 to 8/23/24 showed no documented behaviors exhibited by the resident. Behavior monitoring documentation dated 1/1/24 to 8/23/24 was requested on 8/23/24 but none was received prior to exit on 8/26/23. Review of the resident's fall progress notes dated 1/1/24 to 8/23/24 showed: -Two falls on 3/7/24 where the resident was attempting to ambulate by himself/herself. A description of immediate action taken that included taking a urine sample and a hospice (end of life care) visit to change around a few of the patient's meds. --An increase in Quetiapine occurred within 24 hours. -Three falls on 3/12/24 in which the resident slid out of his/her wheelchair onto the floor and was discovered twice on the floor of his/her room. --An increase in Quetiapine occurred within 24 hours. -A fall on 6/13/24 in which the resident attempted to get out of the wheelchair by himself/herself. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--An increase in Quetiapine occurred within 24 hours. -Falls on 2/12/24, 3/17/24, 5/30/24, 6/8/24, and 7/15/24. Review of the resident's quarterly MDS assessment, dated 5/18/24, showed: -Diagnoses including cognitive communication deficit (difficulty with communication related to cognitive decline), depression, dementia (cognitive decline) without behavioral disturbance, psychotic disturbance, mood disturbance or anxiety. -The resident was moderately cognitively impaired. -The resident exhibited no behaviors or delusions. -The resident had two or more falls within the previous quarter. -The resident received antipsychotics on a routine basis. -A GDR was not attempted and a physician documented a GDR was clinically contraindicated on 5/15/24. Review of a Consultant Pharmacist conducted monthly pharmacy Medication Regimen Review (MRR), dated 6/12/24, showed: -No appropriate diagnosis for the order of Quetiapine. -A recommendation to discontinue the Quetiapine order or add appropriate diagnoses. -A signature on the physician/prescriber response section, dated 6/17/24, with a box checked with Agree and no comments noted. Review of the resident's NP Provider Progress Note dated 7/9/24 showed NP C recommended Quetiapine 50mg twice daily instead of 75mg twice daily. During an interview on 8/13/24 at 11:38 A.M., ADON B said: -He/She had not noticed a change in the resident's behaviors over the previous six months. -The resident could be tearful and irritated then a couple hours later be happy, but he/she was unaware of any other behaviors. -Recommendations from MRR's should be completed by the review the following month. -He/She was unaware of what the physician wanted to do for the MRR on 6/17/24. -He/She would have sought clarification for the physician response to the MRR on 6/17/24. -He/She did not know why Quetiapine was increased for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265759	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's NP Provider Progress Note dated 8/14/24 showed: NP C recommended Quetiapine 50mg twice daily instead of 75mg twice daily. Review of the resident's POS, dated 8/18/24, showed orders for: -Quetiapine 75mg twice daily for delusions beginning 6/14/24. -Behavior monitoring for targeted behaviors (agitation, aggression, crying, withdrawal). -Discontinued orders for Quetiapine as follows: --25mg once at bedtime from 1/18/23 to 3/7/24. --50mg once at bedtime from 3/7/24 to 3/12/24. --50mg twice daily from 3/12/24 to 6/14/24. During an interview on 8/22/24 at 3:10 P.M., Social Services Designee (SSD) A said: -He/She was unaware of any aggressive behaviors by the resident. -He/She did not notice a change in behaviors over the past several months. During an interview on 8/23/24 at 1:09 P.M., the DON said: -ADON A and ADON B were responsible for ensuring MRR's were completed and followed up on. -He/She would expect physician responses to be followed up on by staff. -He/She had not been aware of an increase in behaviors for Resident #50. -He/She would not expect an increase in an antipsychotic medication without an increase in behaviors or another indication. -He/She would not expect an antipsychotic be increased within 24 hours of a resident fall, but would instead have considered a decrease in the medication. 51150 3. Review of Resident #62's Care Plan dated 11/28/23 showed: -The resident had the potential for alterations in psychosocial well-being. -The resident had risk for falls. -The resident was receiving antianxiety medication. -The resident was receiving antidepressant medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's MRR dated 2/20/24 showed: -A recommended GDR for Lorazepam (anti-anxiety) 0.25 mg twice per day (BID). -The physician response was Lorazepam 0.5 mg BID. -No indication/rationale was given for physician's response. Review of the resident's Face Sheet showed the resident was readmitted on [DATE] with the following diagnoses: -Syncope (temporary loss of consciousness caused by a fall in blood pressure), collapse. -Major depressive disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living) single episode, unspecified. -History of falling. -NOTE: Anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus) was not listed. Review of the resident's quarterly MDS dated [DATE] showed: -The resident had a diagnosis of depression. -The resident had no other psychiatric or mood disorders. -The resident was not receiving Antipsychotic Medication (a group of psychoactive drugs (pertaining to a drug or other agent that affects such normal mental functioning as mood, behavior, or thinking processes) commonly but not exclusively used to treat psychosis). -The resident was receiving Antianxiety medication. -The resident was receiving Antidepression medication. Review of the resident's Care Plan dated 6/5/24 showed the resident had depression. Review of the resident's POS dated 7/20/24 showed the following physician's orders: -Lorazepam oral tablet 0.5 mg give 0.25 mg by mouth two times a day for anxiety. Review of the resident's POS dated 8/20/24 showed the following physician's orders: -Lorazepam oral tablet 0.5 mg give 1 tablet by mouth two times a day for anxiety. (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/23/24 at 11:35 A.M. Assistant Director of Nursing (ADON) A said: -GDR recommendations were given to the physician and then given back to the clinical team (ADON's and DON). -There should be a rationale from the physician on all GDR recommendations. -He/She was not sure why the physician would not write a rationale on a recommended GDR on Lorazepam. -He/She would expect that the physician would have written a rationale for not initiating a GDR recommendation on Lorazepam. During an interview on 8/23/24 at 1:31 P.M. the DON said: -If a resident was being treated by a medication for anxiety, the resident should have a diagnosis of anxiety. -ADON A and ADON B were responsible for GDR follow-ups. -If a GDR was recommended by the pharmacist of a psychotropic medication and the physician did not agree with the recommendation, the physician should document a rationale for why they did not agree. -GDR recommendations should be taken care of within a week of receiving them from the pharmacist.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 19916 Based on observation, interview and record review, the facility failed to maintain hot foods on room trays for C and E Hall, at or close to a temperature of 120 F (degrees Fahrenheit) at the time of service; failed to maintain the temperature of milk in glasses on room trays at or close to a temperature of 41 F at the time of service; and failed to evaluate the room tray delivery procedure. This practice potentially affected at least 12 residents who resided on those halls who received room trays towards the end of the room tray delivery time for those halls. The facility census was 84 residents. Review of the Facility's policy entitled Food Temperatures, the Correct Use of the thermometer, dated 2021, showed: -To ensure food safety, food temperatures are taken and recorded. -Food temperatures are taken and recorded on the temperature monitoring log which indicates the correct temperature for each item. -Hot food holding temperature are taken and recorded for food on the steam tables Cold food temperatures are taken and recorded prior to the cold food leaving the kitchen and again in the dining rooms. -A calibrated stem type thermometer is inserted into the thickest part of the food. The sending area of the thermometer (the part of the probe that is below the indentation or dimple) is checked to determine if the indentation or dimple is all the way in the food. and -Corrective action is taken for foods not meeting the temperature standard. 1. Observation on 8/22/24 from 7:03 A.M. to 7:42 A.M. showed the following for C hall: -From 7:03 A.M. to 7:15 A.M., Dietary staff placed trays for C Hall on the cart. -At 7:15 A.M., the room tray cart for C hall, left the kitchen. -At 7:17 A.M. the room tray cart for C Hall arrived at C hall. -At 7:22 A.M., Certified Nursing Assistant (CNA) A and CNA G started to serve trays from the cart. -At 7:24 A. M, CNA A had to stop passing trays to help a resident set up. -At 7:27 A.M. CNA G had to stop passing trays to provide cueing to a resident who kept walking away from the table to sit and eat. -At 7:31 A.M., the temperature of the milk in one of the glasses was measured at 63.9 F. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/22/24 at 7:35 A.M., showed the temperatures of foods on the test tray on C Hall, were the following: -Eggs were 108.1 F. -Bacon was 102.2 F. -The milk was 53.2 F During an interview on 8/22/24 at 7:40 A.M., the Chief Nursing Officer (CNO) said: -He/she had not had a chance to look at the room tray delivery service. -At times, some residents who needed more assistance or more cueing should be served last so that other residents could be served earlier and trays would not sit on the cart and get cold if staff had to help those residents. During an interview on 8/22/24 at 7:42 A.M., CNA G said someone from the dietary department did come down to C Hall and check room trays, but he/she could not remember the last time was that happened. Observation on 8/22/24 at 8:39 A.M., with CNA H showed the temperature of the hot cereal on a test tray for E Hall was 107.4 F. During an interview on 8/22/24 at 9:02 A.M., the Dietary Manager (DM) said he/she checked the temperatures of the room trays randomly, not regularly.

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	265759	A. Building B. Wing	08/27/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 19916 Based on observation and interview, the facility failed to ensure the pureed (food that is blended, chopped, mashed, or strained until it becomes a soft and smooth consistency) sausage was made to a consistency without graininess. This practice potentially affected six residents who consume pureed diets. The facility census was 84 residents. 1. Observation on 8/22/24 at 7:50 A.M., during a taste test showed the texture of the pureed sausage, was grainy (having the existence of small particles). Observation on 8/22/24 at 7:51 A.M., showed Dietary [NAME] (DC) A tasted the pureed sausage and he/she noticed the sausage was grainy also. During an interview on 8/22/24 at 7:51 A.M., DC A said the pureed sausage needed to be smoother. During an interview on 8/22/24 at 7:57 A.M., the Dietary Manager (DM) said the sausage should have been processed in the food processor a little bit longer to be smoother after tasting it. During an interview on 8/22/24 at 10:11 A.M., DC A said he/she had not tasted the sausage after he/she pureed it earlier that morning and before placing the pureed sausage on the steam table. During a phone interview on 8/30/24 at 1:12 P.M., the DM said he/she expected dietary staff to taste the pureed food for proper texture.

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	265759	A. Building B. Wing	08/27/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 19916 Based on observation and interview, the facility failed to maintain the floor under the deep fat fryer and the six burner stove free from a buildup of food debris; failed to maintain the floor under the shelves in the dry good storage room free from dried food debris; failed to maintain the utensil rack free from dust; failed to maintain the sprinkler heads over the back side of the kitchen free from a dust buildup; failed to maintain the temperature of milk in a serving container the dining room at or close to 41 F (degrees Fahrenheit) and failed to maintain the area around the door of the North entrance to the kitchen free from a buildup of dust. This practice potentially affected all residents who ate food from the kitchen. The facility census was 84 residents. 1. Observation on 8/19/24 from 9:49 A.M. to 10:13 A.M., during the initial kitchen review showed: -A buildup of food debris under the shelves the dry goods storage room -A buildup of food debris and one whisk under the six-burner stove, the deep fat fryer and the convection oven, and -A buildup of dust on the sprinkler heads over the side of the kitchen that baking preparation was conducted in. During an interview on 8/19/24 at 10:13 A.M., Dietary [NAME] (DC) A said they have not pulled out the appliances in a few days and collectively, they have been short on dietary staff. Observation on 8/21/24 at 9:48 A.M., showed a buildup of dust on the sprinkler heads located over the baking area of the kitchen. During an interview on 8/21/24 at 9:50 A.M., the Dietary Manager (DM) said he/she did not remember the last time he/she notified the Maintenance Department about cleaning those sprinkler heads. Observation on 8/22/24 from 5:57 A.M. to 8:58 A.M., during the breakfast meal preparation showed: -A buildup of dust on the sprinkler heads over the side of the kitchen that baking preparation was conducted in. -A buildup of dust on the utensil rack over the table. -Milk in a container in the dining room with a temperature of 63 F. -A buildup of dust on the self-closing fixture and the top of the door between the main kitchen and the galley (a long area adjacent to a main kitchen). During interview on 8/22/24 at 9:04 A.M., the DM said the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265759	A. Building B. Wing	08/27/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/she would ask the maintenance department to clean the top of the door between the kitchen and the galley. -He/she had not requested the dietary staff to check the temperature of the milk in the drink cart during the meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 19916 Based on observation, interview and record review, the facility failed to follow its Visitor's Food Policy, by storing foods in the visitor's food refrigerator which were labeled with names of residents the food was for and the dates the foods were received. This practice potentially affected between 3-5 residents. The facility census was 84 residents. Review of the Resident/Visitor food Policy dated 10/19, showed: -Policy -This facility supports and encourages residents to always maintain autonomy of living. The residents may have personal refrigerators to store food brought to the facility by or for the resident or the resident's family. -The facility requires that all food items be stored in a manner using proper sanitation, temperature, light, moisture ventilation and security. -Food and nutrition items brought to the facility by the residents, family members or other visitors will be evaluated by the nursing staff to ensure the items are appropriately and clearly labeled with the resident's name and the contents of packaging, and the date the item was delivered. -If the item is labeled by the food producer with an expiration date, the nurse will confirm the current date is within the labeled timeline. -If the item was not labeled, nursing staff will label and date the food item -Any food brought in from the outside, must be labeled with the resident's name, content, date and room number and will be held in the unit refrigerator. 1. Observation on 8/22/24 at 9:59 AM, showed the following in the resident unit refrigerator: -A sign which stated resident refrigerator only, Every item must be dated, have a resident's name and room number. If not labeled and dated, we will have to toss. -One fruit tray with no name and no date. -Cans of soda with names but no dates. -Three frozen dinners with name and date. -A foam cup in freezer with no name but did have a date. During an interview on 8/22/24 at 10:13 A.M., the Rehab Unit Manager said: -All food and drink should be labeled with a date and the name of the resident. (continued on next page)

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	265759	A. Building B. Wing	08/27/2024

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The items such as the nutrition supplemental drinks should have their own section within the refrigerator.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 19916 Based on observation and interview, the facility failed to ensure the cover of the outdoor dumpster was in good repair to be close fitting and failed to prevent the accumulation of trash on the ground around the outdoor dumpster. The facility census was 84 residents. 1. Observation on 8/22/24 at 10:29 A.M., showed: -The dumpster lid with a 15 inch (in.) long crack. -A significant amount of debris and trash on the ground behind and at the side of the dumpster's. During an interview on 8/22/24 at 10:34 A.M., the Environmental Services (EVS) Director said: -He/she would have to notify the dumpster company for a new dumpster container. -He/she did not know there was a crack in the lid of the dumpster. -Sometimes when employees place trash in the dumpster. they may miss at times and the trash ended up on the ground around the dumpster.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 19916 Based on observation, interview and record review, the facility failed to ensure the audible portion of the call system was operational at the Nurse's area on C Hall (a unit with residents who had some level of dementia), . This practice affected 14 residents who resided on C Hall. The facility census was 84 residents. Review of the description page of the Nurse Call system for the Touchscreen Nurse Console showed: -The Touchscreen Nurse Console is used on the nurse call system as the primary interface among users of the system. -Consoles are typically located in areas where staff congregate and need to communicate with patients, residents and fell ow staff members. -The Console displays incoming calls, including calling station, room number, the bed (A or B), call priority, elapsed time of the call, and other relevant patient information. -The Console has adjustable talk/listen volume settings for each individual patient/staff intercom station. 1. Observation on 8/20/24 at 2:00 PM., showed a call light flashing and alarming on the outside of C Hall but the call light was not audible within C Hall. During an interview on 8/20/24 at 2:03 P.M., the Chief Nursing Officer (CNO) said the alarm did not sound on that unit and then he/she went to answer that call light. Observation on 8/21/24 from 11:21 A.M. through 11:24 A.M., during a call light test showed the following: -The call light in resident room C105 was activated and the sound was heard at the North Unit Nurse's Station which was located outside of the C Hall. -Certified Nursing Assistant (CNA) A had his/her back turned to the hallway while he/she served a resident at the nurse's area. During an interview on 8/21/24 at 11:23 A.M., CNA A said he/she could not hear the call system from where he/she was located at the nurse's area. During an interview on 8/22/24 at 8:16 A.M., the North Unit Manager said he/she told staff on C hall to make regular rounds and the installers of the call light system did not think about placing a Touch Screen Nurse Console at the nurse's area on C hall. Observation on 8/22/24 at 11:37 A.M., showed the call light for resident room C104 was flashing, but there was not an audible sound while the call light from resident room C104 was activated. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/26/24 at 12:13 P. M, the Administrator acknowledged that placing a Touchscreen Console on C Hall would make the call system more audible on that hall.

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	265759	A. Building B. Wing	08/27/2024

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 19916 Based on observation and interview, the facility failed to maintain the covers of cleanouts (an access point which provides access to the sewer or other plumbing line so that blockages could be removed) in a tight fitting manner so the covers would not be a hazard to facility residents or staff located on C Hall and at the area between D Hall and the Rehabilitation Unit Nurse's station. This practice potentially affected 14 residents on C Hall and 19 residents who resided on D Hall and E Hall who would pass through that area. The facility census was 84 residents. 1. Observation on 8/22/24 at 11:01 A.M., showed the cleanout cover on C Hall moved around when the cover was stepped on and the blue tape which once held it to the floor, was broken. During an interview on 8/22/24 at 11:03 A.M., the Environmental Services (EVS) Director said the cap that the screw of the cover, screws into was broken and that caused the cover to be loose. 2. Observation on 8/26/24 at 9:50 A.M., showed the cleanout cover in the area between D Hall and the Rehabilitation Nurse's station moved when it was stepped on. During an interview on 8/26/24 at 9:52 A.M., the Rehabilitation Unit Manager said he/she did not know how long that cleanout cover had been loose. During an interview on 8/26/24 at 10:02 A.M., the EVS Director said when the carpet was removed, the carpet removers accidentally broke the cap that the screw goes into for the cleanout covers.