STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North County Center for Nursing and Rehabilitation	2300 West Broadway Collinsville, OK 74021

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 46909 Based on record review and interview, the facility failed to ensure residents were offered the choice to formulate advanced directives for two (#4 and #7) of two sampled residents reviewed for advanced directives. The DON identified 41 residents resided in the facility. Findings: 1. Res #4 had diagnoses which included chronic kidney disease - stage 3, type 2 diabetes mellitus with diabetic neuropathy, and chronic respiratory failure with hypoxia. The resident's clinical records did not document the resident and/or their representative was offered the choice to formulate an advanced directive. 2. Res #7 had diagnoses which included embolism and thrombosis of unspecified vein, edema, hypokalemia, and cerebral fluid drainage. The resident's clinical records did not document resident and/or their representative were offered the choice to formulate an advanced directive. On 04/01/24 at 10:46 a.m., the social service director stated the facility would starting scanning all advanced directives offered to the resident and/or representative whether they were accepted or refused to show they were offered to them upon admission.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46909 Based on record review and interview, the facility failed to ensure an admission assessment for residents were completed within the required timeframe for one (#246) of 13 residents whose assessments were reviewed. The DON identified 41 residents who resided in the facility. Findings: Res #246 had diagnoses which included congestive heart failure, dementia, psychotic disturbance, mood disturbance, anxiety, hypertension, and pain syndrome. Res #246 was admitted to the facility on [DATE]. The EHR did not document an admission assessment had been completed. On 04/03/24 at 1:40 p.m., MDS coordinator #1 stated the staff nurse assigned to complete the MDS assessments had been out for a family emergency. MDS coordinator #1 stated they have been doing all the assessment and had fallen behind.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33097 Based on record review and interview the facility failed to complete a quarterly assessment within the required time frame two (#14 and #32) of 13 residents whose assessments were reviewed. The administrator identified 41 residents who currently resided in the facility. Findings: 1. Res #32 had diagnoses which included respiratory failure, congestive heart failure, and cerebrovascular disease. The EHR documented a quarterly assessment, dated 12/15/23, had been completed for the resident. The EHR documented a quarterly assessment, dated 03/15/24, was still in progress. On 04/03/24 at 11:54 a.m., the MDS coordinator reviewed the resident's EHR and stated the quarterly assessment dated [DATE] was not completed and should have been. The staff stated the facility was behind on completion of required MDS assessments. 34945 2. Res #14 had diagnoses which included dementia, schizoaffective disorder, and auditory hallucinations. A quarterly MDS assessment, with an ARD date of 03/12/24, documented in progress on the MDS page of the EHR. On 04/02/24 at 3:13 p.m., MDS coordinator #1 stated the quarterly assessment, dated 03/12/24, had not been completed and submitted on time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375504	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 34945 Based on observation, record review, and interview, the facility failed to ensure assessments were encoded and submitted to CMS within seven days of completion of the assessment for one (#16) of 13 residents whose assessments were reviewed. The administrator stated 41 residents were residing in the facility. Findings: Res #16 had diagnoses which included urinary tract infection and cellulitis. The resident's EHR documented a quarterly assessment had been completed on 02/27/24. The EHR documented the facility submitted the assessment on 04/03/24 during the survey. On 04/02/24 at 9:50 a.m., Res #16 was observed in a manual wheelchair moving toward their room. The resident stated they had been receiving an antibiotic for cellulitis in their right leg but did not think they were taking it anymore. On 04/03/24 at 11:59 a.m., MDS coordinator #1 stated someone at the corporate offices had submitted the assessment that morning. They stated the person who submitted the MDS assessment was offsite and not available for interview. The MDS coordinator stated they did not know why this assessment had not been submitted within seven days from completion of the assessment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33097 Based on record review and interview, the facility failed to complete a baseline care plan for three (#31, 45, and #246) of 12 residents whose care plans were reviewed. The DON identified 41 residents who resided in the facility. Findings: 1. Res #31 had diagnoses which included osteomyelitis, stage four pressure ulcer to the left heel, a stage three pressure ulcer to the right heel, diabetes, hypertension, and anxiety. Res #31 was admitted to the facility on [DATE]. The care plan, dated 01/04/24, documented a baseline care plan had been completed six days after admission. On 04/03/24 at 9:19 a.m., the care plan coordinator reviewed the resident's care plan and stated the baseline care plan was completed late. The coordinator stated they completed the baseline care plan upon returning to work. 34945 2. Res #45 was admitted on [DATE] with diagnoses which included non-traumatic intracranial hemorrhage, hypertension, and dementia. The resident's EHR documented a baseline care plan which had been initiated on 02/13/24 which was four days after admission to the facility. On 04/02/24 at 9:25 a.m., MDS coordinator #1 stated the baseline care plan should have been completed within 48 hours of admission. The MDS coordinator stated the admission may have taken place over a weekend and the baseline care plan was not initiated until the care plan staff member returned to work the following week. They stated any nurse could initiate a baseline care plan but it was always completed by the MDS/Care plan staff nurse. 46909 3. Res #246 had diagnoses which included congestive heart failure, dementia, psychotic disturbance, mood disturbance, anxiety, hypertension, and pain syndrome. Res #246 was admitted to the facility on [DATE]. There was not documentation of a baseline care plan in the EHR. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/24 at 1:40 p.m., the MDS stated the other person helping with the baseline care plans so they have been helping but have fallen behind and did not complete a baseline care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan to include the use of bed rails for four (#16, 23, 146, and #246) of four sampled residents reviewed for accident hazards. The DON stated 17 residents at the facility used bed rails. Findings: A policy, titled Care Plans, Comprehensive Person-Centered, dated 03/2022, read in part The comprehensive, person-centered care plan .described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .and reflects currently recognized standards of practice for problem areas and conditions. 1. Resident #16 had diagnoses which included primary osteoarthritis. A physician's order, dated 11/21/23, documented the resident was allowed to use therapeutic devices as needed to assist with positioning changes. On 04/03/24 at 12:40 p.m., Resident #16 was observed to have an assist bar attached to the left side of their bed. A review of the Resident #16's care plan found the assist bar attached to the resident's bed had not been care planned until 04/02/24. 2. Resident #23 had diagnoses which included multiple sclerosis and generalized muscle weakness. A physician's order, dated 07/25/23, documented the resident was allowed to use therapeutic devices as needed to assist with positioning changes. On 04/01/24 at 8:36 a.m., Resident #23 was observed to have half size bed rails on each side of their bed. The resident stated they had the side rails on their bed since they were admitted on [DATE]. A review of Resident #23's care plan found the two bed side rails had not been care planned until 04/02/24. 3. Resident #146 had diagnoses which included broken internal joint prosthesis. An undated admission record documented the resident was admitted to the facility on [DATE]. A physician's order, dated 01/30/24, documented the resident was allowed to use therapeutic devices as needed to assist with positioning changes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/24 at 12:39 p.m., Resident #146 was observed to have side rails attached to the bed they were using. They stated the side rails had been there since they were admitted . A review of Resident #146's care plan found the two bed side rails had not been care planned until 04/03/24. 04/04/24 12:51 p.m., the DON stated the bed side rails had not been care planned for residents #16, 23, and #146 in a timely manner or in accordance with facility policy. 4. Res #246 had diagnoses which included congestive heart failure, dementia, psychotic disturbance, mood disturbance, anxiety, hypertension, and pain syndrome. Res #246 was admitted to the facility on [DATE]. There was not documentation of a comprehensive care plan was available. On 04/03/24 at 1:40 p.m., the MDS stated the other person helping with the assessments and care plans has been out so they helping and have fallen behind with those care plans. They also stated that the comprehensive care plan is complete now.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 34945 Based on record review and interview, the facility failed to develop a discharge summary including a recapitulation of the resident's stay, a reconciliation of the resident's medications, and a post discharge plan of care, for one (#44) of two residents reviewed for discharge from the facility. The DON identified 41 residents who resided in the facility. Findings: Res #44 had diagnoses which included fracture of the shaft of the right fibula, orthopedic after care, osteoarthritis, chronic stage four kidney disease, and diabetes. An admission assessment, dated 12/28/23, documented the resident was intact in cognition. A discharge, return not anticipated, assessment, dated 01/10/24, was documented in the resident's EHR. A social service note, dated 01/10/24, documented Res #14 was discharged from the facility to be admitted to another facility in a different state and would have been transported by a family member. The note documented the new facility had been contacted and were ready to admit the resident. On 04/02/24 at 11:00 a.m., MDS coordinator #1 stated the discharge summary would have been documented in the nursing notes. The MDS coordinator was asked to review the resident's notes. The MDS coordinator stated the notes did not document a discharge summary and did not have a summary of the resident's stay, what interventions the resident had while in the facility and a reconciliation of the resident's medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46909 Based on observation, record review, and interview, the facility failed to ensure the physician was notified of significant weight loss and failed to implement interventions to maintain and/or prevent further weight loss for one (#34) of two sampled resident reviewed for weight loss. The DON identified 41 residents who resided in the facility. Findings: Res #34 was admitted to the facility with diagnoses of tremors, anxiety disorder, weakness, abnormality of gait and mobility, and multiple sclerosis. On 04/19/23 the care plan documents offer supplements or alternates if resident east less than 50% of meals served, or refuses meals. An EHR entry, dated 01/02/24, documented Res #34 had a weight of 145.2 lbs. On 01/26/24 at 07:00 a.m., a dietary order documents, house supplement every day shift for weight loss. An EHR entry, dated 02/04/24, documented Res #34 had a weight of 137.4 lb., a weight loss of 7.8 lbs. A significant change assessment, dated 03/08/24, documented the resident was moderately impaired with cognition and was dependent with all ADLs. The assessment documented the resident had experienced a significant weight loss. On 04/01/24 at 08: 40 a.m., the resident was observed in the dining room eating chocolate ice cream with not supplement offered to resident. On 04/01/24 at 11:23 a.m., the resident was observed in the dining room eating cheesecake with no supplement offered to resident. On 04/04/24 at 12:16 p.m., the MDS Coordinator stated the physician was not notified of any significant weight loss on the resident.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 34270 Based on observation, record review, and interview, the facility failed to attempt alternative interventions prior to the use of bed side rails for three (#16, 23, and #146) of three sampled residents reviewed for accident hazards and failed to assess resident's risk of entrapment prior to use of bed side rails for two (#16 and #146) of three sampled resident reviewed for accident hazards. The DON stated 17 residents at the facility used bed rails. Findings: A policy titled, Bed Safety and Bed Rails, dated 08/2022, read in part, Prior to the installation or use of a side or bed rail, alternatives to the use of side of bed rails are attempted. The policy also documented that after alternatives were concluded to be ineffective the resident would be assessed for their risk associated with the use of bed side rails. 1. Resident #16 had diagnoses which included chronic pain and primary osteoarthritis. An MDS quarterly assessment, dated 02/27/24, documented the resident's cognition was severely impaired. A review of the resident's chart did not find documentation of the attempt to use alternative interventions to the use of bed rails or documentation of a risk assessment performed prior to use of a bed rail. On 04/03/24 at 12:40 p.m., Resident #16 was observed to have an assist bar attached to the left side of their bed. 2. Resident #23 had diagnoses which included multiple sclerosis and generalized muscle weakness. An MDS quarterly assessment, dated 01/30/24, documented the resident's cognition was intact. A review of the resident's chart did not find documentation of the attempt to use alternative interventions to the use of bed rails. On 04/01/24 at 8:36 a.m., Resident #23 was observed to have half size bed rails on each side of their bed. On 04/03/24 at 8:45 a.m., Resident #23 stated they stated no alternative interventions were attempted prior to the use of the side rails. 3. Resident #146 had diagnoses which included a broken internal joint prosthesis. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A MDS five day scheduled assessment, dated 02/24/24, documented the resident's cognition was intact. A review of the resident's chart did not find documentation of attempts to use alternative interventions to bed rails or documentation of a risk assessment performed prior to use of bed rails. On 04/03/24 at 10:31 a.m. the DON stated alternative interventions to the bed rails had not been attempted for residents #16, 23, or #146 prior to their use. At 12:39 PM - Resident #146 was observed to have bed side rails attached on each side of their bed. The resident stated they did not use alternatives to the bed rails prior to their use and did not recall a risk assessment being done before using the bed rails. At 12:51 p.m., the DON stated risk assessments had not been performed on residents #16 and #146 prior to use of bed side rails. They stated the facility staff had not been following policy at it related to the use of bed side rails.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 46909 Based on observation, record review, and interview the facility failed to ensure residents' nutritional issues were supervised by a physician for one (#34) of two residents sampled for weight loss. The DON identified 41 residents who resided in the facility. Findings: Res #34 was admitted to the facility with diagnoses of tremors, anxiety disorder, weakness, abnormality of gait and mobility, and multiple sclerosis. On 04/19/23 the care plan documents offer supplements or alternates if resident east less than 50% of meals served, or refuses meals. An EHR entry, dated 01/02/24, documented Res #34 had a weight of 145.2 lbs. On 01/26/24 at 07:00 a.m., a dietary order documents, house supplement every day shift for weight loss. An EHR entry, dated 02/04/24, documented Res #34 had a weight of 137.4 lb., a weight loss of 7.8 lbs. A significant change assessment, dated 03/08/24, documented the resident was moderately impaired with cognition and was dependent with all ADLs. The assessment documented the resident had experienced a significant weight loss. On 04/01/24 at 08: 40 a.m., the resident was observed in the dining room eating chocolate ice cream with not supplement offered to resident. On 04/01/24 at 11:23 a.m., the resident was observed in the dining room eating cheescake with no supplement offered to resident. On 04/04/24 at 12:16 p.m., the MDS Coordinator stated the physician was not notified of any significant weight loss on the resident.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 33097 Based on record review and interview the facility failed to complete required nurse aide yearly performance reviews for two (CNA #2 and CNA #4) whose employee files were reviewed for competencies. The DON identified 13 nurse aides currently employed by the facility. Findings: The employee file for CNA #2 documented the last skills performance was completed on 09/22/22. The employee file for CNA #4 documented the last skills performance was completed on 09/22/22. On 04/04/24 at 11:34 a.m., the DON reviewed the skills performance checklists provided for two CNAs currently working for the facility. The DON stated to their knowledge no skills performance checks had been completed for the year 2023 for current CNAs. The DON stated they were not aware of the requirement.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34270 Based on observation, record review, and interview, the facility failed to maintain an ice machine in a sanitary condition. The DON stated all 44 residents received ice from the ice machines. Findings: The facility's Sanitation policy, dated 11/2022, read in part, The food service area is maintained in a clean and sanitary manner. On 04/03/24 at 11:13 a.m., the DM wiped the inside of a ice machine located in a employee only hallway next to the kitchen. The cloth came back with a black substance covering it. The DM stated the ice machine provided ice to the residents. The DM stated the ice machine was cleaned once every six month. At 11:42 a.m., the administrator stated the ice machines were cleaned every six months and they would provide documentation of those cleanings. The administrator offered two invoice for inspection and cleaning of two ice machines, dated 12/29/23 and 01/31/24. They did not have any other documentation. On 04/04/24 at 8:05 a.m., the DM stated they had turned off the ice machine that was found to be dirty and the second had not been working for several weeks and was due for repair. They stated the contractor that would clean the dirty machine was due to come to the facility that day or the next. They stated they would purchase ice from a local vendor until theirs is clean. The stated they do not monitor the ice machines for cleanliness on a schedule and do not document inspection of the ice machines. They stated the machines were scheduled to be cleaned every six months.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 33097 Based on observation, record review, and interview, the facility failed to maintain an infection prevention and control program to prevent the transmission of infections: a) for resident #10 during catheter care, b) for resident #21 during incontinent care, and c) implement a water treatment program for the prevention of Legionella. The administrator identifed five residents with a catheter/receive incontinent care. Findings: A handwashing/hand hygiene policy documented .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based had rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies . A policy titled Catheter Care, Urinary documented .Steps in the Procedure .2. Wash and dry your hands thoroughly .5. Put on gloves .11. With non-dominant hand .retract the foreskin of the uncircumcised male resident. Maintain the position of this hand throughout the procedure .18. Discard disposable items into designated containers. Remove gloves and discard into designated container. Wash and dry hands thoroughly . 1. Res #10 had diagnoses which included a stage four pressure ulcer to the sacral region and the lower back, a stage three pressure ulcer to the right heel, and diabetes. A care plan, dated 12/21/23, documented the staff was to wear a gown and gloves while providing care to enhance barrier protection due to a multi-drug resistant organism in the resident's wound to reduce the potential to spread bacteria to other sites of my body or to other people. A physician order, dated 02/20/24, documented the staff was to change the resident's catheter every 30 days for infection control. A quarterly assessment, dated 02/23/24, documented the resident was moderately impaired for daily decision making and had a catheter. A physician order, dated 03/07/24, documented the staff was to provide catheter care every morning and at bedtime. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER North County Center for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 West Broadway Collinsville, OK 74021	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/24 at 1:50 p.m., a sign was observed posted by the resident's door. The sign documented . ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities .Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, . CNA #1 entered the resident's room, donned a pair of gloves, and began repositioning the resident from side to side and reaching across the resident to remove a soiled incontinent brief. The CNA was not wearing a gown. Wearing the same gloved hands the CNA obtained some adult wipes from a packet and continued to clean the resident. The staff changed their gloves three more times during the cleaning process the process. The staff did not wash their hands with glove changes. The staff stated they would wash their hands after care was completed. On 04/03/24 at 3:15 p.m., the DON was interviewed regarding catheter care for the resident. The DON stated the CNA should have used PPE identified on the sign posted at the door. The DON stated the CNA should have changed their gloves and washed their hands when moving from a dirty area to a clean area and between task. 2. Res #21 had diagnoses which included hemiplegia and hemiparesis following a cerebral infarction and mixes incontinence. The care plan, dated 03/31/23, documented the resident was incontinent of bowel and bladder. A quarterly assessment, dated 01/04/24, documented the resident was incontinent of bowel and bladder. The assessment documented the resident required partial/moderate assist with toileting. On 04/04/24 at 10:15 a.m., the resident was lying in bed with their call light activated. The resident stated they had been incontinent of bowel and had activated their call light to be cleaned up. CNA #2 entered the resident's room and donned a pair of gloves. The CNA positioned the resident in bed, removed the soiled undergarment, and cleaned the resident's buttock with adult wipes. Using the same gloved hands the CNA placed a clean undergarment on the resident, assisted the resident with dressing, and assisted the resident to their wheelchair. The CNA removed their gloves and washed their hands. On 04/04/24 at 10:37 a.m., CNA #2 stated they should have changed their gloves and washed their hands when they finished incontinent care and before placing a new adult brief on the resident. The CNA stated they did not change their gloves and wash their hands during care. 34945 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 04/03/24 at 9:40 a.m., the Administrator stated they had received the new water management program from the corporation when they bought this facility during the previous year. The administrator stated the program had not been instituted as yet. The administrator stated they were going to ask the city who tested the water. When asked the facility did anything to prevent standing water and they stated the management team flushed the toilets in unoccupied rooms when during daily rounds. The administrator was asked for documentation of this and stated there was not documentation of the rounds. The administrator was asked if they had followed the new policy and conducted a risk assessment of the facility. The administrator stated not yet. The administrator was asked if a water management team had been assembled to meet and identify issues and possible responses for identified issues, they stated they had not formed a team. The administrator stated the only thing that he had done was to contact the city to determine who can test the water. The administrator was asked to review the water management program and they stated they had not started the program. At that time, the maintenance supervisor stated they ran water in all the unoccupied rooms and the air conditioners had pipes to drain the condensation from under the units. The maintenance supervision stated they did not have a schematic for the piping in the facility and had not conducted an assessment of the facility to identify areas of potential areas where standing water could have been a problem.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on observation, record review, and interview, the facility failed to conduct regular inspections of resident beds and failed to inspect resident beds for safety prior to the attachment and use of bedrails for three (#16, 23, and #146) of three sampled residents reviewed for accident hazards. The DON stated 17 residents at the facility used bed rails. A Resident Listing Report, dated 04/01/24 documented 44 resident resided at the facility. Findings: A policy titled, Bed Safety and Bed Rails, dated 08/2022, read in part, Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. The policy also read Maintenance staff routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks. 1. Resident #16 had diagnoses which included chronic pain and primary osteoarthritis. An undated admission record documented the resident was admitted to the facility on [DATE]. A physician's order, dated 11/21/23, documented the resident was allowed to use therapeutic devices as needed to assist with positioning changes. An MDS quarterly assessment, dated 02/27/24, documented the resident's cognition was severely impaired. On 04/03/24 at 12:40 p.m., Resident #16 was observed to have an assist bar attached to the left side of their bed. 2. Resident #23 had diagnoses which included multiple sclerosis and generalized muscle weakness. An undated admission record documented the resident was admitted to the facility on [DATE]. A physician's order, dated 07/25/23, documented the resident was allowed to use therapeutic devices as needed to assist with positioning changes. An MDS quarterly assessment, dated 01/30/24, documented the resident's cognition was intact. On 04/01/24 at 8:36 a.m., Resident #23 was observed to have half size bed rails on each side of their bed. On 04/03/24 at 8:45 a.m., Resident #23 stated they were unaware of any safety assessment or inspections regarding their bed of the use of bed rails prior to the use of their bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #146 had diagnoses which included broken internal joint prosthesis and infection following surgery. An undated admission record documented the resident was admitted to the facility on [DATE]. A physician's order, dated 01/30/24, documented the resident was allowed to use therapeutic devices as needed to assist with positioning changes. A MDS five day scheduled assessment, dated 02/24/24, documented the resident's cognition was intact. On 04/03/24 at 12:39 p.m., Resident #146 was observed to have side rails attached to the bed they were using. They stated they did not recall and assessments or inspections regarding their bed and bed rails prior to their use of the bed. On 04/04/24 at 8:21 a.m., the Maintenance Supervisor stated they had not been informed the beds required routine inspections or that bed rails required an inspection prior to use. They stated they had not done either. They stated they were unaware of any documentation of routine inspections having been done in the past. At 12:51 p.m., the DON stated they had not been following policy regarding inspections of the beds and bed rails but would do so in the future.