STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675779	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marine Creek Nursing and Rehabilitation	3600 Angle Ave Fort Worth, TX 76106

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview, and record review the facility failed to review and revise the person-centered comprehensive care plan to reflect the resident's current status, for 1 (Resident #1) of 5 residents reviewed for care plans. The facility failed to ensure Resident #1's care plan reflected behaviors of not using the call light when he needed assistance, removing his CPAP mask, and throwing both to the floor when agitated. This deficient practice could place residents at risk of not receiving appropriate care and interventions to meet their current needs. Findings include: Record review of Resident #1's face sheet, dated on 05/02/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Acute Respiratory Failure (lungs cannot Exchange Oxygen and Carbon Dioxide) with Hypoxia (low oxygen), Emphysema/COPD (air flow blockage and breathing), Atrial Fibrillation (irregular or rapid heart rhythm), Dementia (cognitive decline). Record review of Resident #1's admission MDS, dated [DATE], revealed a BIMS score of 02, indicating the resident was severely cognitively impaired. Resident #1 had a resident mood interview severity score of 3, indicating minimal depression. Resident #1's required maximal assistance for with ADLs of bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Resident #1's requires continuous respiratory oxygen therapy, CPAP (Continuous positive airway pressure), and non-mechanical ventilator, non-invasive respiratory support (NIV). Record review of Resident #1's care plan, dated 02/29/24, reflected, the resident has Emphysema/COPD. Monitor/document/report to MD PRN any s/sx of respiratory infection: Fever, Chills, increase in sputum (document the amount, color, and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing .the resident has a communication problem .monitor resident frustration levels .affective communication strategies and assistive care .Resident requires the use of CPAP related to sleep apnea. The care plan did not address Resident #1's behaviors of throwing the call light and BPAP on the floor, also his ability to use the call light r/t dementia. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's revised care plan focus dated 05/02/24 reflected Resident requires the use of CPAP related to sleep apnea .Resident able to remove mask himself when he wakes up .intervention, Resident will use device as ordered. The care plan did not address behaviors and actions for not using call light, throwing call light on the floor, and disassembling CPAP hose and throwing on the floor when he gets agitated. Record review of Resident #1 's physician's order, dated 04/17/24 at 2:00 P.M. reflected May have oxygen at 2-5 l/m via nasal cannula to maintain O2 sats above 92% Q shift .May use home CPAP at home settings at night and when napping. There were no MD orders to address changing oxygen tubing and bagging CPAP when not in use. In an observation and interview on 05/02/24 at 10:45 A.M., Resident #1, revealed a nasal cannula positioned in the nasal canal properly with tubing connected to the oxygen concentrators. The CPAP mask was lying on the floor under the bed, and the disconnected hose to CPAP lying across the back of the resident's head. The call light was in the resident's left hand. He stated that I'm not doing good, this call light does not work, I don't' know how the hose got loose. Resident #1 denied SOB. The interview with Resident #1's interview was limited due to confusion r/t dementia. In an interview on 05/03/24 at 2:16 P.M., ADON M stated that she managed the staff caring for Resident #1. ADON M stated Resident #1 has behaviors of removing his CPAP mask and hose connected to the mask, throwing mask on the floor, when agitated, inability to use call light system, and yelling out for assistance. ADON M stated these behaviors have been increasing since when his POA was out recovering from surgery for 6 weeks. ADON M stated the DON was responsible for updating care plans timely with interventions. ADON M stated herself and staff nurses were responsible for reporting and monitoring resident care and ensuring all information for residents' treatments were provided to the DON for care plans. ADON M said the risk of not updating timely changes to care plans, could lead to the resident receiving inadequate care and timely. In an interview on 05/03/24 at 2:28 P.M., the DON stated she was responsible for updating the care plans with changes to care, behaviors, treatments, and MD orders. She stated that she failed to update Resident #1's care plan to reflect his behaviors related to call light and CPAP. The DON stated that she was aware that Resident #1 had behaviors of removing CPAP mask from the hose and throwing to the floor. The DON said Resident #1 does not use the call light, due to memory decline, and yelling out for help. She stated that this was not documented in the care plan. The DON stated the risk to the resident for not updating the care plan for treatments and behaviors could lead to a decline in breathing and staff monitoring of timely care needs. She stated that she expects the nursing staff to follow up and report new orders, changes in behaviors, and communicate timely for updates to DON and ADM to ensure timely changes to the comprehensive care plans. In an interview on 05/03/24 at 3:53 P.M., the ADM was un-aware of resident behaviors with the call systems and removing CPAP equipment. She expects nursing staff to communicate behaviors to the DON timely to provide the necessary care plan updates. The ADM said some behaviors such as removing mask may not be addressed in the care plan. She said the DON was responsible for updating residents care plans with new medical information, care needs, and level of functioning. She does not know the risk of the resident's care plans not being updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Comprehensive Care planning, undated read in part: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs .the facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. Care plans will be person-centered and reflect the resident's goals for admission and desired outcomes. Person centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home. Residents' goals set the expectations for the care and services he or she wishes to receive. Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care for 4 of 5 resident's (Resident #1, Resident #3, Resident #5, and Resident #7) reviewed for respiratory care. 1. The facility failed to ensure Resident #1's oxygen tubing was dated, and his CPAP mask and portable nasal cannula on his wheelchair were bagged and dated when not in use. 2. Resident #3, #5, and #7's oxygen tubes were not labeled, stored, and changed for resident. These failures affected resident's and placed them at risk of not receiving the needed services for respiratory care. Findings include: Resident #1 Record review of Resident #1's face sheet, dated on 05/02/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Acute Respiratory Failure (lungs cannot Exchange Oxygen and Carbon Dioxide) with Hypoxia (low oxygen), Emphysema/COPD (air flow blockage and breathing), Atrial Fibrillation (irregular or rapid heart rhythm), Dementia (cognitive decline). Record review of Resident #1's admission MDS, dated [DATE], revealed a BIMS score of 02, indicating the resident was severely cognitively impaired. Resident #1 had a resident mood interview severity score of 3, indicating minimal depression. Resident #1's required maximal assistance for with ADLs of bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Resident #1's requires continuous respiratory oxygen therapy, CPAP (Continuous positive airway pressure), and non-mechanical ventilator, non-invasive respiratory support (NIV). Record review of Resident #1's care plan, dated 02/29/24, reflected, the resident has Emphysema/COPD. Monitor/document/report to MD PRN any s/sx of respiratory infection: Fever, Chills, increase in sputum (document the amount, color, and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing .the resident has oxygen use therapy initiated on 02/29/24 .Resident Requires the use of CPAP/BPAP r/t sleep apnea .the resident is at risk for falls initiated 02/29/24. Record review of Resident #1 's physician's order, dated 04/17/24 at 2:00 P.M. reflected May have oxygen at 2-5 l/m via nasal cannula to maintain O2 sats above 92% Q shift .May use CPAP from home with home settings at night. There were no MD orders to address changing oxygen tubing and bagging when not in use to maintain sanitation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 05/02/24 at 11:40 A.M., Resident #1 was lying in bed on his back with a nasal cannula positioned appropriately in his nasal canal. The oxygen concentrator was powered on and appeared to be working properly. The CPAP hose was observed lying across the top of Resident #1's head, detached from CPAP mask. The CPAP mask was observed lying on the floor under the bed. The nasal cannula tubing was not dated. Resident #1 was agitated and confused. The resident's call light was in his left hand, and he stated that it did not work. The Surveyor pressed the roommates call light at 10:47 A.M. for resident assistance. At 10:51 AM, the surveyor searched for staff in the hallway and asked an employee passing by to locate the nurse or CNA. At 10:59 AM, ADON M and ADON S entered the room with 2 other staff. ADON S examined the nasal cannula tubing and concentrator, stating that it was not dated. ADON S picked up the CPAP mask, and stated it would be cleaned before the resident's next use. Additionally, Resident #1's wheelchair was stored outside of his room in the hallway, with an oxygen tank attached and nasal cannula tubing that was undated and unbagged for sanitation. In an observation of Resident #1 on 05/03/24 at 10:45 A.M. revealed his CPAP mask placed in the top drawer of the nightstand unbagged. Resident #1's nasal cannula was connected to the concentrator and was not dated. His wheelchair was parked in his room, with the nasal cannula lying in the seat of the wheelchair undated and unbagged. Resident #3 Record review of Resident #3's face sheet, dated on 05/02/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease Asthma (lung inflammation), heart failure. Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 7, indicating severe cognitive impairment. She required treatment for continuous oxygen, maximum assistance for bed mobility and ADL care. Review of Resident #3's care plan dated 02/27/24 reflected The resident has Asthma. Educate resident to use pursed-lip breathing. Educate resident/family/caregivers regarding side effects and overuse of inhalers and nebulizers. Encourage prompt treatment of any respiratory infection. Give medications as ordered. Review of Resident #3's physician order dated 03/27/24 reflected Check O2 sat Q 2 hrs and PRN every 2 hours AND as needed .Ear Padding for Continuous Oxygen via Nasal Cannula. May use oxygen @_2-3___l/m via nasal cannula every shift as needed. The resident's medical orders did not address tube changing, tube dating, and bagging when not in use. In an observation on 05/02/24 at 11:40 A.M. revealed Resident #3 sitting in her wheelchair with nasal cannula removed and she was holding it in her right hand. Resident had an oxygen tank attached to the back of her chair, and the tubing was undated. Resident #3 also had an oxygen concentrator located next to her bed and window powered on with the nasal cannula tubing attached to the machine. The nasal cannula was observed on the floor under bed with the tubing connected to the bed rail. The nasal cannula tubing was not dated nor bagged for sanitation when not in use. An attempt to interview Resident #3 was unsuccessful due to the resident being confused. The resident was not able to answer any questions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 Record review of Resident #5's face sheet, dated on 05/02/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of A-fib (abnormal heath rhythm), CHF (impaired heart r/t blood flow), COPD, CAD (reduced blood flow). Record review of Resident #5's quarterly MDS dated [DATE] reflected a BIMS score of 11, indicating moderate cognitive impairment. She required supervision as needed for bed mobility and ADL care. Resident receives oxygen treatment. Record review of Resident #5's care plan dated 04/20/24 reflected the resident has Emphysema/COPD Give oxygen therapy as ordered by the physician. Head of bed to be elevated (semi-Fowlers to fowlers) or out of bed upright in a chair during episodes of difficulty breathing (Dyspnea). Report to nurse if increased difficulty . Monitor and report to nurse for s/sx of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB at rest, monitor for difficulty breathing (Dyspnea) on exertion. The resident has Oxygen Therapy Change residents position every 2 hours to facilitate lung secretion movement and drainage for residents who should be ambulatory, provide extension tubing or portable oxygen apparatus. Oxygen at l/pm per nasal When on side, the good side should be down (e.g., damaged lung should be up). The resident's care plan did not address tube changing, tube dating, and bagging when not in use. Review of Resident #5's physician order dated 05/03/24 reflected May use oxygen @ 2-4 l/m via nasal cannula to maintain O2 sats greater than 90%. every shift Phone Active 05/03/2024. Observation of resident room on 05/02/24 at 11:43 A.M. revealed Resident #5 had an oxygen concentrator next to her bed with the nasal cannula tubing attached to concentrator. The nose prong was found wrapped around the bed rail and remainder of the hose was touching the floor. The tubing was undated and unbagged. Resident #5 was not in her room during observation. In an interview with Resident #5 at 3:30 P.M. in the dining room eating snacks. She stated that she was not having any difficulty breathing, and the staff was changing the tubing often. She could not recall the last time her tubing was changed. Resident #7 Record review of Resident #7's face sheet, dated on 05/03/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation (worst, more severe). Record review of Resident #7's quarterly MDS dated [DATE] reflected a BIMS score of 15, indicating intact cognitive response. He required supervision for bed mobility, eating and ADL care. Limited assistance for toileting. Resident received treatment for oxygen COPD, SOB. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's care plan undated reflected, Resident #7 was at risk for complication r/t COPD, will be free of s/sx of respiratory infections through review date .Give oxygen therapy as ordered by the physician. Ear padding as needed .Head of bed to be elevated (semi-Fowlers to fowlers) or out of bed upright in a chair during episodes of difficulty breathing (Dyspnea) .Report to nurse if increased difficulty breathing .Monitor and report to nurse for s/sx of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB at rest, Cyanosis (bluish discoloration in skin), Somnolence (sleepy; drowsy) .Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance. Review of Resident #7's physician order revealed dated 02/04/21 may use oxygen @ 2_l/m via nasal cannula every shift related to COPD with exacerbation. In an observation and attempted interview with Resident #7 on 05/03/24 at 11:59 AM revealed resident in his wheelchair at the bathroom sink washing his hands. His nasal cannula was connected the portable oxygen tank and positioned in his nose and tubing was undated. The Resident #7's oxygen concentrator was observed next to his bed, with the hose wrapped in a circular pattern lying on top of his oxygen concentrator unbagged and undated. Surveyor spoke to resident several times; however, he did not respond. In an interview on 05/03/24 at 2:00 P.M., CNA A stated that all staff are responsible for ensuring resident oxygen tubing was bagged when not in use to prevent infections. She stated that she placed Resident #1's CPAP mask inside a bag and placed in the top drawer of his nightstands this morning. She stated that it was important to bag the oxygen tubing and CPAP mask when the resident was not using the device for infection prevention. She stated that nursing staff were responsible for cleaning the CPAP mask. In an interview on 05/03/24 at 2:10 P.M., RN K was the charge nurse assigned to Resident #1. She stated the night nurses changed the oxygen tubing once a week, usually on the weekend. She stated that tubing should be dated when changed. RN K stated that she did not observe resident #1's tubing lying in his wheelchair seat unbagged and dated nor the date on the nasal cannula in use. She checks the resident's tubing for air flow every two hours. RN K said it was the responsibility of the nurse on duty to clean CPAP mask daily. She had not cleaned the mask on her shift today. She stated that she did not remove Resident #1's mask this morning, and she was unaware that it was not bagged. She stated that respiratory tubing and mask should be bagged when not in use to prevent infections. She stated the consequences of not changing the oxygen tubing would be risk for infection. In an interview on 05/03/24 at 2:00 P.M., the ADON S stated that she manages the staff caring for Resident's #3, #5, and #7. She conducts frequent rounds to check on resident care. She states that the facility policy states that tubing should be changed when visibly soiled, damaged, or found undated and unbagged. RN K said the CPAP mask and tubing should be cleaned daily by the staff nurse with warm water and soap. She stated the risk of not dating the oxygen tubing could result in the overuse of tubing, infections, and resident respiratory problems. In an interview on 05/03/24 at 2:16 P.M., the ADON M stated that she managed the staff caring for Resident #1. ADON M stated Resident #1 has an order for CPAP and oxygen use r/t COPD. She stated herself and staff nurses were responsible for monitoring, dating, and changing resident nasal cannula tubing, this including cleaning the CPAP mask daily. ADON M said the risk of not dating tubing could lead to overuse and infections for the resident, poor air quality, and SOB. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/03/24 at 2:28 P.M., the DON stated the consequences of not dating and changing resident tubing could be infection, poor air quality, and overuse of tubing. She stated that is why dating the tubing and cleansing the CPAP mask are important. The DON stated the oxygen tubing should be stored in a bag when not being used. She stated she was responsible for following up on orders. The DON stated the facility policy did not require weekly tubing changing. The tubing was replaced with soiled, on the floor, found undated to ensure resident prevention for infections. In an interview on 05/03/24 at 3:53 P.M., the ADM stated she expects nursing staff to change nasal cannula's when visibly soiled, dirty, and found on the floor. She states nursing staff should be bagging respiratory tubing of resident's when not in use. Review of the facility policy undated Oxygen therapy includes the administration of oxygen (O2) in liters/minute (1/mm) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. 02 therapy is also Prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of; concentration or L/min, and the method of administration, is ordered by the physician. The Id ministration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The nasal cannula delivers 22-40 % oxygen and is the most common, inexpensive, and easiest device to use. Common oxygen sources for long-term administration include cylinder (portable or stationary) or wall system near the resident's bed, concentrator. Goa1s: 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen. 2. The resident will maintain an effective breathing pattern with administration of oxygen. 3. The resident will be free from infection. Change the tubing (including any nasal prongs or mask) that is in use on one patient when it. malfunctions or becomes visibly contaminated. Document care. Wash hands. Dehydration. Oxygen concentrators should be cleaned according to manufacturer recommendations. Change or clean oxygen concentrator filters according to manufactures' recommendations.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview, and record review, the facility failed to be adequately equipped to allow for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 6 residents (Resident #1) reviewed for resident call system, in that. Resident #1s call lights was on the floor and not within reach. This could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: Resident #1 Record review of Resident #1's face sheet, dated on 05/02/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Acute Respiratory Failure (lungs cannot Exchange Oxygen and Carbon Dioxide) with Hypoxia (low oxygen), Emphysema/COPD (air flow blockage and breathing), Atrial Fibrillation (irregular or rapid heart rhythm), Dementia (cognitive decline). Record review of Resident #1's admission MDS, dated [DATE], revealed a BIMS score of 02, indicating the resident was severely cognitively impaired. Resident #1 had a mood interview severity score of 3, indicating minimal depression. Resident #1's required maximal assistance for with ADLs of bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Record review of Resident #1's care plan, dated 02/29/24, reflected, the resident was a risk for falls and the intervention reflected, anticipate resident needs, be sure the call light was in reach, and encourage the resident to use it for assistance the care plan did not address Resident #1's ability to use call light or behaviors of throwing the call light on the floor. Resident has a communication problem, intervention, ensure/provide a safe environment: Call light in reach, adequate low glare light, bed in lowest position, and wheels locked. Avoid isolation. There was no documentation of resident behaviors or difficulty using call light. In an observation and interview on 05/03/24 at 10:45 A.M. revealed Resident #1's call light lying on the floor under his bed. Resident was agitated stating No, I not doing well, no one have come to help me out of bed. In an interview on 05/03/24 at 2:00 P.M., CNA A stated that she conducts rounds with Resident's every 2 hours. She said she was unaware that Resident #1's call light was on the floor. She stated Resident #1 usually yells out for help when he needs assistance. She educates him on the use of the call light frequently throughout the shift. She said that Resident # 1 throws his call light on the floor, and he does use the call system for help. CNA A had not reported behaviors to ADON and DON for additional interventions to be developed. (continued on next page)

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/03/24 at 2:10 P.M., RN K was the assigned charge nurse assigned to Resident #1. She stated she did not know that Resident #1's call light was on the floor and not in reach. She stated the nurse and CNA conduct frequent rounds to ensure resident call light was within reach. Surveyor observed RN K picking up the call light, cleaning with bleach wipes and placing in the resident's hand. She stated residents with confusion and who are bed bound should have call light in reach to call for assistance. The risk of resident call lights not being in reach could result in falls, needs not getting met, anxiety, agitation. During an interview on 05/03/24 at 2:28 P.M., the DON said the residents should be able to call the nurse in case of an emergency. She said the call lights within the resident reach at all times, as well as educated on the use of the light. The DON said the nurses and CNAs were checking on the residents every 2 hours. She said the possible negative outcome of not having someone to monitor the call light system on Hall 100 could be injury to the resident. The DON said not all residents with behaviors and confusion require documentation in the care plan or Kardex (documentation system that allows nurse to write, organize, and easily reference key patient information that shapes their nursing care plan. During an interview on 05/03/24 at 3:53 P.M., the Administrator stated she has been licensed for over [AGE] years in Nursing facility regulations. She said her expectations were for the residents to be able to call the nurse in case of an emergency. She said the possible negative outcome could be injury to the residents. She expects the DON and ADON's to monitor and report resident changes in care, behaviors, and needs to the IDT to review, update, and add needed interventions for resident when necessary. The surveyor requested call light policy from the ADM and DON on 05/03/24 at 1:45 PM. The ADM stated that the facility does not have a call light policy.