STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676132	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trail Lake Nursing & Rehabilitation	7100 Trail Lake Dr Fort Worth, TX 76133

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 residents (Resident #28) reviewed for comprehensive care plans. The facility failed to ensure Resident #28's care plan included contractures. This failure could place residents at risk of not receiving all care and services to address diagnoses. Findings included: Record review of Resident #28's, undated, Admission Record reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #28 had diagnoses which included cerebral infarction (stroke) due to thrombosis (blocked artery in the brain) of other precerebral artery, muscle wasting and atrophy, contracture of muscle, hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left non-dominant side. Record review of Resident #28's quarterly MDS, dated [DATE], reflected a BIMS score of 99, which indicated the resident was unable to complete interview. Section GG- Functional limitation in range of motion Resident #28 had impairment on one side upper extremity (shoulder, elbow, wrist, hand). Resident #28 did not require a splint or brace assistance. Record review of Resident #28's Care Plan, revised 05/03/24, reflected: Problem: ADLs Functional Status/Rehabilitation Potential [Resident #28] has self-care deficit: requires assistance. Total- Staff Preforms/Provides Total Assistance Goal: Will maintain ability to participate with self-care at current level as evidenced by ADL score remaining 1/2 pt -/+from current score through review date. Will anticipate and meet needs while giving cues/direction to preform ADL at their ability through next review date. Will be clean, dry and free from odors with dignity maintained through next quarter. The Care Plan did not address Resident #28's range of motion. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 06/11/24 at 10:32 AM revealed Resident #28 lying in bed with her eyes open. Resident #28's left hand was contracted. Resident #28 was unable to communicate verbally; however, she could answer yes or no questions. Resident #28 denied using any devices for her left hand. Resident #28 denied any pain. Observation on 06/13/24 at 9:42 AM revealed Resident #28 lying in bed with her eyes open. LVN B opened the resident's left hand to conduct a skin assessment, and the resident had long fingernails that created indents in her palm. Between her fingers and palm, there was a yellow/white substance that emitted a foul odor. Interview on 06/13/24 at 10:03 AM with LVN B revealed she was the nurse assigned to Resident #28. LVN B stated based on nursing judgement Resident #28 should have had at least a washcloth placed in her left hand. LVN B stated she was unsure if Resident #28 was care planned for contractures. LVN B reviewed Resident #28 care plan and stated it did not address the resident's contractures. She stated she was not sure who was responsible for updating care plans. Interview on 06/13/24 at 3:35 PM with the ADON revealed all nursing staff were responsible for updating care plans. The ADON stated she was unsure if Resident #28's contractures were care planned. Interview on 06/14/24 at 12:49 PM with the Social Worker revealed she had been employed at the facility since 05/20/24. She stated the facility was behind on care plans, and she caught them up. She stated she was responsible for conducting the care plan conference. She stated resident contractures or anything that was out of the norm should be care planned. She stated she was not aware Resident #28's contractures were not care planned. She stated the nursing staff were responsible for creating the care plans in the system. She stated the risk of not care planning was that it could lead to staff not knowing how to adequately care for the patient. Follow-up interview on 06/14/24 at 1:53 PM with the ADON revealed Resident #28's contractures were not care planned, and she was not sure why. She stated they might have missed it. She stated it was the responsibility of all nursing staff to update care plans, and it was her responsibility to ensure they were completed. She stated the risk with a care plan not reflecting a resident's care would be staff not knowing how to care for the resident. Interview on 06/14/24 at 2:05 PM with the DON revealed residents who had contractures or limited range of motion should be care planned. She stated it was the responsibility of all nursing staff to update care plans. The DON stated she was not aware Resident #28's contractures were not care planned. The DON stated there was no risk to residents if care plans were not up-to-date due to nursing staff having other ways to communicate. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #28's Care Plan, revised 06/13/24 at 4:29 PM, reflected: Problem: Category: ADLs Functional Status/Rehabilitation Potential mobility impairment: [decreased functional limitation in ROM (range of motion) to Left hand and bilateral legs. Goal: resident will have no further decline of functional ability/mobility over next quarter. Approach: assess for pain to determine pain issues that may be related to functional impairment. assess skin under contracture management device(s) daily and report any skin changes to charge nurse/ MD/ Family per policy. contracture management device(s) as per orders and review continued need for device quarterly, annually, and with significant change or prn (as needed). ensure staff aware of resident's mobility/ADL impairment(s). keep contracted areas clean and dry, provide PROM (Passive Range of Motion)- do not force contracted areas Flowsheet: ADL Twice A Day; 07:00, 19:00 [7:00 PM]. Record review of the facility's Care Plans-Comprehensive policy, revised September 2010, reflected: .1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain .4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan .8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's condition

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 10 residents (Residents #28, #32 and #43) reviewed for ADL care. 1. Staff failed to provide hygiene and nail care to Resident #28's contracted hand. 2. Staff failed to provide nail care for Resident #32. 3. Staff failed to provide nail care and shaving for Resident #43. These failures could place residents at risk of decreased feelings of self-worth. Findings included: 1. Record review of Resident #28's, undated, Admission Record reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #28 had diagnoses which included cerebral infarction (stroke) due to thrombosis (blocked artery in the brain) of other precerebral artery, muscle wasting and atrophy, contracture of muscle, hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left non-dominant side. Record review of Resident #28's quarterly MDS, dated [DATE], reflected a BIMS score of 99, which indicated the resident was unable to complete the interview. Section GG reflected Functional limitation in range of motion Resident #28 had impairment on one side upper extremity (shoulder, elbow, wrist, hand). Resident #28 did not require a splint or brace assistance. Record review of Resident #28's Care Plan, revised 05/03/24, reflected: Problem: ADLs Functional Status/Rehabilitation Potential [Resident #28] has self-care deficit: requires assistance. Total- Staff Preforms/Provides Total Assistance Goal: Will maintain ability to participate with self-care at current level as evidenced by ADL score remaining 1/2 pt -/+from current score through review date. Will anticipate and meet needs while giving cues/direction to preform ADL at their ability through next review date. Will be clean, dry and free from odors with dignity maintained through next quarter. Observation on 06/13/24 at 9:42 AM revealed Resident #28 lying in bed with her eyes open. LVN B opened the resident's left hand for skin assessment, and the resident had long fingernails that created indents in her palm. Between her fingers and palm, there was a yellow/white substance that emitted a foul odor. The was no evidence of skin breakdown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/13/24 at 10:03 AM with LVN B revealed she was the nurse assigned to Resident #28. LVN B stated Resident #28's left hand should be cleaned in between and during her baths. She stated when she opened Resident #28's hand, it had a smell to it . LVN B stated based on nursing judgement Resident #28 should have had at least a washcloth placed in her left hand. She stated if a resident was diabetic, it was the responsibility of the nurses to cut the residents' fingernails. She stated if the resident was not diabetic, it was the responsibility of the CNAs and nurses to cut the resident's fingernails. She stated Resident #28 was not diabetic. LVN B stated she was not sure when was the last time resident's fingernails were last cut. She stated the risk of not cleaning the resident's hand and not keeping the resident's fingernails short was that it could lead skin breakdown or infection. Interview on 06/13/24 at 3:35 PM with the ADON revealed she expected staff to clean/wash the resident's hands often and cut the resident's fingernails. She stated it was the responsibility of the CNAs and nurses to be cut residents' nails. She stated the potential risk would be infection and wounds. 2. Review of Resident #32's undated Admission Record reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure, pressure ulcer and history of falls. Review of Resident #32's quarterly MDS, dated [DATE], reflected her BIMS score was 6 indicating severe mental cognition impairment. Her Functional Status indicated she required substantial assistance with all of her ADLs. Review of Resident #32's care plan, dated 05/21/24, reflected she had multiple pressure ulcers, history of falls, and required extensive assistance with her ADLs. Observation on 06/11/24 at 10:58 AM revealed Resident #32's fingernails were dirty and needed to be trimmed. Observation on 06/12/24 at 9:54 AM revealed Resident #32's nails had not been trimmed. The resident appeared to have been recently bathed as her hair appeared damp. Interview on 06/12/24 at 9:55 AM, Resident #32's roommate stated Resident #32 had a hospice aide to bathe her and attend to her ADLs. The aide had just left per the roommate. 3. Review of Resident #43's undated Admission Record reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included stroke affecting his right side, reflux, feeding tube placement due to swallowing problems, and speech impairment. Review of Resident #43's quarterly MDS, dated [DATE], reflected a BIMS score was not calculated. His Functional Status indicated he required maximum assistance with all of his ADLs. Review of Resident #43's care plan, dated 05/21/24, reflected he had an ADL deficit requiring maximum assistance, and a communication deficit. There was no indication of the resident refusing hygiene care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 06/11/14 at 9:56 AM revealed Resident #43's fingernails needed to be trimmed, and he had several days worth of facial hair growth. Resident stated he thought the last time he had been shaved was last week. Observation and interview on 06/12/24 at 11:23 AM with Resident #43 revealed he was showered. The resident's fingernails were not trimmed, and he had not been shaved. Interview on 06/12/24 at 12:48 PM with CNA A revealed she bathed Resident #43 that morning. CNA A stated the resident refused to have his nails trimmed or to be shaved. She stated the resident answered yes to all questions. Interview on 06/12/24 at 12:55 PM with Resident #43 revealed he wanted to be shaved and to have his nails trimmed. Observation on 06/13/24 at 11:00 AM revealed Resident #43 was not shaved nor had his nails trimmed. Observation on 06/13/24 at 11:08 AM revealed Resident #32 had not had her nails trimmed. Interview on 06/13/24 at 3:45 PM with the ADON revealed the CNAs were responsible for trimming residents' fingernails when they bathed the residents. The ADON stated residents with hospice aides were supposed to have their nails trimmed by the aide, but the facility was still responsible for ensuring it was done. The ADON stated the CNAs cut their residents' nails as well if needed. Interview on 06/14/24 at 1:53 PM with the DON revealed her expectation was for staff to cut residents' fingernails and to the keep residents' hands clean. She stated the risk of not cutting fingernails was that it could cause the resident's fingernails to become embedded into the palms. Review of the facility's Quality of Life - Dignity policy, revised August 2009, reflected: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .3. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). Review of the facility's Care of Fingernails/Toenails policy, dated October 2010, reflected: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin Notify the supervisor if the resident refuses the care. Review of the facility's Shaving the Resident policy, dated October 2010, reflected: .The purpose of this procedure is to promote cleanliness and to provide skin care Notify the supervisor if the resident refuses the procedure. 44140

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based upon the comprehensive assessment of a resident for one of three residents (Resident #54) reviewed for quality of care. Agency LVN E failed to properly insert Resident #54's Foley catheter on 03/13/24 by inflating the balloon in the resident's urethra causing urethal trauma and significant bleeding. Resident #54 had to be transported to the hospital where a CT Scan revealed the urinary catheter balloon had been inflated in the resident's urethra causing trauma to the area. Due to the blood loss, the resident had to receive a blood transfusion to stabilize his vitals. An Immediate Jeopardy (IJ) situation was identified on 06/12/24. While the IJ was removed on 06/14/24, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for an adverse outcome to resident care or services and may also include the potential for physical and psychosocial harm. Findings include: Record review of Resident #54's, undated, Admission Record reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #54 had active diagnoses which included traumatic spinal cord dysfunction, quadriplegia (paralysis below the neck), hidradenitis suppurative (chronic inflammatory skin condition), muscle weakness, neuromuscular (disorders affect nerves or muscles) disfunction of bladder and iron deficiency anemia. Record review of Resident #54's quarterly MDS, dated [DATE], reflected a BIMS score of 14, which indicated intact cognition. Section H - Bladder and Bowel reflected Resident #58 had an indwelling catheter and was always incontinent. Record review of Resident #54's Care Plan, revised 05/05/24, reflected: Problem: Category: Urinary Incontinence [Resident #58] has the Potential for complications related to indwelling urinary catheter. DX:N31.9 Neuromuscular dysfunction of bladder, unspecified. Goal: Will remain free s/sx of complications related to catheter through review date. Approach: Assess for patency and document daily. Assess for urine characteristics (volume, color, clarity, odor) and document daily. Change bag every 30 days or per facility protocol or as per MD orders. Maintain closed drainage system, with drainage bag lower that bladder level at all times. Monitor, document, notify MD PRN s/sx of complications related to catheter use, including UTI, trauma, bleeding. Record review of Resident #54 physician orders reflected: Change Catheter (16F/10cc) for leakage, blockage, or becoming dislodged. As needed. Document clinical reason for catheter change in the progress notes. Start date: 05/05/2023 - 04/02/2024 (DC Date). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observation and interview on 06/11/24 at 12:26 PM revealed Resident #54 lying in bed. The resident stated he was doing well. Resident #54 had a Foley catheter, observed catheter bag to have a privacy bag, the Foley tubing had yellowish color urine. Resident #54 denied any pain, he stated a couple of months ago he had to go to the hospital and had to get a blood transfusion. Resident #54 stated he could not recall much of the incident, but the nurse at the time attempted to change his catheter and caused bleeding. Resident #54 he stated he felt some discomfort. Resident #54 stated he could not recall the name of the nurse. Resident #54 stated he was unsure if he left to the hospital with the catheter inserted or not, he stated he could not recall as it had been a couple of months. Resident #54 stated because of that incident staff were not allowed to change his catheter. He stated he must go to the hospital to get it changed. Record review of Resident #54's progress note, dated 03/13/24 at 11:11 AM, by the PA reflected: [Recorded as Late Entry on 04/05/2024 11:11 AM] Patient Encounter Note . Encounter Date: 03/13/2024 Chief Complaint: Follow up encounter History of Present Illness: This is a [AGE] year-old Male resident of [Facility name] Nursing Home who presents for follow up and management of chronic medical problems. Interval Reports: - Per nursing, resident was found with a dislodged foley catheter without any urine return. - Nursing re-inserted foley catheter but only return bright red urine upon placement. - Resident reports severe discomfort. - Seen and examined at the bedside. - He is alert and oriented x4. - He has significant urethral injuries. Plans in place for SPT placement. - He has contractures to bilateral upper and lower extremities Dislodged Foley Catheter: Re-inserted but severe bloody urine and discomfort. - OK to send to ER for imagery and further evaluation. Record review of Resident #54 progress note, dated 03/13/24 at 18:21 [6:21 PM] by Agency LVN E, reflected: Nurse attempted to re-insert new 16 Fr. Cather using sterile technique blood return observed no urine return. Cath. [catheter] flushed only blood return.119/80, 129, 97.9, 98%, 18 RA 0/10 NP notified client own POA. NP new orders received send to ER for further treatment. Client left via medical transport on stretcher. Record review of Resident #54's EMS report reflected: Dispatch Information: Incident Date: 03/13/24 17:46 [5:46 PM] Complaint: Blood at site of catheter (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Compliant Type: Chief (Primary) Duration of Complaint: 10 Hours 17:59 [5:59 PM] Unit arrived on scene 18:16 [6:16 PM] Vitals: BP 97/64 P 127 18:20 [6:20 PM] Unit left scene - BP 105/69 P 127 18:37 [6:37 PM] Patient arrived at destination [hospital] Provider Impression: Primary Impression: Illness, unspecified Working Diagnosis: UTI Differential Diagnosis: Sepsis, Kidney Stones, Urethra Tear Record review of Resident #54's hospital reflected the following: Reason for visit: Chief Complaint on 03/13/24 6:44 PM: Urinary Catheter Problem (Pt from [Facility] staff attempted to insert foley, unsuccessful attempts per staff due to blood clots coming out, pt hypotensive and tachycardic upon EMS arrival) History of Present Illness 6:46 PM [Resident #54] is a 52 y.o. male with a h/o HTN, leukocytosis, and who comes to ED via EMS from [Facility] NH and c/o urinary catheter dysfunction that started today s/p multiple unsuccessful attempts. EMS denies any medical intervention en route. Pt denies feeling more fatigue than usual .Pt is quadriplegic (paralysis). 03/13/24 1853 [6:53 PM] ED Triage Vitas: BP 124/58 P 139 Physical exam: Constitutional: General: He is in acute distress (mild) Cardiovascular: Rate and Rhythm: Regular rhythm. Tachycardia present. Genitourinary: Comments: Foley in place with chronic appearing urethral tear with mild surrounding bleeding. Blood in foley tubing. 03/13/24 1914 [7:14 PM] RN Assessment: Abdominal Pain: GI Signs/Symptoms: pain; discomfort ABD Pain Location: generalized ABD Pain Character: Intermittent; Stabbing (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	03/14/24 0026 [12:42 AM] ICU NP @ bedside. States to change bed to cardiac PCU so pt may receive low dose levophed (raise blood pressure) if needed. Bed control notified of change. Two sono PIVs placed in R arm. Seeing how pt responds to IV bolus at this time prior to starting Levophed per NP and ER physician. Record review of Resident #54's Discharge Summary (Notes from 03/14/24 through 03/17/24 reflected: Hospital Problems: 1. Gross hematuria (blood in urine) with hydroureteronephrosis (dilation of the ureter due to obstruction of urine outflow) secondary to mispositioned Foley-resolved s/p Foley placed by cysto and CBI, follow-up with Urology. 2. Possible sepsis secondary to complicated UTI with chronic indwelling Foley - completing course of empiric antibiotics per ID recommendation, cultures negative but urine cultures collected after CBI. 3. Acute blood loss anemia-possibly secondary to hematuria, H&H remained stable after transfusion of PRBC 3/14, consider GI workup if needed, no signs of acute GI bleed during hospitalization . 4. Hypotension-resolved, related to acute issues and possible sepsis, resolved with treatment Presenting HPI: .presents to the emergency room with a history of gross blood in the Foley catheter that started yesterday. There was no history of trauma or manipulation of the Foley catheter. Patient denies any fevers or chills. Initial vital signs include a blood pressure 124/58, pulse of 139 and temperature 97.5 F . Labs significant for a high sensitivity troponin of 522 up from 377, procalcitonin of 0.14, white count of 20000, with a neutrophil count of 85%, hemoglobin of 7.9/26, down from 8.9/30 on 02/20/2024, chest x-ray that showed no acute radiographic cardiopulmonary abnormality. CT abdomen pelvis without contrast shows soft tissue attenuation in the left aspect of the urinary bladder concerning for blood clots soft tissue mass. Foley catheter present with balloon inflated in the membrane is a bulbous portion of the urethra. Moderate bilateral hydro nephrosis hydro ureter. In the emergency room patient was given cefepime 2 g (grams) IV, IV Tylenol 1000 mg, normal saline 1.8 L bolus, and is being admitted for urology consult for Foley catheter replacement and proper positioning, irrigation of bladder, empiric antibiotic therapy. During the process of Foley catheter placement, the patient had hypotensive episode with blood pressure dropped to systolic 70s. He was given a Ringer's lactate 1 L bolus and his blood pressure 96/57 from 89/52. Antibiotic therapy with extended and patient was placed on IV ampicillin 2 g. Pulmonary has been consulted, will also consult Cardiology for up trending of high sensitivity troponins. Record review of Resident #54 clinical records for the month of January 2024 and February 2024 reflected Resident #54 was not admitted to the hospital for catheter related issues. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 06/12/24 at 9:43 AM by phone with Agency LVN E revealed from what he recalled Resident #54 asked for his Foley catheter to be changed because it was not draining. Agency LVN E stated he removed the old catheter and attempted to reinsert the new catheter, but he could not. He stated he was not able to get any urine return, but there was bleeding and blood clots noted. Agency LVN E said he did not recall if he had inflated the balloon or gotten any resistance. Agency LVN E stated when he tried to flush and did not get anything in return, he called the DON for assistance. He stated he obtained physician orders to send the resident to the hospital. Agency LVN E stated he could not recall if Resident #54 was sent to the hospital with the catheter inserted. Agency LVN E stated he had been trained on how to insert/change a catheter, he stated inserting a catheter was a sterile technique, and the catheter should be inserted about 4 to 6 inches and wait for urine return. Interview on 06/12/24 at 9:22 AM with LVN D revealed she assisted Agency LVN E with flushing Resident #54's Foley catheter. LVN D stated Agency Nurse E re-inserted Resident #54's Foley catheter, but he was not able to flush the catheter and caused it to bleed. LVN D said she did not attempt to re-insert the catheter since Agency Nurse E had already attempted. LVN D stated she attempted to help flush the catheter once Agency Nurse E inserted the catheter. She stated there was fresh blood coming out in the line and bag. She stated she was able to flush; however, they were just waiting for the urine to clear because it was only blood. LVN D said they monitored Resident #54 and was then sent out to the hospital. LVN D stated she was not present when Resident #54 was discharged to the hospital. LVN D stated Resident #54's penis was flayed all the way to the bottom making it tricky to insert the catheter. She stated prior to this incident they had not had any issues with inserting the catheter when it had come out. LVN D further stated after the incident (03/13/24) Resident #54 was being sent to the hospital to have his catheter replaced. Interview on 06/12/24 at 9:10 AM with CNA C revealed he had been assigned to Resident #54 on 03/13/24 and recalled the time Agency LVN E had tried to replace the catheter and the agency nurse could not get it in. He stated he was in the room with Agency Nurse E and LVN D when the incident happened. He stated Agency Nurse E had set up the catheter kit, he removed the old catheter, and he inserted the new catheter in, but it started bleeding. He stated there was blood in the tube of the catheter, it was clogged, and Agency Nurse E tried to flush it and the water got all over the bed. CNA C stated no urine was coming out, but only blood was noted in the catheter tubing. CNA C stated after the catheter was inserted, they placed the resident on observation and once they noticed it was not working, the resident was sent out to the hospital. He stated Resident #54 did not complained of any pain or distress at that time, because of his paralysis. CNA C stated in the past, Resident #54's Foley catheter had fallen out but had been replaced with no issues. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 06/12/24 at 12:45 PM by phone with the previous DON B revealed she was called to Resident #54's room because Agency Nurse E was unable to insert a catheter. She stated when she went to the room, she did not try to insert the catheter because Agency Nurse E had already attempted. She stated she observed little blood on the line but because Resident #54 was having pain and there was resistance, they sent Resident #54 to the hospital. She stated Agency Nurse E had already tried to flush prior to her entering the room. She stated Resident #54 did not have the Foley inserted when he went out to the hospital, she stated Agency Nurse E had taken out the catheter and was not able to put it back in. She stated she did not think the catheter was inserted back in because they could not flush properly. She stated she could not remember what the hospital discharge summary indicated. She stated it had been some time since the incident. She stated she was unaware the catheter balloon was placed in the urethra if she had known she would have addressed it and education would have been done. She stated Resident #54 had always had trouble with his catheter, that was why the urologist changed his catheter. She stated Resident #54 required a suprapubic catheter, and if not placed resident would continue to have issues with trauma and having a large prostate. DON B stated she could not confirm or deny if the catheter was inserted, she stated she did not have any recollection of the event. She stated her expectation was for nurses to stop if they got any resistance when inserting the catheter. Interview on 06/12/24 at 9:55 AM with ADON A revealed she was not present at the time when Resident #54's catheter was changed. She stated she was brought in at the end. From what she recalled, Resident #54 said his catheter was bothering him. She stated they were going to replace the catheter because the resident felt his bladder was not emptying/draining and that was why they tried to flush it. After inserting the catheter, ADON A said Agency Nurse E attempted to flush the catheter, but he was not able to flush it. She stated there was not a lot of blood and could not tell if the catheter was in place. The DON was called and had requested to send the resident to the hospital. She stated LVN D was called in to help as well, and she was able to flush the catheter. She stated she believed the resident left to the hospital with the catheter inserted. ADON A stated hospital discharge records were reviewed and stated they should not replace the Foley catheter after this incident. She stated the Foley catheter was not placed correctly. ADON A stated Resident #54 was contracted to place a Foley catheter in a nursing home. ADON A stated if the Foley catheter balloon was inflated in the urethra, it could cause pain and bleeding. ADON A stated she was not sure if they had completed an in-service on Foley catheters after this incident. Interview on 06/12/24 at 1:11 PM with DON A revealed she had been employed at the facility since 04/23/24. She stated she was not made aware of the incident regarding Resident #54 Foley catheter until today (06/12/24). She stated her expectation was for LVNs to remove the old catheter and reinsert the new one and receive a good flow of urine. She stated they completed skill check-offs with everyone. She stated she would expect competency-based skills check-offs to be provided before getting into the field for agency nurses. She stated the agency nurses' competencies were completed by their agency. DON A stated she had not had the opportunity to review Resident #54's hospital records. She stated by inflating the catheter balloon in the urethra, it could cause trauma in the urethra. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 06/12/24 at 12:33 PM with Regional Nurse Consultant revealed at the time of the incident she was not made aware of the situation with Resident #54. She stated she was made aware of the urology appointment. She stated they had a urology appointment set for Resident #54 ; however, the insurance would not cover the appointment and family would not pay out of pocket. She stated Resident #54 was recommended to get a suprapubic catheter due to how the resident's penis and urethra were. The Regional Nurse Consultant stated the Foley catheter should be inserted until it reached the Y of the catheter. She stated from what she understood Resident #54's trauma was when the nurse attempted to insert the catheter. She stated she was unaware the balloon was inflated in the urethra. She stated the previous DON was in the room at the time, but she was unaware what was done. She stated the risk of inflating the balloon in the urethra was that it could cause trauma. The Regional Nurse Consultant stated Resident #54's catheter could not be changed at the facility, the resident's catheter should be changed at the hospital due to the pre-existence trauma to his penis. Interview on 06/12/24 at 10:28 AM with PA revealed he was aware of Resident #54's catheter incident; however, it was addressed by another doctor. He stated when he came on board, hospital records were reviewed but the discharge instructions did not provide much detail. The PA stated Resident #54 was recommended to get a suprapubic catheter; however, the resident refused. He stated when inserting a catheter, it could sometimes cause little trauma when inserting and cause bleeding. He stated he was not surprised the resident was sent out to the hospital due to resident's anatomy. The PA stated the process of when inserting a Foley catheter required a sterile technique, lubrication, insertion measurement, and then inserting the catheter based on the measurements and then inflating the balloon. Once urine was observed, that was an indication the catheter was in and should not proceed further than that. The PA stated nurses would need more than 4-6 inches when inserting a catheter. He stated if the catheter balloon was inserted in the urethra, it would cause excessive bleeding. The PA stated he was unaware the catheter balloon was intact at the hospital. He stated he thought it was the trauma of the penis that caused the bleeding. The PA stated if the balloon was inflated in the urethra, it could cause kidney failure and trauma. Follow-up interview on 06/14/24 at 11:16 AM by phone with the PA revealed he was aware of Resident #54 anemia. He stated the resident had an order for ferrous sulfate; however, since the resident refused the medications, the medications were discontinued. The PA stated he was aware of Resident #54's anatomy and if the resident's Foley catheter was not inflated it would have come out on its own. If the balloon was inflated, the catheter would not fall unless tampered with. Interview on 06/12/24 at 12:41 PM with the Administrator revealed at the time of the incident he was at the facility and was made aware of the incident. He stated the agency nurse attempted to insert Resident #54's catheter; however, he was not sure if the agency nurse was able to do so. The Administrator stated Resident #54 was discharged to the hospital and when Resident #54 returned he was on leave. The Administrator stated he was not aware the catheter balloon was place in Resident #54's urethra. He stated the DON and the ADON were responsible for the skills check-offs and to provide orientation to the agency nurses. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 06/14/24 at 1:48 PM by phone with the Hospital RN revealed she recalled the resident very well. The Hospital RN stated the resident arrived with the urinary catheter in place. She stated she did not manipulate the catheter and most especially did not inflate the balloon. She stated the resident was there for a traumatic catheter insertion, so she was very aware of the catheter. She stated she charted/documented the resident arrived at the hospital with the Foley catheter in place. When they received the CT Report indicating the balloon was in the urethra, both she and the ER physician felt uncomfortable with removing the catheter and consulted urology. The catheter was left untouched until urology removed it and replaced it with a new catheter. Record review of EMT Statement dated 06/20/24 reflected: as an EMT for [Company Name] Mobile Healthcare on 3/13/24 responded to a call for service at [facility address]. Facility reports they attempted to reinsert patient's urinary catheter, though they are unable to and have notice blood clots coming out. [I] made contact with a black male who was identified as [Resident #54] DOB: 09/06/1971. Patient was moved to stretcher, moved to ambulance, transported [Hospital Name]. PT was safely moved to ED bed, report was given to facility RN and transfer of care was at 1847 hours [6:47 PM] to Hospital RN. At no time during this call did I ever removed, place, insert, deflate, inflate, or manipulate the patients foley catheter in any manner. Record review of Agency LVN E's Skills competency checklist dated 03/05/24, reflected he was Proficient/Expert/Highly skilled in the area of Catheterization/foley catheter care. Record review of the facility's Catheterization, Intermittent, Male Resident policy, revised October 2010, reflected the following: The purpose of this procedure is to provide guidelines for the aseptic insertion of an intermittent catheter .21. Insert the catheter gently into the meatus (approximately 5-7 inches) until urine begins to flow from the bladder. When urine beings to flow advance the catheter 2 inches. This was determined to be an Immediate Jeopardy (IJ) on 06/12/24 at 1:40 PM. The Administrator and Regional Nurse Consultant were notified. The Administrator was provided with the IJ template on 06/12/24 at 2:00 PM. The following Plan of Removal submitted by the facility was accepted on 06/13/24 at 9:33 AM: The facility failed to ensure nursing staff had appropriate competencies and skills sets necessary to care for resident's needs, as identified through resident assessments and described in the plan of care, when a LVN failed to properly insert a urinary catheter for a male resident resulting in the resident having to be transferred to the hospital after experiencing severe bleeding requiring a blood transfusion. On 6/12/24 The facility Administrator notified the Medical Director of immediate jeopardy. On 6/12/24 the facility DON (Director of Nursing)/designee assessed Resident #54 and all other residents in the facility with Foley Catheters that their catheters were functioning properly. On 6/12/24 the DON (Director of Nursing)/Designee, initiated Foley Catheter Insertion competencies for all nurses. These will continue until all nurses have completed their competencies before their next scheduled shift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/12/24 the RNC /Designee initiated the in-servicing of all nurses including PRN and Agency nurses regarding not to perform catheter insertion unless a competency has been completed or provided. o The Foley Catheter insertion competency of the Agency nurse must be verified by the DON/designee via hand delivery or email from the Agency or Agency nurse prior to performing the skill. If a nurse that does not have competency on file is working, and the need for Foley insertion arises, the DON must be notified, and the DON/designee will come to insert the Foley catheter. o The clinical management team will discuss staffing to include new agency nurses who will be covering the floor during the morning meeting. Any changes in coverage during the day will be discussed with the DON/designee. Ad-Hoc QAPI meeting was held on 06/12/24, with the Medical Director, Regional Nurse Consultant, Director of Nursing & Assistant Director of Nursing to review the alleged deficiencies, policy and procedure and the plan of removal of immediacy. The policies pertaining to Foley Catheter insertion were reviewed on 6/12/24 by the RNC, Facility Administrator and Director of Nursing. No changes were made to the policy. The RNC will monitor for compliance on all residents with Foley Catheters weekly x 4 weeks and send any trends or issues to the ADHOC QAPI Meeting for review. The RNC (Regional Nurse Consultant) will ensure this plan is completed on 6/12/24. Monitoring of the facility's Plan of Removal included the following : Interviews on 06/12/24 from 2:00 PM-2:10 PM with Resident #5, Resident #48, and Resident #118 revealed no concerns regarding their Foley catheters. Record review of the progress notes for Resident #5, Resident #19, Resident #48, and Resident #118, who all had Foley catheters, reflected they were assessed by the DON on 06/12/24 with no concerns reported. Record review of Admit/Discharge Report, from 04/11/24-06/12/24, reflected sample residents had not been to the hospital for catheter related issues. Record review of the facility's in-services, dated 06/12/24, reflected training for Foley Insertion Competencies Completed and Suprapubic Catheter Replacement. In-services reflected all staff completed the trainings . The in-services were conducted and signed by nursing on both shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. Record review of the facility's Nursing staff competency: Catheter, insertion of indwelling completed on 06/12/24 reflected: Performance Criteria included .22. Inserts catheter through meatus. A. Males 1) Lifts penis to position perpendicular to patient/resident's body. 23. Advance catheter 2-3 inches in females and 7-9 inches in males or until urine flows out of catheter end. 24. Inflates balloon. 25. Attaches catheter to collection device and lowers bag below level of bladder . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's Ad Hoc Meeting for Foley Catheters reflected the meeting was completed on 06/12/24. Interviews conducted on 04/13/24 from 2:40 PM through 6:31 PM and 04/14/24 from 9:24 AM through 10:20 AM with LVN B, LVN D, LVN F, ADON A, ADON B, LVN H, LVN I, LVN K, LVN L, RN M and DON who work the shifts of 6:00 AM-6:00 PM and 6:00 PM-6:00 AM revealed nurses were able to verify education was provided to them, nursing staff were able to accurately summarize what to do when changing a foley catheter. Nurses indicated it was sterile technic, insert catheter until urine began to flow and advance the catheter 2 inches. If resistance when inflating the balloon they must deflate the balloon, remove the catheter, and notify the physician. DON A stated she would be responsible for ensuring PRN Nurses and Agency Nurses competency checkoffs were obtained and verified prior to working the floor and if she was on leave the ADONs would be responsible for competency checkoff were obtained and verified. The Administrator and Regional Nurse Consultant were informed the Immediate Jeopardy was removed on 06/14/2024 at 11:00 AM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 32227 Based on interview and record review, the facility failed to use the service of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 13 of 30 days (03/02/24, 03/03/24, 03/16/24, 03/17/24, 03/30/24, 03/31/24, 04/14/24, 04/27/24, 04/28/24, 05/11/24, 05/12/24, 05/25/24, and 05/26/24) reviewed during a look back period from 03/01/24 to 06/09/24 for weekend coverage. The facility failed to have RN coverage in the facility for eight consecutive hours on 03/02/24, 03/03/24, 03/16/24, 03/17/24, 03/30/24, 03/31/24, 04/14/24, 04/27/24, 04/28/24, 05/11/24, 05/12/24, 05/25/24 and 05/26/24. This failure could place residents at risk for not having their nursing and medical needs met and improper care. Findings included: Record review of the facility's Detailed Hours report, printed on 06/14/24, reflected there was no RN coverage on the weekends for the following dates: 03/02/24, 03/03/24, 03/16/24, 03/17/24, 03/30/24, 03/31/24, 04/14/24, 04/27/24, 04/28/24, 05/11/24, 05/12/24, 05/25/24, and 05/26/24. Interview on 06/14/24 at 2:09 PM with the DON revealed there was no RN coverage for the weekends mentioned. The DON said they would begin to use agency staff to cover the shifts in the future. She further stated it was important to have an RN to oversee staff and care and because it was a regulation. Interview on 06/14/24 at 2:39 PM with the Administrator revealed they did not have weekend RN coverage for the mentioned days but said they would begin to use agency staff to cover the weekends going forward. Record review of the facility's Hours of Work policy revised December 2009 reflected the following: Our facility has established hours of work in accordance with resident needs and current regulations governing our facility's staffing requirements.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44140 Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food and nutrition services. The facility failed to ensure the dish machine maintained the minimum temperature of 120 degrees Fahrenheit (F). This failure could place residents at risk of food-borne illness. Findings included: Observation and interview on 06/11/24 at 8:50 AM, in the kitchen, revealed the dish machine would only get up to approximately 105 degrees Fahrenheit for the wash, and 115 degrees Fahrenheit for the rinse. The Dietary Manager completed 4 cycles and the dish machine did not reach the minimum temperature standard for wash and rinse of 120 degrees Fahrenheit. The Dietary Manager stated the dish machine was working properly. The Dietary Manager stated her dishwasher staff had quit about a week ago, and she was responsible for washing dishes until they hired someone else. The Dietary Manager stated the risk of the dish machine not reaching the required temperature was that it could cause cross contamination, which could cause the residents to become ill. Interview on 06/11/24 at 10:15 AM with the Commercial Company employee revealed the facility dish machine was a low temperature of a minimum of 120-140 degrees Fahrenheit. Interview on 06/14/24 at 2:25 PM with the Administrator revealed about a month ago the hot water heater broke, and they had to replace it. He stated the commercial company came out to look at the dishwasher, and they needed to increase the hot water heater. The Administrator stated there was no risk to the residents since the sanitation was good. Record review of the dishwasher temperature and sanitizing logs for the month of June 2024 reflected minimum temperature standard for wash and rinse were 120 degrees Fahrenheit. Record review of the facility's current policy, unnamed and undated, reflected in part the following: .(B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 49 degrees Celsius (120 degrees Fahrenheit). Review of the U.S. Public Health Service, Food Code (2022) reflected: Section S 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature. (B) The temperature of the wash solution in spray-type warewashers that use chemicals to SANITIZE may not be less than 49 [degrees] C (120 F).