

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER LAS FLORES CONVALESCENT HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 14165 PURCHE AVE. GARDENA, CA 90249		
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F 552	<p>Continued From page 1</p> <p>benefits of psychoactive medication (a drug that changes brain function and results in alterations in perception, mood, consciousness, or behavior) for one of five residents (Resident 46).</p> <p>This deficient practice violated the residents' right to make an informed decision regarding the use of psychoactive medications.</p> <p>Findings:</p> <p>During a review of Resident 46's Admission Record, the Admission Record indicated, Resident 46 was initially admitted to the facility on 5/16/2023 and latest readmission was on 2/7/2025. Resident 46's diagnoses included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (CKD-condition which the kidneys are damaged and cannot filter blood as well as they should), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).</p> <p>During a review of Resident 46's History and Physical (H&P), dated 2/19/2025, the H&P indicated Resident 46 had the capacity to understand and make decisions.</p> <p>A review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2025, the MDS indicated Resident 46 was assessed to have clear comprehension (the action or capability of understanding something) in daily decision making. The MDS indicated Resident 46 was receiving antipsychotic</p>	F 552	<p>what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/10/25, the Director of Nursing in-serviced Nursing Staff, including but not limited to License Vocational Nurses and Registered Nurses on the facility's policy and procedure titled, "Informed Consent" with emphasis on ensuring the facility respects the resident's right to make an informed decision prior to deciding to undergo certain medical therapies and procedures. The in-service also included ensuring the informed consent/notice be documented, and placed in the resident's medical record for verification consent/notice was given.</p> <p>On 3/10/25, the Director of Nursing in-serviced Nursing Staff, including but not limited to License Vocational Nurses and Registered Nurses on the facility's policy and procedure titled, "Psychotherapeutic Drug Management," with emphasis on obtaining consent for use of psychotherapeutic drugs, informing the resident of the risks and benefits for the use of these medications and consent remaining in place until medication is discontinued or until consent is revoked by resident/responsible party.</p> <p>Medical Records Director will conduct audits on psychotropic consent forms daily for 5 days, weekly for 2 weeks, and monthly thereafter to ensure residents have received informed consent prior to the administration of psychotropic medication.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p>	<p>3/11/25</p> <p>3/11/25</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 552	<p>Continued From page 2 (medications used to treat mental disorders) and antidepressant (medications used to treat depression [feelings of low mood]) medications.</p> <p>During a review of Resident 46's Order Summary Report (physician orders), dated 3/7/2025, the physician orders indicated, the physician placed a telephone order on 2/15/2025 for Resident 46 to start Seroquel (a medication used to treat certain mental disorders, such as schizophrenia and bipolar disease) 300 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount). The physician orders indicated another telephone order was placed on 2/16/2025 to start Duloxetine HCl (a medication used to treat major depressive disorder) 30 mg.</p> <p>During a review of Resident 46's Medication Administration Record (MAR), dated 2/2025 and 3/2025, the MARs indicated, Resident 46 had been receiving Duloxetine HCl 30 mg and Seroquel 300 mg.</p> <p>During an interview on 3/7/2025 at 9:30 a.m., with Registered Nurse (RN) 1, RN 1 stated an informed consent should be drug specific for the use of psychoactive medication, as it explained the risks and benefits, and side effects. RN 1 stated the resident or RP needed to give consent to administer a psychoactive medication. RN 1 stated the staff needed to make sure the consents were completed and in the resident's chart before medication was started. RN 1 stated, "This is not the proper way to do it, the policy is we consent before giving the medication". RN 1 stated if the consent was not in the chart there would be no way to know if the resident was educated and made the informed</p>	F 552	The Social Service Director will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for receiving informed consent prior to the administration of psychotropic medication for three months or until compliance is met.	3/31/25	

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F 552	<p>Continued From page 3</p> <p>decision whether to receive the medication or not. RN 1 stated it could also affect the resident's behavior.</p> <p>During a concurrent interview and record review on 3/7/2025 at 9:50 a.m., with the Assistant Director of Nursing (ADON), Resident 46's chart was reviewed. No informed consent for Seroquel or Duloxetine HCI was found in the chart. The ADON stated there was no consent for Seroquel or Duloxetine HCI in the chart. The ADON stated the resident or RP needed to be informed completely about the side effects, the effectiveness, and the reason the medication was needed before medication was started. The ADON stated if no informed consent was obtained the resident could potentially have taken medication they did not want to take. The ADON stated that it was very important to make sure the consent was in the chart and that the resident or RP had been informed. The ADON stated the resident or RP had the right to decline the medications.</p> <p>During an interview on 3/7/2025 at 10:55 a.m., with the Director of Nursing (DON), the DON stated it was the staff's responsibility to verify if the informed consent was signed and in the chart before medication was administered. The DON stated the resident and/or RP has the right to make an informed decision to accept or decline the medication. The DON stated starting the medication without an informed consent could potentially affect the resident by taking medication they did not want to take.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Informed Consent,"</p>	F 552			

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F 552	Continued From page 4 revised 4/2024, the P&P indicated, to ensure the facility respects the resident's right to make an informed decision prior to deciding to undergo certain medical therapies and procedures. The P&P indicated informed consent/notice will be documented and placed in the resident's medical record. The P&P indicated the facility will maintain documentation of verification of the informed consent/Notice in the resident's medical record.	F 552			
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 553	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/11/25, the Interdisciplinary Team (IDT) met with Resident 275 and conducted a care conference meeting. How the facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this deficient practice. On 3/20/25, the Medical Records Director	3/11/25	

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F 553	<p>Continued From page 5</p> <p>(iii) The right to be informed, in advance, of changes to the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to:</p> <p>1. Ensure one of 25 sampled residents (Resident 275) participated in care planning meetings.</p> <p>This deficient practice violated Resident 275's rights to be fully informed of the resident's plan of care and had the potential to result in delay of care and services.</p> <p>Findings:</p> <p>During a review of Resident 275's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 275 was admitted to the facility on</p>	F 553	<p>conducted an audit on all new admissions and re-admissions within the last 30 days to ensure residents had attended their baseline care conference meeting.</p> <p>No other residents were affected by this deficient practice.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/18/25, the Director of Nursing and Director of Staff Development in-serviced the Interdisciplinary Team (IDT), including but not limited to Minimum Data Set Nurse and Assistant, Social Services Director and Assistant, Director of Rehabilitation (DOR), Activities Director, and Dietary Manager on the facility's policy and procedure titled, "Care Planning" with emphasis on inviting the resident, if capable, and their family to the care planning meetings and scheduling the care planning meetings at the time of convenience for the resident and family.</p> <p>On 3/18/25, the Director of Nursing and Director of Staff Development in-serviced the IDT, including but not limited to Minimum Data Set Nurse and Assistant, Social Services Director and Assistant, DOR, Activities Director, and Dietary Manager on the facility's policy and procedure titled, "Resident's Rights" with emphasis on the resident having the right to be fully informed and participate in their treatment in a language that they can understand.</p> <p>The Medical Records Director will conduct an audit daily for 5 days, weekly for 2</p>	<p>3/20/25</p> <p>3/18/25</p> <p>3/18/25</p>	

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F 553	<p>Continued From page 6</p> <p>1/2/2025. Resident 275's diagnoses included chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), hypertension ([HTN] - high blood pressure), and congestive heart failure ([CHF] - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).</p> <p>During a review of Resident 275's History and Physical (H&P), dated 1/7/2025, the H&P indicated, Resident 275 had the capacity to understand and make medical decision.</p> <p>During a review of Resident 275's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/7/2025, the MDS indicated, Resident 275 required moderate assistance (helper does less than half the effort) from staff with eating, oral hygiene, and personal hygiene.</p> <p>During an interview on 3/4/2025 at 12:15 p.m., with Resident 275, Resident 275 stated she is a retired nurse, and no facility staff offered for the resident to attend her care plan meetings to discuss her care.</p> <p>During a concurrent interview and record review on 3/5/2025 at 2:35 p.m., with the Director of Nursing (DON), Resident 275's Baseline Care Plan, dated 1/2/2025, was reviewed. The DON stated the Baseline Care Plan did not indicate Resident 275 or her representative was among the members who attended the meeting. The DON stated it was the responsibility of the nursing or social service staff to notify and invite the resident or resident representative to attend the care plan meetings. The DON stated care</p>	F 553	<p>weeks and monthly thereafter on all new admissions and re-admissions to ensure baseline care plans are scheduled and the resident and or resident representative is included in the development of the care plan.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for resident's rights to attend and participate in care plan meetings for three months or until compliance is met.</p>	3/31/25	

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F 553	Continued From page 7 plan meetings allowed Resident 275 to share information about her condition with the facility staff. The DON stated it was important for Resident 275 to be involved in care plan meeting so the facility's Interdisciplinary Team ([IDT] - team members from different disciplines who come together to discuss resident care) could discuss and ensure the resident's needs are met. The DON stated it was a violation of the resident's rights by not allowing Resident 275 to participate in the care planning process. During a review of the facility's policy and procedure (P&P), titled "Care Planning," dated 10/24/2022, the P&P indicated, "The facility will invite the resident, if capable, and their family to care planning meetings and use its best efforts to schedule care planning meetings at times convenient for the resident and family." During a review of the facility's P&P, titled "Resident Rights," dated 5/1/2023, the P&P indicated, "The resident has the right to be fully informed and participate in their treatment in a language that they can understand."	F 553			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 558	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/4/25, Certified Nursing Assistant (CNA) 3, removed call light from floor and placed in reach of resident 36. On 3/4/25, Certified Nursing Assistant (CNA) 5, removed call light of the floor from behind resident 224 bed and placed within reach of resident to 224.	3/4/25	

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F 558	<p>Continued From page 8</p> <p>review, the facility failed to ensure one out of six sampled resident's (Resident 36 and Resident 224) call light was within reach.</p> <p>This deficient practice had the potential to result in a delay in or an inability for the residents to obtain necessary care and services.</p> <p>Findings:</p> <p>A. During a review of Resident 36's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 36 was admitted to the facility on 7/28/2021. Resident 36's diagnoses included chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body), and muscle weakness (a lack of muscle strength).</p> <p>During a review of Resident 36's "History and Physical (H&P)," date unknown, the H&P indicated, Resident 36 had the capacity to understand and make decisions.</p> <p>During a review of Resident 36's Minimum Data Set ([MDS] a resident assessment tool), dated 2/5/2025, the MDS indicated Resident 36's cognition sometimes understands. The MDS indicated Resident 36 was dependent on staff for hygiene, showering, and dressing.</p> <p>During an observation on 3/4/2025 at 11:10 a.m., in Resident 36's room, observed the call light not within reach. The call light was behind Resident 36's bed, on the floor.</p>	F 558	<p>How the facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>On 3/4/25, Department Managers, including but not limited to Administrator, Director of Nursing, Director of Staff Development (DSD), Social Services Director, Activities Director, Case Manager, Admissions Coordinator, Infection Preventionist, Minimum Data Set (MDS) Coordinator and Assistant, and Quality Assurance (QA) Nurse conducted visual rounds to ensure no other resident call light was not within reach.</p> <p>No other residents were affected by this deficient practice.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/13/25, The Director of Nursing and Director of Staff Development in-serviced, Facility Staff, including but not limited to Certified Nursing Assistants, License Vocational Nurses and Registered Nurses, and Department Managers on the facility's policy and procedure titled "Communication-Call System" with emphasis on the facility providing a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities and promptly being able to communicate</p>	3/4/25	

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F 558	<p>Continued From page 9</p> <p>During a concurrent observation and interview on 3/4/2025 at 11:15 a.m. with Certified Nursing Assistant (CNA) 3, in Resident 36's room, observed the call light on the floor behind the bed. CNA 3 stated the call light was not within reach. CNA 3 stated the protocol was to make sure the call light was within reach at all times. CNA 3 stated it was important to have the call light within reach, so the resident does not try to get out a of the bed. CNA 3 stated keeping the call light within reach helped to prevent falls.</p> <p>During an interview on 3/6/2025 at 1:57 p.m. with Registered Nurse (RN) 1, RN 1 stated the call light should be near the resident and on the chest area at all times. RN 1 stated the call light was used to communicate with staff the resident's needs. RN 1 stated when the call light was not within reach it would cause a delay in service and care for the residents.</p> <p>B. During a review of Resident 224's Admission Record, the Admission Record indicated, Resident 224 was admitted to the facility on 2/6/2025. Resident 224's diagnoses included difficulty walking, muscle weakness, asthma (a chronic lung disease making it difficult to breathe), and congestive heart failure (CHF- heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).</p> <p>During a review of Resident 224's H&P, dated 2/16/2025, the H&P indicated Resident 224 had the capacity to understand and make decisions.</p> <p>During a review of Resident 224's MDS, dated</p>	F 558	<p>heir needs. The in-service also included placing the call cords within the residents reach.</p> <p>Department Managers, including but not limited to DSD, Social Services Director and Assistant, Activities Director, Case Manager, Admissions Coordinator, Infection Preventionist, MDS Coordinator and Assistant, and QA Nurse will conduct room rounds daily for 5 days, weekly for 2 weeks and monthly thereafter to ensure residents call lights are in reach.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will review the Department Manager room rounds and will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for call lights being in reach for three months or until compliance is met.</p>	3/15/25	3/31/25

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F 558	<p>Continued From page 10</p> <p>2/21/2025, indicated Resident 224 was able to comprehend most conversation. The MDS indicated Resident 224 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) such as showering and toileting and stand, chair/bed-to-chair transfer, and toilet transfer.</p> <p>During a review of Resident 224's Care Plan, revision dated 2/12/2025, the care plan indicated, Resident 224 had a self-care and mobility deficit. The staff interventions indicated to keep the call system within reach and answer promptly and encourage the resident to use bell to call for assistance.</p> <p>During a concurrent observation and interview on 3/4/2025 at 10:44 a.m. with CNA 5, in Resident 224's room, observed the call light device behind Resident's 224 bed on the floor, not within reach of the resident. CNA 5 stated the call light was not within Resident 224's reach. CNA 5 stated the call light should have been within reach. CNA 5 stated the call light was for safety purposes, emergencies, and if the resident was to need anything. CNA 5 stated if the call light was not within reach there was no way the staff would know the resident needed. CNA 5 stated not addressing Resident 224's call light could affect the resident mentally, physically and emotionally.</p> <p>During an interview on 3/4/2025 at 10:50 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated the call light should be placed next to the resident for easy access. LVN 5 stated if the call light was not within reach the resident could not alert the nurse for an emergency, which would</p>	F 558			

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F 558	Continued From page 11 create a safety risk, and could impact access to pain medication. LVN 5 stated the needs of the resident would not be addressed in a timely manner and could potentially cause the resident to experience pain for longer than necessary. During an interview on 3/7/2025 at 10:55 a.m. with the Director of Nursing (DON), the DON stated the call light should be within the resident's reach. The DON stated when the call light was out of reach, the needs of the resident would not be met in a timely manner. During a review of the facility's policy and procedure (P&P) titled, "Communication-Call System," dated 10/2022, the P&P indicated the facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities. The P&P indicated call cords will be placed within the resident's reach in the resident's room. The P&P indicated the purpose of a call system is to provide a mechanism for residents to promptly communicate with nursing staff. The P&P indicated call cords will be placed within the resident's reach in the resident's room.	F 558			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and	F 561	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/4/25 Resident 273 was given a shower by assigned CNA. Social Services Director followed up with resident 273 in regards to receiving a shower. Resident 273 expressed no further adverse reaction or negative outcome from not receiving a shower.	3/4/25	

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F 561	<p>Continued From page 12</p> <p>waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of 25 sampled resident's (Resident 273) preference to have a shower was honored.</p> <p>This deficient practice had the potential to affect Resident 273's psychosocial wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 273's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 273 was admitted to the facility on 2/27/2025. Resident 273's diagnoses included urinary retention (a condition that makes it</p>	F 561	<p>How the facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>On 3/18/25 Social Services Director and Social Services Assistant conducted resident interviews to ensure residents are receiving a shower.</p> <p>No other residents were affected by this deficient practice.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/11/25 the Director of Staff Development (DSD) in-serviced Nursing Staff, including but not limited to License Vocational Nurse, Registered Nurses, Certified Nursing Assistants (CNA), and Restorative Nursing Assistants (RNA) on the facilities policy and procedure titled, "Showering a Resident" with emphasis on ensuring residents are offered a shower at a minimum of once weekly and given per resident request.</p> <p>On 3/11/25, the DSD in-serviced Nursing Staff, including but not limited to LVNs, RNs, CNAs, and RNAs on the facilities policy and procedure titled, "Resident Rights," with emphasis on residents being allowed to choose activities, schedules and health care that are consistent with their interest, assessments and plan of care including personal care needs such as bathing methods and grooming styles.</p>	<p>3/19/25</p> <p>3/12/25</p> <p>3/12/25</p>	

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F 561	<p>Continued From page 13</p> <p>difficult to empty your bladder), dysphagia (difficulty of swallowing), and urinary tract infection ([UTI] - an infection in the bladder/urinary tract).</p> <p>During a review of Resident 273's History and Physical (H&P), dated 3/2/2025, the H&P indicated, Resident 273 had the capacity to understand and make decisions.</p> <p>During a review of Resident 273's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/4/2025, the MDS indicated Resident 273 was independent in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 273 required moderate assistance (helper does more than half the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene.</p> <p>During a review of the facility's shower schedule, the shower schedule indicated Resident 273's shower days were on Mondays and Thursdays.</p> <p>During an interview on 3/4/2025 at 10:22 a.m., with Resident 273, Resident 273 stated he had been asking staff for showers instead of bed baths (a wash that you give to someone who cannot leave their bed) since his admission to the facility. Resident 273 stated he was told by staff they could not provide him with a shower because the staff needed an approval from the Physical Therapist ([PT] - a healthcare professional who helps people improve their movement aiming to restore function and prevent further problems). Resident 273 stated he was embarrassed for not having showered for 5 days.</p>	F 561	<p>Department Managers will conduct rounds daily for five days weekly for two weeks and monthly thereafter to ensure residents are receiving a shower as scheduled.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will review the Department Manager rounds and will report to the Quality Assessment and Assurance committee during its monthly meeting the status of the compliance for showers given to residents for three months or until compliance is met.</p>	3/31/25

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F 561	<p>Continued From page 14</p> <p>During an interview on 3/5/2025 at 10:17 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated Resident 273 had an approval from the PT for him to have a shower. CNA 1 stated Resident 273 should have been given a shower as scheduled on Thursday and Monday. CNA 1 stated Resident 273 was not given a shower since his admission. CNA 1 stated it was important for Resident 273 to shower to be clean and comfortable.</p> <p>During an interview on 3/5/2025 at 10:33 a.m., with the Director of Staff Development (DSD), the DSD stated Resident 273 had the right to choose their own shower day schedule. The DSD stated the risk of not honoring the resident's preference would cause the resident to be upset and embarrassed affecting his quality of life.</p> <p>During an interview on 3/5/2025 at 10:38 a.m., with the Director of Rehab (DOR), the DOR stated Resident 273 was able to stand up, ambulate (walk) and required minimum assistance (helper assist only prior to or following the activity) with transfer. The DOR stated there was no reason for staff not to give Resident 273 a shower.</p> <p>During a review of the facility's policy and procedure (P&P), titled "Showering a Resident," dated 5/1/2018, the P&P indicated, "Residents are offered a shower at a minimum of once weekly and given per resident request."</p> <p>During a review of the facility's P&P, titled "Resident Rights," dated 5/1/2023, the P&P indicated, "Residents are allowed to choose activities, schedules and health care that are</p>	F 561			

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F 582	<p>Continued From page 16</p> <p>60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to inform and provide the Notice of Medicare Non-Coverage ([NOMNC] - a notice that indicates when your care is set to end from a skilled nursing facility) form 48 hours prior to the end of skilled nursing services to resident representative for one of three sampled residents (Resident 32).</p> <p>This deficient practice had the potential to result in the resident not being able to exercise his right to file an appeal and unknowingly paying for non-covered care expenses.</p> <p>Findings:</p> <p>During a review of Resident 32's Admission Record (front page of the chart that contains a</p>	F 582	<p>policy and procedure titled, "Medicare Denial Process," with emphasis on delivering the NOMNC at least two calendar days before Medicare covered services end or the second to last day of services if care is not being provided daily as referenced in the NOMNC instructions (CMS-10123).</p> <p>The Administrator will conduct audits on residents who are receiving NOMNCs daily for 5 days, weekly for 2 weeks and monthly thereafter to ensure that NOMNC are being provided at least two calendar days before Medicare coverage services end or the second to last day of services if care is not being provided daily.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will report to the Quality Assessment and Assurance committee during its monthly meeting the status of the compliance for NOMNC given to residents for three months or until compliance is met.</p>	<p>3/10/25</p> <p>3/31/25</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 582	<p>Continued From page 17</p> <p>summary of basic information about the resident), the Admission Record indicated Resident 32 was admitted to the facility on 1/19/2022. Resident 32's diagnoses included unspecified dementia (a progressive state of decline in mental abilities), cerebrovascular accident ([CVA] - a stroke, loss of blood flow to a part of the brain), and dysphagia (difficulty of swallowing).</p> <p>During a review of Resident 32's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/14/2025, the MDS indicated Resident 32's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 32 required set-up assistance (helper sets up, resident completes activity) from staff with eating, oral hygiene, and upper body dressing.</p> <p>During a concurrent interview and record review on 3/6/2025 at 9:09 a.m., with the Business Office Manager (BOM), Resident 32's Notice of Medicare Non-Coverage ([NOMNC] - a notice that indicates when your care is set to end from a skilled nursing facility) form was reviewed. The BOM stated she was responsible in providing and maintaining signed copies of the NOMNC form. The BOM stated Resident 32's last covered day for Medicare Part A skilled services ended on 11/18/2024. The BOM stated Resident 32's NOMNC was given to the resident representative on 11/17/2024. The BOM stated the facility process was to give NOMNC to the resident or resident representative 48 to 72 hours prior to the end of Medicare Part A skilled services so they would have time enough time to make an appeal.</p>	F 582			

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F 582	Continued From page 18 The BOM stated Resident 32's representative was deprived of her rights to appeal for financial coverage should the representative wish to continue Resident 32 to receive skilled care services. During a review of the facility's policy and procedure (P&P), titled "Medicare Denial Process," dated 10/24/2022, the P&P indicated, "The Notice of Medicare Non-Coverage (CMS-10123) is required to be delivered to the resident/representative at least two calendar days before Medicare covered services end."	F 582			
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized	F 640	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/5/25, the Minimum Data Set Nurse (MDSN) reviewed Resident 93's Minimum Data Set (MDS) assessment, dated 10/21/2024. MDSN noted Resident 93's MDS Assessment Reference date was 10/21/2024 and had been submitted late to the CMS on 11/21/2024. There were no negative outcome related to this deficient practice for Resident 93 who discharged home on 11/7/24. How do facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this deficient practice. On 3/19/25, the Medical Records Director	3/5/25	

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F 640	<p>Continued From page 19 edits defined by CMS and the State.</p> <p>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.</p> <p>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to transmit the Minimum Data Set ([MDS] - a resident assessment tool) within 14 days after completion to the Centers for Medicare and Medicaid Services (CMS) for one of 25 sampled residents (Resident 93).</p> <p>This deficient practice resulted in incorrect data transmitted to CMS and had the potential to affect continuity of care.</p>	F 640	<p>conducted an audit on the past quarters MDS submissions.</p> <p>There 2 residents affected by this deficient practice.</p> <p>There was no negative outcome noted for residents affected.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/18/25, the facility Consultant and Administrator in-serviced the Director of Nursing, MDSN and MDSN Assistant were in-serviced on the facility's policy and procedure titled, "MDS Completion and Submission Timeframes," with emphasis on the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes including but not limited to submitting MDS assessments within 14 days after the completion to the Centers of Medicare and Medicaid Services (CMS).</p> <p>The Medical Records Director will conduct an audit on MDS assessments daily for five days weekly for two weeks and monthly thereafter to ensure MDS assessments were transmitted to CMS within 14 days after completion.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will report to the</p>	<p>3/19/25</p> <p>3/18/25</p>	

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F 640	<p>Continued From page 20</p> <p>Findings:</p> <p>During a review of Resident 93's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated Resident 93 was admitted to the facility on 10/14/2024. Resident 93's diagnoses included diabetes mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), cerebrovascular accident ([CVA] - a stroke, loss of blood flow to a part of the brain), and anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a review of Resident 93's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/21/2024, the MDS indicated Resident 93's cognitive (ability to think and reason) skills for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 93 was totally dependent (helper does all of the effort) on staff with eating, oral hygiene and personal hygiene.</p> <p>During a review of the CMS MDS Validation Report, the CMS MDS Validation Report indicated Resident 93's MDS assessment was submitted more than 14 days after the comprehensive assessment.</p> <p>During a concurrent interview and record review on 3/5/2025 at 12:02 p.m., with the Minimum Data Set Nurse (MDSN), Resident 93's MDS assessment, dated 10/21/2024, was reviewed. The MDSN stated Resident 93's MDS Assessment Reference Date ([ARD] - the specific date used as the endpoint of the observation</p>	F 640	Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for submitting MDS assessments to CMS within 14 days after completion for three months or until compliance is met.	3/31/25	

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F 640	Continued From page 21 period when assessing resident's condition) was 10/21/2024 and the MDS assessment was submitted late to the CMS on 11/21/2024. The MDSN stated Resident 93's MDS assessment should have been submitted to the CMS within 14 days from the ARD. The MDSN stated the MDS assessment reflects the condition and care provided to the resident. The MDSN stated it was essential to transmit the MDS assessment in a timely manner so the facility would be in compliance with the regulation.	F 640			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), 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 must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/7/25 the Minimum Data Set Nurse (MDSN) Assistant care planned the psychotropic medication, Seroquel and Duloxetine, for Resident 46. The care plan included the use of the psychotropic medication being a risk, the goal that Resident 46 will remain free of psychotropic drug related complications, and the interventions including, but not limited to providing a safe and calm environment, monitor for side effects of the use of psychotropics and encourage activities of preference. How the facility will identify other residents, having the potential to be	3/7/25	

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F 656	<p>Continued From page 23</p> <p>affected resident not to receive the care and services needed and the provision of a poor-quality care.</p> <p>Findings:</p> <p>During a review of Resident 46's Admission Record, the Admission Record indicated Resident 46 was initially admitted to the facility on 5/16/2023 and latest readmission was on 2/7/2025. Resident 46's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (CKD-condition which the kidneys are damaged and cannot filter blood as well as they should), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).</p> <p>During a review of Resident 46's History and Physical (H&P), dated 2/19/2025, the H&P indicated Resident 46 had the capacity to understand and make decisions.</p> <p>A review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2025, the MDS indicated Resident 46 was assessed to have clear comprehension (the action or capability of understanding something) in daily decision making. The MDS indicated Resident 46 was receiving antipsychotic and antidepressant medications.</p> <p>During a concurrent interview and record review on 3/7/2025 at 9:20 a.m., with Registered Nurse (RN) 1, Resident 46's electronic medical record</p>	F 656	<p>with emphasis on nursing responsibility to implement and update the care plan as indicated. The in-service also included not administering psychotherapeutic medication until an informed consent has been obtained and documented by the Attending Physician/LHP (Licensed Healthcare Professional) from the resident and/or surrogate decision maker.</p> <p>The Medical Records Director will conduct an audit daily for 5 days, weekly for 2 weeks and monthly thereafter on psychotropic medication being care planned.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Social Services Director will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for care planning psychotropic medication use for three months or until compliance is met.</p>	<p>3/11/25</p> <p>3/31/25</p>	

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F 656	<p>Continued From page 24</p> <p>and care plan was reviewed. No care plan was found for the administration of Seroquel and Duloxetine HCL. RN 1 stated there was not a care plan for the use of psychotropic medication. RN 1 stated a care plan should have been created for the psychotropic medication. RN 1 stated a care plan was important to let the staff know how to care for the resident's behavior, provide proper care, what signs to look for and interventions to use. RN 1 stated if a care plan was not completed, proper treatment could not be given to the resident.</p> <p>During an interview on 3/7/2025 at 9:44 a.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated care plans were initiated upon admission, with any change of condition and new orders. The MDSN stated care plans were a guide to give residents personal individualized care. The MDSN stated there should have been a care plan for the use of antipsychotic and antidepressant medication. The MDSN stated if a care plan was not developed the resident could be missing out on effective care they may need.</p> <p>During an interview on 3/7/2025 at 10:55 a.m., with the Director of Nursing (DON), the DON stated care plans were individualized to implement the plan of care to meet the resident's needs. The DON stated the staff incorporated the goals and interventions for the resident. The DON stated a care plan was needed when a resident was receiving psychotropic medications. The DON stated if a care plan was not developed interventions, goals, and the needs of the resident may not be met.</p> <p>During a review of the policy and procedure</p>	F 656			

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F 656	Continued From page 25 (P&P) titled, "Care Planning," revised 10/2022, the P&P indicated, a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. The P&P indicated the care plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. During a review of the facility's P&P titled, "Psychotherapeutic Drug Management," revised 5/2024, the P&P indicated nursing responsibility is to implement and update the care plan as indicated. The P&P indicated licensed nurses will not administer psychotherapeutic medication until an informed consent has been obtained and documented by the Attending Physician/LHP (Licensed Healthcare Professional) from the resident and/or surrogate decision maker.	F 656			
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to meet the professional standards of nursing practice by failing to: 1. Properly obtain accurate orthostatic blood pressure (a form of low blood pressure that happens when standing after sitting or lying down) readings for two of two sampled residents (Residents 1 and 25).	F 658	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/10/25, License Vocational Nurse (LVN) 4 received one-on-one in-servicing with return demonstration by the Director of Nursing and Director of Staff Development to ensure she understood the definition of orthostatic hypotension and how to perform orthostatic hypotension monitoring. On 3/17/24, Resident 55 started Midodrine HCl 5 mg, give 5 milligrams (mg) orally every 8 hours for hypotension; hold if systolic (top number in a blood pressure reading) blood pressure (SBP) is greater than 110, not to be taken after the evening meal or less than 3-4 hours	3/10/25	

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F 658	<p>Continued From page 26</p> <p>This deficient practice had the potential for Residents 1 and 25 to experience a delay in interventions if they were positive for orthostatic hypotension (low blood pressure).</p> <p>2. Ensure medication, Diclofenac Sodium External Gel 1% (a medication to treat pain and inflammation), was administered to the correct site as ordered by the physician for one of five sampled residents (Resident 96).</p> <p>This deficient practice had the potential to result in unintended complications of the medication, which could potentially lead to overdose or an adverse reaction for Resident 96.</p> <p>3. Administer Midodrine HCl (a medication to treat low blood pressure) following parameters set by physician order for one of four sampled residents (Resident 55).</p> <p>This deficient practice had the potential to result in unintended consequences of the management of blood pressure such as hypertension (HTN-high blood pressure) for Resident 55.</p> <p>Findings:</p> <p>1a. During a review of Resident 25's Admission Record, the admission record indicated Resident 25 was admitted to the facility on 7/28/2023 and readmitted on 5/27/2024 with diagnoses that included muscles weakness, schizophrenia (a mental illness that is characterized by disturbances in thought), and restlessness and agitation.</p>	F 658	<p>before bed. Resident 55 was noted to have received medication Midodrine HCl 5 mg outside of parameters.</p> <p>No adverse or negative outcome was noted for Resident 55 as a result of this deficient practice.</p> <p>On 3/10/25, Licensed Vocational Nurse (LVN) 4 received an on-one-one in-service on administering medication per physician order.</p> <p>There were no negative or adverse outcomes for Resident 96 as a result of this deficient practice.</p> <p>On 3/14/25 LVN 4 received order from Resident 96's Primary Physician for pain medication (Diclofenac Sodium External Gel 1%) to be administered to left shoulder.</p> <p>How the facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>On 3/19/25, the Medical Record Director conducted an audit on residents receiving orthostatic hypotension monitoring to ensure orthostatic hypotension monitoring was being recorded accurately.</p> <p>There was 1 other resident affected by this deficient practice.</p> <p>The residents affected by this deficient</p>	<p>3/17/25</p> <p>3/10/25</p> <p>3/14/25</p> <p>3/19/25</p>	

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F 658	<p>Continued From page 27</p> <p>During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool), dated 12/8/2024, the MDS indicated Resident 25 was cognitively intact (ability to reason, understand, remember, judge, and learn).</p> <p>During a review of Resident 25's Order Summary, the Order Summary indicated an order was placed on 12/5/2024 to have orthostatic hypotension monitoring done every evening shift on Saturdays while lying and sitting.</p> <p>During a review of Resident 25's Care Plan, dated 11/16/2023, the care plan indicated Resident 25 uses psychotropic (used to treat mental illness) medications related to schizoaffective disorders (a mental illness that can affect thoughts, mood, and behavior). The interventions indicated to monitor orthostatic hypotension while sitting and lying weekly on Saturdays.</p> <p>During a review of Resident 25's Medication Administration Record (MAR), for the month of February 2025, the MAR indicated the following blood pressure readings:</p> <p>2/22/2025 8:20 p.m. - 128/70 millimeters of mercury (mmHg- unit of measurement) -Lying rightt (r)/ arm. 2/22/2025 11:30 a.m. -124/72 mmHg -Lying r/arm. 2/22/2025 1:34 a.m. - 126/74 mmHg -Lying r/arm. 2/15/2025 10:13 p.m. - 128/70 mmHg -Lying r/arm. 2/15/2025 11:34 a.m. - 126/74 mmHg - Lying r/arm.</p>	F 658	<p>practice experienced no negative outcome.</p> <p>On 3/10/25, the Director of Nursing conducted interviews on resident who have topical pain medication orders to ensure residents are receiving topical pain medication as ordered.</p> <p>No other residents were affected by this deficient practice.</p> <p>On 3/24/25, the Medical Records Director conducted an audit on resident's with blood pressure medication orders to ensure medication is being administered within parameters ordered by the physician.</p> <p>No other residents were affected by this deficient practice.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/19/25, the Director of Nursing and Director of Staff Development in-serviced Nursing Staff including, but not limited to LVNs and Registered Nurses on the facility's policy and procedure titled, "Blood Pressure, Measuring" with emphasis on orthostatic hypotension being defined as 20 millimeters of mercury (mmHg- unit of measurement) decline in systolic blood pressure (the contraction phase of the hear) or a 10 mmHg decline in diastolic blood pressure (relaxing phase of the heart) upon standing and to measure orthostatic hypotension, note the changes in both the systolic and diastolic</p>	<p>3/10/25</p> <p>3/24/25</p>	

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F 658	<p>Continued From page 29</p> <p>resident sit up wait a few minutes and then take the blood pressure because there would not be enough information to determine if the resident had orthostatic hypotension.</p> <p>b. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on 11/2/2013 and last readmitted on 6/11/2024. Resident 1's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 8/21/2024, the H&P indicated Resident 1 did not have the capacity to understand and make medical decisions.</p> <p>A review of Resident 1's MDS, dated 12/31/2024, the MDS indicated Resident 1 was assessed to have some understanding, responds to direct adequately to simple, direct communication only. The MDS indicated Resident 1 needed maximal assistance from staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) such as showering, personal hygiene and supervision from staff for sit to lying and lying to sitting.</p> <p>During a review of Resident 1's Order Summary, the Order Summary indicated an order was placed on 11/9/2024 for to start orthostatic</p>	F 658	<p>limited to Licensed Vocational Nurses (LVNs) and Registered Nurses (RNs) on the facility's policy and procedure titled, "Medication -Administration," with emphasis on providing professional standards of practice for safe administration of medications for residents in the facility including following information about any medication they are administering, the drug's route of administration, the drug's indication for use and desired outcome. The in-service also emphasized the seven "rights" of medication when administering medication: right medication, right amount, right resident, right time, right route, right indication, and right outcome and the "rule of 3" (performing 3 checks): comparing the physician's order, pharmacy label, and medication administration record (MAR).</p> <p>On 3/31/25, the Director of Nursing/ designee, revised orders for residents with pain medication being administered topical to included documentation requirements for where the licensed nurse administered the medication to ensure medication is being administered to the site as ordered.</p> <p>The Medical Records Director will conduct an audit on following parameters for administering medication for residents with topical pain medication orders daily for five days, weekly for two weeks, and monthly thereafter to ensure residents parameters are being followed.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Director of Nursing will report to the Quality Assessment and Assurance</p>	<p>3/22/25</p> <p>3/31/25</p>	

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F 658	<p>Continued From page 30</p> <p>hypotension monitoring every evening shift every Saturday while lying and sitting.</p> <p>During a review of Resident 1's MAR for the months of February and March 2025, the MARs showed the results of the orthostatic blood pressure (BP) which were:</p> <p>3/1/2025 9:33 p.m. - 133/69 mmHg (Lying l /arm). 2/22/2025 9:07 p.m. - 127/63 mmHg (Lying upper r /arm). 2/15/2025 9:35 p.m. - 118/76 mmHg (Sitting r /arm). 2/15/2025 9:34 p.m. - 122/78 mmHg (Lying right r /arm). 2/8/2025 9:05 p.m. - 122/70 mmHg (Sitting l /arm). 2/8/2025 9:05 p.m. - 128/72 mmHg (Sitting r /arm). 2/1/2025 8:40 p.m. - 119/71 mmHg (Lying l /arm).</p> <p>During a concurrent interview and record review on 3/6/2025 at 11:30 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 1's Orthostatic Blood Pressure readings were reviewed for the month of February 2025 and March 2025. LVN 4 stated on 2/1/2025 the BP was 119/71, 2/22/2025 the BP was 127/63, and 3/1/2025 the BP was 133/69, the blood pressure readings for lying and sitting were the same. LVN 4 stated "No, I don't really know how to take orthostatic blood pressures."</p> <p>During an interview on 3/7/2025 at 10:55 a.m., with the Director of Nursing (DON), the DON stated residents receiving antipsychotic medication were ordered for orthostatic BPs. The DON stated the orthostatic BPs would never be</p>	F 658	<p>Committee during its monthly meeting the status of the compliance for orthostatic hypotension monitoring being monitor accurately, following parameters for administering medication for residents with blood pressure medication orders, and medication administration related to pain medication being administered to the correct site as ordered for three months or until compliance is met.</p>	3/31/25	

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F 658	<p>Continued From page 31</p> <p>the same, there should always be a difference. The DON stated if it was documented that both sitting and lying BPs were the same or taken at the same time, you would not be able to tell if the BPs were taken from both locations and taken correctly. The DON stated orthostatic BP's need to be done correctly, so the physician would know how to manage the medication, dosage and treatment plan depending on the results. The DON stated if the orthostatic BPs are not accurate the resident may receive a medication that needed to be discontinued or dosage decreased, which could potentially harm the resident.</p> <p>During a review of the facility's policy and procedure (P&P), titled "Blood Pressure, Measuring", dated 1/2018, the P&P indicated orthostatic hypotension is defined as 20 millimeters of mercury (mmHg- unit of measurement) decline in systolic blood pressure (the contraction phase of the hear) or a 10 mmHg decline in diastolic blood pressure (relaxing phase of the heart) upon standing. To measure orthostatic hypotension, note the changes in both the systolic and diastolic blood pressure in the standing position compared to the sitting position.</p> <p>2. During a review of Resident 55's Admission Record, the Admission Record indicated, Resident 55 was initially admitted to the facility on 6/1/2022 and latest readmission was on 3/17/2024. Resident 55's diagnoses included ESRD (End Stage Renal Disease-irreversible kidney failure), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and major</p>	F 658			

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F 658	<p>Continued From page 32</p> <p>depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 55's H&P, dated 3/22/2024, the H&P indicated Resident 55 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 55's MDS, dated 1/17/2025, the MDS indicated Resident 55 was assessed to have clear comprehension in daily decision making. The MDS indicated Resident 55 required supervision from staff for ADLs such as tub/shower transfer, walk 10 feet, wake 50 feet with two turns, and walk 150 feet.</p> <p>During a review of Resident 55's Order Summary, an order was placed on 3/17/2024 for Resident 55 to start Midodrine HCl 5 mg, give 5 milligrams (mg) orally every 8 hours for hypotension; hold if systolic (top number in a blood pressure reading) blood pressure (SBP) is greater than 110, not to be taken after the evening meal or less than 3-4 hours before bed.</p> <p>During a concurrent interview and record review on 3/7/2025 at 1:20 p.m., with LVN 5, Resident 55's MAR for February 2025 and March 2025 was reviewed. The MAR showed Midodrine HCl 5 mg tablet was administered when the SBP and 10:00 p.m. dosage was not within parameters which were:</p> <p>2/1/2025 -2:00 p.m. SBP 126. 2/3/2025 - 6:00 a.m. SBP 119 - 10:00 p.m. SBP 104. 2/4/2025 - 6:00 a.m. SBP 116 - 2:00 p.m. SBP</p>	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	Continued From page 33 116. 2/5/2025 - 6:00 a.m. SBP 113. 2/6/2025 - 6:00 a.m. SBP 126 - 10:00 p.m. SBP 109. 2/7/2025 - 6:00 a.m. SBP 111. 2/8/2025 -10:00 p.m. SBP 109. 2/10/2025 -6:00 a.m. SBP 120. 2/11/2025 -10:00 p.m. SBP 106. 2/13/2025 - 6:00 a.m. SBP120 - 10:00 p.m. SBP 105. 2/15/2025 - 6:00 a.m. SBP 116 - 10:00 p.m. SBP 105. 2/16/2025 - 6:00 a.m. SBP118 - 2:00 p.m. SBP 118 - 10:00 p.m. SBP 98. 2/17/2025 - 10:00 p.m. SBP 98. 2/18/2025 - 10:00 p.m. SBP 106. 2/19/2025 - 6:00 a.m. SBP 115 - 10:00 p.m. SBP 102. 2/20/2025 -6:00 a.m. SBP 113. 2/21/2025 - 6:00 a.m. SBP 136 -10:00 p.m. SBP 115. 2/22/2025 - 6:00 a.m. SBP 120. 2/23/2025 - 6:00 a.m. SBP 130 - 2:00 p.m. SBP 130. 2/24/2025 - 6:00 a.m. SBP116 - 10:00 p.m. SBP 108. 2/25/2025 - 6:00 a.m. SBP 114. 2/26/2025 - 6:00 a.m. SBP 124. 2/28/2025 - 6:00 a.m. SBP124 - 10:00 p.m. SBP 105. 3/1/2025 - 6:00 a.m. SBP 120. 3/2/2025 - 6:00 a.m. SBP 125. 3/3/2025 - 6:00 a.m. SBP 115. 3/4/2025 - 6:00 a.m. SBP 113. 3/5/2025 - 6:00 a.m. SBP 112 - 2:00 p.m. SBP112 - 10:00 p.m. SBP 101. 3/6/2025 - 6:00 a.m. SBP 123.	F 658			

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F 658	<p>Continued From page 34</p> <p>LVN 5 stated the medication should not have been administered when the SBP was greater than 110 and the 10:00 p.m. dose of Midodrine HCl should not have been given at all. LVN 5 stated it could possibly put the resident at risk for hypertension or a stroke.</p> <p>During a concurrent interview and record review on 3/7/2025 at 1:40 p.m., with the DON, Resident 55's MAR for February 2025 and March 2025 was reviewed. The Medication order indicated Midodrine HCl 5mg tablet, give 5mg orally every 8 hours for hypotension, HOLD if SPB was greater than 110; not to be taken after the evening meal or less than 3-4 hours before bed. The DON stated there were many entries when the medication was administered with the SBP greater than 110 and administered the 10:00 p.m. dose. The DON stated the 10:00 p.m. dose should have been clarified with the physician. The DON stated the licensed nursing staff should have held the medication when the SBP was greater than 110 and not administer the 10:00 p.m. dose at all. The DON stated this could affect the resident, it could cause potential harm, an episode of hypertension, or a stroke.</p> <p>During a review of the facility's P&P titled, "Medication -Administration," revised 5/2018, the P&P indicated, Test and taking of vital signs, upon which administration of medications or treatments are conditioned, will be performed as required and the results recorded. When administration of the drug is dependent upon vital signs or testing, the vital signs/testing will be completed prior to administration of the medication and recorded in the medical record. The resident's MAR will be reviewed for allergies</p>	F 658			

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F 658	<p>Continued From page 35 and/or special consideration for administration including, vital sign parameter and lab results as appropriate.</p> <p>3. During a review of Resident 96's Admission Record, the Admission Record indicated, Resident 96 was admitted to the facility on 9/16/2024. Resident 96's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing).</p> <p>During a review of Resident 96's H&P, dated 11/3/2024, the H&P indicated Resident 96 did have the capacity to understand and make decisions.</p> <p>During a review of Resident 96's MDS, dated 2/13/2025, the MDS indicated Resident 96 was assessed to have clear comprehension in daily decision making. The MDS indicated Resident 96 was dependent on staff for ADLs such as toileting, upper and lower body dressing, personal hygiene, putting on/taking off footwear, and lying to sitting.</p> <p>During an observation on 3/6/2025 at 9:20 a.m., with LVN 4, medication administration, in Resident 96's room. Resident 96 complained of</p>	F 658			

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F 658	<p>Continued From page 36</p> <p>shoulder pain. LVN 4 let resident know it was not time for her oral pain medication, but she had the gel that would help the pain. LVN 4 was observed to check the medication Diclofenac Sodium External Gel 1% (a medication to treat pain and inflammation), label, and then prepared the gel. LVN 4 proceeded to apply the gel to Resident 96's right shoulder.</p> <p>During a concurrent interview and record review on 3/6/2025 at 1:38 p.m., with LVN 4, Resident 96's Order Summary was reviewed, an order was placed on 2/3/2025 for Resident 96 to start Diclofenac Sodium External Gel 1%, apply to bilateral (both) knee topically every 12 hours as needed for knee pain, apply 4 gram (a metric unit of measurement) 4.5 inches to bilateral knee. LVN 4 stated the medication order was for Diclofenac Sodium External Gel 1% applied to bilateral knee for pain. LVN 4 acknowledged administering the medication to Resident 96's right shoulder. LVN 4 stated "I remember the resident did have an order for placing the diclofenac gel to the shoulder," LVN 4 reviewed the orders and stated "No, there was not a current order for Diclofenac gel applied to shoulder. LVN 4 stated "I checked the system for the right medication, I guess I didn't realized there was no order for the shoulder just the knees." LVN 4 stated that it could affect the resident by potentially giving more medication than needed, cause adverse reaction, or harm the resident.</p> <p>During an interview on 3/7/20025 AT 9:30 a.m., with Registered Nurse (RN) 1, RN 1 stated it was important to follow the physician's order before administering a medication. RN 1 stated double</p>	F 658			

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F 658	Continued From page 37 check the medication label with the order in the chart, if not done there could potentially be a medication error. RN 1 stated it could affect the resident by potentially giving a wrong medication, wrong dosage, or have an adverse reaction. During an interview on 3/7/2025 at 10:55 a.m., with the DON, the DON stated before a medication was administered the medication's 5 rights needed to be checked, right patient, right medication, right dosage, right time and right route. The DON stated a medication should not be given if there is not an order for that medication or route, notify the physician. The DON stated it was not within the nursing scope of practice to not follow the physician's order. The DON stated this could potentially harm the resident. During a review of the facility's P&P titled, "Medication -Administration," revised 5/2018, the P&P indicated, the purpose is to provide practice standards for safe administration of medications for residents in the facility. The licensed nurse must know the following information about any medication they are administering, the drug's route of administration, the drug's indication for use and desired outcome. Nursing staff will keep in mind the seven "rights" of medication when administering medication, right medication, right amount, right resident, right time, right route, right indication, and right outcome. The "rule of 3" - the licensed nurse administering medications will perform 3 checks comparing the physician's order, pharmacy label, and medication administration record (MAR).	F 658			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676			

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F 676	Continued From page 38 §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced	F 676	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/6/25 Resident 104 was provided with a wheelchair. On 3/6/25 Director of Rehabilitation (DOR) offered resident 104 to get out of bed with provided wheelchair, however resident refused to get out of bed. On 3/7/25 DOR offered resident 104 to get out of bed with provided wheelchair, however, Resident 104 refused to get out of bed. On 3/21/25 Resident 104 was offered to get out of bed by DOR, however, resident 104 refused. How do facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this deficient practice. On 3/10/25 Director of Rehabilitation (DOR) conducted an audit to ensure all residents, who I can have a wheelchair has a wheelchair. Wheelchair tags were provided for each resident to identify their wheelchair. No other residents were affected by this deficient practice. What measures will be into place or what systemic changes the facility will	3/6/25 3/7/25 3/21/25 3/11/25	

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F 676	<p>Continued From page 39</p> <p>by: Based on observation, interview, and record review, the facility failed to provide one of six sampled residents (Resident 104) with care and services to perform activities of daily living (ADLs, basic daily activities such as eating and transferring) by failing to provide Resident 104 with an appropriate wheelchair (WC, chair fitted with wheels for transport) for transfers and out of bed activities.</p> <p>This deficient practice had the potential for Resident 104 to experience a decline in overall physical and mental wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 104's Admission Record, the admission record indicated Resident 104 was readmitted to the facility on 12/2/2024 with diagnoses including muscle weakness and lack of coordination.</p> <p>During a review of Resident 104's Initial History and Physical (H&P) dated 12/3/2024, the H&P indicated Resident 104 had the capacity to understand and make decisions.</p> <p>During a review of Resident 104's Minimum Data Set (MDS, resident assessment tool) dated 12/9/2024, the MDS indicated Resident 104 had severe cognitive impairment (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 104 did not exhibit any behavior of rejecting care for health and well-being. The MDS indicated Resident 104 had</p>	F 676	<p>make to ensure that the deficient practice is not recur;</p> <p>On 3/11/25, The DOR in-serviced the Therapy Department on assessing and providing a resident with a wheelchair.</p> <p>The DOR/designee will evaluate new admissions and re-admissions on their functional ability to use a wheelchair. The DOR/designee will then provide the new admission or re-admission with the appropriate wheelchair.</p> <p>The Medical Records Director will audit daily for 5 days weekly for 2 weeks and monthly thereafter to ensure new admissions and readmissions have been provided a wheelchair if applicable.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Director of Nursing will report to the Quality Assessment and Assurance committee during its monthly meeting the status of the compliance for providing residents with a wheelchair for three months or until compliance is met.</p>	<p>3/11/25</p> <p>3/31/25</p>	

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F 676	<p>Continued From page 40</p> <p>functional limitations in range of motion (ROM, full movement potential of a joint) on both sides of the upper extremities (shoulder, elbow, wrist/hand) and both sides of the lower extremities (hip, knee, ankle/foot). The MDS indicated no mobility devices were used. The MDS indicated Resident 104 required dependent assistance for bed to chair transfers.</p> <p>During a review of Resident 104's Care Plan revised on 1/6/2025, the care plan indicated Resident 104 had functional abilities (self-care and mobility) deficit. The goal indicated Resident 104 will improve current level of function. The interventions indicated to provide necessary equipment and adequate time for self performance or participation with daily care tasks.</p> <p>During a concurrent observation and interview on 3/4/2025 at 11:54 a.m. in Resident 104's room, Resident 104 was observed laying on the bed. Resident 104 was able to move the left arm up and down about halfway and both legs a little. Resident 104 stated the right arm was "bad" and required use of the left arm to assist moving the right arm up and down. Resident 104 stated he was never given a wheelchair (WC) since admission to the facility and had been asking for a WC. Resident 104 stated that he could not go outside or do activities because he was waiting for a WC. Resident 104 stated he was waiting for his wife to buy a WC because the facility was not providing a WC for him. There was no WC observed in Resident 104's room.</p> <p>During an interview on 3/5/2025 at 8:53 a.m., in the therapy gym, with the Director of</p>	F 676			

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F 676	<p>Continued From page 41</p> <p>Rehabilitation (DOR), the DOR stated when a resident was admitted to the facility, physical therapy staff would identify a resident's sitting balance and endurance to see what device was best for a resident such as a WC. The DOR stated there were many benefits for a resident to get out of bed and be out of the room and this required the facility providing the proper equipment such as a WC. The DOR stated if a resident was in bed all the time, then the muscles would atrophy (to become smaller). The DOR stated residents benefit from getting out of bed and out of the room, because residents would use their muscles and receive environmental stimulation.</p> <p>During a concurrent observation and interview on 3/5/2025 at 10:17 a.m., with Resident 104, in Resident 104's room, there was no WC observed. Resident 104 stated in an excited tone that he was going to get his WC that day (3/5/2025). Resident 104 stated once he got his WC he would be out and about in the facility.</p> <p>During a concurrent observation and interview on 3/5/2025 at 1:03 p.m., with Resident 104, in Resident 104's room, Resident 104 was observed laying in bed. Resident 104 stated he was still waiting for the facility to order him a WC. Resident 104 stated he would like to get out of bed and around the facility. Resident 104 stated it was the first time the staff indicated they would get him a WC.</p> <p>During an interview on 3/5/2025 at 1:16 p.m., in the therapy gym, with the DOR, the DOR stated he found a WC for Resident 104, but the WC was wet because it was outside in the rain and had to</p>	F 676			

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F 676	<p>Continued From page 42</p> <p>wait for the WC cushion to dry before Resident 104 could use the WC. The DOR stated residents should always have the opportunity to get out of bed and that the facility should have started the process of assessing and providing Resident 104 for an appropriate WC once Resident 104 was admitted in 12/2024. The DOR stated therapy staff should not have waited until that day (3/5/2025) to start assessing and providing a proper WC for Resident 104. The DOR stated it was the responsibility of staff to encourage and ask the resident if they wanted to get out of bed.</p> <p>During an interview on 3/5/2025 at 1:29 p.m., with Certified Nursing Assistant (CNA 4), CNA 4 stated he had never gotten Resident 104 out of bed before.</p> <p>During an interview on 3/5/2025 at 1:32 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated staff should encourage residents to get out of bed, because residents who stay in bed had a risk of contracting pneumonia (infection of lungs).</p> <p>During an interview on 3/6/2025 at 12:39 p.m., with the Director of Nursing (DON), the DON stated all residents should get out of bed, because it helped a resident's mental health to meet and talk to other people and for physical health such as increased circulation. The DON stated the facility provided the proper WC or devices so that residents could get out of bed and out of the room. The DON stated that no resident wanted to be in bed all the time.</p> <p>During an interview on 3/6/2025 at 11:24 a.m., with the Medical Records Supervisor, the Medical</p>	F 676			

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F 679	<p>Continued From page 44 that causes recurrent seizures).</p> <p>During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool) dated 2/10/2025, the MDS indicated Resident 24 had the ability to express ideas and wants and the ability to understand others. The MDS also indicated it was very important for Resident 24 to do things with groups of people and go outside to get fresh air when the weather is good.</p> <p>During a review of Resident 24's Care Plan focusing on activities, initiated 1/11/2019 and revised on 8/26/2022, the care plan indicated interventions for Resident 24 included, "The resident needs a variety of activity types and locations to maintain interests" and "The resident needs assistance/escort to activity functions."</p> <p>During an observation and interview on 3/5/2025 at 8:33 am, with Resident 24, Resident 24 was observed in the hallway near her room in a Geri-chair (a supportive reclining chair that provides more support and comfort than a wheelchair). Resident 24 stated the only time she leaves the room is when housekeeping deep cleans weekly. Resident 24 stated the Activities Director (AD) does come to her room and offer games. Resident 24 stated she wanted to get out of the room sometimes and go to the activity room with the other residents and outside to get some sun.</p> <p>During an interview on 3/5/2025 at 2:39 pm with the AD, the AD stated the facility provided one to one activities with Resident 24 in Resident 24's room, three times a week. The AD also stated when Resident 24 is asked to go to the activities</p>	F 679	<p>what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/18/25, The Director of Nursing and Director of Staff Development (DSD) in-serviced the Activities Department and Certified Nursing Assistants on the facility's policy and procedure titled "Activities Program" with emphasis on the facility providing an activity program designed to meet the needs, interests, and preferences of the residents and ensuring residents who express the desire for a particular activity example group activities be assisted in participation.</p> <p>Department Managers will conduct room rounds daily for five days weekly for two weeks and monthly thereafter to ensure residents who have the desire to participate in group activities are assisted with attending group activities.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for assisting residents with participation in group activities for three months or until compliance is met.</p>	<p>3/19/25</p> <p>3/31/25</p>	

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F 679	Continued From page 45 room, she usually declined. The AD stated staff will continue to encourage Resident 24 to participate in group activities and to go outside if it is not too cold so she will not feel isolated or left out. During an interview on 3/5/2025 at 4:02 pm with the Director of Rehabilitation (DOR), the DOR stated Resident 24 has expressed wanting to go outside of her room and the building. The DOR stated on 11/25/2024, he ordered a custom wheelchair for Resident 24 so the resident would be safe and comfortable when out of the bed. The DOR stated Resident 24 could become sad or depressed if no one takes her out of her room for activities. During a review of the facility's policy & procedure (P&P) titled "Activities Program", revised 4/1/2021, the P&P indicated, "The facility provides an activity program designed to meet the needs, interests, and preferences of the residents."	F 679			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/5/25 the Director of Rehabilitation (DOR) completed Resident 3's joint mobility assessment. Based on the joint mobility assessment, Resident 3 did not experience any negative outcome or adverse reaction in functional ability as a result of this deficient practice. On 3/7/25, Resident 27 order was clarified to allow the Restorative Nursing Assistant (RNA) to provide extension splint as ordered. On 3/7/25, 3/8/25,	3/5/25	

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F 688	<p>Continued From page 47 brain) affecting left non-dominant side.</p> <p>During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 11/20/2024, the MDS indicated Resident 3 had severe cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 3 had functional limitations in ROM on one side of the upper extremity (UE, shoulder, elbow, wrist/hand) and one side of the lower extremity (LE, hip, knee, ankle/foot). The MDS indicated Resident 3 required supervision assistance with eating, oral hygiene, and was dependent with bathing, lower body dressing, and bed to chair transfers.</p> <p>During a review of Resident 3's care plan revised on 4/3/2024, the care plan indicated Resident 3 required a Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) to maintain maximum joint capacity, minimize risk for contractures, and minimize risk for functional decline. The goal indicated Resident 3 will maintain maximum joint capacity, maintain/minimize risk for functional decline, and minimize risk for contractures (loss of motion of a joint). The care plan interventions indicated for passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises for both UE and both LE, apply resting hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) and elbow extension splint on left UE up to four hours or as tolerated.</p>	F 688	<p>joints as part of the resident's assessment. The in-service also included completing joint mobility assessments on admission or re-admission and quarterly thereafter.</p> <p>The Medical Records Director will audit daily for 5 days weekly for 2 weeks and monthly thereafter to ensure that the therapy department is completing joint mobility assessments on a quarterly basis.</p> <p>On 3/13/25, the Director of Rehabilitation in-serviced RNAs on the facility policy and procedure, titled "Splinting," with emphasis on preventing contractures or decrease tone and to protect joint alignment. The in-serviced also emphasized RNAs being responsible for applying the splint as ordered and documentation, and initialing on the schedule for splint application each time splint is applied, removed or refused.</p> <p>The Medical Records Director will audit daily for five days weekly for two weeks and monthly thereafter splint orders, and RNA documentation to ensure that residents are receiving their splints as ordered and less resident has refused.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for the therapy department completing quarterly joint mobility assessments and providing</p>	<p>3/10/25</p> <p>3/13/25</p>	

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F 688	<p>Continued From page 48</p> <p>During a review of Resident 3's Rehabilitation Joint Mobility Assessments (JMAs), the JMAs indicated completion dates of 8/23/2024 and 11/20/2024.</p> <p>During an observation on 3/5/2025 at 12:28 p.m. in the dining room, Resident 3 was observed sitting in a wheelchair and eating lunch with the right hand. Resident 3's left elbow was in a splint and left wrist/hand was in a splint.</p> <p>During a concurrent interview and record review on 3/5/2025 at 1:10 p.m., with the Director of Rehabilitation (DOR), the DOR stated the JMAs were completed upon admission, quarterly, and as needed. DOR reviewed Resident 3's JMAs and stated the last JMA completed was on 11/20/2024 and another quarterly JMA should have been completed by 2/2024. DOR stated it was not completed and the quarterly JMA due 2/2024 was late. DOR stated rehabilitation staff completed JMAs to monitor and identify any contractures upon admission and to track the ROM. DOR stated it was important to complete the JMAs quarterly to catch any declines in ROM as soon as possible to prevent contractures, because contractures can happen quickly, and staff needed to identify any contractures quickly.</p> <p>During an interview on 3/6/2025 at 11:18 a.m., with the Director of Nursing (DON), the DON stated JMAs should be completed at least quarterly and timely.</p> <p>B. During a review of Resident 27's Admission Record, the admission record indicated Resident 27 was initially admitted to the facility on 3/29/2024 and was last readmitted on 9/3/2024. Resident 27's diagnoses included muscle</p>	F 688	residents with splints as ordered for three months or until compliance is met.	3/31/25	

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F 688	<p>Continued From page 49</p> <p>weakness (a decrease ability to generate and control muscle force, leading to a reduced strength and difficulty in performing normal movements), pressure ulcer stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone), and hemiplegia (a condition by paralysis of one side of the body).</p> <p>During a review of Resident 27's History and Physical (H&P), date 9/25/2024 the H&P indicated, Resident 27 had capacity to understand and make decisions.</p> <p>During a review of Resident 27's MDS, dated 12/20/2024, the MDS indicated Resident 27's cognition was severely impaired. The MDS indicated Resident 27 was dependent on staff for toileting hygiene, showering, and dressing.</p> <p>During a review of Resident 27's physician orders titled, "Order Summary Report," dated 12/26/2024, the Order Summary Report indicated Resident 27 was to have a left elbow extension splint placed one time a day for four to six hours on Monday, Tuesday, Wednesday, Thursday, and Fridays.</p> <p>During a review of Resident 27's Medication Administration Record ([MAR] -a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 2/1/2025, 2/17/2025, 2/24/2025, and 3/3/2025, the MAR indicated Resident 27's left elbow extension splint was not placed on the resident.</p> <p>During a concurrent interview and record review</p>	F 688			

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F 688	<p>Continued From page 50</p> <p>on 3/4/2025 at 2:40 p.m. with Restorative Nurse Assistant (RNA) 3, Resident 27's MAR, dated 2/1/2025, 2/17/2025, 2/24/2025, and 3/3/2025 was reviewed. The MAR indicated on 2/1/2025, 2/17/2025, 2/24/2025, and 3/3/2025 the left elbow extension splint was not placed on Resident 27. RNA 3 stated the left elbow splint was to be placed on Resident 27 five days a week on Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays. RNA 3 stated the MAR showed the splint was not placed on Resident 27. RNA 3 stated when the splint is not placed regularly it could cause a decline in the resident left elbow.</p> <p>During a concurrent interview and record review on 3/4/2025 at 2:40 p.m. with Registered Nurse (RN) 1, Resident 27's MAR, dated 2/1/2025, 2/17/2025, 2/24/2025, and 3/3/2025 was reviewed. The MAR indicated on 2/1/2025, 2/17/2025, 2/24/2025, and 3/3/2025 the left elbow extension splint was not placed on Resident 27. RN 1 stated on the MAR there was no documentation that the left elbow splint was placed on Resident 27. RN 1 stated the resident did not receive the treatment for left elbow extension splint on 2/1/2025, 2/17/2025, 2/24/2025, and 3/3/2025. RN 1 stated if it was not documented was not done. RN 1 stated the left elbow splint is used to prevent contractures (a permanent tightening of the muscles, tendons, and skin that causes the joints to shorten and become very stiff). RN 1 stated not placing the left elbow extension splint could cause Resident 27's arm to become flaccid (muscle weakness or paralysis where muscles are soft, limp, and lacking in tone) over time or become contracted.</p>	F 688			

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F 688	Continued From page 51 During a review of the facility's policy and procedures (P&P) dated 1/2018, titled "Resident Mobility and Range of Motion," the P&P indicated as part of the resident's assessment, staff will identify the resident's current ROM of his or her joints. During a review of the facility's P&P titled, "Splinting," dated 5/2018, the P&P indicated to prevent contractures or decrease tone and to protect joint alignment. The P&P indicated the RNA is responsible for splint application, will document, and initial on the schedule for splint application each time splint is applied and removed.	F 688			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/5/25, Licensed Vocational Nurse (LVN) 6 repositioned Resident 57 head of bed between 30-45 degree angle. LVN 6 evaluated Resident 57 for any negative or adverse outcomes. There were no negative or adverse outcomes related to this deficient practice for Resident 57. How do facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this deficient practice. On 3/5/25, the Director of Nursing (DON) made visual rounds to ensure all residents receiving enteral feeding head	3/5/25	

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F 693	<p>Continued From page 53</p> <p>During a review of Resident 57's History and Physical (H&P), date unknown the H&P indicated, Resident 57 did not have capacity to understand and make decisions.</p> <p>During a review of Resident 57's Minimum Data Set ([MDS] a resident assessment tool), dated 12/13/2024, the MDS indicated Resident 57's cognition (ability to learn, reason, remember, understand, and make decisions) had the ability to sometimes understand. The MDS indicated Resident was dependent on staff for personal hygiene, showering, and dressing.</p> <p>During an observation on 3/5/2025 at 8:03 a.m. in Resident 57's room, Resident 57's was observed in the bed lying flat on her back while the tube feeding (TF) was running.</p> <p>During a concurrent observation and interview on 3/5/2025 at 8:06 a.m. with Licensed Vocational Nurse (LVN) 6, in Resident 57's room, Resident 57 was observed in the bed lying flat on her back while the TF was running. LVN 6 stated Resident 57's HOB should be up more. LVN 6 stated the HOB should be 30 to 45 degrees (a unit of measurement of angles) when the TF is running. LVN 6 stated if the HOB is not 30 to 45 degrees the resident is at risk for aspiration and could get aspiration pneumonia (a lung infection that occurs when food, liquid, other material is inhaled into the lungs).</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Enteral Feedings-Safety Precautions," dated 11/2018, the P&P indicated to ensure the safe administration of enteral nutrition. The P&P indicated prevention of</p>	F 693	the status of the compliance for residents receiving enteral feeding head of bed is at 30 to 45 degrees for three months or until compliance is met.	3/31/25	

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F 694	<p>Continued From page 55</p> <p>life-threatening infection), diabetes mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension ([HTN] - high blood sugar).</p> <p>During a review of Resident 21's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/29/2025, the MDS indicated, Resident 21's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 21 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene.</p> <p>During a review of Resident 21's Order Summary Report (a document containing active orders), dated 3/6/2025, the order summary report indicated Resident 21's physician prescribed Meropenem (drug used to treat infection) 1 gram ([gm] - metric unit of measurement, used for medication dosage and/or amount) intravenously ([IV] - into or within the vein) every 12 hours for 7 days for sepsis.</p> <p>During an observation on 3/4/2025 at 10:54 a.m., in Resident 21's room, Resident 21 was observed with a PICC line to the left upper arm.</p> <p>During a concurrent interview and record review on 3/5/2025 at 2:53 p.m., with the Director of Nursing (DON), Resident 21's IV Medication Administration Record ([MAR] - a daily documentation record used by licensed nurse to document medications/treatment given to a resident) from 2/28 to 3/5/2025 were reviewed. The DON stated Resident 21's PICC line site was not assessed once every shift by Registered</p>	F 694	<p>what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/10/25, the Director of Nursing in-serviced, Nursing Staff, including, but not limited to Licensed Vocational Nurses and Registered Nursing Staff on the facility's policy and procedure title, "PICC Line Maintenance and Cleaning in a Skilled Nursing Facility," with emphasis on the facility ensuring safe and effective maintenance and cleaning of Peripherally Inserted Central Catheters (PICC lines) to prevent infection, maintain patency, and ensure patient safety. The in-serviced also included recording all assessments, dressing changes, flushing, cap changes, and any observed complications in the patient's medical records.</p> <p>The Medical Records Director/designee will conduct an audit on residents, who are admit or re-admit with line orders, or receive IV orders in the facility, to ensure such residents, have monitoring orders, flush orders, and maintenance orders including but not limited to dressing changes for their lines daily for 5 days, weekly for 2 weeks and monthly thereafter.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Director of Nursing will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for residents have PICC line, Peripheral IV,</p>	3/11/25	

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F 694	Continued From page 56 Nurse (RN) and the dressing was not changed since it was inserted. The DON stated it was important to monitor the PICC line site for redness, swelling, and pain and document in IV MAR to identify infection and for resident safety. During a review of the facility's policy and procedure (P&P), titled "PICC Line Maintenance and Cleaning in a Skilled Nursing Facility," dated 5/1/2018, the P&P indicated, "The facility ensure safe and effective maintenance and cleaning of Peripherally Inserted Central Catheters (PICC lines) to prevent infection, maintain patency, and ensure patient safety". The P&P indicated to record all assessments, dressing changes, flushing, cap changes, and any observed complications in the patient's medical records.	F 694	midline lines have monitoring orders, flush orders and maintenance orders for three months or until compliance is met.	3/31/25	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Ensure pain was managed for one of 25 sampled residents (Resident 224) in a timely manner. This deficient practice resulted in Resident 224 experiencing unnecessary pain.	F 697	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/4/25, Licensed Vocational Nurse (LVN) 5, administered two 325mg tablets of Tylenol pain medication to Resident 224. Pain medication was noted to be effective. On 3/4/25, Certified Nursing Assistant (CNA) 5, removed call light of the floor from behind Resident 224 bed and placed within reach of Resident 224. How do facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken;	3/4/25 3/4/25	

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F 697	<p>Continued From page 58</p> <p>pain. Resident 224 stated the call light was not pressed. Resident 224 stated, "I lost it, I don't know where it is, I want some Tylenol for my back."</p> <p>During a review of Resident 224's Physician Order Summary (physician orders), dated 3/6/2025, the physician orders dated 2/6/2025 indicated to administer Tylenol tablet 325 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), give 2 tablets by mouth every six hours as needed for mild pain 1-3 (zero is no pain and ten as the worst pain a person may experience).</p> <p>During a review of Resident 224's Care Plan, revision dated 2/12/2025, the care plan indicated Resident 224 had a self-care and mobility deficit. The interventions indicated to keep the call system within reach and answer promptly and encourage the resident to use bell to call for assistance.</p> <p>During a review of Resident 224's care plan, revision dated 2/28/2025, the care plan indicated Resident 224 had complained of lower back pain. The goal was pain would be a bearable level per resident tolerance. The intervention indicated to anticipate the resident's need for pain relief and respond immediately to any complaint of pain.</p> <p>During an interview on 3/4/2025 at 10:50 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that pain needed to be addressed as soon as possible; it was important for the resident. LVN 5 stated that the resident would experience pain longer than necessary if they could not alert nursing due to the call light not being within</p>	F 697	<p>managed.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will review the Department Manager room rounds and will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for pain management with emphasis on administering pain medication timely for three months or until compliance is met.</p>	3/31/25	

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F 697	Continued From page 59 reach. LVN 5 stated the resident could potentially isolate and not interact with others due to the pain not being addressed in a timely manner. During an interview on 3/7/2025 at 10:55 a.m. with the Director of Nursing (DON), the DON stated if a resident was in pain we would address it as soon as possible. The DON stated if the call light was not within reach the resident would have no way to alert nursing about their pain. The DON stated it was important for residents to get their needs met in a timely manner to not have pain longer than necessary. During a review of the facility's policy and procedure (P&P) titled, "Pain Management," revised 5/2018, the P&P indicated, facility staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. Nursing staff will implement timely intervention to reduce the increase in severity of pain.	F 697			
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the	F 711	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/10/25, the Quality Assurance (QA) Nurse called Resident 100 ophthalmologist office to clarify, eyedrop order. The order was clarified to Brimonidine 0.2% (1) drop to both eyes two times a day, Cosopt 0.2% (1) drop to both eyes two times a day, & Latanaprost 0.005% (1) drop to both eyes at hour of sleep. The order was noted and carried out. Resident 100 had no negative outcomes as a result of this deficient practice.	3/10/25	

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F 711	<p>Continued From page 61</p> <p>During a review of Resident 100's Minimum Data Set ([MDS] a resident assessment tool), dated 12/13/2024, the MDS indicated Resident 100's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 100's vision was impaired. The MDS indicated Resident 100 required substantial assistance from staff for personal hygiene, showering, and dressing.</p> <p>During a review of Resident 100's ophthalmologist (eye doctor) services, dated 2/7/2025, the ophthalmologist indicated Resident 100 had glaucoma (a eye disease that damage the optic nerve, potentially leading to vision loss and blindness, due to increased pressure inside the eye) to both eyes and aged related nuclear cataracts (affects the central part of the eye's lens, leading to a gradual clouding and yellowing, potentially causing blurry vision) to both eyes.</p> <p>During a review of Resident 100's ophthalmologist services report, dated 2/7/2025, the report indicated the ophthalmologist indicated to start the following medications: 1. Latanoprost (to lower eye pressure to treat glaucoma) 1 drop at bedtime in both eyes. 2. Cosopt (to lower eye pressure) 1 drop two times a day in both eyes.</p> <p>During a concurrent interview and record review on 3/6/2025 at 9:21 a.m. with Registered Nurse (RN) 1, Residents 100's ophthalmologist services report was reviewed. The ophthalmologist services report had indicated Resident 100 was to start to start the following medications: 1. Latanoprost 1 drop at bedtime in both eyes. 2. Cosopt 1 drop two times a day in both eyes. RN</p>	F 711	<p>appointments daily for five days, weekly for two weeks, and monthly thereafter to ensure physician orders received from resident appointments are noted and carried out.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Director of Nursing will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for orders received from residents appointments for three months or until compliance is met.</p>	3/31/25

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F 711	Continued From page 62 1 stated the order was faxed on 2/10/2025 after Resident 100's eye appointment. RN 1 stated once the orders are faxed over to the facility; staff will call the physician for clarification of the order. RN 1 was not able to locate the clarification to the physician for the eye drops medications. RN 1 stated the eye drops Latanoprost and Cosopt were not initiated and needed to be carried out. RN 1 stated the resident needed the medications to prevent further complications of his decrease vision and decrease his discomfort of not being able to see well. During a review of facility's policy and procedure (P&P) titled, "Telephone Orders for Medication," dated 5/2018, the P&P indicated to reduce errors associated with misinterpreted verbal or telephone communication of physician orders. The P&P indicated the receiver documents the order immediately on the prescriber order form including 1. Date and time order is received 2. Patient name 3. Drug name 4. Strength 5. Dose 6. Frequency 7. Route 8. Quantity and/or duration 8. Name of prescriber 9. Signature of or recipient.	F 711			
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 726	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/11/25, the Director of Rehabilitation (DOR) conducted annual competencies for the facility's Restorative Nursing Assistants (RNAs). On 3/10/25, License Vocational Nurse (LVN) 4 and LVN 2 received one-on-one in-servicing with return demonstration by the Director of Staff Development to	3/14/25	

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F 726	<p>Continued From page 63</p> <p>accordance with the facility assessment required at §483.71.</p> <p>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>§483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Complete initial and annual skills competencies for four of four Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility) staff. This deficient practice had the potential to cause injury and worsening contractures (loss of motion of a joint) for 51 current residents who required RNA treatments. 2. Ensure their Licensed Vocational Nurse knew what the purpose of checking orthostatic hypotension (a condition where blood pressure drops significantly when a person stands up from 	F 726	<p>ensure they understood the definition of orthostatic hypotension and how to perform orthostatic hypotension monitoring.</p> <p>How the facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>On 3/17/25 The Director of Staff Development (DSD) conducted an audit on the facility's Restorative Nursing Assistant (RNA) employee files to ensure all Restorative Nursing Assistants had competencies completed.</p> <p>No other residents were affected by this deficient practice.</p> <p>On 3/19/25, the Medical Record Director conducted an audit on residents receiving orthostatic hypotension monitoring to ensure orthostatic hypotension monitoring was being recorded accurately.</p> <p>There was 1 other resident affected by this deficient practice.</p> <p>The resident affected by this deficient practice experienced no negative outcome.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient practice is not recur;</p>	<p>3/10/25</p> <p>3/17/25</p> <p>3/19/25</p>	

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F 726	<p>Continued From page 64</p> <p>a sitting or lying position or sits up from a lying position) was for and how to obtain blood pressure readings to check for orthostatic hypotension. This deficient practice had the potential to place residents at risk for a delay in care and services which could result in falls or injury.</p> <p>Findings:</p> <p>1. During a concurrent interview and record review with the Director of Staff Development (DSD), on 3/6/2025 at 9:58 a.m., Restorative Nursing Aide 1 (RNA 1), Restorative Nursing Aide 2 (RNA 2), Restorative Nursing Aide 3 (RNA 3), and Restorative Nursing Aide 4 (RNA 4)'s employee files were reviewed. The DSD stated there were no annual RNA competencies completed for RNA 1, RNA 2, and RNA 3. The DSD stated RNA 4 was a newly hired RNA and did not complete an initial RNA competency upon hire. The DSD stated RNA staff had different job tasks than Certified Nursing Assistants and the RNA staff focused primarily on resident mobility, range of motion (ROM, full movement potential of a joint), ability to do activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as feeding, ambulation, and putting on and taking off splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) and orthotics (an external device to support, align, or correct a movable part of the body). The DSD stated RNA staff would need to know how to perform specific RNA tasks with residents. The DSD stated the purpose of an annual competency skills check was to make sure the</p>	F 726	<p>On 3/11/25, the Director of Nursing and Director of Staff Development in-serviced the DOR, Physical Therapist, Occupational Therapist and Speech therapist on the facility's policy and procedure titled, "Restorative Nursing Program Guidelines," with emphasis on nursing aides are trained in the techniques that promote resident involvement in the activity. The in-service included completing initial and annual competencies and any training needed when areas of improvement are identified.</p> <p>The Administrator will conduct audits on new hire, RNAs and current employees who receive new certifications for Restorative Nursing Assistant employee files, to ensure employees have initial competencies as needed.</p> <p>The DSD will conduct audits to ensure RNAs, receive their annual competencies when due.</p> <p>On 3/19/25, the Director of Nursing and Director of Staff Development in-serviced Nursing Staff including, but not limited to LVNs and Registered Nurses on the facility's policy and procedure titled, "Blood Pressure, Measuring", with emphasis on orthostatic hypotension being defined as 20 millimeters of mercury (mmHg- unit of measurement) decline in systolic blood pressure (the contraction phase of the hear) or a 10 mmHg decline in diastolic blood pressure (relaxing phase of the heart) upon standing and to measure orthostatic hypotension, note the</p>	3/11/25	

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F 726	<p>Continued From page 65</p> <p>staff was up to date on their skills and that the staff was competent to do their job for the residents. The DSD stated if there was not an initial or annual competency skills check for the RNAs, then the residents who received RNA treatments could have injuries, RNA staff may not know how to identify declines in ROM or mobility, and residents may not receive their RNA treatments properly. The DSD stated the rehabilitation department should be the staff to complete the annual competencies and be included in the employee file.</p> <p>During an interview on 3/6/2025 at 10:41 a.m., with the Director of Rehabilitation (DOR), the DOR stated the rehabilitation department did not complete any initial or annual skills competencies for RNA staff.</p> <p>During an interview on 3/6/2025 at 12:39 p.m., with the Director of Nursing (DON), the DON stated the RNA program was to assist residents in keeping their functional abilities and to prevent contractures (loss of motion of a joint). The DON stated there were specific RNA staff to carry out the RNA program. The DON stated there should be an annual competency for all clinical staff and the annual competencies were important to complete, because the facility needed to make sure that whatever skills the staff were completing care wise, that the staff were doing it right with the residents. The DON stated it was important for the RNA staff to complete initial and annual competencies specifically for RNA skills and tasks.</p> <p>During a review of the facility's policy and procedure (P&P), revised 5/1/2018, titled,</p>	F 726	<p>changes in both the systolic and diastolic blood pressure in the standing position compared to the sitting position.</p> <p>The Medical Records Director will conduct an audit orthostatic hypotension monitoring daily for five days, weekly for two weeks, and monthly thereafter to ensure residents orthostatic hypotension monitoring is being recorded accurately.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Director of Staff Development will report to the Quality Assessment and Assurance committee during its monthly meeting the status of the compliance for RNAs initial annual competencies being completed, for three months or until compliance is met.</p> <p>The Director of Nursing will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for orthostatic hypotension monitoring being monitor accurately for three months or until compliance is met.</p>	<p>3/20/25</p> <p>3/31/25</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 726	<p>Continued From page 66</p> <p>"Restorative Nursing Program Guidelines," the P&P indicated nursing aides are trained in the techniques that promote resident involvement in the activity.</p> <p>During a review of the facility's undated Job Description for "Restorative Nurse Aide," the Job Description indicated "the Restorative Nurse Aide performs restorative nursing duties to the residents."</p> <p>2a. During a concurrent interview and record review on 3/6/2025 at 11:30 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 1's orthostatic (measuring blood pressure both while lying down and standing to assess for a significant drop in blood pressure upon standing) blood pressure readings were reviewed for the month of February 2025 and March 2025. LVN 4 stated on 2/1/2025, 2/22/2025, and 3/1/2025 the blood pressure readings for lying and sitting were the same. LVN 4 stated "No, I don't really know how to take orthostatic blood pressures." LVN 4 stated I did not ask for guidance on how to take orthostatic blood pressures.</p> <p>During an interview on 3/7/2025 at 10:55 a.m., with the DON, the DON stated residents on antipsychotic medication were ordered for orthostatic blood pressures. The DON stated the orthostatic blood pressures would never be the same, there should always be a difference. The DON stated if it was documented that both sitting and lying blood pressures were the same or taken at the same time, could tell if the blood pressures were taken from both positions and taken correctly. The DON stated orthostatic blood pressures need to be done correctly, so the physician would know how to manage the</p>	F 726			

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F 726	<p>Continued From page 67</p> <p>medication, dosage and treatment plan depending on the results. The DON stated if the orthostatic blood pressures are not accurate the resident may receive a medication that needed to be discontinued or dosage decreased, which could potentially harm the resident.</p> <p>2b. During an interview on 3/5/2025 at 3:46 p.m. with LVN 2, LVN 2 was asked how orthostatic blood pressure readings were obtained. LVN 2 stated she would first start but introducing herself to the resident, perform hand hygiene, and explain to the resident what she would be doing. LVN 2 stated she would ask the resident to sit down and then apply the blood pressure cuff on their arm and obtain a blood pressure reading. LVN 2 stated she would then document the blood pressure reading and clean the equipment she used. LVN 2 stated the purpose of taking orthostatic blood pressure is to determine if the resident's blood pressure is too high or too low and to determine what their high and low ranges are. LVN 2 further stated that before taking any of the blood pressure, it is important to ensure that if the resident was doing any activities beforehand, to let them rest for a bit so she could obtain a more accurate reading.</p> <p>During a concurrent interview and record review on 3/6/2025 at 1:41 p.m. with the Director of Staff Development (DSD), Resident 25's orthostatic blood pressure readings were reviewed for the month of February 2025. The DSD stated on 2/8/2025, 2/15/2025, 2/22/2025 the blood pressure readings for both lying and sitting were the exact same. The DSD stated that is suspicious because there would always be a change in the blood pressure reading even if the change was minor, but the fact that it was the</p>	F 726			

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F 726	<p>Continued From page 68</p> <p>same reading on 3 separate dates it was suspicious something was not done correctly.</p> <p>During an interview on 3/6/2025 at 2:00 p.m. with the DSD, the DSD stated it is inaccurate if a nurse stated that the purpose of taking orthostatic blood pressure readings was to determine the high and low ranges of their blood pressures. The DSD also stated it would be inaccurate if the staff stated the method of taking orthostatic blood pressures was by having the resident sit up wait a few minutes and then taking the blood pressure because there would not be enough information to determine if the resident had orthostatic hypotension.</p> <p>During a follow-up concurrent interview and record review on 3/6/2025 at 4:15 p.m. with LVN 2, Resident 25's Order Summary Report and Medication Administration Record (MAR) for the month of February 2025 was reviewed. LVN 2 stated Resident 25 had an order to monitor vital signs every shift which included checking their blood pressure, and on Saturday's, there was also an order to check orthostatic hypotension blood pressures. LVN 2 stated she did not question or ask another staff member what the difference was in checking a blood pressure every shift and checking the orthostatic blood pressures on Saturday. LVN 2 also stated she does not recall or remember if there were any in-services provided on how to obtain orthostatic blood pressure readings.</p> <p>During a review of the facility's P&P, titled "Blood Pressure, Measuring", dated 1/2018, it indicated orthostatic hypotension is defined as 20 millimeters of mercury (mmHg- unit of</p>	F 726		

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F 755	<p>Continued From page 71</p> <p>1. During a concurrent observation and interview on 3/6/2025 at 2:16 p.m., in station 1 medication storage room with Licensed Vocational Nurse (LVN) 4, one E-Kit with prescription #836, with a red zip tie and one E-Kit with prescription #890 with a red zip tie was observed. LVN 4 stated a red zip tie meant the E-Kit had been opened.</p> <p>During a concurrent interview and record review on 3/6/2025 at 2:20 p.m., with LVN 4, Emergency Drug Kit Slips were reviewed. LVN 4 stated the E-Kit in the first refrigerator was opened on 2/25/2025 at 10:00 a.m. and the E-Kit had not been replaced. LVN 4 stated the E-Kit in the second refrigerator was opened on 12/23/2024 at 12:20 a.m. and the E-Kit had not been replaced. LVN 4 stated the E-Kits should have been replaced within 48 hours after they were opened. LVN 4 stated it was important to have the E-Kit available to administer medication to residents during emergency situations. LVN 4 stated if the medication was not available there would be a delay of treatment for the resident.</p> <p>During an interview on 3/6/2025 at 2:39 p.m., with the Director of Nursing (DON), the DON stated it was the responsibility of the licensed nursing staff to check and document all the E-Kits were sealed and intact. The DON stated there was no documentation or monitoring log by the licensed nursing staff that showed the E-Kits were being checked daily. The DON stated the E-Kits should be replaced immediately not to exceed 72 hours. The DON stated there could potentially be an emergency and the medication in the E-Kit would not be available. The DON stated this could cause a delay in care for residents.</p>	F 755	<p>of kit/dose. The in-service also emphasized if exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening and if replacing used medications, the replacement doses are added to the kit withing 72 hours of opening.</p> <p>On 3/12/25, the facility created an E-Kit monitoring log and in-serviced Nursing Staff, including but not limited to LVNs and RNs on how and when to complete it.</p> <p>The DON/designee will conduct audits daily for five days weekly for two weeks in monthly for three months to ensure E-kits are not expired and log is completed for monitoring.</p> <p>On 3/17/25, the facility's assigned Pharmacist from Star Pharmacy in-serviced the Director of Nursing (DON) and Register Nurse (RN) on the facility's policy and procedure titled, "Disposal of Medications and Medication-Related Supplies," with emphasis on controlled substances being retained in a securely locked area with restricted access until destroyed by a Drug Enforcement Administration (DEA) representative; or by the facility director of nursing and/or consultant pharmacist and/or administrator. The in-service also included ensuring signature of licensed nurse witnessing the destruction of the medications.</p> <p>The Medical Records Director will conduct an audit on the medication destruction sheets, monthly and as needed (PRN) to ensure signatures include the signature of licensed nurse witnessing the destruction of the medications.</p>	<p>3/13/25</p> <p>3/13/25</p> <p>3/17/25</p>	

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F 755	<p>Continued From page 72</p> <p>During a review of the facility's P&P titled, "Medication Ordering and Receiving from Pharmacy," undated, the P&P indicated, emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy. The P&P indicated "as soon as possible, the nurse calls the pharmacy for replacement of the kit/dose and flags the kit with a color-coded lock to indicate need for replacement of kit/dose." The P&P indicated, if exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening. The P&P indicated "If replacing used medications, the replacement doses are added to the kit withing 72 hours of opening."</p> <p>2. During a concurrent observation and interview on 3/6/2025 at 3:06 p.m., with the DON in her office, a controlled medication area inspection was conducted. The DON produced multiple Controlled Drug Record sheets (a log containing the time, quantity, and nurse's signature each time a dose is administered) that were destroyed by her and facility's pharmacy consultant. The DON stated the facility's Controlled Drug Record dated 12/12/2024, had twenty-four resident medications disposed (to get rid of) without the signature of licensed nurse witnessing the destruction of the medications. The disposed medications included the following:</p> <ol style="list-style-type: none"> 1. Lorazepam (medication used to relieve anxiety) 1 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) tablet. 2. Hydrocodone-Acetaminophen (narcotic 	F 755	<p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Director of Nursing will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for the facility's E-kits not being expired for three months or until compliance is met.</p> <p>The Administrator will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance medication destruction and disposal for ensuring a signature of licensed nurse witnessing the destruction of the medications for three months or until compliance is met.</p>	3/31/25	

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F 755	<p>Continued From page 73</p> <p>medication used to treat pain) 5-325 mg tablet.</p> <p>3. Temazepam (a sedative-hypnotic medication to help one sleep) 7.5 mg capsule.</p> <p>4. Morphine Sulfate (narcotic medication used to treat pain) 0.25 milliliter (mL-unit of volume).</p> <p>5. Temazepam 15 mg capsule.</p> <p>6. Tramadol HCL (narcotic medication used to treat pain) 50 mg tablet.</p> <p>7. Tramadol HCL 50 mg tablet.</p> <p>8. Diazepam (medication used to relieve anxiety) 4 mg tablet.</p> <p>9. Tramadol HCL 50 mg tablet.</p> <p>10. Tramadol HCL 50 mg tablet.</p> <p>11. Hydrocodone-Acetaminophen 5-325 mg tablet.</p> <p>12. Temazepam 15 mg capsule.</p> <p>13. Pregabalin (medication used to treat nerve pain) 75 mg capsule.</p> <p>14. Alprazolam (medication used to treat anxiety) 0.5 mg tablet.</p> <p>15. Hydrocodone-Acetaminophen 5-325 mg tablet.</p> <p>16. Tramadol HCL 50 mg tablet.</p> <p>17. Hydrocodone-Acetaminophen 5-325 mg tablet.</p> <p>18. Hydrocodone-Acetaminophen 5-325 mg tablet.</p> <p>19. Temazepam 15 mg capsule.</p> <p>20. Morphine Sulfate 7.5 mg tablet.</p> <p>21. Morphine Sulfate 15 mg tablet.</p> <p>22. Hydrocodone-Acetaminophen 5-325 mg tablet.</p> <p>23. Lorazepam 2 mg / per ml.</p> <p>24. Morphine Sulfate 0.25 ml.</p> <p>During an interview on 3/6/2025 at 2:39 p.m., with the DON, the DON stated the process of controlled substance destruction includes two</p>	F 755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2025
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F 755	Continued From page 74 signatures on the Controlled Drug Record, one from the Registered Pharmacy (RPH) Consultant and from a Registered Nurse (RN). The DON stated, she was the only licensed nurse responsible for the controlled substance destruction. The DON stated she was busy with other tasks on 12/12/2024 and that was the reason she was not able to sign the Controlled Drug Record sheets. The DON stated, she made a mistake and should have signed the destruction form along with the RPH Consultant, but she did not. The DON stated, the RPH Consultant was the only one signed the form for destruction of the medications. The DON stated if the narcotic/controlled substance destruction was not documented accurately, there was no validation that it was done and there was a risk for diversion and theft of the medications if the process was not completed accurately.	F 755			
F 761 SS=E	During a review of the facility's policy and procedure (P&P) titled, "Disposal of Medications and Medication-Related Supplies," undated, the P&P indicated, controlled substances are retained in a securely locked area with restricted access until destroyed by a Drug Enforcement Administration (DEA) representative; or by the facility director of nursing and/or consultant pharmacist and/or administrator. Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/6/25 License Vocational Nurse (LVN) 4, remove the unopened insulin from the cart. On 3/6/25, LVN 4 re-ordered the insulin.	3/6/25	

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F 761	<p>Continued From page 76 cart 1.</p> <p>These deficient practices had the potential for the loss of efficacy of Lantus and Insulin Glargine YFGN, cause ineffective management of the residents' diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and had the potential for the resident to receive contaminated medications.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 3/6/2025 at 1:45 p.m., with Licensed Vocational Nurse (LVN) 4 at medication cart 1, an unopened insulin pen of Lantus, an unopen insulin vial and an insulin pen of Glargine YFGN and was found on the cart. LVN 4 stated the insulins were stored in medication cart 1 and unopened. LVN 4 stated all insulin should be stored in the refrigerator until it was used or opened. LVN 4 stated the directions were to keep unopened insulin refrigerated until opened.</p> <p>During an interview on 3/7/2025 at 10:55 a.m., with the Director of Nursing (DON), the DON stated unopened insulin should be stored in the refrigerator and not put into the cart until it is opened. The DON stated this practice would decrease the potency and the effectiveness of the medication. The DON stated the blood sugar would be uncontrolled and negatively affect the resident.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Medication Storage in the Facility; Storage of Medications," undated,</p>	F 761	<p>with emphasis on medications and biologicals being stored safely, securely, and properly, following manufacturer's recommendations or those of the suppliers and when medications requiring "refrigeration" or "temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit" being kept in a refrigerator with a thermometer to allow temperature monitoring.</p> <p>The Director of Nursing (DON)/ designee will conduct rounds on the facility's medication carts daily for five days weekly for two weeks and monthly thereafter to ensure an unopened insulin is not being stored in the medication cart.</p> <p>On 3/12/25, the Director of Nursing conducted an in-serviced Nursing Staff including but not limited to LVNs and Registered Nurses (RNs) on the facility's policy and procedure titled, "Medication Storage in the Facility; Storage of Medications," with emphasis on outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy.</p> <p>The Director of Nursing/designee will conduct rounds daily for 5 days weekly for 2 weeks and monthly thereafter to ensure mutli-dose medications are clean and free from particles</p>	<p>3/13/25</p> <p>3/13/25</p>	

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F 761	<p>Continued From page 77</p> <p>the P&P indicated, medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the suppliers. The P&P indicated medications requiring "refrigeration" or "temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit" are kept in a refrigerator with a thermometer to allow temperature monitoring.</p> <p>2. During a concurrent observation and interview on 3/6/2025 at 1:45 p.m., with LVN 4 at medication cart 1, a multi-dose bottle of Clear Lax (a stool softener) was observed soiled and uncleaned, LVN 4 stated the medication bottle was soiled and unclean. LVN 4 stated it was an infection control issue, and the medication bottle should always be clean. LVN 4 stated if the bottle was unclean and contaminated the resident could get sick or be harmed.</p> <p>During an interview on 3/7/20025 at 9:36 a.m., with Registered Nurse (RN) 1, RN 1 stated all items in the medication cart should be clean and free from any particles. RN 1 stated this was an infection control issue. RN 1 stated there could be bacteria on the dirty container which could cause the resident to become sick.</p> <p>During an interview on 3/7/2025 at 10:55 a.m., with the DON, the DON stated the licensed nursing staff assigned to a medication cart should check the cart and medications to make sure everything is in place and clean. The DON stated a medication bottle should never be dirty because there could be bacteria around the bottle. The DON stated this is an infection control issue. The DON stated this practice</p>	F 761	<p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Director of Nursing will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for proper storage of insulin and multi-dose medication being clean and free from particles for three months or until compliance is met.</p>	3/31/25	

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F 761	Continued From page 78 could make residents sick, if there is any cross contamination. During a review of the facility's policy and procedure (P&P) titled, "Medication Storage in the Facility; Storage of Medications," undated, the P&P indicated, outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy.	F 761			
F 770 SS=E	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to have laboratory orders implemented for three of six sampled residents (Residents 25, 42 and Resident 100) by failing to: 1.Ensure Resident 25 and Resident 42 had laboratory orders drawn as ordered by the physician. 2. Ensure Resident 100 had a Keppra (anti-seizure drug) level blood draw (a procedure	F 770	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/5/25, Resident 25 and Resident 42 labs were drawn. The Primary Physician was made aware of the results with no new orders noted. On 3/12/25, Resident 100, labs were drawn. The Primary Physician was made aware of the results with no new orders noted. How do facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this deficient practice. On 3/13/25, the Medical Records Director conducted an audit on active resident lab orders to ensure all residents are receiving their labs as ordered, unless otherwise	3/5/25 3/12/25	

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F 770	<p>Continued From page 79 in which a needle is used to take blood from a vein, usually for laboratory testing) monthly.</p> <p>These deficient practices caused Resident 25 and Resident 42 a delay in care and placed Resident 100 at risk for seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness)</p> <p>Findings:</p> <p>1. During a review of Resident 25's Admission Record (document containing basic information regarding a resident), The Admission Record indicated Resident 25 was admitted on 7/28/2023 and readmitted on 5/27/2024 with diagnoses that included acute kidney failure (a sudden decline in kidney function), anemia (a condition in which the blood does not have enough healthy red blood cells), severe obesity (overweight), and Type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 25's Minimum Data Set (MDS- a resident assessment tool), dated 12/8/2024, the MDS indicated Resident 25 was cognitively intact (ability to reason, understand, remember, judge, and learn).</p> <p>During a review of Resident 25's Order Summary, dated 12/5/2024 the Order Summary Report indicated Resident 25 to have drawn a complete blood count ([CBC]- a blood test that measures the number and types of blood cells, including red blood cells, white blood cells, and platelets), complete metabolic panel ([CMP]- a</p>	F 770	<p>refused.</p> <p>There were 2 residents affected by this deficient practice.</p> <p>On 3/15/25, the Director of Nursing/ designee re-ordered the missing labs for those affected resident. There were no negative or adverse outcomes to this deficient practice.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/26/25, the Director of Nursing (DON) in-serviced Nursing Staff, including but not limited to Licensed Vocational Nurses (LVNs) and Registered Nurses (RN) on the facility's, policy and procedure titled, "Laboratory, Diagnostic and Radiology Services," with emphasis on laboratory, diagnostic, and radiology services are provided to meet resident needs and the facility being responsible for the quality and timeliness of services provided by the laboratory. The in-serviced also included laboratory services ordered being documented on the 24-hour report or electronic health record, to ensure that services are coordinated, and results are received, notification of results to the Primary Physician including any refusals.</p> <p>The Medical Records Director will audit residents lab orders daily for five days weekly for two weeks and monthly thereafter to ensure residents are receiving lab drawn's as ordered, unless otherwise noted by a refusal.</p>	<p>3/17/25</p> <p>3/17/25</p> <p>3/27/25</p>	

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F 770	<p>Continued From page 80</p> <p>blood test which measures various substances in the blood to provide information about the body's overall chemical balance, including kidney and liver function, electrolyte levels, and blood sugar levels) and a Hemoglobin A1C ([Hgb A1C]- a blood test that measures the average blood sugar level over the past 2-3 months) drawn every 3 months in November, February, May, and August.</p> <p>During a review of Resident 25's Care Plan, dated 5/28/2024, the care plan indicated Resident 25 had acute kidney injury and chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products from the blood). The care plan interventions included monitoring laboratory reports and reporting to the physician if the potassium (a mineral the body needs to function) is high.</p> <p>2. During a review of Resident 42's Admission Record, the admission record indicated Resident 42 was initially admitted on 11/20/2018 and readmitted on 11/25/2022 with diagnoses that included Vitamin D deficiency (body has less than normal amounts of this vitamin), hyperlipidemia (high level of fats in the blood), and gastro-esophageal reflux disease (GERD- stomach contents flow back up into the esophagus, causing irritation and inflammation).</p> <p>During a review of Resident 42's Minimum Data Set, dated 11/21/2024, the MDS indicated Resident 42 was cognitively intact (ability to reason, understand, remember, judge, and learn).</p> <p>During a review of Resident 42's Care Plan,</p>	F 770	<p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Director of Nursing will report to the Quality Assessment and Assurance committee during its monthly meeting the status of the compliance for providing laboratory services as ordered for three months or until compliance is met.</p>	3/31/25	

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F 770	<p>Continued From page 81</p> <p>dated 6/2/2023, the care plan indicated Resident 42 was at risk for poor food intake, weight loss, and dehydration. The care plan interventions included to obtain and monitor laboratory work as ordered, report results to the doctor, and follow up as indicated.</p> <p>During a review of Resident 42's Order Summary, dated 9/17/2024, the Order Summary report indicated to have a CBC and CMP, and a Lipid Panel (a blood test that measures the levels of various fats in the blood) drawn every 3 months, in September 2024, December 2024, March 2025, and June 2025.</p> <p>During a review of Resident 42's Care Plan, dated 8/27/2024, the care plan indicated Resident 42 was at risk for poor oral intake (decreased eating and drinking), weight loss, and dehydration (body losing more amounts of water than usual). The care plan goals included to obtain, monitor laboratory results as ordered and to report results to the doctor as needed.</p> <p>During a review of Resident 42's laboratory results dated 9/23/2024, a CMP was not done for the month of September.</p> <p>During a review of Resident 42's laboratory results dated 12/18/2024 a CMP was not done for the month of December.</p> <p>During a concurrent interview and record review on 3/5/2025 at 1:48 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 25 laboratory results and orders were reviewed. LVN 1 stated Resident 25 had orders for a CBC, CMP, and Hgb A1C to be drawn every 3 months in</p>	F 770			

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F 770	<p>Continued From page 82</p> <p>November, February, May and August. LVN 1 stated it was not done in the month of February. LVN 1 stated if laboratory tests are not done, the doctor would not know if there were any issues with the residents' blood work.</p> <p>During a concurrent interview and record review on 3/5/2025 at 2:11 p.m. with LVN 1, Resident 42's laboratory results and orders were reviewed. LVN 1 stated a CMP was not done. LVN 1 stated the doctor would not know if there would be any abnormal results with the CMP because it was not done.</p> <p>During a review of the facility's policy and procedure (P&P), titled "Laboratory, Diagnostic and Radiology Services," dated 5/1/2018, the P&P indicated the facility is responsible for the quality and timeliness of services provided by the laboratory.</p> <p>3. During a review of Resident 100's Admission Record indicated Resident 100 was admitted to the facility on 3/13/2024. The Admission Record indicated Resident 100's diagnoses included respiratory failure (a condition in which you blood does not have enough oxygen or has too much carbon dioxide), epilepsy (a condition characterized by recurrent, unprovoked seizures, caused by abnormal electrical activity in the brain), and polycystic kidney (a genetic disorder characterized by the growth of numerous fluid-filled cysts in the kidneys).</p> <p>During a review of Resident 100's "History and Physical (H&P)," dated unknown, the H&P indicated, Resident 100 did not have capacity to</p>	F 770			

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F 770	<p>Continued From page 83 understand and make decisions.</p> <p>During a review of Resident 100's Minimum Data Set dated 12/13/2024, the MDS indicated Resident 100's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 100's vision was impaired. The MDS indicated Resident 100 required substantial assistance (a helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) from staff for personal hygiene, showering, and dressing.</p> <p>During a review of Resident 100's physician orders titled, "Order Summary Report," dated 11/13/2024, the Order Summary Report indicated Resident 100 to have Keppra level drawn every month.</p> <p>During a concurrent interview and record review on 3/5/2025 at 3:37 p.m. with Registered Nurse (RN) 1, RN 1 stated, Resident 100's "Order Summary Report," dated 11/13/2024 was reviewed. The Order Summary Report indicated Resident 100 was to have Keppra blood level draw every month. RN 1 stated the last Keppra blood level was drawn 11/15/2024. RN 1 stated December 2024, January 2025, February 2025, the Keppra blood level was not done. RN 1 stated Resident 100 had epilepsy and Keppra blood levels were to track of the therapeutic levels to prevent seizures. RN 1 stated not completing the Keppra blood draws can cause worsened the resident epilepsy disorder.</p> <p>During a review of the facility's policy and procedure (P&P) titled, dated 5/2018, the P&P</p>	F 770		

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F 770	Continued From page 84 indicated to ensure that laboratory, diagnostic, and radiology services are provided to meet resident needs. The P&P indicated laboratory services ordered will be documented on the 24-hour report or electronic health record, to ensure that services are coordinated, and results are received.	F 770			
F 812 SS=E	<p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the dietary staff followed proper storage practices in the kitchen by:</p> <p>1. Not properly closing opened bags of dry food</p>	F 812	<p>How corrective actions will be accomplished for those residents found to have been affected by this deficient practice;</p> <p>On 3/4/25, the Dietary Manager discarded the three bags of dry cereal that were loosely tied with plastic wrap, the open gallon of pancake mix and the open gallon of waffle syrup that did not have a label indicating the date it was opened.</p> <p>How do facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>On 3/4/25, the Administrator conducted visual rounds throughout the facility's kitchen to ensure that all items that were opened were properly stored in containers with tight fitted lids or sealed tightly, and labeled with open dates.</p> <p>No other residents were affected by this deficient practice.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient</p>	<p>3/4/25</p> <p>3/4/25</p>	

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F 812	<p>Continued From page 85 and ensuring the dry food products were stored in containers with tight fitting lids. 2. Not dating opened multi-use containers.</p> <p>This deficient practice had the potential to result in the attraction of pests and contamination of food served to residents.</p> <p>Findings:</p> <p>During an observation on 3/4/2025 at 8:20 a.m. in the kitchen dry storage room, three bags of dry cereal were observed with plastic wrap tied loosely around the bag, causing the bag to stay open. An opened gallon of pancake mix and waffle syrup without a label indicating the date it was opened was also observed.</p> <p>During a concurrent observation and interview on 3/4/2025 at 8:25 am in the kitchen dry storage room with Dietary Aide (DA), the DA stated the dry cereal bags were not tied close and could allow pests to enter the bag and contaminate the food. The DA stated the bottle of pancake mix and waffle syrup were not labeled with the opened date. The DA also stated, the bottle of pancake and waffle syrup should have been labeled with the opened date to ensure residents did not receive an expired product that could make them sick.</p> <p>During a concurrent interview and record review on 3/6/2025 at 1:05 p.m. with the Dietary Service Supervisor (DSS), the facility's policy and procedure (P&P) titled, "Food Storage" dated 3/1/2018, was reviewed. DDS stated the P&P indicated opened products should be placed in storage containers with tight fitting lids and</p>	F 812	<p>practice is not recur;</p> <p>On 3/11/25, the Dietary Manager in-serviced Dietary Staff, including but not limited to, dietary cooks and aids, on the facility's policy and procedure titled, "Food Storage" with emphasis on opened products being placed in storage containers with tight fitting lids and storage products being labeled and dated.</p> <p>The Administrator will conduct rounds in the facility's kitchen daily for five days, weekly for two weeks, and monthly thereafter to ensure products are being properly, stored in tight, fitted containers or sealed tightly and labeled and dated.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for food storage, including being properly labeled and dated for three months or until compliance is met.</p>	<p>3/11/25</p> <p>3/31/25</p>	

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F 813	<p>Continued From page 87</p> <p>stomach contents flow back up into the esophagus, causing irritation and inflammation).</p> <p>During a review of Resident 42's Minimum Data Set (MDS- a resident assessment tool), dated 11/21/2024, the MDS indicated Resident 42 was cognitively intact (ability to reason, understand, remember, judge, and learn).</p> <p>During an observation on 3/4/2024 at 10:06 a.m. in Resident 42's room, a bottle of opened, and used creamy horseradish was seen on her bedside table with a label that indicated to refrigerate after opening. The bottle did not have a label with the resident's name on it.</p> <p>During an interview on 3/4/2025 at 3:23 p.m. with Resident 42, Resident 42 stated the creamy horseradish belonged to her and was brought to the facility by her sister.</p> <p>During a concurrent observation and interview on 3/4/2025 at 4:00 p.m. with Licensed Vocational Nurse (LVN) 2, in Resident 42's room, LVN 2 stated the opened bottle of creamy horseradish left on Resident 42's bedside table was not labeled or refrigerated and was not sure when the bottle was opened. LVN 2 stated, the resident personal food items that required refrigeration should be stored in the refrigerator in the dining room and should be dated and labeled with the resident's name. LVN 1 stated there was no LVN 2 further stated if eaten, this could have caused an upset stomach.</p> <p>During an interview on 3/6/2025 at 2:32 p.m. with the Dietary Service Supervisor (DSS), the DSS stated perishable food (food likely to go bad</p>	F 813	<p>On 3/13/25, the Director of Staff Development and Administrator in-serviced Facility Staff, including but not limited to Certified Nursing Assistants (CNAs), Licensed Vocational Nurses (LVNs), Registered Nurses (RNs), Dietary Staff, and Activities Department on the facility's policy and procedure titled, "Food Brought in by Visitors", with emphasis on perishable food requiring refrigeration being discarded after 2 hours at bedside, and if refrigerated, it will be labeled, dated, and discarded after 48 hours. The in-service also included if the resident desires to have food brought in, the Dietary Staff would provide education regarding safe food handling practices and need to have the resident's name and date it was brought to the facility.</p> <p>Department Managers, including but not limited to Director of Staff Development, Social Services Director and Social Service Assistant, Activities Director, Case Manager Admissions Coordinator, Infection Preventionist, Minimum Data Set Nurse (MDSN) and MDSN Assistant, Quality Assurance Nurse, will conduct room rounds daily for five days weekly for two weeks in monthly thereafter to ensure food brought into the facility is properly stored and labeled.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for food brought into</p>	3/15/25	

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F 813	Continued From page 88 quickly) items could only be left out at the bedside for no longer than 2 hours and must be thrown away after 2 hours to avoid the resident eating food that was spoiled. If it has been less than 2 hours, the residents can have it be placed in the refrigerator in the activity room meant to store residents' food for up to 48 hours. During a review of the facility's P&P titled, "Food Brought in by Visitors", dated 5/1/2023, the P&P indicated perishable food requiring refrigeration will be discarded after 2 hours at bedside, and if refrigerated, it will be labeled, dated, and discarded after 48 hours. The P&P indicated if the resident desires to have food brought in, the Dietary Staff would provide education regarding safe food handling practices and need to have the resident's name and date it was brought to the facility.	F 813	the facility by visitors is stored properly labeled for three months or until compliance is met.	3/31/25	
F 838 SS=E	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following:	F 838	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/12/25, the Administrator held a meeting that included the Medical Director, the Director of Nursing, Social Services Director, Activities Director, a Registered Nurse Supervisor, a License Vocational Nurse, two Certified Nursing Assistants to revise the facility's facility assessment to include a contingency plan. The contingency plan included having a pool of on-call staff to assist in providing additional staff needed in a case of events that does not require the facility to activate its emergency plan.	3/12/25	

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F 838	<p>Continued From page 89</p> <p>§483.71(a)(1) The facility's resident population, including, but not limited to:</p> <p>(i) Both the number of residents and the facility's resident capacity;</p> <p>(ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20;</p> <p>(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;</p> <p>(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and</p> <p>(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.</p> <p>§483.71(a)(2) The facility's resources, including but not limited to the following:</p> <p>(i) All buildings and/or other physical structures and vehicles;</p> <p>(ii) Equipment (medical and non- medical);</p> <p>(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;</p> <p>(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;</p>	F 838	<p>How do facility will identify other residents, having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>On 3/14/25, the Administrator reviewed the facility's reported incidents to identify any events that required the facility to activate it's facility assessment related to the contingency plan. There were no facility reported incidents that required an activation of the facility assessments contingency plan.</p> <p>No other residents were affected by this deficient practice.</p> <p>What measures will be into place or what systemic changes the facility will make to ensure that the deficient practice is not recur;</p> <p>On 3/10/25, the Director of Nursing and Director Staff Development in-serviced the Administrator on the facility's policy and procedure titled, "Facility Assessment," with emphasis on the facility using the Facility Assessment to inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to the availability of direct care nurse staffing or other resources needed for resident care. The in-service also included the "Revised Guidance for Long-Term Care Facility Assessment Requirements" with emphasis on conducting and documenting a facility-</p>	3/14/25	

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F 838	<p>Continued From page 90</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).</p> <p>§ 483.71(b) In conducting the facility assessment, the facility must ensure:</p> <p>§ 483.71(b)(1) Active involvement of the following participants in the process:</p> <p>(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and</p> <p>(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.</p> <p>(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.</p> <p>§483.71(c) The facility must use this facility assessment to:</p> <p>§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).</p>	F 838	<p>wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations including nights and weekends and emergencies.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for the facility assessment having a contingency plan for three months or until compliance is met.</p>	<p>3/10/25</p> <p>3/31/25</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2025
FORM APPROVED
OMB NO. 0938-0391

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F 838	<p>Continued From page 91</p> <p>§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.</p> <p>§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.</p> <p>§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.</p> <p>§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a contingency plan (a pre-defined set of actions to be taken if an original plan fails or an unexpected event occurs) was developed and included in the Facility Assessment (a process for evaluating a facility's resident population and identifying the resources needed to provide care and services).</p> <p>This deficient practice had the potential for the facility to ineffectively respond during unexpected circumstances and negatively impact resident care.</p> <p>Findings:</p>	F 838			

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F 838	<p>Continued From page 92</p> <p>During a concurrent interview and record review on 3/5/2025 at 9:25 a.m., with the Administrator (ADM), the Facility's Assessment dated 12/27/2024, was reviewed. The ADM stated the Facility's Assessment was incomplete. The ADM stated the Facility's Assessment did not include the contingency plan including staffing needs during emergency that would affect resident's care. The ADM stated the Facility Assessment was an overview of the resident population and it reflected the services provided by the facility to the residents. The ADM stated a contingency plan should be included in the Facility Assessment so the facility would be able to identify risks and operate fully without delay to safeguard the health and safety of the residents during unforeseeable events.</p> <p>During a review of the facility's, undated policy and procedure (P&P) titled, "Facility Assessment," the P&P indicated "The facility must use the Facility Assessment to inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to the availability of direct care nurse staffing or other resources needed for resident care".</p> <p>During a review of Centers for Medicare and Medicaid Services (CMS), reference QSO-24-13-NH (Quality, Safety and Oversight-guidance clarifications and instructions for facilities) dated 6/18/2024 titled, "Revised Guidance for Long-Term Care Facility Assessment Requirements," indicated the new requirements specify that the facility must</p>	F 838			

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F 842	<p>Continued From page 95</p> <p>facility failed to document in resident clinical records, when one of 25 sampled residents (Resident 76), was sent to General Acute Care Hospital (GACH) from dialysis center (a health office/clinic for treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) due to unresponsiveness (a state where resident was not responding to stimuli).</p> <p>This deficient practice had the potential to cause delay in communication among staff and placed Resident 76 at risk of not receiving appropriate care.</p> <p>Findings:</p> <p>During a review of Resident 76's Admission Record, the Admission Record indicated, Resident 76 was admitted to the facility on 6/15/2024. Resident 76's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), and dysphagia (difficulty of swallowing).</p> <p>During a review of Resident 76's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/19/2024, the MDS indicated, Resident 76's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor/cues/supervision required). The MDS indicated, Resident 76 was totally dependent (helper does all the effort) from staff with toileting hygiene, upper body dressing, and personal hygiene.</p> <p>During a review of Resident 76's progress notes,</p>	F 842			

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F 842	Continued From page 96 dated 3/3/2025, the progress notes indicated Resident 76 was picked at 4:20 a.m. for dialysis in stable condition. During a concurrent interview and record review on 3/6/2025 at 11:26 a.m., with Registered Nurse 1 (RN 1), Resident 76's clinical records were reviewed. RN 1 stated on 3/3/2025 at approximately 9:00 a.m., she received a call from Resident 76's representative informing her that Resident 76 was transferred to the hospital from the dialysis center due to unresponsiveness. RN 1 stated Resident 76's clinical record was incomplete due to missing note of Resident 76's transfer to the hospital. RN 1 stated she was busy and forgot to document. RN 1 stated resident medical records should be complete to provide continuity of care and to prevent communication breakdown among healthcare providers. During a review of the facility's policy and procedure (P&P), titled "Nursing Documentation," dated 5/1/2018, the P&P indicated, any communication with family, durable power of attorney, or physician, should be noted in the nurse's notes". During a review of the facility's P&P, titled "Care Standards," dated 5/1/2018, the P&P indicated, care should be documented in the medical record according to state and/or federal regulations.	F 842			
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of	F 865	How corrective actions will be accomplished for those residents found to have been affected by this deficient practice; On 3/24/25, Quality Assurance (QA) Nurse reviewed the facility's "Statement of		

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F 865	<p>Continued From page 99 indicator data, and resident and staff input, and other information.</p> <p>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and</p> <p>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.</p> <p>§483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>§483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide meeting minutes (notes) of the Quality Assurance and Performance Improvement ([QAPI] - a data driven proactive approach to improvement used to ensure services are meeting quality standards) program to prove three repeat deficiencies in the areas of Resident Rights, Laboratory Services, and Pharmacy Services, cited during the previous recertification survey of 2024, were discussed and evaluated.</p> <p>This deficient practice had the potential for repeated deficiencies and placed the residents at risk for harm if areas identified were not</p>	F 865			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/07/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 865	<p>Continued From page 100 investigated, analyzed and ensure corrective actions or activities to improve performance were effectively implemented.</p> <p>Findings:</p> <p>During a review of documents titled, "Statement of Deficiencies (SOD)," dated 3/8/2024, the SOD indicated the facility had deficiencies related to Resident Rights, Laboratory Services, and Pharmacy Services.</p> <p>During an interview on 3/7/2025 at 11:47 a.m., with the Administrator (ADM), the ADM stated the facility did not have any minutes or any evidence of QAPI program efforts to correct the previous and repeat deficiencies identified by the California Department of Public Health ([CDPH] - licensing and certification agency). The ADM stated it was important to discuss and develop a QAPI program for the deficient practices identified by the CDPH so the facility would be in compliance with their policy and procedure (P&P) and for areas of improvement. The ADM stated an effective QAPI program should have identified and analyze the root cause, develop intervention and goal and how the facility would monitor and audit the program.</p> <p>During a review of the facility's, undated P&P, titled "QAPI Plan," the P&P indicated, the QAPI Steering committee analyzes performance to identify and follow up on areas of opportunity. The P&P indicated the facility should continually identify opportunities for improvement and uses the criteria to prioritize opportunities such as aspects of care affecting large numbers of residents and regulatory requirements. The P&P</p>	F 865			

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F 907	<p>Continued From page 102</p> <p>he prepared and cleaned a WC for a resident, but it was stored outside in the rain, and now needed to be dried. The DOR stated because the WC was outside and was wet, the WC could not be used for the resident today and hopefully, would be dried by tomorrow for resident use. The DOR stated there was no other WC for the resident to use because the resident required a custom WC. The wheelchair was observed with thick and wet cushion and could not be used.</p> <p>During an observation and interview at 3/5/2025 at 3:56 p.m., the Maintenance Supervisor (MS) walked outside to a rectangular outdoor area bordered by resident rooms. In the outside rectangular patio area, there were four WCs and one geriatric chair. The MS stated the covered shed was full and mainly for activity equipment. The MS stated the four WCs and one geriatric chair outside in the rain and elements, should have been stored inside the resident's room. The MS stated the medical equipment should be stored in a covered storage area, and not outside because they could get wet, dirty, or hot. The MS stated the facility had no covered storage space to store extra WCs and equipment.</p> <p>During an interview on 3/6/2025 at 12:39 pm. with the Director of Nursing (DON), the DON stated WCs and other medical equipment should not be stored outside ,uncovered area but in a covered storage area.</p> <p>During an interview on 3/6/2025 at 11:24 a.m., the Medical Records Supervisor stated the facility did not have a policy regarding storing medical equipment in the facility.</p>	F 907	<p>Vocational Nurses (LVN), and Certified Nursing Assistants (CNA), along with the Maintenance Department and Housekeeping Department were in-serviced on having and maintaining proper covered storage for resident equipment.</p> <p>The Maintenance Director/designee will conduct rounds on the facility outside areas daily for 5 days weekly for 2 weeks and monthly thereafter to ensure resident equipment is not being stored in non-covered areas.</p> <p>How the facility plans to monitor its performance to make sure that solutions are maintained;</p> <p>The Administrator will report to the Quality Assessment and Assurance Committee during its monthly meeting the status of the compliance for proper storage of resident equipment for three months or until compliance is met.</p>	<p>3/28/25</p> <p>3/31/25</p>	