STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. Building B. Wing	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health and Wellness	2201 Glenn Hendren Dr Liberty, MO 64068

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 31102 Based on interview and record review, the facility failed to act promptly upon the grievances of the resident council members concerning issues of resident care and life in the facility. Facility staff failed to communicate back with the resident council regarding their concerns and failed to follow up on a grievance which affected one of 19 sampled residents (Resident #8). The facility census was 92. Review of the facility's policy for resident and family grievances, revised 6/1/22, showed: - It is the policy of the facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal; - The grievance official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; - A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their long term care facility stay; - The facility will not prohibit or in any way discourage a resident from communicating with external entities including federal and state surveyors or other federal or state health department employees; - Information on how to file a grievance or complaint will be available to the resident. Information may include, but is not limited to: the contact information of the grievance official with whom a grievance can be filed, including his/her name, business address (mailing and email) and business phone number. The contact information of independent entities with whom grievances may be filed, that is, the pertinent State Agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system. The time frame that a resident may reasonably expect completion of the review of the grievance and a written decision regarding his/her grievance; (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Grievances may be voiced in the following forums: verbal complaint to a staff member or grievance official. Written complaint to a staff member or grievance official. Written complaint to an outside party. Verbal complaint during resident or family council meetings; - The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form; - Take any immediate actions needed to prevent further potential violations of any resident right; - Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property immediately to the administrator and follow procedures for those allegations; - Forward the grievance form to the grievance official as soon as practicable; - The grievance official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form; - Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the grievance official. Prompt efforts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance. All staff involved in the grievance investigation or resolution will take steps to preserve the confidentiality of files and records relating to grievances, and will share them only with those who have a need to know; - The grievance official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances; - The facility will take appropriate action in accordance with State law if an alleged violation of resident's rights is confirmed by the facility or an outside entity, such as State Survey Agency, Quality Improvement Organization, or local law enforcement agency; - In accordance with the resident's right to obtain a written decision regarding his/her grievance, the grievance official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: the date the grievance was received, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, the date the written decision was issued; - For investigations regarding allegations of neglect, abuse, injuries of unknown source, and/or misappropriation of resident property, a report of the investigative results will be submitted to the State Survey Agency, and other officials in accordance with State law, within five working days of the incident; - Evidence demonstrating the results of all grievances will be maintained for a a period of no less than three years from the issuance of the grievance decision; (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility will make prompt efforts to resolve grievances. 1. Review of the resident council minutes dated 4/4/22 showed: - 13 residents in attendance; - Old business: Residents want a food committee for food concerns; - New business: Concerns of dry chicken and overdone vegetables. Review of the resident council minutes dated 5/2/22 showed: - Six residents in attendance; - Old business: Chicken dry - still happening. The resident council minutes did not address who was responsible to address the issue of dry chicken and did not address the overdone vegetables; - New business: Certified Nurse Aides (CNAs) need to help in the dining room. Smoking times interfere with activities, would like another smoke time added. Resident said he/she had not had a shower in two weeks. Residents suggested a food committee. Review of the resident council minutes dated 6/7/22 showed: - Seven residents in attendance; - Old business: Chicken is better. Dining room needs to be open for all meals. CNAs need to start getting residents up for meals. The resident council minutes did not address who was responsible to address the issues or what action was taken; - New business: Condiments (salt, pepper and jelly) should be on the hall trays. The residents would like to talk to the doctors and go to Wal-Mart on their outings. During the Resident Council meeting and interview on 6/30/22 at 10:34 A.M., the residents said: - About a month ago a resident had $20 come up missing, and had two pairs of new shoes taken which had his/her name on them. He/she spoke with the Administrator about it but nothing was done; - Another resident had $60 come up missing. He/she did not tell anyone because nothing ever gets done about it. He/she quit filling out grievances because nothing ever gets done; - Resident #8 said he/she filed a grievance with Social Services about a staff member and no one followed up with him/her about it; - The staff don't always follow up when residents voice concerns during resident council meetings. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/30/22 at 4:32 P.M., the Social Services Director (SSD) and Social Services Assistant (SSA) said: - It was the SSD's sixth day of employment and he/she did not know who Resident #8 was and did not know anything about the grievance being filed; - The SSA has been in his/her position for three months. He/she looked in the grievance book, but did not see any grievance from Resident #8 about a staff member. If a resident has a complaint he/she would ask the resident if they wanted to file a grievance. If the resident said yes, they would fill out a yellow sheet and staff will discuss it the following morning during the morning meeting. He/she would give it to Assistant Director of Nursing (ADON) A and he/she does the investigation and follows up with the resident. During an interview on 6/30/22 at 4:46 P.M., the ADON A said: - He/she did not remember getting a grievance from Resident #8 about a staff member; - Any of the ADONs or DON could investigate a grievance and follow up with the resident; - The Director of Nursing (DON) and ADON B did not recall any grievances about a staff member from Resident #8. During an interview on 7/11/22 at 9:37 A.M., Licensed Practical Nurse (LPN) B said: - If a resident wanted to fill out a grievance, they would have the resident fill out a grievance form or direct the resident to Social Services. During an interview on 7/11/22 at 10:23 A.M., the Activities Director said: - He/she had been in the current position since the end of May; - If the residents have concerns or grievances during their resident council meetings, notes are taken on the issues. Staff notify the residents at the next meeting and let them know what has been taken care of and what has not been taken care of; - If a resident had a grievance, they would fill out a pink form and give it to that department head. During an interview on 7/12/22 at 1:49 P.M., the DON said: - To report a grievance, a resident would fill out a grievance form and take it to Social Services, the nurse's station. On the 200 hall there are forms at wheelchair level and throughout the building in different locations; - If a resident is unable to write the grievance themselves, then they can ask a staff member to assist them; - Social Services should follow up with the resident.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 31102 Based on observation, interview, and record review, the facility failed to provide accessible information on the location of the State Long Term Care Ombudsman program or the State Survey Agency that was readily available and could be read by residents in the facility without assistance. The facility census was 92. 1. Observation on 6/28/22 at 7:50 A.M., showed a poster with the resident's rights on the wall in the hallway before you entered the main dining room from the bottom 100 hall; - Did not have the Ombudsman number or the State Agency number; - Did not observe the Ombudsman or State Agency information on any of the other halls. During a group interview on 6/30/22 at 10:34 A.M., the residents said: - One resident was aware of where the Ombudsman and State Agency information was located, but the other 12 residents did not know where it was located. During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing said: - The Ombudsman and State numbers should be posted.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 31102 Based on record review and interview, the facility failed to issue the Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) (form Centers for Medicare and Medicaid (CMS)-10055 to each resident. The SNF ABN provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid by Medicare and assume financial responsibility. This affected two of three sampled residents (#12 and #89). The facility census was 92. Review of the undated facility policy titled Advance Beneficiary Notices, included the following: - It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage; - The facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay, before the facility provides: o An item or service that is usually paid for by Medicare, but may not be paid for in a particular instance because it is not medically reasonable and necessary, or; o Custodial Care. - The current Centers for Medicaid and Medicare Services (CMS) approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instruction and regulations regarding the use of the form; o For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, Form CMS-10055l); o A notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if the resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (QIO); - Additional notices shall be issued to Medicare beneficiaries when appropriate; o If services are being terminated and the beneficiary wants to continue receiving care that is no longer considered medically reasonable and necessary, the facility shall issue an ABN prior to furnishing non-covered care; o If a resident has skilled benefit days remaining and elects the hospice benefit, the facility shall issue an ABN and NOMNC when the coverage criteria for dual eligibility for Part A skilled and hospice are not met; (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided within 48 hours of the last anticipated covered day. The notices must not be provided while the resident/representative is under duress or in an emergency situation; - The BOM or designee is responsible for issuing notices; - The facility shall issue a notice each time, and as soon as, it makes the assessment that Medicare payment certainly or probably will not be made; - The original notice shall be placed into the resident's financial file. The notice shall be retained at least five years. In certain situations, such as delivery by fax, retention of a signed copy is acceptable. Electronic retention of the signed document is acceptable; - The BOM shall maintain a log of notices that have been provided. 1. Review of Resident #12's medical record showed: - The resident had a NOMNC issued that showed Medicare Part A benefits were ending on 2/17/22. The resident did not have a SNFABN in their records. Records showed the resident remained in the facility after being discharged from Part A services with benefit days remaining. 2. Review of Resident #89's medical record showed: - The resident had a NOMNC issue that showed Medicare Part A benefits were ending on 2/17/22. The resident did not have a SNFABN in their records. Records showed the resident remained in the facility after being discharged from Part A services with benefit days remaining. 3. During an interview 6/29/22 at 11:44 A.M. the Social Services Director (SSD) said she was responsible for providing the beneficiary notices. During an interview on 7/8/22 at approximately 2:00 P.M., the SSD said she just recently started working at the facility. She just sends the notices that the Minimum Data Set (MDS) Coordinator tells her to send. During an interview on 7/8/22 at 2:30 P.M., the MDS Coordinator said: - She could not find SNFABN's for either resident. They should have SNFABN notices; - She did not tell the SSD what to send, but the therapy department sent out documents to staff to let them know when residents were being discharged from Part A services; - Social Services were responsible for providing the notices, but neither one of them had been working at the facility very long.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on record review and interview, the facility failed to provide residents with a written letter of the reason for discharge/ transfer before transferring or as soon as practicable for three of 19 sampled residents, (Resident #34, #59, #79). The facility census was 92. Review of the facility's policy for transfer and discharge, revised 6/1/22, showed, in part: - It is the policy of the facility to permit each resident to remain in the facility and not to transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered; - The facility may initiate transfers or discharges in the following limited circumstances: the transfer or discharge is necessary for the resident's welfare and the resident's welfare and the resident's needs cannot be met in the facility; the health of the individuals in the facility would otherwise be endangered; - Emergency transfers or discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident. Obtain physician's orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis. Notify resident and/or resident representative. Contact an ambulance service and provider hospital, or facility of resident's choice, when possible, for transportation and admission arrangements. Complete and send with the resident (or provide as soon as practicable) a Transfer Form which documents: resident status, including baseline and current mental, behavioral and functional status and recent vital signs; current diagnoses, allergies and reasons for transfer/discharge; contact information of the practitioner responsible for the care of the resident; resident representative information including contact information; current medications (including when last received), treatments, most recent relevant labs and/or radiological findings and recent immunizations; special instructions or precautions for ongoing care to include precautions such as isolation or contact; special risks such as risk for falls, elopement, bleeding or pressure injury and/or aspiration precautions; comprehensive care plan goals and any other documentation, as applicable, to ensure a safe and effective transition of care. A copy of any Advance Directive, Durable Power of Attorney, DNR or withholding or withdrawing of life-sustaining treatment forms should be sent with the resident; - The original copies of the transfer form and Advance Directive accompany the resident. Copies are retained in the medical record; - Provide orientation for transfer or discharge to minimize anxiety and to ensure safe and orderly transfer or discharge, in a form and manner that the resident can understand; - Document assessment findings and other relevant information regarding the transfer in the medical record; - Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Provide transfer notice as soon as practicable to resident and representative; - Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long - Term Care Ombudsman via monthly list. 1. Review of Resident #34's quarterly Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/29/22 showed: - Cognitive skills moderately impaired; - Required extensive assistance of two staff for bed mobility; - Dependent on the assistance of two staff for transfers, dressing, and toilet use; - Lower extremity impaired on one side; - Had a catheter (sterile tube inserted into the bladder to drain urine); - Had a colostomy (a surgical operation where a piece of the colon is diverted to an artificial opening in the abdominal wall); - Diagnoses included cellulitis (inflammation of subcutaneous connective tissue) of right lower limb, wound infection, high blood pressure, obstructive uropathy (a condition in which the flow of urine is blocked), diabetes mellitus, depression, stroke and left below the knee amputation. Review of the resident's notice of proposed discharge, dated 5/27/22, showed: - The name of the person notified and the name of the hospital where the resident was transferred. The form did not have a date or time the person was notified; - Staff marked the reason for the discharge because it was necessary for the resident's welfare, and needs could not be met at the facility; - The form was signed the Quality Assurance (QA) Nurse, dated 5/27/22. The QA Nurse's date of hire was 6/20/22; - The form was not signed by the resident or their representative. 2. Review of Resident #79's notice of proposed discharge, dated 5/17/22, showed: - The name of the person notified and the name of the hospital where the resident was transferred. The form did not have a date or time the person was notified; - Staff marked the reason for the discharge because it was necessary for the resident's welfare, and needs could not be met at the facility; - The form was signed the QA Nurse, dated 5/17/22. The QA Nurse's date of hire was 6/20/22; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The form was not signed by the resident or their representative. Review of the resident's quarterly MDS, dated [DATE] showed: - Cognitive skills severely impaired; - Independent with bed mobility; - Supervision of one staff for transfers, dressing, toilet use and personal hygiene; - Always continent of bowel and bladder; - Diagnoses included stroke, anemia (lack of healthy red blood cells to carry adequate oxygen to the body's tissues), high blood pressure, renal insufficiency, diabetes mellitus, depression, seizure disorder. 22973 3. Review of Resident #59's MDS information showed the following: - On 5/17/22, staff completed a discharge, return anticipated MDS assessment when they transferred the resident to the hospital. Review of the resident's progress notes showed: - 5/17/2022 at 6:30 P.M., showed the resident had a episode of syncope (fainting) after the shower aides had him/her in the shower this morning. - 5/17/2022 at 11:17 P.M. Nurse's Note: Resident left with ambulance to hospital; - 5/18/22 at 3:19 A.M. Nurse's Note Note: Resident was being admitted with a urinary tract infection (UTI) and possible sepsis. Review of the Notice of Proposed Discharge, provided by the facility, showed: - The form had the resident's name and was dated 5/17/22; - Indicated they notified the resident's durable power of attorney with an effective date of 5/17/22; - The resident was transferred to the hospital due to it being necessary for the welfare and the facility could not meet his/her needs; - The form was signed by the Quality Assurance nurse with a date of 5/17/22, who did not begin employment at the facility until 6/20/22. 4. During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing said: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If the resident had an active Durable Power of Attorney (DPOA), they would get a copy. If the resident did not have a DPOA and was alert and oriented and if there was time to make copies before they go to the hospital, then yes they would get a copy. The facility would keep the original for the medical records.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 31102 Based on interview and record review, the facility failed to inform the resident and family/legal representative of their bed hold policy at the time of transfer/discharge to the hospital for three (Residents #34, #59, and #79) of 19 sampled residents. The facility census was 92. The facility did not provide a bed hold policy. 1. Review of Resident #34's Minimum Data Set information, (MDS), a federally mandated assessment instrument completed by facility staff, showed: - On 5/27/22 staff completed a discharge assessment for transfer to an acute hospital with return anticipated; - On 6/3/22 staff completed a re-entry MDS showing the resident returned to the facility from the acute hospital. Review of the resident's bed hold agreement, dated 5/27/22 showed: - Staff documented the resident's name and where the resident was being transferred; - The form was signed by the QA Nurse and dated 5/27/22. The QA Nurse's hire date was 6/20/22; - The form did not indicate if family had been notified or provided with a copy. The bed hold agreement did not indicate the effective date, expiration date, or the price per day. 2. Review of Resident #79's MDS information showed: - On 5/17/22 staff completed a discharge assessment for transfer to an acute hospital with return anticipated; - on 5/19/22 staff completed a re-entry MDS showing the resident returned to the facility from the acute hospital. Review of the resident's bed hold agreement, dated 5/17/22 showed: - Staff documented the resident's name and where the resident was being transferred; - The form was signed by the QA Nurse and dated 5/17/22. The QA Nurse's hire dated was 6/20/22; - The form did not indicate if family had been notified or provided them a copy. The bed hold agreement did not indicate what the effective or expiration dates were or the price per day. 22973 (continued on next page)

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Liberty Health and Wellness	2201 Glenn Hendren Dr Liberty, MO 64068

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #59's MDS information showed the following: - On 5/17/22, staff completed a discharge, return anticipated MDS assessment when they transferred the resident to the hospital. Review of the progress notes showed: - 5/17/2022 at 6:30 P.M., showed the resident had a episode of syncope (fainting) after the shower aides had him/her in the shower this morning. - 5/17/2022 at 11:17 P.M. Nurse's Note: Resident left with ambulance to hospital; - 5/18/22 at 3:19 A.M. Nurse's Note Note : Resident is being admitted with a urinary tract infection (UTI) and possible sepsis. Review of the MDS information showed the resident returned from the hospital on 5/23/22. Review of the Bed Hold Agreement, provided by the facility, showed: - The form had the resident's name and the name of the facility; - Nothing else was completed on the form; - The form was signed by the Quality Assurance nurse with a date of 5/17/22, who did not begin employment at the facility until 6/20/22. 4. During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing said: - The resident may not be able to sign at the time of transfer, but should at least get an acknowledgement.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observation, interview and record review, the facility failed to ensure staff followed professional standards of care for two of 19 sampled residents when staff failed to clarify an order for Resident #79 and failed to enter a physician's order following a dietician's recommendation for Resident #15. The facility census was 92. 1. Review of the facility's policy for hemodialysis, revised 5/1/22, showed: - This policy will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis; - The nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency (open or unobstructed) by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist. Review of Resident #79's care plan, revised 3/7/22 showed: - The resident needed hemodialysis related to end stage renal disease (ESRD, a medical condition where a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life); - Auscultate bruit (listen for turbulent blood flow) and palpate thrill (feel for a rumbling sensation) to AV fistula/shunt; - Check and change dressing daily at access site. Document. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/14/22, showed: - Cognitive skills severely impaired; - Independent with bed mobility; - Supervision of one staff for transfers, dressing, toilet use and personal hygiene; - Diagnoses included stroke, anemia (lack of healthy red blood cells to carry adequate oxygen to the body's tissues), high blood pressure, renal insufficiency, diabetes mellitus, depression, seizure disorder. Review of the resident's physician order sheet (POS), dated June 2022, showed: - Order date 3/18/22- monitor AV fistula for bruit and thrill every shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medication administration record (MAR) and treatment administration record (TAR) for June 2022 showed the MAR and TAR did not contain the order from the resident's physician to monitor the AV fistula for bruit and thrill every shift. During an interview on 7/8/22 at 1:57 P.M., Licensed Practical Nurse (LPN) C said: - He/she looked at the resident's MAR and TAR and did not see the order to monitor the AV fistula for bruit and thrill every shift transcribed onto the MAR and/or TAR. During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing (DON) said: - Staff should follow physician's orders to assess the area. 39366 2. Review of the facility policy titled Weight Monitoring, dated 7/5/22, included the following: -Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; -This facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: o Identifying and assessing each resident's nutritional status and risk factors; o Evaluating/analyzing the assessment information; o Developing and consistently implementing pertinent approaches; o Monitoring the effectiveness of interventions and revising them as necessary; - Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status; -Though a significant weight change may not occur, the resident may be identified as below ideal body weight by the Registered Dietician or designee; -Documentation: o The physician should be informed of a significant change in weight and may order nutritional interventions; o The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Meal consumption information should be recorded and may be referenced by the interdisciplinary care team as needed o If the interdisciplinary care team desires to explore specific meal consumption information for a resident, the Registered Dietitian, Dietary Manager, or the nursing department may initiate this process; o The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition process notes; o Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate; o The interdisciplinary plan of care communicates care instructions to staff. Review of Resident #15's quarterly MDS, dated [DATE], included the following: - Date admitted [DATE]; - Severe cognitive impairment; - No noted nutrition issues. Review of the resident's care plan did not indicate any nutrition issues. Review of the resident's physician orders for June 2022 showed regular diet. No supplements were ordered. Review of the resident's medical record showed staff recorded the following weights for the resident: o 6/3/2022 174.0 pounds (lbs); o 6/1/2022 174.0lbs; o 5/12/2022 175.8lbs; o 4/7/2022 178.0lbs; o 3/3/2022 182.8lbs; o 3/2/2022 182.8lbs; o 12/3/2021 178.5lbs; o 11/2/2021 184.5lbs; o 10/7/2021 191.5lbs; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o 9/3/2021 195.8lbs; o 9/2/2021 197.3lbs; o 8/6/2021 203.4lbs; o 8/2/2021 203.4lbs; o 7/13/2021 207.8lbs; o 7/3/2021 201.6lbs; o 6/7/2021 206.0lbs; o 6/3/2021 207.5lbs. Review of the resident's Progress Note, dated 4/23/2022 by the Registered Dietitian (RD), showed the resident was down 5 pounds (lbs) in one month and 14 lbs in six months. Eating 50-75 percent (%) of meals. Suggest adding Ready Care 2.0 60 milliliters (ml) (High protein supplement) three times per day due to weight loss trend. Review of the Physician's Order Sheet showed no orders to indicate the recommendation by the RD was addressed. During an interview on 7/1/22 at 4:18 P.M. the DON said: - He prints out the RD's recommendation reports that he receives by email, and then inputs them as orders; - He did not see the recommendation in April for the resident from the RD until now; - He should receive reports from the RD or the RD should stop in and talk to him about the recommendation; - It was hard to capture everyone's progress notes. During an interview on 7/12/22 at 1:49 P.M., the DON said the RD recommendations should be made into an order or there should be documentation to show the recommendation was addressed.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39366 Based on record review and interview, the facility failed to complete a comprehensive discharge summary for one of three sampled closed records (Resident #90) to include a recapitulation of the resident's stay at the facility. The facility census was 92. Review of the facility policy titled Discharge Summary and Plan of Care, dated reviewed/revised 7/8/22, included the following: - It is the policy of this facility to ensure that a discharge planning process is in place which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies; - Upon discharge of a resident (other than in emergency to hospital or death) a discharge summary will be provided to the receiving care provider. The Discharge Summary should include: - An overview of the resident's stay that includes but not limited to: diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results, and instructions or precautions for ongoing care; - A final summary of the resident's status at the time of discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative; - Reconciliation of all pre-discharge medications with the resident's post discharge medication to include prescription and over the counter medications. 1. Review of Resident #90's medical records showed: - Date admitted [DATE]; - Date discharged [DATE]; - Medical records indicated the resident moved to another long-term care facility; - The electronic health record had a document titled Discharge Assessment and Plan, dated 1/6/22, and a document titled Discharge Plan of Care Assessment, dated 4/27/22. There was not a document that included the recapitulation of stay. During an interview on 7/08/22 at 9:15 A.M., The Social Services Director said: - Each department had a section to complete in the discharge summary. Social Services would also add a progress notes in the nurse notes. During an interview on 7/8/22 at 9:15 A.M., Social Services Assistant said: (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- She thought there was a discharge summary assessment that was completed in the electronic health record. Each department had a section in the assessment to complete; - Nursing would initiate the process. During an interview on 7/08/22 at 9:26 A.M., Assistant Director of Nursing (ADON) A said: - Nurse will do the discharge summary, there was a discharge summary section in their electronic medical record (EMR) as well as put it in the nurse notes. During an interview on 7/08/22 09:26 A.M., ADON B said: - The facility completed two discharge assessments. One was completed by Nursing and one was completed by Social Services; - Nursing would complete the discharge summary. It depended on the time of day who would complete the assessment, it could be the charge nurse or she could if it was during the day and she was in the building. The discharge summary is in the electronic health record. There was also a Discharge Nurse Note document under assessments in the electronic health record; - She thought Social Services completed the Discharge Plan of Care Assessment. During an interview on 7/08/22 at 9:47 A.M., the Director of Nursing said: - Nursing and Social Services complete discharge note and discharge assessment that starts on Day one. This discharge summary was in the electronic health record; - The discharge document for the resident was what was used at that time. The facility now had a newer one that included the recapitulation of stay that was implemented earlier this month.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on observation, interview, and record review, the facility failed to ensure residents received assistance with Activities of Daily Living (ADL's) when staff did not trim excess facial hair, did not ensure the resident's face, nails, and bed were free from dirt and debris for two sampled residents (Residents #52 and #88). The facility census was 92. Review of the facility's policy titled, Grooming a Resident's Facial Hair, dated 7/5/22, included the following: -It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice. 1. Review of Resident #52's Minimum Data Set (MDS), a federally mandated assessment tool, dated 5/23/22, showed: - A BIMS of three, which indicated severe impairment; - Extensive staff assistance with bed mobility, transferring from one surface to another, dressing, toilet use, and personal hygiene; total dependence on staff for bathing; did not walk in his/her room or in the corridor; - Diagnoses included: high blood pressure, diabetes, and schizophrenia (a serious mental disorder in which people interpret reality abnormally). Review of the resident's care plan showed: - Has an ADL self-care performance deficit related to weakness, initiated 3/21/21. Interventions included: o The resident required total assist of two staff with bathing twice weekly and as necessary; o The resident required total assist of two staff for toileting; o The resident required set up assist of one with eating. Review of the resident's shower sheets dated 6/3/22, 6/12/22, 6/16/22, and 6/21/22, showed: -No documentation of shaving; -No documentation of nail care. Observation on 6/27/22 at 1:45 P.M., showed: -Resident lay in bed; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Quarter sized pieces of food in the bed next to the resident; -Pillow stained with a brown substance; -Facial hair on his/her chin and above his/her upper lip; -Pieces of food on his/her face; -Dirt and debris on his/her hands and under his/her fingernails. Observation on 6/28/22 at 8:45 A.M., showed: -Facial hair on his/her chin and above his/her upper lip; -Dirt and debris on his/her hands and under his/her finger nails; -Pillow stained with a brown substance. Observation on 6/28/22 at 3:15 P.M., showed: -Facial hair on his/her chin and above his/her upper lip; -Dirt and debris on his/her hands and under his/her finger nails; -Pillow stained with a brown substance; -Five penny sized pieces of food in the bed next to him/her. Observation on 6/29/22 at 2:32 P.M., showed: -Facial hair on his/her chin and above his/her upper lip; -Dirt and debris on his/her hands and under his/her finger nails; -Pillow stained with a brown substance; -Five penny sized pieces of food in the bed next to him/her. Observation on 6/30/22 at 2:32 P.M., showed: -Curly facial hair on his/her chin, above his/her upper lip and on his/her cheeks; -Dirt and debris under his/her finger nails; -Pillow stained with a brown substance; -Five penny sized pieces of food in the bed next to him/her; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Four dime sized pieces potatoes on his/her chest and gown; -Scattered pieces of corn and potatoes at the foot of the bed; -Pillowcase stained with light brown substance in scattered areas. Observation on 7/1/22 from 7:57 A.M. to 8:32 A.M., showed: -CNA C raised the head of bed and moved the bedside table into position; -CNA C uncovered the resident's food; -The resident fed himself/herself in bed; -CNA C left the room and CNA I picked up the food tray; -No staff cleaned the resident's face, nails, or bed; -There was dirt and debris on his/her hands and under his/her finger nails; -Scattered dime-sized pieces of oatmeal on his/her chest and gown. During an interview on 7/1/22 at 8:45 A.M., CNA C said: -Staff should check on the resident after meals to make sure his/her face, and fingernails are clean; -Staff should make sure the bed is free from food and if the gown or linens are dirty they should be changed; -Residents should be shaved according to their preference; -If the resident cannot communicate their preference for shaving, they should be shaved as a reasonable person would like. During a telephone interview on 7/6/22 at 1:44 P.M., CNA J said: -He/she gives the resident a shower two times a week; -He/she provides nail care and shaves the resident on shower days; -A reasonable person of the resident's gender would like to be shaved before facial hair was noticeable. During a telephone interview on 7/08/22 at 9:33 A.M., Resident #52's guardian said: -He/she expected the resident's face to be shaved and free of facial hair; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected the resident's hands and nails to be free from debris and dirt; -He/she expected the resident's face to be clean and for staff to make sure his/her face and hands are clean after every meal; -He/she expected the facility to staff to check on him/her after meals to make sure there is no food in his/her bed. 2. Review of Resident #88's MDS, dated [DATE], showed: - A BIMS of zero, which indicated severe impairment; - Extensive staff assistance with bed mobility, transferring from one surface to another, dressing, toilet use, and personal hygiene; total dependence on staff for bathing; did not walk in his/her room or in the corridor; - Diagnoses included: high blood pressure, diabetes, and stroke. Review of the resident's care plan showed: - Has an ADL self-care performance deficit related to weakness, initiated 3/21/21. Interventions included: o The resident required total assist of two staff with bathing twice weekly and as necessary; o The resident required total assist of two staff for toileting; o The resident required set up assist of one with eating. Review of Shower sheets, dated 6/3/22 and 6/21/22, showed: -No documentation of shaving; -No documentation of nail care. Further review of the resident's medical record showed no other shower sheets. Observation on 6/27/22 at 2:17 P.M., showed the resident had: -Facial hair under their chin and on their cheeks; -Dirt and debris under the finger nails of their left hand; -Hair was oily and unkempt. Observation on 6/29/22 at 9:15 A.M., showed the resident had: -Facial hair under their chin and on their cheeks; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dirt and debris under the finger nails of their left hand; -Right hand had yellow substance on the back of hand; -Hair was oily and unkempt. Observation on 7/1/22 from 7:37 A.M. to 8:32 A.M., showed: -Resident in bed positioned on his/her back; -Dirt and debris under their nail beds; -Facial hair under their chin and on their cheeks; -CNA I raised the head of bed and moved bedside table into position; -CNA I uncovered the resident's food and the resident fed himself/herself in bed; -CNA I left the room; -The CNA returned to the room and picked up the food tray; -No staff cleaned the resident's, face, or nails; -Dirt and debris on his/her hands and under his/her fingernails. During an interview on 7/1/22 at 9:00 A.M., CNA I said: -Staff should check on the resident after meals to make sure his/her face, hands and fingernails are clean; -If the resident cannot communicate the preference for shaving, they should be shaved as a reasonable person would like. During a telephone interview on 7/6/22 at 1:44 P.M., CNA J said: -He/she gives the resident a shower two times a week; -He/she provides nail care and shaves the resident on shower days; -A reasonable person of the resident's gender would like to be shaved before facial hair was noticeable. During a telephone interview on 7/7/22 at 5:10 P.M., the resident's family member said: -When he/she visits the resident he/she is unshaven, his/her hair is dirty, nails are long, and there is dirt caked under them; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she combs the resident's hair, clips his/her fingernails, and usually shaves the resident's face with a shaving kit he/she brings to the facility; -He/she puts lotion on the resident's legs and arms, because he/she has dry skin; -The resident told him/her that he/she did not like having facial hair and being dirty because it makes him/her sad; -It was embarrassing when his/her church friends come and he/she looks like this; -He/she expected the facility to make sure the resident gets a shower a few times week, facial hair shaved, and nails kept clean; -He/she has told staff at the facility about his/her expectations, but the resident continues to not get the grooming he/she needs. 3. During an interview on 7/08/22 at 10:23 A.M., the Director of Nursing and the Administrator said: -It was not acceptable for any resident to have a dirty face or nails; -The staff should make sure the resident's fingernails, hands, and face are clean after meals if the resident cannot do it him/herself; -Residents should be shaved according to their preference, or if they cannot make their needs known, shaving should be done as a reasonable person would like; -There should not be food in a resident's bed and the linens should be clean; -The DON is in charge of ensuring that staff complete these tasks.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39366 Based on interview and record review, the facility failed to perform life saving measures to include Cardio-pulmonary resuscitation (CPR) for one sampled resident (Resident #89) when the resident wanted to be resuscitated in the event his/her heart and/or respirations stopped. On [DATE] staff found the resident in bed in his/her room, unresponsive with no sign of life. Staff did not initiate CPR or any other life saving measures. The resident died in the facility on [DATE]. The facility census was 92. The facility Administrator was notified on [DATE] at approximately 5:30 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE]. Review of the facility policy Communication of Code Status, dated [DATE], included the following: - It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information; - The facility will follow facility policy regarding a resident's rights to request, refuse and or continue medical or surgical treatment and to formulate an Advance Directive; - When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include but are not limited to: Full code; Do Not Resuscitate; Do Not Intubate; Do not hospitalize; - The nurse who notates the physician order is responsible for documenting the direction in all relevant sections of the medical record; - The designated sections of the medical record are: Face sheet and orders; - Additional means of communication of code status include: Report sheets and crash cart book; - In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code; - The presence of an Advance Directive or any physician directives related to the absence or presence of an Advance Directive shall be communicated to Social Services; - The Social Services Director shall maintain a list of residents who have an Advance Directive on file; - The resident's code status will be reviewed at least quarterly and documented in the medical record. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the undated facility policy titled Medical Emergency Response included the following: - It is the policy of this facility to respond to medical emergencies for residents, staff and visitors; - The employee who first witnesses or is first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance. - CPR will continue unless: o There is a DNR order in place o There are obvious signs of clinical death (rigor mortis, dependent lividity, decapitation, transection, or decomposition); o Initiating CPR could cause injury or peril to the rescuer Review of the facility policy titled Cardiopulmonary Resuscitation, dated [DATE], included the following: - It was the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding CPR; - The facility will follow current American Heart Association (AHA) guidelines regarding CPR; - If a resident experiences a cardiac arrest, the facility staff will provide basic life support, including CPR prior to the arrival of emergency medical services, and: o In accordance with the resident ' s advance directives, or; o In the absence of advance directives or a DNR order; and o If the resident does not show obvious signs of clinical death (rigor mortis, dependent lividly, decapitation, transection, or decomposition; - CPR certified staff will be available at all times; - Staff will maintain current CPR certification for healthcare providers through a CPR provider who evaluates proper technique through in-person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in-person skills demonstration to obtain certification or re-certification is also acceptable. 1. Review of Resident #89's quarterly Minimum Data Set (MDS),a federally mandated assessment tool completed by facility staff, dated [DATE], included the following: - Cognitively intact. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's care plan, last revised [DATE], showed the following: - The resident was a full code status. Interventions included: o Advance Directive and resident wishes will be honored; o Physician will be notified of resident's wishes and any needed physician's order will be obtained; o Resident will be informed of any changes in condition and benefits, risks, and possible choices of treatment; o Date initiated was [DATE]. Review of the resident's medical records on [DATE] showed the following: - The resident was legally responsible for himself/herself. - The resident had Durable Power of Attorney for Health Care document (a legal document that gives another person the authority to make a medical decision for an individual), but it had not been invoked. - The resident had a Outside the Hospital DNR (OHDNR) order signed by the resident on [DATE]. - The resident signed to revoke the OHDNR order on [DATE]. - Physician order in the electronic health record (EHR), dated [DATE], showed the resident had a Do Not Resuscitate (DNR) order; The Physician Order Sheet (revision dates) showed: -[DATE] - DNR -[DATE] - Full Code -[DATE] - Full Code -[DATE] - Full Code -[DATE] - DNR Further review of the resident's medical record showed in the hard copy records the facility had a copy of the OHDNR that was the same form that had not been revoked yet (signed by the resident [DATE]) and a copy of the OHDNR that had been revoked by the resident on [DATE]. There were no other OHDNR in the record. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's nurse note by Registered Nurse (RN) A, dated [DATE], showed staff documented during a visit from the hospice nurse, patient revoked his/her hospice services. He/she stated this was because he/she wanted his/her medications back and he/she wanted to be a full code again. The hospice nurse educated him/her that both of these things were possible while remaining on hospice. However, the patient was adamant about revoking. Will update code status. Will contact physician about reinstating his/her pre-hospice medications. Review of the resident's nurse note, dated [DATE], staff documented that Social services discussed invoking hospice. The resident said he/she did not want hospice and was not going to die anytime soon. Resident stated he/she did not need the service at this time and stated he/she would like to go to the emergency room if needed. Review of the resident's nurse note, dated [DATE] at 9:03 A.M., showed Licensed Practical Nurse (LPN) D documented the resident was found in bed with oxygen in place via nasal cannula at 3 liters. The resident was absent of all signs of life. Verified by additional nurse (LPN B). Pronounced deceased at 7:20 A.M. Physician's office was notified, resident's family was notified and the funeral home was contacted. The note did not indicate CPR had been provided. During a phone interview on [DATE] at 10:18 A.M., LPN D said: - He/she came to work at 6:00 A.M. on [DATE]. He/she received report then was called down to the resident's room around 7:00 A.M. and found the resident expired (deceased) in bed. The resident's oxygen was in place and he/she looked like he/she just had a breathing treatment. He/she looked like he/she had been gone awhile. He/she checked and the resident had a DNR order. The resident's electronic health record (EHR) had him/her listed as a DNR and the facility also kept a book with a list of the DNR orders; - CPR was not performed because the resident was a DNR; - If the resident had been a full code then they would have started CPR on the resident. During a phone interview on [DATE] at 4:58 P.M., LPN D said: - The aides had called him/her to the resident's room when the resident did not respond when they went to get him/her up. He/she immediately checked the resident's chart which said the resident was a DNR; - The resident was cool to the touch and was discolored, there was not rigidity or rigor mortis. During a phone interview on [DATE] at 9:42 A.M., LPN B said the resident had a DNR order so CPR was not performed. Purple DNR sheets were kept in the resident's chart and was in the EHR as well. LPN B confirmed the resident was deceased . During a phone interview on [DATE] at 3:35 P.M., Family Member B said: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- About a week before the resident passed, Family Member A found that the facility put a DNR on her/her. He/she learned this when the Social Services Assistant called him/her checking on him/her. SSA said the resident was a DNR which Family Member B said he/she was not supposed to be, it was supposed to be removed when the resident was pulled off hospice; - He/she told Family Member A who confirmed the resident was not supposed to be a DNR and they both spoke to SSA and requested the DNR to be revoked; - He/she shortly came and visited with the resident after the most recent hospitalization and was told the the facility had him/her as a DNR. The resident said What, I don't want them to just let me die. The resident was clearly upset and told SSA, who was leaving for the day at the time to remove the DNR. SSA said he/she was working on it. The resident also told Family Member A that he/she wanted to see his/her grand-kids grow up; - Family Member A felt like they just let the resident die and did not try to save him/her; - The facility did not remove the DNR like they were told to. During an interview on [DATE] at 4:30 P.M., the Social Services Assistant said: - A facility staff member verified the residents' code status during the 48 hour assessment then reviewed at the quarterly care plan meetings as well; - She thought the resident's family member had mentioned something about his/her code status being revoked, but he/she did not recall what was said because they were busy talking about other things. - Each nurse station kept a binder with code status. - She was not sure what the procedure was for someone who wanted to revoke their DNR status. During an interview on [DATE] at 4:35 P.M., the Social Services Director said: - Social services verifies code status after the nurses also had verified it; - The EHR should show the code status; - If a resident wants to revoke their DNR then the facility would check to see if their was a DPOA document in effect. - Usually nursing staff take care of making the changes. - Social Services would also verify code status when a resident readmits to the facility. -He/she was not familiar with the resident's code status. During an interview on [DATE] at 5:08 P.M., LPN E said: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The crash carts had a book that showed residents code status and the EHR will have the actual signed DNR/OHDNR; - If there was a change in code status then he/she would feel responsible, as the charge nurse, to make the changes. During an interview on [DATE] at 2:50 P.M., the Director of Nursing (DON) said: - There are different stages to no signs of life; - If a resident was a full code and had a cardiac arrest or if it was a fresh death then he would expect staff to perform CPR. If lividly had set in or rigor mortis had set in then there would be no need to provide CPR at that point. Nursing staff would make the assessment at that time then call the physician with their findings. If there was obvious signs of death then CPR would not be initiated; - Social Services verify code status. - DNR's are kept in a binder once it was scanned in to medical records; - When the resident returned from the hospital on [DATE] records showed he/she had a DNR (this was the same form dated [DATE] but it had not been revoked yet); - He confirmed the DNR in the hospital packet was the same DNR form that the resident later revoked on [DATE]. - He had not seen the DNR that the resident had revoked, dated [DATE]; - He would expect staff to confirm DNR status at readmission. During a follow-up interview on [DATE] at 5:19 & 5:29 P.M., the DON said: - Social services should verify code status, with the resident at admission then during the quarterly assessment; - Changes to the code status depended on who the resident/legal representative had informed. - If they informed Social Services, then Social Services would gather information and take it to nursing staff and nursing staff would verify with the physician and get a (DNR) form and update records; - If the resident/legal representative notified a nurse, then the nurse would need to get with social services and obtain a DNR form and notify physician of the status; - Code status form on the crash carts were updated at a minimum of weekly or during midnight census. - The resident's EHR also shows a residents' code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Evening nurses update the crash carts and code status book as needed. - He understood the resident's code status was incorrect, but cold to touch and discolored is lividity. During a phone interview on [DATE] at 11:26 A.M., the resident's physician said: - He/she thought the resident had a DNR order, but did not remember if he/she had revoked it; - If the resident was a full code and staff found him/her with no sign of life then he/she would expect staff to start CPR. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22973 Based on observation, record review and interview, the facility failed to implement interventions to promote healing and relieve pain and discomfort as a result of a pressure ulcer for one of 19 sampled residents (Resident #59). The facility census was 92. Review of the facility's Pressure Injury Prevention and Management policy, implemented on March 2022, showed: the facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. The policy explanation and compliance guidelines included: - The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment. - Interventions for prevention and to promote healing included: a. After completing a thorough assessment/evaluation, the interdisciplinary team (IDT) shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment and any pressure injury assessment. c. Evidence-based interventions for prevention will be implemented for all residents who are assessed as at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.) iii. Provide appropriate pressure -redistributing support surfaces; f. Interventions will be documented in the care plan and communicated to all relevant staff. g. Compliance with interventions will be documented in the weekly summary charting. - Monitoring a. The registered nurse (RN) Unit Manager or designee will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing and compliance at least weekly and document a summary of findings in the medical record. d. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QAA (Quality Assessment and Assurance) Committee Schedule, and as needed when actual or potential problems are identified. - Modifications of Interventions (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a. Any changes to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner. b. Interventions on the resident's care plan will be modified as needed. Consideration for needed modifications included: Resident non-compliance. 1. Review of Resident #59's admission Minimum Data Set (MDS), a federally mandated assessment instrument, dated 4/20/22, showed: - admitted [DATE]; - A Brief Interview for Mental Status (BIMS) score of 4 which indicated severe cognitive impairment; - No behaviors noted; - Total dependence on staff for bed mobility, transferring from one surface to another, moving on and off the nursing unit, dressing, toilet use and bathing; extensive staff assistance with personal hygiene; - Diagnoses of hip and knee replacement, high blood pressure, urinary tract infection, hip fracture, and dementia; - Has been on pain medication in the previous five days; has received as needed (PRN) pain medication; resident experiences occasional pain; pain has not affected sleep at night or limited his/her day-to-day activities; - At risk for pressure ulcers and has no unhealed pressure ulcers upon admission. Review of the progress notes showed: - 5/5/22 at 4:17 P.M. Nurse's Note: Fluid-filled blister observed on inside of left (L) heel. Has not opened. Order for layered sureprep three times a day and keep elevated up off bed. Float heels until resolved. Sureprep (water-based polymer solution which forms a durable protective film over the skin, designed to protect broken or intact skin from irritation caused by moisture, friction, or adhesives) to heels in layers. Applied Prafo boots (used to prevent pressure ulcers from developing on the back of the heel) to keep heels elevated off of the bed. - 5/12/22 at 3:01 P.M. Nurse's Note: the resident has a blister on the right (R) heel, called the physician for a treatment plan. Review of the physician's progress note, dated 5/13/22 at 5:15 P.M., showed: - History of present illness: now has blisters on both heels that have dried up and become unstageable pressure ulcers; - In general, appears in no apparent distress. Extremities reveal no edema, with dried eschar on both heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Assessment: unstageable pressure ulcer of right and left heel. - Plan: Keep pressure off both heels. Review of the resident's MDS assessments showed: - A discharge assessment, dated 5/17/22, with return anticipated for an issue unrelated to heel wounds; - An entry assessment dated [DATE]. Review of the 5-day scheduled MDS assessment for a Medicare Part A stay, dated 5/27/22, showed: - A BIMS of 4; - Resistive to care one to three days during the assessment period; - Total dependence on staff for transferring from one surface to another, moving on and off the nursing unit, dressing, toilet use, personal hygiene and bathing; extensive staff assistance with bed mobility; - At risk for pressure ulcers; has one or more unhealed pressure ulcers; - Has one unstageable pressure ulcer (full-thickness tissue loss but is either covered by extensive necrotic tissue or by eschar (dead tissue)), suspected deep tissue injury. Review of the resident's care plan showed: - Date initiated 4/21/22: Resident has an ADL (activities of daily living) self-care performance deficit related to weakness, deconditioning, pain, and recent left hip replacement; the resident requires total assistance of two staff to turn and reposition in bed; requires total assistance of two staff to move between surfaces; - Date initiated 5/24/22: Resident has a behavior problem related to yelling out Help instead of using call light. Explain all procedures to the resident before starting and allow the resident to adjust to changes; if reasonable, discuss the behavior. Explain and reinforce why behavior is inappropriate and/or unacceptable to the resident; intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed; monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved and situations. Document behavior and potential causes. - Resident has a potential for pressure ulcer development related to incontinence and weakness and an unstageable to right (R) heel. Interventions included: o Administer treatments as ordered and monitor for effectiveness; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	o Educate resident as to causes of skin breakdown including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning; - The care plan did not include instructions to keep pressure off of heels or to position with a pillow under the resident's feet to eliminate pressure and elevate pain. - The care plan did not include any information regarding the resident refusing to comply with treatment or instructions for alternatives if resident did not comply. Review of the progress notes showed: - 5/23/22 at 10:42 P.M. Nurse's Note: The resident arrived back at the facility from local hospital via facility van accompanied by a facility driver. The resident has dressings in place to bilateral heels, both heels have black eschar areas with scant amount of drainage. Review of the wound care provider's (WCP) progress note, dated 5/25/22, showed: - Wound #1, L medial heel is an unstageable pressure injury obscured full-thickness skin and tissue loss pressure ulcer and has received a status of not healed. Measurements are 2.5 centimeters (cm) length x 2.5 cm width x 0.1 cm depth, with an area of 6.25 square cm and a volume of 0.625 cubic cm. There is no drainage noted. Wound bed has 76-100% eschar. - Wound #2 R heel is a deep tissue pressure injury. Persistent non-blanchable deep red, maroon or purple discoloration pressure ulcer and has received a status of Not Healed. Measurements are 3 cm length x 2.5 cm width with no measurable depth, with an area of 7.5 square cm. No drainage noted. Wound bed is 76-100% epithelialization (a process of covering raw skin). Normal periwound skin texture, periwound skin moisture, and periwound skin color. - Lower extremity assessment: Offloading: Offloading device in use: Yes; device used correctly: Yes; Offloading device used: Prafo boots. - Plan of care: Advanced wound specialist to follow up in one week to reassess progress of wound/skin issues; Plan of Care discussed with facility staff- discussed importance of offloading, pressure relief, frequent turning/position changes and Prafo boots to bilateral lower extremities. Review of the Nurse's Notes, dated 5/25/22 at 2:52 P.M. showed staff documented the WCP nurse in to assess, no new orders- continue sureprep and protective boots to feet. Review of the WCP's progress notes, dated 6/1/22, showed: - Wound #1 (L medial heel): 2.5 cm length x 2.5 cm width x 0.1 cm depth; wound bed is 76-100% eschar. Wound remains unchanged; - Wound #2 (R heel): 3 cm x 2.5 cm with no measurable depth. Wound bed 76-100% epithelialization. Area remains closed; blister noted to center of area; - Lower extremity assessment: Off-loading device in use: No; staff report he/she refuses to wear Prafo boots or use a heel elevating pillow; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Plan of care: Advanced wound specialist to follow up in one week to reassess progress of wound/skin issues; Plan of Care discussed with facility staff- discussed importance of offloading, pressure relief, frequent turning/position changes and Prafo boots to bilateral lower extremities. Review of the facility's Weekly Wound assessment dated [DATE] showed: - Left medial heel, date of onset 4/22/22 (documented in progress notes as identified on 5/5/22); Facility acquired; pressure, unstageable, resolved; - Right heel; onset date 5/17/22 (documented in progress notes as identified on 5/12/22), facility acquired; pressure, suspected DTI, 3 cm x 2.5 cm x 0 cm; pink wound bed color, 100% epithelialization/new skin; stable. The facility did not provide WCP progress notes for the week of 6/8/22. Review of the WCP's progress notes, dated 6/14/22, showed: - Wound #1 not listed; - Wound #2: R heel measurements are 2 cm length x 1.5 cm width x 0.1 cm depth, with an area of 3 square cm. Wound bed is 76-100% eschar. Wound is smaller today, eschar is forming, stable and intact. - Lower extremity assessment: Off-loading device in use: No; staff report he/she refuses to wear Prafo boots or use a heel elevating pillow. - Plan of care: advanced wound specialist to follow up in one week to reassess progress of wound/skin issues; Plan of Care discussed with facility staff - discussed importance of offloading, pressure relief, frequent turning/position changes and Prafo boots to bilateral lower extremities. Review of the facility's Weekly Wound assessment dated [DATE] showed: - Right heel; onset date 5/17/22, facility acquired; pressure, suspected DTI, 2 cm x 1.5 cm; 100% necrosis/black; wound bed black; improved. Review of the WCP's progress notes, dated 6/21/22, showed: - Wound #2: measurements 1.3 cm length x 1 cm x 0.1 cm depth with an area of 1.3 square cm. Wound bed is 76-100% eschar. Wound has improved Eschar remains stable and intact; - Lower extremity assessment: Off-loading device in use: No; staff report he/she refuses to wear Prafo boots or use a heel elevating pillow. - Plan of care: Advanced wound specialist to follow up in one week to reassess progress of wound/skin issues; Plan of Care discussed with facility staff- discussed importance of offloading, pressure relief, frequent turning/position changes and Prafo boots to bilateral lower extremities. Review of the facility's Weekly Wound assessment dated [DATE] showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Right heel; onset date 5/17/22, facility acquired; pressure, suspected DTI; 1.3 cm x 1 cm x 0.1 cm; wound bed color black; 100% necrosis/black; improved. Review of the WCP's progress notes, dated 6/30/22, showed: - Wound #2: measurement 1.8 cm length x 1.4 cm x 0.1 cm; black 100% necrosis/eschar; Wound has worsened. - Lower extremity assessment: Off-loading device in use: No; staff report he/she refuses to wear Prafo boots or use a heel elevating pillow. - Plan of care: Advanced wound specialist to follow up in one week to reassess progress of wound/skin issues; Plan of Care discussed with facility staff- discussed importance of offloading, pressure relief, frequent turning/position changes and Prafo boots to bilateral lower extremities. Review of the facility's Weekly Wound Assessment, dated 6/30/22, showed: - Right heel; onset date 5/17/22, facility acquired; pressure, suspected DTI; 1.8 cm x 1.4 cm x 0.1 cm; wound bed color black; 100% necrosis/black; wound healing progression worsened. Observations on 6/27/22 through 7/1/22 at various times throughout the day showed the resident lay in bed on his/her left side with his/her feet and ankles resting directly on the mattress. No heel boots or Prafo boots were observed in the room. Observation on 6/30/22 at 11:32 A.M. showed the resident lay in bed yelling out Oh my! Somebody help me! My foot! Why does it hurt so bad? His/her feet were pressed against the footboard of the bed. A pillow stood flat against the footboard and away from the resident. Various staff walked by the resident's room as he/she hollered out for help and no staff entered the room. Approximately 10 minutes later, two staff went in and readjusted his/her feet. The staff did not place the pillow under his/her feet or apply Prafo boots. No heel boots or Prafo boots were observed in the room. Observation and interview on 7/1/22 at 3:34 P.M. showed the surveyor entered the resident's room to visit with his/her roommate. The resident asked if the surveyor was a nurse. He/she said his/her right heel is hurting something awful. Both of the resident's feet were flat on the bed with a pillow pushed upright against the footboard of the bed. The resident's heels were not floated and lay directly on the bed. During an interview on 7/8/22 at 4:56 P.M., Licensed Practical Nurse (LPN) B said the resident is supposed to wear boots, but he/she kicks them off. Staff try to keep his/her heels off of the bed by using a pillow. Most of the time he/she will keep them up on the pillow. He/she hollers out frequently in pain. He/she broke his/her hip before he/she came here. It is healed but it still bothers him/her. They try to keep him/her repositioned. Staff will try other things before giving the pain medications, like reposition, put the pillow under his/her heels, etc. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/12/22 at 1:49 P.M., the DON said interventions should be on the care plan for pressure ulcers and staff should follow the interventions listed on the care plan. Staff should always try to have a preventative measure for pressure ulcers. Sometimes they can add too much which could cause more issues. If a resident has wounds on the feet or heels they should be offloading in some manner.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22973 Based on observation, record review and interviews, the facility failed to ensure staff provided adequate supervision and assistive devices to prevent accidents when staff did not implement interventions to prevent one of 19 sampled residents (Resident #20) from falling and failed to complete a fall investigation after all of the resident's falls. The facility failed to ensure staff used proper techniques to reduce the possibility of accidents or injuries during a gait belt (safety device and mobility aid used to provide assistance during transfers, ambulation or repositioning) transfer for Resident #14, and during the use of a mechanical lift for Resident #21. The facility census was 92. 1. Review of the Fall Prevention Program, implemented in April 2022, showed each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy gave the following guidelines: - The facility utilizes a standardized risk assessment for determining a resident's fall risk: o The risk assessment categorizes residents according to low, moderate or high risk; o For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment; - Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of risk; - The nurse will indicate on the (specific location) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk; - The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions; - High Risk Protocols: o The resident will be placed on the facility's Fall Prevention Program; o Indicated fall risk on the care plan; o Place Fall Prevention Indicator (such as star, color coded sticker) on the name plate to resident's room; o Place Fall Prevention Indicator on resident's wheelchair; o Implement interventions from Low/Moderate Risk Protocols; o Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status or recent change in functional status. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Provide additional interventions as directed by the resident's assessment, including but not limited to: o Assistive devices; o Increased frequency of rounds; o Sitter, if indicated; o Medication regimen review; o Low Bed; o Alternate call light system access; o Scheduled ambulation or toileting assistance; o Family/caregiver or resident education; o Therapy services referral; - Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. o Interventions will be monitored for effectiveness; o The plan of care will be revised as needed; - When any resident experiences a fall, the facility will: o Assess the resident; o Complete a post-fall assessment; o Complete an incident report; o Notify the physician and family; o Review the resident's care plan and update as indicated; o Document all assessments and actions; o Obtain witness statements in the case of injury. - The policy did not address how the facility would track and trend falls or attempt to find the root cause analysis. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #20's significant change in condition Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/12/21, showed: - A Brief Interview for Mental Status (BIMS) of 00 which indicated severe cognitive impairment; - Needed extensive staff assistance with bed mobility, transferring from one surface to another, dressing, eating, toilet use; total dependence on staff for bathing, personal hygiene and moving on and off the nursing unit; - Diagnoses included: dementia, high blood pressure, renal insufficiency, diabetes, osteoporosis, anxiety and depression; - Has the resident had any falls since admission or the prior (MDS) assessment, whichever is more recent? Yes; one fall with minor injury since admission; - Received antianxiety, antidepressants and opioid medications seven of the previous seven days; - admitted to Hospice; - Restraints not used. Review of the resident's care plan showed: - Date initiated 3/12/21: Resident has had an actual fall. Interventions included: o Fall on 3/11/21. Provide High-Low bed (a fully adjustable bed with an expanded head, foot, and height adjustability. The bed moves up and down at the touch of a button on its remote control) and ensure bed is in lowest position when in bed. o Continue interventions on the at-risk plan, 3/12/21; o Fall on 3/17/21: Place bolsters on bed; provide wound care to skin tear as ordered. Ensure fall mat is at bedside while patient is in bed; o Fall on 3/28/21: Staff to provide frequent rounding and provide wound care to skin tear as ordered; o Fall on 4/20/21: Review medications with physician; o Fall on 6/19/21: Therapy to evaluate; o Fall on 8/14/21: Therapy to evaluate and treat; o Fall on 8/30/21: Encourage resident to get out of bed before meals; o Fall on 10/17/21: Therapy to evaluate and treat as indicated; o Fall on 12/14/21: Therapy to assess for side rails; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o For no apparent acute injury, determine and address causative factors of the fall; - Date initiated 4/1/21: at risk for falls related to weakness, impaired vision and use of antidepressant medications: o Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance; o Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; o Ensure that the resident is wearing appropriate footwear when mobilizing in the wheelchair; o Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team (IDT) as to causes; o The resident needs a safe environment with: even floors free from spills and/or clutter; adequate glare-free light, a working and reachable call light, the bed in low position at night, personal items within reach. Review of the resident's quarterly MDS, dated [DATE], showed: - A BIMS of seven (7), which indicated moderate cognitive impairment; - Extensive staff assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene; total dependence on staff for moving on and off the nursing unit and bathing; - Has the resident had any falls since admission or the prior assessment? No. - Did not indicate the resident used any restraints. Review of the resident's care plan showed: - Resident has had an actual fall. Interventions included: o Fall on 4/9/22. Will have therapy evaluate for bed mobility and safety, also reminded resident on the use of call light when wanting things and trying to get up. Review of the resident's interdisciplinary progress notes showed: - 4/9/22 at 10:46 P.M. Incident Note: At 10:20 P.M., the resident was found on the floor in his/her room by a certified nurse aide (CNA). Has a skin tear to pinky finger on left hand and a hematoma close to left wrist. Hospice has been contacted and a nurse will be out to check on him/her on 4/10/22. Power of attorney (POA) contacted and physician as well. Resident is stable at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/10/22 at 1:45 P.M.: Resident continues on monitoring for recent fall. Resident is alert with baseline intermittent confusion noted. Neuro checks within normal limits. Continues to have hematoma and small tear to left hand. As needed (PRN) morphine administered for complaints of pain as ordered. Medication was effective upon reassessment. Staff continues to anticipate resident's needs to ensure safety. Hospice visited resident this shift and ordered a new floor mat and also gave a new order for Ativan (a sedative, psychotropic medication used to treat anxiety). The facility did not provide a Fall Risk Assessment Worksheet or a 72 Hour Post-Fall Assessment for the fall on 4/9/22. Review of the resident's quarterly MDS, dated [DATE], showed: - A BIMS score of six (6) which indicated moderate cognitive impairment; - Total dependence on staff for bathing, toilet use and moving on and off the nursing unit; extensive assistance for bed mobility, transfers, dressing and personal hygiene; - Has the resident had any falls since the prior assessment? Yes, one fall with minor injury; - No restraints used. Review of the resident's interdisciplinary progress notes showed: - 4/15/22 at 3:59 A.M.: Approximately 3:15 A.M. resident was found by a CNA, lying on his/her left side in his/her room in front of bed. Was unable to tell nurse how the incident happened. Upon assessment noted a cut to left eyebrow and skin tear to left wrist. This nurse cleaned the area with normal saline and covered with a dressing. Vital signs initiated within normal limits. Tylenol given for general discomfort. Hospice notified, a nurse will be in to check resident; voice message left for POA and physician made aware by fax. - 4/15/22 at 4:41 A.M., hospice nurse is here, agreed to send resident out for stitches due to laceration to left eyebrow. Emergency Medical Services (EMS) called and resident left facility at 4:40 A.M. to hospital. The facility did not provide a Fall Risk Assessment Worksheet or a 72 Hour Post-Fall Assessment for the fall on 4/15/22. Review of the resident's interdisciplinary progress notes showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/20/22 at 3:45 P.M. Resident is resting in Broda chair (tilt-in-space positioning chair, allows the whole chair to tilt up to 30 or 60 degrees, depending on the model, while maintaining the hip and knee angles at 90 degrees) at the nurses' station at this time. This nurse was called to come quick to resident right at 2:00 P.M. Resident was laying on the floor in front of his/her bed along his/her left side. Resident's left wrist and hand already had a lateral skin tear along wrist that had been re-steri-stripped and dressed after shower this morning, but area was bleeding and two new lateral skin tears were present. Resident denied any further pain once he/she was on his/her back and once staff assisted him/her back to Broda chair. He/she was smiling and chatting about his/her puppy he/she had been chasing after. Resident is confused and unable to express how he/she fell and recall any events. Skin tears were cleansed, steri-stripped and wrapped for protection. Denies pain each time he/she has been asked since. Family, hospice and administration informed. Resident has been in good spirits and had no complaints of any nature. The facility did not provide a Fall Risk Assessment Worksheet or a 72 Hour Post-Fall Assessment for the fall on 4/20/22. Review of the resident's interdisciplinary progress notes showed: - 6/19/22 at 12:22 A.M.: called to resident's room by CNA. Resident found on floor lying on his/her back, alert and confused. Head to toe assessment performed, no injuries noted at this time. Resident placed back in bed, bed in low position. Floor mat at the side of the bed, pain medication given for pain, faces a 5. - 6/19/22 at 10:44 P.M.: Resident had a fall on previous shift, but no reported injuries or complaints of discomfort voiced. Resident resting in bed currently with bed in lowest position. The facility did not provide a Fall Risk Assessment Worksheet or a 72 Hour Post-Fall Assessment for the fall on 6/19/22. Review of the resident's interdisciplinary progress notes showed: - 6/26/22 at 11:05 A.M.: This writer called to resident room as he/she had fallen out of bed. Resident could not explain what happened. Upon assessment, vital signs were blood pressure 160/84, pulse 88, oxygen saturation 97%, respirations 21, temperature 98.1. Resident apparently hit his/her head as left forehead beginning to bruise and a small area that looks like a rug burn. A small 1 centimeter (cm) x 1 cm skin tear on left shoulder. Scant amount of bloody drainage. Covered with a Band-Aid. Also has hematoma on left forearm. Measures 2.5 cm x 2.5 cm, no bruising or skin tears to back or back of head. Resident does voice that he/she is in pain, given for signs and symptoms of pain from fall. Resident alert, confused, at times was talking about some strange person. Resident does have dementia. This writer notified hospice and family, DPOA, will notify Director of Nurses (DON). Hospice to come out for a visit at this nurse's request. Resident up in wheelchair by nurses' station watching television show. He/she has calmed down and signs and symptoms of less pain and discomfort noted. Review of the 72-Hour Post Fall Assessment worksheet, effective 6/26/22 at 11:43 A.M., showed: - Most recent vitals date 6/26/22: blood pressure 160/84; respirations 21; pulse 84; temperature 98.1; no other vitals were listed for the 72 hours after the fall; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Most recent pain level = 3; evaluated on 6/26/22; no other pain assessments listed for the 72 hours after the fall; - Injury: no reports of swelling, bruising or other signs/symptoms of injury since the event; - Cognition: no reports of a change in mental status or cognition; - Function: no reports of a change in activities of daily living (ADL) ability or mobility; - Orders: No new physicians' orders related to this event; - Sleep Patterns: No change in sleep pattern such as inability to stay asleep or frequent waking. - No other 72-Hour Post Fall Assessments found in the electronic medical record. Review of the un-witnessed form, dated 6/26/22 at 11:43 A.M. showed: - Resident was found lying next to his/her bed with legs on the bed, and had covers with him/her, call light was not on when found. He/she did hit his/her forehead; resident was moving around in his/her bed and got off center and slid out of the top part of the bed but legs staying in the bed. - Full head to toe assessment, skin assessment, first aid to skin tear, hospice and family notified, physician notified via fax; - Abrasion, left shoulder (front); bruise, right wrist; hematoma, forearm; - Alert and oriented to baseline; wheelchair bound; - Oriented to person; - No injuries observed post incident; - Confused, incontinent, impaired memory; - Notes: 6/27/22-Resident became off centered in his/her bed while moving around in it and his/her upper body did slide off the bed. Resident was educated to call for help by using his/her call light when needing help and to try to maintain him/herself in the center of the bed more. Hospice to evaluate on bed safety and may wish to have therapy look and screen him/her also. Review of the resident's Fall Risk Assessment worksheet, dated 6/26/22 at 12:34 P.M., showed: - Low risk score: 1 -7; Moderate risk score: 8-17; High risk score: 18+; - Fall risk category High Risk; Fall risk score 54; - During the last 90 days the resident has had two falls in last 30 days; most recent fall on 6/19/22; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Moderately impaired - limited vision, but can identify objects; - Incontinent; - Confined to chair/bed and attempts to move, get up, reposition; - Not able to attempt balance test without physical help; - History of pain that is generally well controlled; - Three or more medications (such as antipsychotics, antianxiety, antidepressants, diuretics, anesthetics, antihistamines, antihypertensive, antiseizures, benzodiazepines, cardiovascular medications, cathartics, hypoglycemic, narcotics, hypnotics; - Staff answered NO to the question Resident is on Psychotic Medications. Review of the resident's care plan showed: - Resident has had an actual fall. Interventions included: o 4/15/22 Resident sent to emergency department (ED) for sutures to left eyebrow, and testing related to fall and cleared and did return. Will also have therapy evaluate for bed safety and mobility. o Fall on 4/20/22, Resident was seen by therapy for fall safety. Review of the Incidents by Incident Type (a list of falls provided by the facility), date range 4/1/22 to 6/30/22 and printed on 7/1/22, showed: - Witnessed fall incidents: the resident was listed as having only one fall on 4/20/22; - Un-witnessed fall incidents: the resident was listed as having falls on 4/9/22, 6/19/22 and 6/26/22. Review of the resident's June 2022 physician's order sheet (POS) showed: - Resident may have bed rail assistive device applied to bed to help with mobility while in bed and/or with car, also help with transfer in and out of bed in a safe way to maintain highest level of independence; order date 5/31/22; - Ativan 0.5 milligrams (mg); give 0.5 mg tablet by mouth at bedtime, order date 4/23/21; - Ativan concentrate 2 mg/milliliters (ml), give 1 ml by mouth ever one hour as needed for anxiety. - Paroxetine HCl tablet 20 mg, give 20 mg by mouth at bedtime for depression, order date 10/22/21. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/27/22 at 2:39 P.M., showed the resident lying in bed on his/her left side, not moving, covered up to his/her chin, and with bolsters on his/her bed. A fall mat lay on the floor under his/her bed. The bed had a metal frame and elevated to approximately waist high if standing next to the bed. The bed could not physically be lowered any lower to the floor than it was. Observation on 6/28/22 at 11:44 A.M., showed the resident lying in bed with a fall mat on the floor underneath the bed. Bolsters remained on the bed. He/she had a large bruise to the left side of his/her forehead with a dark scabbed area. The resident would not speak, only smile when spoken to. The bed was in the elevated position and was the same bed which was not able to be lowered any lower to the floor. Observation on 6/30/22 at 11:09 A.M., showed the resident lying in bed with fall mats on the floor underneath the bed. Bolsters remained in place. The resident remained in the same bed with the metal frame. Review of the resident's electronic medical record on 6/30/22 showed: - No assessment for the bolsters and no consent form. - The resident's care plan showed the bolsters had been in place since a fall on 3/17/21. - Staff had not added the 6/26/22 fall to the care plan. Observation on 6/30/2022 at 3:30 P.M., showed the resident sat up in his/her Broda chair in his/her room. He/she had a large greenish-purple bruise to the left forehead with a scabbed area. The resident's bed remained an older metal framed bed that was physically unable to be lowered any closer to the floor. Review of the resident's care plan, provided by the facility on 7/1/22, showed: - Resident has had an actual fall. Interventions included a fall on 6/26/22. Ensure the resident is centered properly in bed and use pillows for positioning as needed. During observation and interview on 7/8/22 at 4:10 P.M., CNA F said: - The resident's bed should be in low position because he/she is a fall risk. - The bed does not go all the way to the floor, only to the legs. - Fall mats should be put down all the time. They should be beside the bed not under the bed. The other shift must have put them under the bed. - Observation at this time showed the fall mat underneath the bed. - The resident needs staff assistance to get out of bed because he/she falls but can sit on the side of the bed unassisted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If a resident is a fall risk, staff put fall mats down and check on them often. Staff put extra pillows next to them in bed to keep them from falling out of bed and the side rails up to keep them from falling out of bed. During an interview on 7/8/22 at 4:37 P.M., CNA B said: - The resident's bed does not go all the way to the floor. - Fall mats should not be under the bed, but are supposed to be beside the bed. - Bolsters keep residents from falling and not getting trapped. - For residents who are fall risks, staff make sue the fall mats are in place beside the bed and side rails are up. During an interview on 7/8/22 at 4:56 P.M., Licensed Practical Nurse (LPN) B said: - The resident's bed should be in the lowest position. It does not quite go all the way to the floor, some beds do not. - If the bed did not go all the way to the floor, he/she would let maintenance know and put it on the log. If it were on the weekends, he/she would change it out him/herself. - The resident has one floor mat because the bed is positioned up against the wall. The fall mat should be on the floor by the bed, not under it. - The resident has bolsters because he/she is wiggly and for safety reasons. They do not keep him/her from getting out of bed. - For a resident with frequent falls, they increase monitoring. If the resident is on Hospice, they assess the resident for bolsters because they provide them but mainly they just increase monitoring. During an interview on 7/12/22 at 1:49 P.M., the DON said: - Staff would not update the care plan with falls if interventions have been working; you don't just take away. - Staff can update what is already there but if interventions are in place then they are in place. - If the resident has fallen twice, they would not necessarily need a new intervention; only if it is deemed necessary would they add new interventions. - Staff should reassess interventions during the quarterly MDS reviews. - It is normal to complete fall investigations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He has told nurses to put it into the risk assessment, have had nurses put it just in the progress notes, but tell them to put it in the risk assessment. - The risk assessment is the primary way and will carry out the full program. If it was completed by the nurse correctly, it would be seen in the electronic medical record. - They have never completed assessments for bolsters or mattress overlays; - If a resident is in bed, fall mats should be in place in case the resident rolls out of bed. Enough of the mat should be out from under the bed so if the resident rolls out they are protected. The mat should not be all the way under the bed. - If the resident is in the bed and not being given care then the bed should be at the lowest level. 31102 3. Review of the facility's policy for safe resident handling/transfers, revised 2/2022, showed in part: - It is the policy of the facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines; - The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status; - The resident's mobility needs will be addressed on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations; - Handling aids may include gait belts, transfer boards and other devices. 4. Review of Resident #14's annual MDS, dated [DATE], showed: - Long and short term memory problems; - Required extensive assistance of one staff for bed mobility, transfers, dressing, toilet use and personal hygiene; - Upper extremity impaired on one side; - Had an indwelling catheter (sterile tube inserted into the bladder to drain urine); - Always incontinent of bowel; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diagnoses included high blood pressure, obstructive uropathy (a condition in which the flow of urine is blocked), diabetes mellitus, stroke, seizure disorder, aphasia (partial or total loss of the ability to understand or convey spoken or written communication), and hemiparesis (muscular weakness on one side of the body). Observation on 7/5/22 at 9:24 A.M., showed: - LPN B placed the gait belt under the resident's arm pits; - Certified Medication Technician (CMT) A and LPN B reached under the resident's armpits with one hand and grabbed the back of the resident's pants with their other hand and transferred the resident from his/her wheelchair to the side of the bed; - LPN B removed the gait belt. During an interview on 7/6/22 at 12:27 P.M., LPN B said: - If a resident could stand, he/she placed the gait belt around the resident's waist; - If the resident could not stand on their own, he/she placed the gait belt under the resident's arm pits because it gave him/her more leverage; - He/she should have placed one hand on the front of the gait belt and one hand on the back of the gait belt; - Staff should not grab a hold of the resident's pants during the transfer. During an interview on 7/8/22 at 9:35 A.M., CMT A said: - Staff should place the gait belt around the resident's waist but sometimes they put the gait belt under the resident's arm pits; - He/she reached under the side of the resident and grabbed the gait belt towards the back; - Staff should not grab the resident's pants during the transfer. During an interview on 7/12/22 at 1:49 P.M., the DON said: - The gait belt should be placed mid-thoracic and should not be placed high on the resident unless the resident has stomach issue; - For a two person transfer, staff should place their hands on the front and back of the gait belt; - Staff should not grab the resident's pants during the transfer. 46706 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the manufacturers instructions for the Drive Electric Patient Lift, dated 2005, showed: - Spread the legs to the widest position before lifting; - Lock the rear brakes before lifting. 6. Review of Resident #21's quarterly MDS, dated [DATE], showed: -BIMS score of 15 (cognitively intact); -Requires extensive assistance of two staff for bed mobility and toilet use; -Total dependence with transfers. Observation on 7/5/22 at 10:15 A.M., showed: -CNA C and CNA F placed the lift pad under the resident; -CNA C pushed the lift to the bedside of the resident; -CNA C did not lock the rear breaks of the lift; -CNA C did not open the legs of the lift; -CNA C lifted the resident off the bed using the lift; -CNA C pushed the lift approximately four feet with the legs closed and positioned it in front of the resident's wheel chair; -CNA C did not lock the rear breaks of the lift; -CNA C opened the legs of the lift; -CNA C lowered the resident into his/her wheel chair. During an interview on 7/7/22 at 11:28 A.M., CNA C said: -The rear breaks of the lift should be locked before lifting a resident; -The legs of the lift should be opened to the widest position before lifting and transferring a resident; -He/she forgot to lock the rear breaks; -The rear breaks should be locked before lowering a resident to the bed or wheel chair. During an interview on 7/8/22 at 8:50 A.M., the DON said: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The rear breaks should be locked when lifting or lowering a resident; -The legs of the lift should be opened to the widest position before lifting and transferring a resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observation, interview and record review, the facility staff failed to provide complete catheter (sterile tube inserted into the bladder to drain urine) care for two of 19 sampled residents (Residents #34 and #21). The facility census was 92. Review of the facility's policy for catheter care, revised 3/2022, showed, in part: - It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use; - With a new moistened cloth, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter. 1. Review of Resident #34's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 4/29/22, showed: - Dependent on the assistance of two staff for transfers, dressing, and toilet use; - Lower extremity impaired on one side; - Had a catheter; - Diagnoses included obstructive uropathy (a condition in which the flow of urine is blocked) and left below the knee amputation. Review of the resident's care plan, revised 5/2/22, showed: - The resident had a indwelling catheter; - Cleanse catheter with soap and water, rinse, pat dry every shift and as needed if soiling occurs. Observation on 7/1/22 at 10:43 A.M., showed: - Certified Nurse Aide (CNA) A and CNA B entered the resident's room, washed hands and applied gloves; - CNA A wiped around the skin fold three times with a different wipe each time; - CNA A wiped down the top of the catheter tubing and did not anchor it; - CNA A wiped the the catheter tubing twice more with the same area of the wipe and did not anchor the catheter tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/6/22 at 1:15 P.M., CNA A said: - He/she should anchor the catheter tubing; - When cleaning the catheter tubing, it should be one wipe one swipe; - The catheter tubing should never rest on the floor. During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing (DON) said: - Staff should anchor at the insertion site and wiped down the tubing; - Staff should be able to secure the catheter so as not to pull it; - Staff should clean the port with an alcohol pad. 46706 2. Review of Resident #21's quarterly MDS dated [DATE] showed: -Dependent on the assistance of two staff for transfers, dressing, and toilet use; -Inability to voluntarily move the lower parts of the body; -Had a catheter; -Diagnoses included Multiple Sclerosis (a disease in which the immune system destroys the protective covering of nerves) and neurogenic bladder (damage to the nerves in the bladder). Observation on 7/5/22 at 10:50 A.M., showed: -CNA H entered the resident's room, washed hands and applied gloves; -CNA H removed the port from the catheter drainage bag; -CNA H drained the catheter drainage bag; -CNA H put the port back in the catheter drainage bag; -CNA H did not clean the port with an alcohol pad. During an telephone interview on 7/7/22 at 10:59 P.M., CNA H said: -The port should be cleaned with an alcohol pad before inserting it back into the catheter drainage bag. During an interview on 7/8/22 at 8:50 A.M., the DON said: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Staff should clean the port of the catheter bag with an alcohol pad.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observation, interview and record review, the facility failed provide proper respiratory care when staff did not properly clean and maintain oxygen concentrator filters and failed to date oxygen tubing which affected two of 19 sampled residents, (Resident #4 and #56). The facility census was 92. The facility did not provide a policy for oxygen therapy. 1. Review of Resident #56's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/26/22, showed: - Cognitive skills intact; - Dependent on the assistance of two staff for bed mobility, transfers, dressing and toilet use; - Diagnoses included congestive heart failure (CHF, accumulation of fluid in the lungs and other areas of the body), high blood pressure, diabetes mellitus and blindness. Review of the resident's care plan, revised 5/26/22, showed: - The resident had oxygen therapy; - Oxygen settings: at two liters via nasal cannula (2L/NC) as needed. Titrate to maintain oxygen saturation (amount of oxygen in the blood) at 88% or greater. Review of the resident's physician order sheet (POS), dated June, 2022, showed: - Change oxygen tubing, bubbler, plastic bag and clean filters of oxygen machine with warm soapy water. Dry and replace filters weekly on every Wednesday night shift. -Change oxygen tubing and supplies every night shift on every Wednesday. Observation on 6/27/22 at 3:31 P.M., showed: - The oxygen tubing was not dated; - The humidified water bottle was dated 6/22/22 and had approximately 1/4 water in the bottle; - Did not have filters on either side of the oxygen concentrator. During an interview on 6/30/22 at 7:50 A.M., the resident said: - There was water in the oxygen tubing and he/she did not know why; - The humidified water bottle was dated 6/29/22 and had a little less than a 1/4 water in it. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/5/22 at 11:04 A.M., showed: - The humidified water bottle was almost empty and was dated 6/30/22; - The oxygen tubing was not dated; - Did not have a filter on either side of the oxygen concentrator. 2. Review of Resident #4's quarterly MDS, dated [DATE], showed: - Cognitive skills intact; - Independent with bed mobility; - Limited assistance of one staff for transfers, dressing and toilet use; - Diagnoses included CHF, high blood pressure, diabetes mellitus and chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing), and atrial fibrillation (A-fib, irregular, often rapid heart rate that commonly causes poor blood flow). Review of the resident's care plan, 6/27/22 showed: - The resident had oxygen therapy related to COPD; - Oxygen settings: oxygen at 3L/NC. Titrate to maintain oxygen saturation at 88% or greater. Review of the resident's POS, dated June, 2022, showed: - Oxygen at 3L/NC as needed to keep oxygen saturation greater than 90%; - Change oxygen tubing, bag, humidifier bottle weekly. Ensuring tubing is labeled with the date and placed in a clean bag. Rinse oxygen machine filter weekly. Due every night shift, every Wednesday Observation on 7/5/22 at 10:37 A.M., showed: - The oxygen tubing was not dated; - The humidified water bottle was dated 6/29/22 and was empty; - The filters on both sides of the oxygen concentrator were covered in gray lint. 3. During an interview on 7/6/22 at 12:27 P.M., Licensed Practical Nurse (LPN) B said: - Staff change the oxygen tubing out weekly on the night shift; - If the humidified water bottles were empty, the certified nurse aides (CNs) or the charge nurses (CNs) could change them out; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The oxygen concentrators should have filters on them and the night shift cleaned and changed them; - Oxygen tubing should be dated. During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing said: - The oxygen concentrators should have filters if there's a place for them. If the filter comes off, staff should replace it; - Nursing staff is responsible to clean the filters when changing the oxygen tubing and humidified water bottles and this should be done weekly; - The oxygen tubing should be dated.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39366 Based on observation, interview, and record review, facility staff failed assess residents for risk of entrapment from bed rails prior to installation, failed to review the risks and benefits with the resident or resident representative, and failed to obtain informed consent from the resident or resident representative. This affected two of 19 sampled residents (Residents #21 and #50). The facility census was 92. Review of the facility policy titled Proper Use of Side Rails, dated 5/2022, included the following: - It is the policy for this facility to utilize a person-centered approach when determining the use of side rails, also known as bed rails. Alternative approaches are attempted prior to installing a side or bed rail. If used, the facility ensures correct installation, use, and maintenance of the rails; - Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars; - The use of side rails will be specified in the resident's plan of care; - The facility will provide ongoing monitoring and supervision of side rail/bed rail use for effectiveness, assessment of need and determination when the side rail/bed rail will be discontinued. Responsibilities are specified as follows: o Direct care staff will be responsible for care and treatment in accordance with the plan of care; o A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but no less then quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail; - The policy did not address reviewing risks and benefits of utilizing bed rails and obtaining informed consent from the resident or resident representative. 1. Review of Resident #21's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 4/16/22, included the following: - Date admitted [DATE]; - Cognitively intact; - Required extensive assistance with bed mobility; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Use of bed rails were not indicated. Review of the resident's care plan, revised 1/16/22, showed the following: - The resident had side rails per physician orders for safety during care provision, to assist with bed mobility; - Observe for injury or entrapment related to side rail use; - Reposition as necessary to avoid injury. Review of the resident's physician orders as of 6/30/22 included the following: - May utilize bed rails for bed mobility and transfers, ordered on 1/28/21. Review of the resident's medical records showed the following: - Therapy Screening document, dated 5/2/22, indicating bed rails for repositioning; - One bed rail assessment, dated 5/18/22 . The assessment indicated the rails were requested by the resident. It did not indicate that informed consent had been obtained. Observation on 6/28/22 at 2:49 P.M. and various dates and times throughout the survey, showed the resident had two grab bars on each side of his/her bed. During an interview on 6/28/22 at 2:49 P.M., the resident said he/she used the grab bars to reposition. During an interview on 7/1/22 at 9:04 A.M., the resident said: - He/she requested the rails be installed; - The current bars had been on his/her bed for about three weeks, but several months ago he/she had a different set of rails on the bed; - No one discussed with him/her the risks and benefits of utilizing rails and no one had him/her sign a consent. Review of the resident's medical records showed the following: - There was document titled Bed Rails Informed Consent for Use, signed by the Assistant Director of Nursing with a date of 7/1/22, and signed by the resident but was not dated. 2. Review of Resident #50's quarterly MDS, dated [DATE], included the following: - Date admitted [DATE]; - Cognitively intact; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Required extensive assistance with bed mobility; - Use of bed rails were not indicated. Review of the resident's care plan, dated 5/19/22, did not indicate the use of bed rails. Review of the resident's physician orders as of 6/30/22, showed the following: - Resident may have bed rail assistive device applied to bed to help with mobility while in bed and/or with cares, also to help with transfers in and out of bed in a safe manner to maintain highest level of independence, ordered on 5/31/22. Review of the resident's medical records included the following: - Multidisciplinary Therapy Screen, dated 5/6/22, indicated use of bed rails for repositioning/transfers; - Bed rail assessment, dated 5/19/22, indicated the resident requested the bed rails. It did not indicate an informed consent was obtained. It indicated the plan of care was updated. Observation on 6/28/22 at 2:00 P.M. and various dates and times throughout the survey, showed the resident had quarter bed rails on each side of his/her bed. During an interview on 6/28/22 at 2:00 P.M., the resident said: - The facility put the rails up because he/she had fallen out of bed a couple of times. During an interview on 7/1/22 at 9:03 A.M., the resident said: - He/she got the current rails a few weeks ago, but had a different kind of rails on the bed before them and had those for several months; - No one had reviewed risks or benefits of using the rails and no one had him/her sign a consent. Review of the resident's medical records included the following: - There was document titled Bed Rails Informed Consent for Use, signed by the Assistant Director of Nursing with a date of 7/1/22, and the documented was signed by the resident but was not dated; - Document titled Bed Rail/Mattress Safety Assessment, dated 7/5/22, indicated the resident had small folding rails and they passed the assessment. 3. During an interview on 6/30/22 at 4:46 P.M., the Director of Nursing (DON) said: - Use of rails usually came as a recommendation from Therapy to help residents with transfers and bed mobility; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nursing obtained the order and assessed residents for the rails. They also assessed to ensure the bed rails are appropriate to the specific bed. During an interview on 7/12/22 at 1:49 P.M., the DON said: - They should have a signed consent for use of rails; - Assessments were completed by nursing initially and then quarterly; - Not all bed rails are necessarily a restraint; - The facility had noticed this as an issue during an audit and had implemented a Performance Improvement Project (PIP).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 31102 Based on observation, interview, and record review, the facility failed to ensure staff maintained a medication error rate of less than five percent. Staff made four medication errors out of 29 opportunities for error, which resulted in a medication error rate of 13.79% and affected three of 19 sampled residents (Resident #19, #30, and #84). The facility census was 92. Review of the facility policy for medication administration, revised 2/2022, showed, in part: - Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection; - Review medication administration record (MAR) to identify medication to be administered; - Observe resident consumption of medication; - Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Review of the facility's administration of transdermal medication patch policy, revised 3/2022 showed, in part: - It is the policy of the facility to ensure residents receive transdermal medication in accordance with professional standards of practice; - Transdermal drug application refers to the application of a medication through the skin, usually through a patch, so that is is absorbed slowly into the body; - Verify practitioner's orders and labeling prior to administration: compare label with the order to verify correct medication, dose, route, and time of administration; - Apply the patch to a dry, hairless area on the body, ensuring alternate sites are used. 1. Review of Resident #30's physician's order sheet (POS), dated June 2022, showed: - An order for Lidoderm patch 5% (an anesthetic), apply to right upper arm topically every day shift for right arm discomfort. Review of the resident's medication administration record (MAR), dated June 2022, showed: - Lidoderm patch 5%, apply to right upper arm topically every day shift for right arm discomfort. Observation and interview on 6/29/22 at 8:55 A.M., showed Certified Medication Technician (CMT) A removed a Lidoderm patch 4% from the medication cart and said he/she did not have 5% only 4%. CMT A applied the 4% Lidoderm patch to the resident's right upper arm. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing (DON) said: - The Lidoderm patch should cover the area where the resident was having pain and should be the correct dose. 2. Review of the facility's policy for administration of eye drops or ointments, revised 2/2022, showed, in part: - Eye medications are administered as ordered by the physician and in accordance with professional standards of practice to lubricate the eye or treat certain eye conditions; - Compare the label with the order to verify correct medication, dose, route, and time of administration; - Remove medication cap and place on clean dry surface to prevent contamination; - Steady hand holding the medication, as needed, on resident's forehead; - With other hand, pull down lower eyelid to form a pouch of the conjunctival sac, instructing resident to look up; - For eye drops: squeeze the prescribed number of drops into the conjunctival sac, avoiding placement of the drops directly on the eyeball; - Avoid touching the tip of the bottle or tube to the resident, lid, lashes, or surface of the eye; - Instruct resident to close eyes slowly to allow for even distribution over the surface of the eye and apply gentle pressure to the tear duct (lacrimal pressure) for one minute or by gently closing the eye for three minutes. Review of Resident #19's POS, dated June 2022, showed: - An order for Combigan solution 0.2-0.5%, instill one drop in the right eye two times a day for Glaucoma (group of eye conditions that damage the optic nerve). Review of the resident's MAR, dated June 2022, showed: - Combigan solution 0.2-0.5%, instill one drop in the right eye two times a day for Glaucoma. Observation on 6/29/22 at 8:04 A.M., showed: - CMT B gave the resident the Combigan eye drop bottle; - The resident applied one drop in his/her right eye and did not apply any lacrimal pressure; - CMT B did not give the resident any instructions on how to use the eye drop. During an interview on 7/1/22 at 12:08 P.M., CMT B said: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He/she should have instructed the resident to apply lacrimal pressure for one minute. During an interview on 7/12/22 at 1:49 P.M., the DON said: - Staff should follow the guidelines and apply lacrimal pressure and instruct the resident on what to do. 3. Review of the facility's policy for administration of dry powder inhalers, revised 3/2022, showed, in part: - Medications are administered as prescribed, in accordance with current nursing principles and practices and only by persons legally authorized to do so; - Explain the procedure to the resident and answer any questions; - Instruct resident to exhale away from device; - Instruct resident to press down on canister while breathing in slowly and deeply or breathe in deeply until they hear or feel the rattle of capsule; - Instruct to hold breath for as long as possible to ensure deep instillation of medication; - Remove inhaler from mouth, and instruct resident to breathe out gently. Review of the facility's policy for nasal spray administration, revised 3/2022, showed, in part: - Nasal spray medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice; - Remove medication cap and place on clean, dry surface to prevent contamination; - Occlude opposite nostril with your finger, and insert tip of medication container into desired nostril; - Spray medication into nostril while instructing resident to inhale with mouth closed, Instruct resident to exhale through the mouth; - If ordered, spray the nostril again, repeating the procedure in the other nostril as ordered; - Instruct resident to tilt head back for several minutes, breathing through his/her nose. Instruct to not blow nose for about 15 minutes. Review of the manufacturer's guidelines for Flonase nasal spray showed, in part: - Blow your nose to clear your nostrils; - Close one nostril, tilt your head forward slightly and keeping the bottle upright, carefully insert the nasal applicator to release the spray; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Repeat in other nostril. Review of Resident #84's POS, dated June 2022, showed; - An order for Anoro Ellipta aerosol powder breath activated 62.5-25 micrograms/inhalation (mcg./inh.), one puff orally in the morning for chronic obstructive pulmonary disease (COPD, obstruction of air flow that interferes with normal breathing); - An order for Flonase 50 mcg, one spray in each nostril in the morning for allergies. Review of the resident's MAR, dated June 2022, showed: - Anoro Ellipta aerosol powder breath activated, 62.5-25 mcg./inh, one puff orally in the morning for COPD; - Flonase 50 mcg, one spray in each nostril in the morning for allergies. Observation on 6/29/22 at 8:08 A.M., showed: - CMT B gave the resident his/her Ellipta aerosol inhaler without giving instructions on how to use the inhaler. The resident took the inhaler and inhaled five times; - CMT B did not shake the Flonase bottle. He/she gave the resident one spray in each nostril. CMT B did not have the resident blow his/her nose beforehand and did not close either side of the resident's nostril. During an interview on 7/1/22 at 12:08 P.M., CMT B said: - The resident should have only inhaled once. He/she should have instructed the resident how to use the inhaler; - He/she should have followed the manufacturer's guidelines for the nasal spray, should have shook the bottle, had the resident blow their nose and closed one side of the nostril. During an interview on 7/12/22 at 1:49 P.M., the DON said; - Staff should follow the manufacturer's guidelines for the nasal spray and the inhalers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 31102 Based on observation, interview and record review, the facility failed to ensure staff did not place food in the medication refrigerator, failed to date an opened bottle of Lorazepam (used to treat anxiety) for two of 19 sampled residents (Resident #20 and #49), failed to ensure staff were able to read the pharmacy label for Resident #48, failed to date an opened insulin pen for Resident #79, failed to date an opened bottle of Haldol (used to treat schizophrenia, a disorder that affects a person's ability to think, feel and behave clearly) for Resident #73, and failed to destroy expired medication for Resident #37. Staff stored money for Resident #56 and stored two staff member's paychecks in the medication cart. The facility census was 92. Did not obtain a policy for storage of medications and destruction of medications 1. Observation and interview on 6/29/22 at 10:09 A.M., of the medication room for the 100, 200 and 300 halls showed: - In the medication refrigerator freezer was a hot pocket and did not have a label to indicate who the food item belonged to; - The medication refrigerator had a container of applesauce labeled da sauce and dated 6/28/22; - Resident #49 had an opened vial of Lorazepam and did not have a date when it was opened. The box said to discard opened bottles after 90 days; - Resident #48 had an opened bottle of Lorazepam and did not have a date when it was opened. The box said to discard opened bottle after 90 days. It looked like the medicine had leaked or something had been spilled on the pharmacy label making it illegible. Licensed Practical Nurse (LPN) A said the resident had an order for the medication but it was discontinued a while back; - Resident #20 had an opened bottle of lorazepam and did not have a date when it was opened. The box said to discard after 90 days; - LPN A said the hot pocket and the applesauce should not be in the medication refrigerator because it's not the resident's refrigerator. The medications should be dated when opened. All the nurses should check the medications for an expiration date and make sure they are dated when opened. 2. Observation and interview on 6/29/22 at 10:45 A.M., of the nurse's bottom 100 hall medication cart showed: - Resident #79 had an opened Novolog (fast acting) insulin flexpen and did not have a date when it was opened; - Bottom of the second drawer had pill fragments and was dirty; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #49 had an opened bottle of Morphine Sulfate (used to treat moderate to severe pain) and did not have a date when it was opened; - Resident #56 had an envelope with two one dollar bills in it. The outside of the envelope had the resident's first name on it. LPN A said the resident kept it there in case he/she wanted something from the vending machine. 3. Observation and interview on 6/29/22 at 11:01 A.M., of the top 100 hall nurse's medication cart showed: - Resident #20 had an opened bottle of Morphine Sulfate and did not have a date when it was opened; - Resident #73 had an opened bottle of Haldol and did not have a date when it was opened; - Resident #37 had a tube of bengay cream ultra strength (used to treat minor aches and pains of muscles and joints) with an expiration date of 2/20/22; - Two employee's paychecks with a piece of paper wrapped around them; - LPN B said medication should be dated when opened, should not use expired medications, and expired medications should be destroyed. The paychecks were for the weekend staff. 4. During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing said: - There should not be any food in the medication refrigerator; - Insulin pens should be dated when opened; - Lorazepam should be dated when opened; - Morphine Sulfate and Haldol should be dated when opened; - Medication drawers should be clean and free of debris; - Residents at times will give money to the certified medication technicians (CMTs) in case they want something on the weekends. The money and paychecks should be stored away from opened medications; - Expired medications should not be used. They should be removed and destroyed.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observation, interview, and record review, the facility failed to honor resident preferences for meals. This deficient practice affected all residents residing in the facility who ate food prepared in the facility's kitchen. The facility census was 92. Review of the facility's undated policy for standardized menus, showed, in part: - The facility shall provide nourishing, palatable meals to meet the nutritional needs of the residents based on the Recommended Daily Allowances (RDA) of the Food and Nutrition Board of the National Research Council, of the National Academy of Sciences, standardized cycle menus are planned in advance and utilized; - Reasonable effort means assessing individual needs and preferences and demonstrating actions to meet those needs and preferences. 1. During an interview on 6/27/22 at 2:14 P.M., Resident #139 said: - He/she was admitted on [DATE]; - He/she did not get a meal for breakfast or lunch on 6/25/22; - When the staff brought his/her medications in around 6:00 P.M., the resident asked the staff what he/she needed to do to get something to eat. The staff asked if he/she had already had dinner and the resident said he/she had not had breakfast or lunch. 2. During the resident council meeting on 6/30/22 at 10:34 A.M., seven out of 13 residents said they do not get what they order on their meal tickets; - The residents have been getting sack lunches on the weekends and they do not like it; - They do not always get a menu to fill out and if they do get a menu, the dietary staff do not send what the resident has ordered; - The residents do not get a menu on the days they get served sack lunches. 3. Observation and interview on 7/1/22 at 8:32 A.M., showed: - Resident #71 had a biscuit, hard egg, ground sausage and coffee, which was served in a Styrofoam cup; - The resident's breakfast menu said assorted juice, hot cereal, egg and ground sausage with gravy biscuit sandwich, milk/beverage, margarine/jelly; - The resident said he/she doesn't get to order his/her food. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation and interview on 7/1/22 at 8:48 A.M., Resident #53 said: - He/she did not get any silverware with breakfast, he/she had to use plastic silverware that he/she had in his/her room; - Drinks were served in Styrofoam cups. 5. Observation and interview on 7/3/22 at 5:20 P.M., showed: - Resident #41 had white milk in a Styrofoam cup, had a Styrofoam container with chicken salad on two slices of white bread, and had garden vegetable soup in the small section of the container, package of chips and one chocolate cookie and plastic silverware; - The resident said there wasn't much chicken salad on the sandwich. 6. Observation and interview on 7/3/22 at 5:33 P.M., Resident #7 said: - They had Styrofoam containers for lunch and dinner and on 7/2/22 they had Styrofoam containers for dinner along with plastic silverware; - It would be nice to have regular dishes and silverware. He/she thought they didn't have enough help in the kitchen; - The resident had chocolate milk in a Styrofoam cup and had a Styrofoam container with chicken salad on a bun. The resident said there wasn't much chicken salad on the bun, there was garden vegetable soup in the small section of the container, a package of plain chips and one chocolate chip cookie. 7. During an interview on 7/3/22 at 5:47 P.M., Resident #58 said: - Yesterday, staff served us lunch and dinner using Styrofoam containers and plastic silverware; - He/she would like to have regular dishes and silverware. 8. Observation and interview on 7/3/22 at 5:57 P.M., Resident #53 said: - He/she was served meals in a Styrofoam container for dinner yesterday, lunch today, and dinner today; - There was vegetable soup in a Styrofoam bowl, a chicken salad sandwich on a bun, chocolate chip cookie and a package of chips; - The resident said there wasn't much chicken salad on the bun; - He/she had ordered the vegetable soup, chicken salad sandwich without any bread and the potato chips; - He/she would like to have regular dishes and silverware. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. During an interview on 7/6/22 at 12:27 P.M., Licensed Practical Nurse (LPN) B said: - He/she thought the Certified Nurse Aides (CNAs) filled out the menus for Saturday,Sunday and Monday; - He/she tried to look at the residents' menus to make sure got what they ordered; - He/she felt like they used a lot of Styrofoam containers. During an interview on 7/6/22 at 1:15 P.M., CNA A said: - During the week, the hospitality aide fills out the resident's menus and the CNAs do it if needed; - He/she checks the resident's plate once he/she took the plate into the resident's room to make sure they had the right diet, drinks and food. If not correct, he/she would let the kitchen know. During an interview on 7/8/22 at 10:32 A.M., the Dietary Manager said: - He/she had only been in this position for three weeks; - The residents fill out their menus. The nurse gives the resident the menu, the resident circles what they want or writes in what they want; - The dietary staff make sure everything the resident orders is on their plate; - The Director of Nursing (DON) is responsible to make sure all the residents have a menu; - The Styrofoam containers were used on Sunday because the dietary staff were deep cleaning the kitchen. The dietary staff have been using the Styrofoam cups, containers and plastic silverware, but he/she is trying to get things back in order; - He/she was not aware of a resident not getting breakfast or lunch. He/she thought it happened before he/she started. During an interview on 7/12/22 at 1:49 P.M., the DON said: - For new admits after hours, admissions notified that someone is coming in at a certain time so the kitchen would be notified to get the resident a meal; - Staff should check the order to ensure the resident gets what they ordered. It should be done at the time of preparation and at time of delivery; - There's a standardized menu for the day and if the resident doesn't want it, there's always an available menu; - The meal ticket is delivered with the meal, a resident can change their mind at the time of delivery and ask for something else; (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Whoever is delivering the meal should verify it; - There are circumstances where the menu may need to be changed, like due to delivery issues or they run out of an item; - Disposable containers should not be used unless there's a circumstance going on. Styrofoam cups are used due to the amount used at the meal times; - During normal circumstances would use regular silverware and cups; - If the the dish machine goes down, they would have to use secondary equipment. During an interview on 7/1/22 at 9:43 A.M. Regional Dietary Staff said: - There should not have been any plastic ware served to Resident #53, he knew there was no plastic ware sent out this morning. Maybe the resident already had it in their room; - There was no shortage for silverware; - Styrofoam was used in the hall because they did not want to take glassware down the hall due to safety purposes. He understood use of Styrofoam was an issue and they had been getting some plastic cups in; - Residents should get what they order, sometimes they order something that they do not have and cannot accommodate but if it was on the menu and on the always available menu then they should get it; - Menus are sent out the day before and filled out with Restorative Aide (RA) staff. 39366

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 31102 Based on observation, interview and record review, the facility failed to ensure physician ordered adaptive equipment was made available for meals for one sampled resident (Resident # 71) out of 19 sampled residents. The facility census was 92. Review of the facility's policy for adaptive feeding equipment, revised May 2022, showed, in part: - Residents requiring assistance in feeding are potential candidates for a restorative dining program or adaptive utensil use, as determined by the occupational therapist; - The dietary department should be notified of residents needing adaptive equipment; the equipment is stored and maintained in the dietary department. Appropriate utensils should be placed on the resident's food tray, at each meal, and returned tot he dietary department, on the food tray for sanitization. 1. Review of Resident #71's care plan revised 4/13/21 showed: - The resident had a potential nutritional problem related to a diagnoses of dysphagia (difficulty swallowing) and received a therapeutic and mechanically altered diet; - The resident required nectar thickened liquids served in a two handled cup with a lid and mechanically soft diet served with a plate guard and built up utensils. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/7/22 showed: - Cognitive skills moderately impaired; - Dependent on the assistance of two staff for bed mobility, transfers, dressing, toilet use and bathing; - Independent with eating; - Diagnoses included cancer, anxiety, depression, diabetes mellitus, high blood pressure, and unspecified protein calorie malnutrition. Review of the resident's physician order sheet (POS) dated June 2022, showed: - Order date - 5/27/21 - add a plate guard to the resident's plate for all meals. - Order date: 6/11/21 - Resident will need built up handles on fork, spoon, and knife, two handled cup with a cover for liquids and a white scoop plate with all meals; Review of the resident's meal card, dated 6/27/22 for breakfast showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. Building B. Wing	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health and Wellness	2201 Glenn Hendren Dr Liberty, MO 64068

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Regular diet, mechanical soft, with diabetic precautions; - Adaptive equipment - two handled cup with lid for ALL liquids, plate guard, built up utensils. Observation on 7/1/22 at 9:32 A.M., showed;- The resident was in his/her room eating breakfast; - The resident had coffee in a Styrofoam container; - He/she did not have a plate guard on his/her plate, did not have a two handled cup with a lid and did not have any built up silverware. Observation on 7/1/22 at 1:05 P.M., showed: - The resident was eating lunch in his/her room; - He/she did not have a plate guard on his/her plate, did not have a two handled cup with a lid and did not have any built up silverware. During an interview on 7/6/22 at 1:01 P.M., Certified Nurse Aide (CNA) C said: - He/she passed out the room trays; - He/she checked the resident's trays to make sure they had the correct adaptive equipment. During an interview on 7/8/22 at 10:32 A.M., the Dietary Manager (DM) said: - He/she had been the dietary manager for three weeks; - All the dietary staff make sure the residents have the adaptive equipment they need, such as divided plates, weighted silverware, and plate guards; - The dietary staff check the resident's trays to make sure they have the adaptive equipment. During an interview on 7/12/22 at 1:49 P.M., the Director of Nursing said: - The adaptive equipment should be on the resident's meal card so the cooks would know to prepare plates with the proper equipment, and the aides should check the ticket to know what they need to deliver to the resident with the their meals.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31102 Based on observation and interview, the facility failed to maintain a call system that was adequately equipped to allow residents to call for staff through a communication system which relayed the call directly to a staff member or to a centralized staff work area. This affected one of 19 sampled residents, Resident #79. The facility census was 92. Review of the facility's policy for call lights: accessibility and timely response, dated November, 2017, showed, in part: - The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response; - All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light; - All residents will be educated on how to call for help by using the resident call system; - Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied . 1. Review of Resident #79's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE] showed: - Independent with bed mobility; - Required supervision of one staff for transfers, dressing, toilet use and personal hygiene; - Diagnoses included stroke, high blood pressure, renal insufficiency, diabetes mellitus, seizure disorder, depression and falls. During an observation and interview on [DATE] at 2:50 P.M., the resident said: - His/her call light has not worked in what seems like forever, but has been at least five to six days; - He/she has talked to a couple of different staff about it but no one has addressed it; - He/she has to have the room mate use his/her call light if the resident needs anything; - The surveyor asked the resident to press his/her call light and it did not light up in the resident's room or in the hallway. (continued on next page)

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	265857	A. Building B. Wing	07/12/2022

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:58 P.M., Resident #30 said: - He/she had to use his/her call light to get help for Resident #79 when he/she needed it because his/her call light has not worked for a couple of weeks; - Both of the residents had mentioned it to the staff (unable to recall the staff's name) and no one has done anything about it. During an interview on [DATE] at 1:42 P.M., Certified Medication Technician (CMT) C said he/she was not aware Resident #79's call light was not working. Observation and interview on [DATE] at 4:20 P.M., showed: - The resident said he/she thought the call light was working; - The surveyor asked the resident to turn the call light on and it did not light up inside the room or in the hallway. During an interview on [DATE] at 10:59 A.M., the Maintenance Director said: - The nursing staff usually put a note in the maintenance log at the nurse's station if a call light isn't working or they will just stop him/her in the hallway and let him/her know; - He/she was not aware the resident's call light was not working. During an interview on [DATE] at 9:37 A.M., Licensed Practical Nurse (LPN) B said: - If a resident's call light was not working, he/she would write it in the maintenance log. Record review of the maintenance call log at the nurse's station on [DATE] at 9:40 A.M., showed no recent entries related to the resident's call light not working. During an interview on [DATE] at 1:49 P.M., the Director of Nursing (DON) said: - If a resident's call light was not working, staff should notify maintenance. For life safety, staff should put it in the log book but should address the issue immediately and tell maintenance directly.