APOC 3/18/24 EC.

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

PRINTED: 02/29/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC CARE CENTER	1500 W WARM SPRINGS RD HENDERSON, NV 89014

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare Recertification Survey, Complaint and Facility-Reported Incident investigations conducted in your facility from 02/06/2024 through 02/09/2024, in accordance with 42 Code of Federal Regulations (CFR) Chapter IV, Part 483, Requirements for Long Term Care Facilities. The census was 231. The sample size was 35. There were four complaints and five facility-reported incidents (FRIs) investigated: Verified: 1. Complaint #NV00069831 was verified. A regulatory deficiency was identified (See Tag F880). Verified without deficient practice: 2. Complaint #NV00069978 was verified with no deficient practice. Unverified: 3. Complaint #NV00070254 could not be verified. No regulatory deficiencies could be identified. 4. Complaint #NV00070270 could not be verified. No regulatory deficiencies could be identified. 5. FRI #NV00070409 could not be verified. No regulatory deficiencies could be identified. 6. FRI #NV00069751 could not be verified. No regulatory deficiencies could be identified.	F 000		

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

Daniel Hills | Administrator | 03/15/2024

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.

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F 000	Continued From page 1 7. FRI #NV00070164 could not be verified. No regulatory deficiencies could be identified. 8. FRI #NV00070105 could not be verified. No regulatory deficiencies could be identified. 9. FRI #NV00070177 could not be verified. No regulatory deficiencies could be identified. The investigation into the complaints and FRIs included: Observations of snacks in nourishment rooms, meal observation which included a test tray, medication pass, infection control practices, staff and resident interactions, staff providing supervision and care to residents, general appearance of residents, call light response, and a tour of the facility. Interviews were conducted with residents, Certified Nursing Assistants, Licensed Nurses, Housekeeping, Social Services, Registered Dietician, Dietary Manager, Infection Preventionist (IP), Consultant Pharmacist, Director of Nursing, and the Administrator. Clinical record review of residents which included the residents of concern. Document review included facility policies and procedures, facility assessment, facility investigation reports, rash line listing, transmission-based precautions (TBP) precautions resident list, staffing schedules, pest control binder, grievance log and resident council minutes. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal	F 000		

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F 000	Continued From page 2 or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

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F 655	Continued From page 3 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure a baseline care plan was completed for a resident who was admitted with a surgical wound (Resident 635) and a resident with a contracture (Resident 108). The deficient practice had the potential the residents would not receive the wound care or contracture care the residents required. Findings include: Resident 635 (R 635) was admitted to the facility on 02/03/2024 with diagnoses including left leg cellulitis and left leg wound. The clinical record contained an admission note dated 02/03/2024 which documented the resident was admitted from an acute care hospital via stretcher for left lower leg cellulitis. The History and Physical late entry note for 02/05/24 documented the resident had a non-occlusive left femoral deep vein thrombosis	F 655		

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F 655	Continued From page 4 (DVT). The resident was also evaluated by the Surgical/Burn team for evaluation of left lower extremity complicated cellulitis with presence of open wound. Documentation in the clinical record from the acute care hospital revealed the resident had been taken for surgical intervention with the application of graft. The resident was medically cleared and was transferred to the Skilled Nursing Facility for the continuation of wound care, antibiotics, and skilled therapy services. The clinical record lacked documented evidence a baseline care plan for the resident's wound had been completed. On 02/09/2024 in the afternoon, a Registered Nurse (RN) reviewed the clinical record and was not able to locate a baseline care plan for the resident's wound. The RN stated the care plan should have been initiated by Wound Care, because they would document all interventions needed for the wound. The facility's policy Baseline Care Plans (undated), documented a baseline plan of care to meet the immediate needs shall be developed for each resident within forty-eight (48) hours of admission. Resident 108 (R108) R108 was admitted on 01/05/2024 with diagnoses including epilepsy and dementia. On 02/06/2024 at 2:04 PM, R108 was laying supine in bed. The resident answered questions with one or two word verbal responses. The resident's right hand was clenched into a tight fist	F 655	1. Resident 635 baseline care plan was revised and reviewed. Resident 108 was unable to be corrected due to resident being discharged. 2. Current residents with surgical wounds and contractures will be re-evaluated to ensure baseline care plans are completed. 3. New baseline care plans will be reviewed daily during the daily clinical stand-up meeting byt the unit managers for completion - all pertinent findings from the review will be brought forward to the QAPI committee. Licensed nurses will be re-educated regarding completing baseline care plans timely. 4. Findings from corrective action plan will be reviewed for evaluation in the QAPI meeting monthly for the next 3 months, quarterly thereafter and annually if indicated. 5. Date of compliance - 03/27/2024	

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F 655	Continued From page 5 a with the tip of the thumb protruding through the fingers. The left hand had a normal appearance and movement. R108 verbalized they were unable to move the right hand, and verbalized, by answering yes or no questions, being unable to open the right hand. On 02/07/2024 at 3:26 PM, R108's right hand remained clenched in a fist. On 02/07/2024 at 3:32 PM, the Licensed Practical Nurse (LPN) examined R108's right hand and verbalized the rigid fingers of the hand was a condition called a contracture. The LPN verbalized the resident was unable to open the hand. The LPN verbalized the Certified Nursing Assistant (CNA) should open R108's fingers to the extent possible and clean the hand during bathing. On 02/08/2024 at 3:19 PM, the CNA observed R108's hand. The CNA verbalized today being the first day the CNA had been assigned to care for R108. The CNA verbalized having an inter-shift report with the off-going CNA from the prior shift. The CNA revealed had not been informed about the contracture of R108's right hand. The CNA verbalized the hand should be opened so that the palm of the hand could be accessed for cleaning. The CNA attempted to open R108's right hand by gently pulling on the fingers. The fingers moved slightly, and the resident exclaimed feeling pain and the CNA stopped the action. The CNA revealed residents with contractures of the hand should ordinarily have a hand-roll (a rolled up washcloth) placed in the palm of the hand to keep the fingers from becoming progressively more rigidly locked in the closed position. The CNA verbalized not being sure if a hand-roll should	F 655		

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F 655	Continued From page 6 have been used for R108 due to lacking instructions. On 02/09/2024 at 10:09 AM, a different LPN verbalized the usual process for contractures was to notify the physical therapy department about the contracture and then a care plan should be written. The LPN reviewed R108's clinical record and verbalized the record lacked a care plan for the contracture. On 02/09/20244 at 10:43 AM the Registered Nurse Unit Manager verbalized newly admitted residents were assessed by a Physical Therapist (PT) and an Occupational Therapy (OT) within 24 to 48 hours of admission. If a contracture was identified during the initial therapy screening, a baseline care plan would be written. The Registered Nurse Unit Manager revealed such a care plan might include interventions such as performing range of motion on the affected extremity 2-3 times per week, provide a hand-roll, and monitor to ensure nursing staff provided good hygiene care to the contracted hand. The Registered Nurse Unit Manager reviewed R108's clinical record and verbalized R108 had been admitted on 01/05/2024, had undergone a therapy assessment within 48 hours, yet lacked a baseline care plan for the contracture. The Registered Nurse Unit Manager reported the facility process had not been followed.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

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F 656	Continued From page 7 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656		

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F 656	Continued From page 8 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to develop a care plan for a resident with bed rails (Resident 95). The deficient practice placed the resident at a risk for safety. Findings include: Resident 95 (R95) R95 was admitted to the facility on 08/09/19 and re-admitted on 03/02/22, with diagnoses including encephalopathy, unspecified, personal history of traumatic brain injury and seizure disorder. On 02/06/24 at 10:21 AM, R95 was in bed with the upper side rails in the up position on both sides of the bed. On 02/08/24 at 9:15 AM, R95 was in bed with the upper side rails in the up position on both sides of the bed. R95's Comprehensive Care Plan lacked documented evidence of a care plan for bedrails, to include the risks, benefits, and evidence of alternatives tried and failed. R95's clinical record lacked documented evidence of an evaluation of the ability to raise and lower the bed rails. On 02/09/24 at 8:14 AM, the Director of Nursing (DON) confirmed a care plan for bed rails was not developed for R95 and should have included the risks, benefits, and evidence of alternatives tried and failed.	F 656	1. Resident 95 ADL care plan was revised to indicate the use of half bed-rails to promote safety while in bed. The risks and benefits of bed rails used were explained to R95 and their responsible party, and consent was obtained. On 02/09/2024, a side rail and entrapment risk assessment was completed , and a physician order for the use of half-bed rails to promote safety while in bed was obtained. 2. Charts of active residents with bed rails will be re-evaluated to ensure that comprehensive care plans are completed. 3. MDS nurses and and licensed nurses will be educated regarding completing comprehensive care plans for residents with bed rails. New comprehensive care plans will be reviewed daily during the clinical stand-up meetings by the Unit Managers for completion. Pertinent findings from the review will be brought forward to the QAPI meeting. 4. Findings from the corrective action plan will be reviewed for evaluation at the QAPI meeting monthly for 3 months, quarterly for 3 quarters and annually if indicated thereafter. 5. Date of compliance - 03/27/2024.	

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F 656	Continued From page 9 The facilities policy titled Proper Use of Side Rails, undated, documented the use of side rails as an assistive device will be addressed in the resident's care plan. Cross reference with tag F700	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer medications timely in accordance with the facility's policy for 1 of 35 sampled residents (Resident 42). The deficient practice had the potential to cause physical and psychosocial harm to the resident. Findings including: Resident 42 (R42) R42 was admitted on 11/28/2020 with diagnoses including chronic pain syndrome, mononeuropathy, and anxiety disorder. On 02/07/24 at 7:52 AM, R42 indicated scheduled medication for pain and anxiety were	F 684		

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F 684	Continued From page 10 frequently administered late. A review of the medical record documented: - A physician order for Lorazepam oral tablet 1 milligram (mg), give 1 mg by mouth three times a day for anxiety. - A physician order for Methadose oral concentrate 10 mg/milliliter (ml), give 0.5 ml by mouth three times a day for pain for 14 Days A review of the medication administration record (MAR) documented the following medications were administered more than 1 hour late: - Lorazepam scheduled for 2:00 PM on 02/01/24 was administered at 3:32 PM. - Methadose scheduled for 8:00 PM on 02/01/24 was administered at 10:44 PM. - Lorazepam scheduled for 6:00 AM on 02/02/24 was administered at 8:42 AM. - Methadose scheduled for 8:00 PM on 02/02/24 was administered at 11:11 PM - Methadose scheduled for 8:00 PM on 02/03/24 was administered at 11:02 PM - Methadose scheduled for 8:00 PM on 02/04/24 was administered at 10:21 PM - Methadose scheduled for 1:00 PM on 02/06/24 was administered at 2:33 PM. 02/09/24 at 9:23 AM, The Director of Nursing (DON) verbalized staff can administer a resident's scheduled medication 1 hour before or 1 hour after the scheduled dose time. If medication is administered late staff must document the reason for late administration, such as lack of availability of the medication or the resident was unavailable for medication administration. The DON confirmed staff did not follow policy and medication had been administered outside of	F 684	1. Resident #42 (R42)'s attending physician was informed of the medications administered per order. R42 is interviewed and informed of the facility's action. R42 was monitored for potential physical and psychosocial harm related to the event. The licensed nurse was re-educated on the importance of administering medications as ordered and following the Medication Administration policy. 2. The MAR of active residents will be audited daily and checked for timelieness of administration. 3. On or before March 27, 2024, licensed nurses will be re-educated director of staff development (DSD), unit managers, or designee regarding the importance of administering medications as ordered and following the Medication Administration policy. MAR of active residents will be reviewed daily by the nursing supervisor and findings will be brought forward to stand up daily clinical stand-up meetings. All pertinent findings from the review will be brought forward to the QAPI meeting. 4. Findings from the corrective action plan will be reviewed for evaluation in the next QAPI meeting monthly for the next 90 days, quarterly thereafter, and annually if indicated. 5. Date of compliance - 03/27/2024	

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F 684	Continued From page 11 acceptable parameters. The Medication Administration General Guidelines Policy revised 02/2015 documented, non-time critical scheduled medications are administered within 60 minutes of scheduled time, except before, with, or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure a physician's order for a pressure redistributing mattress was implemented for a resident with a stage four coccyx pressure ulcer. The deficient practice potentially resulted in the worsening of the resident's coccyx pressure ulcer.	F 686		

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F 686	Continued From page 12 Findings include: Resident 182 (R182) R182 was admitted on 08/21/2023 and readmitted on 01/02/2024, with diagnoses including stage four pressure ulcer. An Admission Nursing Evaluation dated 01/03/2024 revealed R182 was admitted with a stage four coccyx pressure ulcer. Interventions included use of specialty devices, positioning devices, and turning routine. An Admission minimum data set (MDS) dated 01/08/2024, revealed R182 had a stage four pressure ulcer. A physician's order dated 01/02/2024, documented to provide R182 with a pressure redistributing mattress. A care plan for actual skin impairment stage four pressure ulcer initiated 08/22/2023, documented to provide pressure redistributing mattress. On 02/07/24 at 8:10 AM, R182 was awake and alert in bed and indicated having a coccyx pressure ulcer which was causing the resident pain. R182 reported requesting a specialty mattress but the request had remained ignored. According to the resident, grab rails allowed the resident to self-reposition and treatment nurses came to provide wound care, but the regular mattress was hard and uncomfortable. R182 indicated the treatment nurse had been telling R182 the specialty mattress had been ordered but had not yet arrived. R182 indicated being	F 686	1. On February 12, 2024, the resident 182 was discharged. The wound nurse was provided corrective action. 2. Residents with physician orders for specialty mattress will be reviewed and a visual inspection will be performed to ensure the appropriate mattress is in place. 3. Licensed nurses will be re-educated by the director of staff development (DSD), unit managers, or designee regarding following the physician's order for specialty mattresses. Residents with physician orders for specialty mattresses will be reviewed, and the unit managers or designees will perform a visual inspection to ensure the appropriate mattress is in place. Findings will be brought forward to daily clinical stand-up meetings. All pertinent findings from the review will be brought forward to the QAPI meeting. 4. Findings from the corrective action plan will be reviewed for evaluation in the next QAPI meeting monthly for the next 90 days, quarterly thereafter, and annually if indicated. 5. Date of compliance - 03/27/2024	

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F 686	Continued From page 13 moved from Room 100-A on 02/05/2024 but neither bed had a specialty mattress. On 02/07/2024 at 8:12 AM, the surveyor pressed on the resident's mattress which was rigid and firm and appeared to be a regular mattress. On 02/07/24 at 8:15 AM, the bed in the resident's former room (Room 100-A) was vacant. Upon touch, the mattress appeared to be a regular mattress not a specialty mattress. A Licensed Practical Nurse (LPN) confirmed R182 occupied Room 100-A until the evening of 02/05/2024. The LPN entered the room, pressed on the mattress, and confirmed the mattress was not a specialty mattress but rather a regular one. The LPN indicated the mattress had not been changed since 02/05/2024. On 02/07/24 at 8:48 AM, the Treatment Nurse confirmed R182 had a stage four coccyx pressure ulcer which was present on admission. The nurse explained all residents with pressure ulcer stages three and above were to be placed on a pressure redistributing mattress (a specialty mattress which allowed redistribution of weight) and the nurse personally entered the order for R182 's specialty mattress on 01/02/2024. The treatment nurse entered R182 's room, pressed on the mattress and confirmed the mattress was not a specialty mattress but a regular one. The treatment nurse entered the resident's former room (Room 100-A) and confirmed the bed had a regular mattress not a specialty mattress. The nurse explained placing a request with central supply to order a specialty mattress for R182 on 01/03/2024. On 02/07/24 at 8:51 AM, the Treatment Nurse	F 686		

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F 686	Continued From page 14 was present when the Central supply clerk indicated not being able to recall the treatment nurse placing an order for R182's specialty mattress. The Central Supply clerk stated there were currently no active orders for pressure redistributing mattresses which had not been fulfilled by the vendor. The Central supply indicated not being able to recall the treatment nurse making a follow up regarding an unfulfilled specialty mattress for R182. The Central supply clerk confirmed the mattress in Room 100-A had not been replaced since R182 was transferred to Room 410-A on 02/05/2024. 02/07/24 08:54 AM, Treatment Nurse verbalized R182 not being provided a pressure redistributing mattress since 01/02/2024 was an oversight on the part of the treatment team. A Wound Evaluation dated 01/03/2024, revealed R182's coccyx pressure ulcer measured 4 centimeters (cm) in length (L) x 3 cm in width (W) x 0.3 cm in depth (D) with 10% slough tissue, light exudate, and moderate drainage. Interventions in place included specialty devices, positioning devices, and turning routine. A Wound Evaluation dated 02/06/2024, revealed R182 's coccyx pressure ulcer measured 5.1 cm (L) x 5.2 cm (W) x 1.8 cm (D) with granulation tissue beefy red, serosanguinous drainage, with tunneling. On 02/09/2024 at 8:14 AM, the Wound Nurse Practitioner (NP) indicated R182 was being treated for a stage four pressure ulcer and indicated expecting R182 to be on a pressure redistributing mattress. The NP verbalized not noticing R182 had been on a regular mattress	F 686		

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F 686	Continued From page 15 from 01/03/2024 to 02/07/2024 during the NP's weekly rounds. The NP indicated R182's coccyx wound was getting better in terms of drainage and odor but getting worse in terms of size. The NP indicated the resident being on a regular mattress for more than a month may have contributed to the increase in size of wound. On 02/09/24 at 2:05 PM, the Director of Nursing (DON) indicated due to having a stage four coccyx ulcer, would have expected R182 to be on a pressure redistributing mattress, which was ordered by the physician on 01/02/2024. The DON verbalized agreement with the Wound NP regarding R182 not being provided a specialty mattress for more than a month, may have contributed to the increase in wound size of the resident's stage four coccyx wound. The Pressure Injury Prevention and Management policy (undated), documented the intent of the facility was to develop and maintain systems to promote the healing of existing pressure injuries including prevention of infection and prevent additional pressure injuries. Preventative measures include the use of a pressure redistributing mattress.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		

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F 688	Continued From page 16 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure restorative nursing services (RNA) was provided to residents in accordance with therapy recommendations for 3 of 35 sampled residents (Residents 34, 108 and 110). The failure to provide RNA services had the potential for the resident's further decline in mobility. Findings include: The facility's policy titled Restorative Nursing dated 06/01/2021, documented restorative programs were coordinated by nursing or in collaboration with rehabilitation and were resident specific based on individual resident needs. The practice standards included to review current clinical assessments to determine if restorative nursing programs were indicated such as after a resident's discharge from formalized rehabilitation therapy. Resident 34 (R34) R34 was readmitted on 5/02/2023 with diagnoses including abnormalities of gait and mobility. On 2/6/2024 in the morning, R34 indicated having	F 688		

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F 688	Continued From page 17 physical therapy (PT) until a month ago. R34 indicated having three insurances and did not know why the resident could not get PT services. R34 expressed PT was needed to be able to get better. On 02/07/24 at 1:33 PM, a Licensed Practical Nurse (LPN) indicated R34 was evaluated by physical therapy and currently under the facility's Restorative Nursing Assistant (RNA) program. A Physical Therapy (PT) Evaluation and Plan of Treatment Plan dated 1/18/2024, documented R34 was referred to skilled PT services to assess current functional status to determine if R34 was at the highest practical level. The assessment summary documented no further skilled PT services was warranted at this time and R34 was at baseline functional level. PT referred R34 to the restorative program due to the documented physical impairments and associated functional deficits, and the risk for falls. On 02/09/24 at 3:23 PM, an interview with the RNA staff responsible for providing RNA services for R34 revealed the RNA services did not start until at approximately 12:00 PM on 2/9/2024. The two RNAs verbalized they were responsible for weighing residents at the beginning of the month, and this caused delays in providing RNA services due to having to weigh residents. The RNAs acknowledged receiving a referral to see R34 on 1/18/2024. The Director of Nursing (DON) disclosed the facility stopped using Agency Nurses on January 1, 2024. The DON indicated the facility was behind in providing RNA services.	F 688	1. Resident 34 was re-evaluated for appropriateness for the restorative nursing program (RNP) and non-participation, was transitioned to CNA maintenance program on 3/6/2024. Resident108 was discharged on February 16, 2024. Resident 110 was discharged on February 19, 2024. 2. Residents on the restorative program will be evaluated for appropriateness and ensure restorative programs will be followed and therapy referrals are reviewed and implemented timely. 3. Restorative nursing aides (RNA) will be re-educated by the Director of Nursing (DON)or designee regarding ensuring therapy recommendations for restorative programs are reviewed and implemented timely and incomplete visits due to staffing levels are reported timely to the DON or designee. DON or designee will review the restorative nursing program roster weekly or as needed to ascertain all therapy referrals are implemented timely. Findings will be brought forward to daily clinical stand-up meetings. All pertinent findings from the review will be brought forward to the QAPI meeting. 4. Findings from the corrective action plan will be reviewed for evaluation in the next QAPI meeting monthly for the next 90 days, quarterly thereafter, and annually if indicated. 5. Date of compliance - 03/24/2024	

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F 688	Continued From page 18 Documents provided by the RNA staff revealed the RNA Program was responsible for providing R34 with active range of motion (AROM - when a resident performs stretching exercises, moving the muscles around a weak joint without any assistance) to the bilateral upper and left lower extremities, and active assisted range of motion (AAROM - performed when the patient needs assistance with movement from an external force because of weakness, pain, or changes in muscle tone) of the right lower extremity three times 10 repetitions as needed six days per week. Additionally, bed mobility, edge of bed with minimal assistance/stand by assistance to the point of comfort six days per week. R34 was not seen by RNA services until approximately three weeks after the referral was made by the physical therapy department. Resident 108 (R108) R108 was admitted on 01/05/2024 with diagnoses including epilepsy and dementia. On 02/06/2024 at 2:04 PM, R108 was laying supine in bed. The resident answered questions with one or two word verbal responses. The resident's right hand was clenched into a tight fist a with the tip of the thumb protruding through the fingers. The left hand had a normal appearance and movement. R108 verbalized they were unable to move the right hand, and verbalized, by answering yes or no questions, being unable to open the right hand. On 02/08/2024 at 3:19 PM, a CNA observed R108's hand. The CNA verbalized today being the first day the CNA had been assigned to care for R108. The CNA verbalized having an inter-shift	F 688		

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F 688	Continued From page 19 report with the off-going CNA from the prior shift and revealed they had not been informed about the contracture of R108's right hand. The CNA verbalized the hand should be opened so that the palm of the hand could be accessed for cleaning. The CNA attempted to open R108's right hand by gently pulling on the fingers. The fingers moved slightly, and the resident exclaimed feeling pain and the CNA stopped the action. On 02/09/2024 at 12:10 PM, the Director of Rehabilitation verbalized Occupational Therapy (OT) was the discipline that focused on the upper extremities of the resident. Director of Rehabilitation reviewed R108's clinical record and verbalized an OT evaluation dated 01/06/2024, documented contracted fingers. The Director of Rehabilitation verbalized the OT evaluation had been communicated to the Restorative Nursing Assistant (RNA) program for follow up. On 02/09/2024 at 12:33 PM an observation of R108 was conducted with the Director of Rehabilitation. The Director of Rehabilitation verbalized the resident's right hand was tightly contracted. The Director of Rehabilitation attempted to mobilize the fingers and asked the resident if that hurt and the resident stated yes. Director of Rehabilitation asked the resident if the hand felt tighter or looser now than since admission and the resident replied "tighter." The Director of Rehabilitation asked the resident if it would be OK apply a hand-roll to the hand and the resident stated, "that's fine." The Director of Rehabilitation verbalized R108's contracture could lead to skin breakdown or skin infection due to the pressure of the fingers pressing on each other and forming a pocket in the palm area where moisture could accumulate and cause	F 688		

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F 688	Continued From page 20 irritation or infection. On 02/09/2024 at 03:07 PM, the DON reviewed the clinical record for R108. The DON revealed R108 had been referred to the RNA program for the treatment of the right hand contracture on 01/06/2024. The DON verbalized R108's program plan specified to perform range of movement (ROM) 2-3 times weekly, with each session to last at least 15 minutes. The DON verbalized RNA documentation from 01/09/2024 through 02/09/2024, indicated R108 had received three 15 minutes sessions, which occurred on 01/14/2024, 01/15/2024, and 01/22/2024. The DON verbalized R108 should have received a minimum of eight RNA sessions within that time period. The DON verbalized the resident had received a minimum of five fewer visits than had been prescribed. The DON verbalized lack of staff was the likely reason for R108 not receiving all of the needed visits. The DON revealed failure to keep the fingers of the contracted hand mobilized could potentially lead to skin breakdown. Resident 110 (R110) R110 was admitted on 11/28/2023 with diagnoses including contractures of both arms. On 02/06/2024 at 8:52 AM, R110 was in bed and unable to respond to questions. R110 was observed with contractures of the arms, wrists, hands, and the right leg. On 02/09/2024 at 3:07 PM, the DON reviewed the clinical record for R110. The DON revealed R110 had been referred to the RNA program for the	F 688		

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F 688	Continued From page 21 treatment of multiple contractures on 01/06/2024. The DON verbalized R110's program plan specified to perform range of movement (ROM) 2-3 times weekly, with each session to last at least 15 minutes. The DON verbalized RNA documentation from 01/09/2024 through 02/09/2024, indicated R110 had received four 15 minute sessions, which occurred on 01/14/2024, 01/15/2024, 01/22/2024, and 01/29/2024. The DON verbalized R110 should have received a minimum of eight RNA sessions within that time period. The DON verbalized the resident had received a minimum of four fewer visits than had been prescribed. The DON verbalized lack of staff was the likely reason for R110 not receiving all of the needed visits. The DON revealed failure to keep R110's contractures mobilized could potentially lead to worsening of the contractures. The policy and procedure titled Contractures dated 07/2010, indicated a care plan would be initiated by nursing and rehabilitation and the plan would be implemented.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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F 689	Continued From page 22 Based on observation, interview, record review and document review, the facility failed to ensure, 1) Oxygen tanks were stored appropriately, 2) medications were not left at bedside, 3) storage rooms were secured, 4) a respiratory cart and medication cart were secured, and 5) the facility's smoking policy was followed when residents were allowed to have possession of smoking supplies. The deficient practice had the potential to place residents at risk for harm or injury. Findings include: 1) Storage of Oxygen tanks: On 02/06/2024 in the morning, in room 801, there were two free-standing unsecured portable oxygen tanks. One unsecured oxygen tank was next to the wall with the window and one unsecured oxygen tank was at the foot of the resident's bed. On 02/06/2024 at 8:13 AM, a Certified Nursing Assistant (CNA) entered the room and observed the unsecured oxygen tanks. The CNA verbalized the oxygen tanks were not stored properly and should be stored in a rack. The CNA stated it was a safety issue. On 02/09/2024 at 1:05 PM, a Respiratory Therapist indicated portable oxygen tanks should be stored in a rack or it was dangerous. On 02/09/2024 at 1:20 PM, a Physical Therapy Assistant revealed portable oxygen tanks should be stored in a rack. The oxygen tanks should be stored in a holder, so it does not fall over or leak. It was a safety issue.	F 689	1. The oxygen tanks found in room 801 were immediately secured, and the employees of concern were re-educated regarding proper oxygen tank storage. On February 6, 2024, the medications found in rooms 602A, 801B, 804A, 810B, and 812B were confiscated and discarded. Attending physicians of the affected residents were informed and the residents were monitored for any adverse effects. The residents and their representatives were re-educated regarding the process of requesting home medication reconciliation. The employees of concern were re-educated on the Medication Preparation and General Guidelines. The employees of concern were re-educated on ensuring the central supply room was locked at all times. The residents and employees of concern were re-educated on ensuring the medication and respiratory treatment were locked at all times. Regarding smoking, the resident that was not following the safe smoking protocol was educated on safe smoking policy and risks and benefits of complying with the policy. Resident was agreeable and turned in smoking materials. 2. Residents on oxygen therapy and use oxygen tanks are affected by the deficient practice. The department heads, unit managers, or designee will perform daily compliance rounds and discuss findings at the daily stand-up meetings. Residents requiring assistance with medication administration are affected by the deficient practice. The department heads, unit managers, or designee will perform daily compliance rounds and discuss findings at the daily stand-up meetings. The deficient practice (unlocked central supply room) affects all residents. The department heads, unit managers, or designees will perform daily compliance rounds and discuss findings at the daily stand-up meetings.	

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F 689	Continued From page 23 The facility's policy Fire Safety and Prevention dated 10/01/2021, documented Oxygen Safety: Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room or living area. 2) Medications left at bedside: On 02/06/2024 at 8:05 AM, in room 804, a jar of Triamcinolone 0.11 ointment was observed on the resident's tray table. The resident advised the ointment was used for itching on the stomach, legs, and arms. The jar had a prescription label and the expiration date on the container was 02/15/2020. On 02/06/2024 at 8:10 AM, in room 810 B there was a bottle of Advance Care lubricating eye drops on the bedside nightstand. The resident stated the eye drops were used when their eyes were dry. On 02/06/2024 at 8:16 AM, in room 812 B on the bedside tray table, was a tube of Diclofenac Sodium Topical 1% ointment. The container indicated for arthritis pain relief. The resident indicated used the medication once per day. On 02/06/2024 at 9:10 AM, a Licensed Nurse (LN) from the 800 unit confirmed the medication was on the resident's tray table. The LN reviewed the orders in the computer and stated the resident in 804 did not have a physician's order for the Triamcinolone 0.11 ointment and it should not be in the resident's room. The LN from the 800 unit and surveyor went to room 810 B where the nurse confirmed the bottle	F 689	Failure to follow the smoking policy has the potential to affect all residents who smoke. 3. DON, director of staff development (DSD), unit managers, or designees will re-educate all staff regarding the policies, Fire Safety and Prevention, Preparation and General guidelines, Medication Storage, and ensuring storage rooms are locked. Residents who smoke shall educated on the smoking policy upon admission, and periodically as needed. 4. The department heads, unit managers, or designees will perform daily compliance rounds that shall include, but not be limited to, checking oxygen storage, storage of medications at bedside, unlocked treatment/med carts, open storage rooms, and safe smoking practices and discuss findings at the daily stand-up meetings. Pertinent findings from the review will be brought forward to the QAPI meeting. 5. Date of compliance - 03/27/2024	

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F 689	Continued From page 24 of Advance Care lubricating eye drops was on the resident's bedside stand. The LN reviewed the resident orders on the computer and verbalized the resident did not have an order for the eye drops. The LN confirmed the eye drop bottle had expired in January 2023. On 02/06/2024, at 12:03 PM, in room 801 B on the resident's tray table there was a clear plastic medication cup which contained a capsule and a small round pink/peach in color pill. The capsule was red in color and the resident stated the nurse told the resident the capsule was a stool softener. The resident verbalized the nurse had advised the resident the small pink pill was a laxative as well. The resident stated the nurse had left the medications on the tray table at around10:00 AM. On 02/06/2024 at 12:10 PM, a LN from the 800 unit was advised of the observation of the two medications at bedside in room 801B. The LN verbalized did not know the resident in 801B had not taken the two medications given to the resident. The LN was aware should have waited until the resident had taken the medication. On 2/6/2024 at 12:30 PM, in room 602 A, a clear plastic medication cup was on the resident's tray table, (resident not in room). The medication cup contained a white capsule, a large round white pill, a round peach colored pill and a medium size round pill. On 2/6/2024 at 12:35 PM, a Registered Nurse (RN) confirmed the observation in room 602A and indicated medications should not be left at the bedside, and this was a safety issue. The facility's policy Preparation and General	F 689		

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F 689	Continued From page 25 guidelines (undated) documented the resident was always observed after the administration to ensure that the dose was completely ingested. 3) Open Storage room: On 02/06/2024 at 12 noon, the door to the storage room located next to resident room 800, was wide open and there was no staff in attendance. There was a sign on the door which indicated authorized personnel only. Some of the items in the storage room were disposable razors, shampoo, shave cream, peri wash and diapers. A CNA stated the door to the storage room should be locked. It should not be open, this was a safety issue. On 02/08/2024 at 8:05 AM, the door to the storage room located next to resident room 800, was wide open and there was no staff in attendance. The sign on the door indicated authorized personnel only. The room contained razors, shampoo, shave cream, peri wash and diapers. A different CNA verbalized the door should be locked. A staff member from Central supply walked by and indicated the door should be locked. The staff member revealed they did not know why the staff propped the door open, but it is a safety issue. On 02/09/2024 at 9:05 AM, the staff member from Central Supply explained the supply room door should be locked, but the facility was missing the key for the door. The staff member had a master key that could open the door if it got locked. The door to the supply room should be closed and there was usually a nurse at the nurse's station who would be able to see anyone	F 689		

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F 689	Continued From page 26 going in to the storage room or hear them. The staff member from Central Supply explained the night nurses leave the door open, because at night that section of the unit was a part of the building with a reduction in lighting, and the only way to see in the room was with the flashlight on their phones. On 02/09/2024 the Administrator advised the facility did not have a policy to indicate if the storage rooms should be locked or not. 4) Medication Carts: On 02/09/2024 at 1:15 PM, on the 100 unit across from the nursing station a medication cart which contained respiratory therapy supplies and medications was unlocked and unattended. The cart contained Ipratropium Bromide and Albuterol Sulfate inhalation solution, Levalbuterol inhalation solution, syringes of Normal Saline and other respiratory supplies. A Certified Nursing Assistant and a Licensed Practical Nurse on the 100 unit revealed the cart with the respiratory supplies and medications should be locked at all times because there were medications in the cart and was a safety issue if left unlocked. On 02/09/24 at 2:06 PM, the medication cart at the 800-900 hallway was observed unlocked with a drawer ajar. On 02/09/24 at 2:07 PM, a Registered Nurse was at the nurse's station and confirmed the medication cart was unlocked and verbalized the cart should be locked. On 02/09/24 at 2:11 PM, the Licensed Practical	F 689		

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F 689	Continued From page 27 Nurse (LPN) using the cart, was at the nurse's station and confirmed the medication cart was unlocked and verbalized the cart should be locked when not in use. The LPN verbalized residents could access the medications in an unlocked cart. On 02/09/24 at 2:35 PM, the DON verbalized the DON expected the medication cart to be locked when a nurse was not standing by the cart or using the cart. The facility policy titled "Medication Storage," undated, documented compartments containing drugs shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if opened or otherwise potentially available to others. Cross reference with tag F761 5) Smoking Policy R56 R56 was admitted to the facility on 01/06/24, with diagnoses including lack of coordination, legal blindness, and seizure disorder. On 02/06/24 at 11:53 PM, R56 explained being able to smoke without supervision and was able to hold own tobacco products. On 02/06/24 at 2:18 PM, R56 was observed smoking out on the lobby courtyard and no staff was present. A facility smoking assessment dated 01/23/24, documented R56 was to have facility supervision	F 689		

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F 689	Continued From page 28 when smoking. On 02/08/24 at 11:14 AM, the Activities Director explained the smoking assessments determines if residents require supervision when smoking and if the facility was to secure resident's cigarettes and lighters. On 02/08/24 at 11:24 AM, the Activities Assistant verbalized the assessment completed on 01/23/24 documented the resident required supervision and staff did not supervise the lobby courtyard when residents were there. On 02/08/24 at 11:37 AM, the Administrator explained residents were not to smoke on the lobby courtyard patio. On 02/09/24 at 1:21 PM, an Activities Assistant explained not all resident's cigarettes and lighters were secured by the facility. The Activities Assistant confirmed prior to 02/08/24, R56's cigarettes and lighters were not secured by the facility. R56's "Resident Smoking Agreement," signed and dated 01/24/24 by R56, documented residents are not allowed to have any tobacco products, lighters, or any other smoking related items on my person. The facility policy titled "Smoking Permitted," revised 10/20/22, documented residents who desire to smoke may not keep smoking related material on their person when not smoking or in their room. The facility would identify safe smoking locations and times supervised smoking would be provided. Resident 431 (R431)	F 689		

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F 689	Continued From page 29 R431 was admitted on 01/18/2024, with diagnoses including diabetes mellitus and chronic kidney disease. On 02/06/2024 at 8:45 AM, R431 was seated in wheelchair outside the double door leading to the designated smoking area. The resident held an unlit cigarette in left hand and verbalized having possession of cigarettes, but lighters were kept by facility staff. On 02/07/2024 at 8:46 AM, was seated in wheelchair outside the double door leading to the designated smoking area. The resident held an unlit cigarette in left hand. On 02/08/2024 at 8:49 AM, in the lobby between the 400-Hall and 500-Hall, R431 was observed flicking a black lighter with left thumb. The resident pointed to left pocket when asked where cigarettes were being kept. A rectangular box was protruding from the left pocket. The observation was confirmed by the Unit Manager who tried to take away R431's lighter which caused the resident to get mad, the Unit Manager returned the lighter to R431. A Smoking care plan initiated on 01/19/2024, documented R431 had been informed of the facility's smoking policy which R431 was expected to follow, and the resident had been informed of the risks and consequences of violating the facility's policy. A Smoking Evaluation dated 01/24/2024, revealed R431 was assessed to be safe to smoke without supervision.	F 689		

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F 689	Continued From page 30 On 02/08/2024 at 9:19 AM, R431 was smoking in the designated area. A black lighter and red box of cigarettes were on the resident's lap. The resident did not respond when asked if R431 routinely kept smoking supplies in possession. On 02/08/2024 at 9:22 AM, the resident propelled wheelchair into activities room from the smoking area holding lighter and cigarettes and then proceeded to the lobby outside the 500-Hall. Two activities staff members who were providing supervision to smokers did not collect R431's cigarettes and lighters until a few minutes later, when the surveyor pointed out R431 was still in possession of smoking supplies. On 02/08/24 at 9:26 AM, two activities assistants explained being responsible for supervising the 9:00 AM and 1:00 PM smoke breaks. After smoking, the residents were expected to hand smoking supplies to activities staff to store in a plastic container which was later locked in a drawer in the receptionist area. The activities staff members indicated residents were not allowed to keep smoking supplies with them for safety reasons and verbalized, for example, the lighter may ignite Oxygen causing fire and some residents might smoke inside the facility when there was no supervision. On 02/08/24 at 9:38 AM, two activities staff members indicated doing their best to collect smoking supplies after smoke breaks but even with best effort, some residents would sneak and hide supplies and bring them to their rooms. The activities assistants indicated not being responsible for lapses during the 5:00 PM and 8:00 PM smoke breaks because other staff members were responsible for supervision of	F 689		

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F 689	Continued From page 31 smokers after hours. On 02/08/24 at 9:47 AM, the Unit Manager indicated smoking supplies which included lighters and cigarettes were to be secured by staff for safety reasons. The Unit Manager indicated any smoker who lit a lighter inside the facility could cause a fire especially when there was Oxygen nearby. The Smoking policy (undated) revealed residents who desire to smoke may not keep smoking related materials (e.g., cigarettes, lighter, match, electronic smoking devices). For safety purposes, all smoking materials must be stored in a safe place in the facility such as the nurse's station.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		

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F 690	Continued From page 32 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure care orders were obtained and implemented for a resident who was admitted with an indwelling catheter for 1 of 35 sampled residents (Resident 182). Specifically, a physician's order was not obtained when the resident's catheter had to be replaced and perineal (area between the anus and posterior part of external genitalia) wash was not performed routinely in accordance with the facility's policy. The deficient practice placed the resident at risk for a recurrent urinary tract infection (UTI). Findings include: Resident 182 (R182) R182 was admitted on 08/21/2023 and readmitted on 01/02/2024, with diagnoses including severe sepsis with septic shock related to urinary tract infection.	F 690		

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F 690	Continued From page 33 An Admission Nursing Evaluation dated 01/03/2024, revealed R182 was admitted with an indwelling catheter and a history of chronic urinary tract infection (UTI). A physician encounter note dated 01/03/2024, documented R182 was treated for UTI in the hospital. Antibiotic therapy was completed prior to discharge from the hospital. An Admission minimum data set (MDS) dated 01/08/2024, revealed R182 was admitted with an indwelling catheter and was dependent on staff for perineal hygiene. Foley Change: A nursing note dated 02/06/2024, documented a nurse changed R182's Foley due to complaints of discomfort and pain. Nurse reinserted 18 French (diameter size) Foley catheter with 10 cubic centimeters of normal saline. Urine amber in color and cloudy in clarity, no odor observed at this time. The clinical record lacked documented evidence care and management orders were obtained, transcribed, and carried out, which included changing the resident's Foley catheter as needed. On 02/09/24 at 1:56 PM, the DON confirmed there was no physician's order to re-insert the resident's Foley catheter on 02/06/2024, which went against facility policy. In addition, the resident's old catheter was 16 French which was smaller in size than what the nurse had inserted on 02/06/2024. According to the DON, the nurse should have reported the resident's complaints of	F 690	1. Resident 182 was discharged. The employees of concern were re-educated on ensuring a physician's order was obtained for indwelling catheter re-insertion when dislodged and catheter care. 2. Residents with indwelling catheters have the potential to be affected by the deficient practice. Charts of active residents with indwelling catheters will be re-evaluated to ensure the appropriate physician orders for catheter care and management are documented. 3. Licensed nurses will be re-educated by the director of staff development (DSD), unit managers, or designee regarding the importance of ensuring a physician's order was obtained for indwelling catheter re-insertion when dislodged and catheter care. Unit Managers or designees will review the charts of active residents with indwelling catheters to ensure the appropriate physician orders for catheter care and management are documented daily. Findings will be brought forward to daily clinical stand-up meetings. All pertinent findings from the review will be brought forward to the QAPI meeting. 4. Findings from the corrective action plan will be reviewed for evaluation in the next QAPI meeting monthly for the next 90 days, quarterly thereafter, and annually if indicated. 5. Date of compliance - 03/27/2024	

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F 690	Continued From page 34 pain and discomfort and obtained an order to re-insert, clarifying the Foley catheter size. The DON indicated using a catheter size which was bigger than necessary could cause urethral damage, pain, and discomfort. Perineal wash: On 02/07/2024 at 8:10 AM, R182 was awake and alert in bed. An indwelling catheter was hanging on the right side of the bed. The resident indicated being hospitalized for a UTI and returned to the facility on 01/02/204. R182 indicated staff do not routinely provide perineal care and cleaning needs were limited to incontinence care after a bowel movement. On 02/08/24 at 8:36 AM, the call light outside R182 's was on. R182 informed indicated needing incontinence care due to having a bowel movement. There was a strong fecal odor in the room. The resident indicated perineal care was not provided this morning. On 02/08/2024 at 9:06 AM, the CNA assigned to R182 explained perineal care for residents who had an indwelling catheter was part of morning routine care, but the CNA was not able to provide care to R182 due to a staff call off. The CNA indicated being aware R182 had an indwelling catheter and history of UTI. A Care plan dated 01/05/2024, revealed R182 had bladder incontinence related to active infection with symptoms of UTI with a goal of preventing another septicemia episode. Interventions included perineal care with each incontinence episode.	F 690		

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F 690	Continued From page 35 On 02/09/24 at 10:09 AM, the Licensed Practical Nurse (LPN) assigned to R182 reviewed the resident's clinical record and confirmed there were no care and management orders for the indwelling catheter which included Foley change and perineal wash. On 02/09/24 at 10:16 AM, the Unit Manager explained R182 had care orders for catheter care on 08/21/2023 which were discontinued on 11/02/2023, when the resident was hospitalized for altered mental status related to a UTI. According to the Unit Manager, R182 was readmitted on 01/02/2024 and the admission nurse must have failed to enter care orders for the resident's indwelling catheter which should include 1) change monthly or prn for dislodgement or occlusion, 2) change Foley drainage bag monthly, 3) monitoring for s/s of infection, 4) catheter care every shift which includes perineal wash. The Unit Manager indicated because care orders were not transcribed, there was no documented care for R182's indwelling catheter since 01/02/2024. On 02/09/24 at 1:52 PM, the Director of Nursing (DON) indicated when a resident was admitted with an indwelling catheter the admission nurse should obtain orders for care and management which typically included 1) change catheter monthly and PRN when dislodged or leaking, 2) change Foley drainage bags monthly, 3) monitoring for complications which included infection, 4) catheter care every shift which included perineal wash. The Urinary Catheter Care (undated), documented indwelling catheters would be	F 690		

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F 690	Continued From page 36 changed in accordance with physician's orders. Check urine for unusual appearance and signs and symptoms of UTI and notify physician. Routine hygiene as appropriate and do not use antiseptics for periurethral areas to prevent catheter-related urinary tract infections.	F 690		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure assessment for entrapment was completed, alternatives were attempted, and informed consent was obtained prior to installation of side	F 700		

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F 700	Continued From page 37 rails for 1 of 35 sampled residents (Resident 95). Resident 95 (R95) R95 was admitted to the facility on 08/09/19 and re-admitted on 03/02/22, with diagnoses including encephalopathy, unspecified, personal history of traumatic brain injury and seizure disorder. On 02/06/24 at 10:21 AM, R95 was in bed with the upper side rails in the up position on both sides of the bed. On 02/08/24 at 9:15 AM, R95 was in bed with the upper side rails in the up position on both sides of the bed. On 02/08/24 at 10:23 AM, a Certified Practical Nurse (CNA) confirmed R95 had upper side rails in the up position on both sides of the bed. The CNA explained an evaluation was to be completed by nursing upon admission. R95's record lacked documented evidence an informed consent was obtained, assessment for entrapment and if alternatives were attempted prior to installation. On 02/09/24 at 8:14 AM, the Director of Nursing (DON) verbalized prior to installation of side rails, an assessment for entrapment would be completed, alternative interventions were attempted, and informed consent was obtained. The DON confirmed R95's clinical record lacked evidence an informed consent was obtained, assessment for entrapment was completed and if alternatives were attempted prior to installation.	F 700	1. On February 9, 2024, an entrapment risk assessment was completed, and verbal consent to use bed rails was obtained from Resident 95 (R95)'s mother. The risks and benefits of bed rail use were explained to R95's mother. A physician's order for the use of 1/2 bed rails to promote safety was obtained. R95's ADL (activities of daily living) care plan was revised to indicate the use of half-bed rails to encourage safety while in bed. 2. Charts of active residents with bed rails will be re-evaluated to ensure that an assessment, consent, physician's order, and care plan for bed rail use are documented. 3. Nursing staff will be re-educated by the director of staff development (DSD), unit managers or designee regarding the policy, Proper Use of Side Rails. Charts of active residents with bed rails will be reviewed during daily clinical stand-up meetings by the unit managers or designee for completion. Pertinent findings from the review will be brought forward to the QAPI meeting. 4. Findings from the corrective action plan will be reviewed for evaluation in the next QAPI meeting monthly for the next 90 days, quarterly thereafter, and annually if indicated. 5. Date of compliance - 03/27/2024	

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F 700	Continued From page 38 The facility policy, Proper Use of Side Rails, undated, documented risks, and benefits of side rails would be considered for each resident, consent for side rails use would be obtained from the resident or legal representative and the side rail entrapment assessment would be completed to determine the resident's reason for using side rails. Cross reference with tag F656	F 700		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review, the facility failed to ensure: 1) an admission and quarterly social services assessment was completed for 1 of 35 sampled residents (Resident 182), 2) the Social Worker followed-up with the acute care hospital and the onsite dental services regarding the missing dentures for 1 of 35 sampled residents (Resident 53), and 3) there were sufficient number of social services staff members in accordance with the facility assessment. The deficient practice had the potential for the facility not meeting the social services needs of the residents. Findings include: Resident 53 (R53) R53 was readmitted on 12/08/2023 with	F 745		

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F 745	Continued From page 39 diagnoses including respiratory syncytial virus pneumonia. R53 required the use of dentures. A review of the medical record revealed R53 was discharged to the acute care hospital on 11/30/2023, and R53 was discharged from the hospital 12/08/23. On 02/06/2024 in the afternoon, R53 indicated they had been missing their dentures approximately 4 to 5 weeks after they went to the hospital. R53 expressed, "I just want to eat pizza or a sandwich." R53 was eating a pureed meal for lunch. A Social Services Note dated 01/25/2024, documented a call made to the acute care hospital by the Social Worker to follow-up regarding R53's dentures left during the hospital stay. The note indicated the nurse who helped R53 was off, and the staff checked with security but were unable to locate R53's dentures. The note indicated the Social Worker would follow up when the nurse was back on duty. On 02/08/2024 at 1:51 PM, the Social Worker indicated the acute care hospital was contacted a few times and had their security staff check the lost and found, but did not find R53's dentures. The Social Worker indicated asking to speak to the nurse who admitted R53 to inquire about the dentures, but the hospital had not returned the call. The Social Worker indicated asking the onsite dental services to see if R53 qualified for a new pair of dentures. The Social Worker acknowledged there was no further follow-up when the hospital did not return the phone call. The Social Worker indicated it	F 745	1. Resident 53 will be referred to dental services. Resident 182 was unable to be corrected as the resident had discharged. 2. Facility review residents for dental or other psycho-social related needs and no other cases were identified.. 3. The facility has hired and started a new Medical Social Worker that started at the facility on 03/11/2024. Additionally, that facility extended and offer to a Director of Social Services Candidate - that offer was accepted and is scheduled to start on 03/18/2024. 4. The facility will review residents needs and request during the daily clinical stand-up meeting and ensure psycho-social needs are being met. 5. Date of compliance - 03/27/2024	

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F 745	Continued From page 40 was not an excuse, but expressed being the only social worker for the entire facility with more than 200 residents to keep track of and follow-up with regarding care concerns. On 02/08/2024, the Social Worker acknowledged the last time speaking with the onsite dental hygienist was on 01/25/24, to inform of R53's missing teeth and to inquire of the insurance coverage. The Social Worker indicated there would be follow up with the onsite dental. An email was sent on 02/08/2024 while the inspector was present. On 02/09/24 at 2:22 PM, a Registered Nurse responsible for providing care for R53 indicated they did not know if Social Services had inquired about R53's missing dentures. The RN explained had been with the facility since January 2024 and R53 had been eating a pureed diet. Resident 182 (R182) R182 was admitted on 08/21/2023 and readmitted on 01/02/2024, with diagnoses including severe sepsis with septic shock and age-related debility. On 02/07/2024 at 8:10 AM, R182 indicated being dissatisfied with care received in the facility and R182 had made multiple requests to speak with social services regarding a possible transfer to another facility, but the resident's requests had been ignored. The clinical record lacked documented evidence any social services assessments were completed for R182 since the resident's admission on 08/21/2023.	F 745		

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F 745	Continued From page 41 The clinical record lacked documented evidence social services staff had seen R182 since an inter-disciplinary team (IDT) meeting on 09/28/2023. On 02/09/2024 at 12:02 PM, a Licensed Social Worker (LSW) reviewed R182's medical record and confirmed there had been no social services assessments done for R182 since admission on 08/21/2023. The LSW explained social services were responsible for certain portions of the minimum data set (MDS) which included assessment and goal setting (section Q) and this was completed timely for R182. The LSW indicated a social services assessment was a different requirement and served the purpose of identifying the resident's changes in mood, behavior, psycho-social needs, and discharge planning. On 02/09/2024 at 12:15 PM, the LSW explained R182 was admitted on 08/21/2023 and the admission social services assessment was due to be completed on 08/28/2023, but this was not done. According to the LSW, R182 was hospitalized in November 2023 and was readmitted on 01/02/2024, which made R182's quarterly social services assessment due no later than 01/08/2024, but this was not completed as well. On 02/09/2024 at 12:17 PM, the LSW explained the facility was licensed for 255 beds and the facility used to have three social workers who divided the case load but currently, the facility only had one LSW and a social services assistant (SSA). The LSW verbalized being overwhelmed and acknowledged having difficulty completing social services assessments, and other requests	F 745		

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F 745	Continued From page 42	F 745		

for assistance from residents in a timely manner. The LSW indicated being the only LSW since the former social services director (SSD) left a year ago and the other LSW left in November 2023. The LSW indicated currently being responsible for 231 residents which was an unmanageable load.

The facility assessment reviewed 04/25/2023, documented the average daily census of the facility was between 220 to 240 and the staffing plan, based on resident population and their needs for care and support, described the general approach to staffing to ensure sufficient staff to meet resident needs would include three social workers.

On 02/09/2024 at 1:29 PM, the Administrator acknowledged the facility assessment documented the facility needed three social workers, but currently only had one LSW and one SSA. According to the Administrator, the former SSD left in August 2023 and another LSW left in November 2023, and the facility had not been able to hire for open positions.

The facility policy Social Services Assessment policy (undated), revealed a social services assessment was done to help identify the resident's personal and social situation, needs and problems. Data obtained from the social assessment shall be used to develop all relevant portions of the resident's care plan which would include social services, activities, and ancillary services. Components of the assessment include physical factors, cognitive factors, mood and behavior, personal information, active disease and diagnoses, functional status, financial information and ability and willingness to

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F 745	Continued From page 43 participate in assessment and goal setting.	F 745		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were not left unsecured in a medication cart at the 800-900-Hall nursing station, and medications were not left at bedside. The deficient practice posed a risk for resident's safety of obtaining medications not prescribed and not taking	F 761		

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F 761	Continued From page 44 ordered medications. Findings include: On 02/09/24 at 2:06 PM, the medication cart at the 800-900 hallway was observed unlocked with a drawer ajar. On 02/09/24 at 2:07 PM, a Registered Nurse was at the nurse's station and confirmed the medication cart was unlocked and verbalized the cart should be locked. On 02/09/24 at 2:11 PM, the Licensed Practical Nurse (LPN) using the cart, was at the nurse's station and confirmed the medication cart was unlocked and verbalized the cart should be locked when not in use. The LPN verbalized residents could access the medications in an unlocked cart. On 02/09/24 at 2:35 PM, the Director of Nursing (DON) verbalized the DON expected the medication cart to be locked when a nurse was not standing by the cart or using the cart. The facility policy titled "Medication Storage," undated, documented compartments containing drugs shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if opened or otherwise potentially available to others. Cross reference with tag F689 On 02/09/2024 at 1:15 PM, on the 100 unit across from the nursing station, a cart which contained respiratory therapy supplies and medications was unlocked and unattended. The	F 761	1. On February 6, 2024, the medications found in rooms 602A, 801B, 804A, 810B, and 812B were confiscated and discarded. Attending physicians of the affected residents were informed and the residents were monitored for any adverse effects. The residents and their representatives were re-educated regarding the process of requesting home medication reconciliation. The employees of concern were re-educated on the Medication Preparation and General Guidelines. The employees of concern were re-educated on ensuring the medication and respiratory treatment were locked at all times. 2. Residents requiring assistance with medication administration are affected by the deficient practice. The department heads, unit managers, or designee will perform daily compliance rounds and discuss findings at the daily stand-up meetings, The deficient practice (unlocked medication and treatment carts) affects all residents. The department heads, unit managers, or designees will perform daily compliance rounds and discuss findings at the daily stand-up meetings. 3. The DON, director of staff development (DSD), unit managers, or designees will re-educate all staff regarding the policies, Preparation and General guidelines and Medication Storage. Department heads, unit managers, or designees will perform daily compliance rounds and discuss findings at the daily stand-up meetings. Pertinent findings from the review will be brought forward to the QAPI meeting. 4. All findings from the corrective action plan will be reviewed for evaluation in the next QAPI meeting monthly for the next 90 days, quarterly thereafter, and annually if indicated. 5. Date of compliance - 03/27/2024	

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F 761	Continued From page 45 cart contained Ipratropium Bromide and Albuterol Sulfate inhalation solution, Levalbuterol inhalation solution, syringes of Normal Saline and other respiratory supplies. A Certified Nursing Assistant and a Licensed Practical Nurse on the 100 unit revealed the cart with the respiratory supplies and medications should be locked at all times because there were medications in the cart as it was a safety issue. On 02/06/2024 at 8:05 AM in room 804, a jar of Triamcinolone 0.11 ointment was observed on the resident's tray table. The resident advised the ointment was used for itching on the stomach, legs, and arms. The jar had a prescription label and the expiration date on the container was 02/15/2020. On 02/06/2024 at 8:10 AM, in room 810 B, there was a bottle of Advance Care lubricating eye drops on the bedside nightstand. The resident stated the eye drops were used when their eyes were dry. On 02/06/2024 at 8:16 AM, in room 812 B on the bedside tray table, was a tube of Diclofenac Sodium Topical 1% ointment. The container indicated for arthritis pain relief. The resident indicated used the medication once per day. On 02/06/2024 at 9:10 AM, a Licensed Nurse (LN) from the 800 unit confirmed the medication was on the resident's tray table. The LN reviewed the orders in the computer and stated the resident in 804 did not have a physician's order for the Triamcinolone 0.11 ointment and it should not have been in the resident's room. The LN from the 800 unit and surveyor went to	F 761		

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F 761	Continued From page 46 room 810 B where the nurse confirmed the bottle of Advance Care lubricating eye drops was on the resident's bedside stand. The LN reviewed the resident orders on the computer and verbalized the resident did not have an order for the eye drops. The LN confirmed the eye drop bottle had expired in January 2023. On 02/06/2024, at 12:03 PM, in room 801 B on the residents' tray table, there was a clear plastic medication cup which contained a capsule and a small round pink/peach in color pill. The capsule was red in color and the resident stated the nurse told the resident the capsule was a stool softener, and the resident verbalized the nurse had told the resident the small pink pill was a laxative as well. The resident stated the nurse had left the medications on the table at around10:00 AM. On 2/6/2024 at 12:10 PM, a LN was advised of the observation of the two medications at the bedside in room 801B. The LN verbalized did not know the resident in 801B had not taken the two medications the nurse had given the resident. The LN was aware should have waited until the resident had taken the medication. On 2/6/2024 at 12:30 PM, in room 602 A, a clear plastic medication cup was on the resident's tray table (resident not in room). The medication cup contained a white capsule, a large round white pill, a round peach colored pill and a medium size round pill. On 2/6/2024 at 12:35 PM, a Registered Nurse (RN) confirmed the observation of the medications in room 602A and indicated medications should not be left at the bedside as this was a safety issue.	F 761		

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F 761	Continued From page 47 The facility's policy Preparation and General guidelines (undated) documented the resident was always observed after the administration to ensure that the dose was completely ingested.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to 1) label and date food items, and 2) discard potentially hazardous foods. The deficient practice had the potential to expose resident to foodborne illness. Findings include: On 02/06/2024 at 7:55 AM, a tray of salads in the	F 812		

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F 812	Continued From page 48 walk in refrigerator was unlabeled and undated. On 02/06/2024 at 7:57 AM, the following items were stored in the walk-in refrigerator in serving containers separate from the original packaging: - Two containers of cottage cheese dated 01/15/2024 - Five containers of mixed fruit dated 01/24/2024 - Five containers of orange slices dated 01/30/2024 On 02/06/2024 at 7:58 AM, the Dietary Manager confirmed the unlabeled and undated should have been discarded. Food items removed from their original container must be discarded within seven days. The Food Storage: Cold Foods policy, last revised 02/2023 documented, All time and temperature control for safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA food code. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.	F 812	1. Expired products were immediately discarded. No residents were affected by the deficient practice. 2. The Dietary Manager conducted rounds, no other expired products were identified. 3. Dietary staff will be in-serviced on labeling and dating, including utilizing and following received on, prepared on, and/or use by dates. The supervisor will utilize an opening/ closing checklist inspection daily to monitor label and dating practices. 4. Manager to complete supervisor rounds daily. A copy of the checklist will be turned into the District Manager and Administrator daily for 2 weeks, weekly for 4 weeks, and bi weekly for 8 weeks RD or designee to complete Sanitation audit 1xweekly for weeks, Biweekly 4 weeks, Monthly indefinitely and turned into to QAPI monthly 5. Date of compliance - 03/27/2024	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the	F 849		

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F 849	Continued From page 49 resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition.	F 849		

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	295071	A. BUILDING _____ B. WING _____	02/09/2024

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F 849	Continued From page 50 (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice	F 849		

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F 849	Continued From page 51 administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice:	F 849		

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F 849	Continued From page 52 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure the hospice physician's order to place a resident on transmission-based precautions for possible scabies infection was followed for 1 of 35 sampled residents (Resident 112). The deficient practice placed other residents and staff at risk for spreading scabies.	F 849		

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F 849	Continued From page 53 Findings include: Resident 112 (R112) R112 was admitted on 05/12/2021, with diagnoses including non-traumatic subdural hemorrhage and unspecified dementia and hospice status. A hospice face sheet dated 08/03/2024, revealed R112 was admitted to Hospice with primary diagnoses including encephalopathy and subdural hemorrhage. On 02/06/2024 in the morning, R112 laid in bed asleep and was unarousable. The resident's body including arms were covered in blanket. On 02/06/2024 in the morning, an individual was observed donning gown, foot cover, head cover, mask, and gloves outside R112's room. The individual introduced self as R112's hospice nurse and explained personal protective equipment (PPE) was required prior to entering R112's room because the resident was being treated for scabies and was on contact precautions. The hospice nurse confirmed the resident's door did not have contact isolation signage and PPE supplies, but the hospice nurse had brought own PPE provided by the hospice agency. The hospice nurse recalled communicating the hospice physician's order with the Unit Manager on 01/23/2024 and could not speak to why the facility had not implemented contact isolation precautions for R112. A hospice progress note dated 01/23/2024, revealed R112 was noted with diffused redness to arms and back, significant dryness worse in the	F 849	1. Resident 112 no longer resides at the facility as of 02/26/2024. The employees of concern were re-educated on ensuring hospice physician orders were clarified timely. 2. Charts of residents under hospice care will be re-evaluated to ensure physician orders are carried out timely. 3. Nursing staff will be re-educated by the director of staff development (DSD), unit managers or designee regarding the Hospice Services Policy. Charts of residents under hospice care will be reviewed during daily clinical stand-up meetings by the unit managers or designee for completion. Pertinent findings from the review will be brought forward to the QAPI meeting. 4. Findings from the corrective action plan will be reviewed for evaluation in the next QAPI meeting monthly for the next 90 days, quarterly thereafter, and annually if indicated. 5. Date of completion - 03/27/2024	

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F 849	Continued From page 54 webbing of fingers and back, new crusting present to webbing of fingers and light yellowing color to patient's back. Hospice physician 1) diagnosed R112 with late-stage scabies, 2) ordered Ivermectin (oral anti-parasitic drug) and Permethrin cream (topical anti-parasitic drug), and 3) ordered to place R112 on facility's precautions list. Orders were communicated to facility staff who stated they would communicate this with the Infection Preventionist (IP). On 02/06/2024 at 1:14 PM, the Hospice Administrator explained diagnostic tests were not typically performed on hospice patients, so no skin scraping was ordered by the hospice physician. The Hospice Administrator indicated the physician diagnosed the resident with scabies based on nursing assessment and photo documentation communicated by the hospice nurse, in addition to reports received from facility staff there were other residents and staff with possible scabies. The Hospice Administrator indicated the hospice physician presided over the care of R112 and the facility was expected to carry out all hospice physician's orders. The Hospice Administrator indicated expecting the facility to have implemented contact isolation precautions for R112 since 01/23/2024, and became aware of non-implementation of precautionary measures only today. On 02/08/2024 at 11:15 AM, the Director of Nursing (DON) indicated the hospice physician was considered R112's primary physician and the facility was expected to follow the hospice physician's orders. The DON indicated the facility should have implemented contact isolation precautions beginning 01/23/2024, after the hospice nurse communicated the hospice	F 849		

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F 849	Continued From page 55 physician's orders with the Unit Manager. The DON verbalized consequences for not implementing contact precautions on 01/23/2024 placed staff and other residents at risk for cross contamination of infectious disease which may include scabies. On 02/08/2024 at 1:06 PM, the Unit Manager confirmed the hospice nurse had informed the Unit Manager regarding R112's scabies diagnosis and orders to put R112 on the precautions list. The Unit Manager indicated communicating the information with the Infection Preventionist (IP), during the stand-up meeting the following day, 01/24/2024. On 02/08/2024 at 11:45 AM, the IP could not recall being informed by the Unit Manager regarding R112's scabies diagnosis, treatment, and orders to place the resident on contact isolation precautions. The IP indicated scabies was a highly contagious skin disease and suspected and confirmed scabies cases were to be placed on contact isolation precautions to prevent cross-contamination. The IP confirmed contact isolation precautions were not implemented for R112 from 01/23/2024 until 02/06/2024. The Hospice Services policy (undated), the hospice agency retains overall professional management responsibility for directing the implementation of the plan of care. The hospice nurse designates a registered nurse to coordinate the implementation of the resident's plan of care and would be responsible for communication between the hospice and facility when changes were made to the plan of care.	F 849		

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F 880	Continued From page 56	F 880		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 57 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, the facility failed to ensure: 1) residents with suspected scabies were placed on contact precautions for 1 of 35 sampled residents (Resident 112), 2) a staff member who was assigned to provide care to residents with unconfirmed rashes and who themself was undergoing treatment for scabies, was not assigned to another unit, 3) laundry items of	F 880		

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F 880	Continued From page 58 residents with unconfirmed rashes were handled in accordance with the facility's policy, 4) the wound care team was notified of residents with unconfirmed rashes and 5) suspected resident and staff scabies cases were reported to the health department. The deficient practice placed other residents and staff at risk of contracting scabies. Findings include: On 02/06/2024 in the morning, two Certified Nursing Assistants (CNAs) showed surveyor rashes on their bilateral arms and reported being under treatment for scabies by their personal physicians. CNA #1 indicated submitting a physician's report regarding scabies status and treatment to the IP and Director of Nursing (DON). CNA #1 indicated having reported suspected scabies cases on multiple residents in the 400-Hall to the IP and DON, who indicated the skin issue was dermatitis. CNA #2 indicated not submitting physician's report of scabies treatment to the DON and IP after no action was taken by the facility administration. 1. Contact precautions not implemented for suspected scabies cases: On 02/06/2024 in the morning, there were a total of 16 rooms in the 400-Hall. Twenty-four residents were screened, and rashes were observed on Residents 16, 112, 115, 166 and 84. Resident 112 (R112)	F 880		

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F 880	Continued From page 59 R112 was admitted on 02/10/2021 and readmitted on 07/11/2023, with diagnoses including nontraumatic acute subdural hemorrhage and hospice status. On 02/06/2024 in the morning, R112 laid in bed asleep and unarousable. The resident's body and the arms were covered in blanket. On 02/06/2024 in the morning, an individual was observed donning gown, foot cover, head cover, mask, and gloves outside R112's room. The individual introduced self as R112's hospice nurse and explained donning personal protective equipment (PPE) which was provided by the hospice agency. According to the nurse, R112 was being treated for scabies and was on contact precautions. The hospice nurse confirmed the resident's door did not have contact isolation signage and PPE supplies for facility staff. The hospice nurse recalled communicating the hospice physician's orders to the Unit Manager on 01/23/2024 and could not speak to why the facility had not implemented contact isolation precautions for R112. A hospice progress note dated 01/23/2024, revealed R112 was noted with diffused redness to arms and back, significant dryness worse in the webbing of fingers and back, new crusting present to webbing of fingers and light yellowing color to patient's back. Hospice physician: 1) diagnosed R112 with late-stage scabies, 2) ordered Ivermectin (oral anti-parasitic drug) and Permethrin cream (topical anti-parasitic drug), and 3) placed R112 on facility's precautions list. Orders were communicated to facility staff who	F 880	1. Residents 16, 84, 112, 115, and 166 were all immediately placed on appropriate transmission based precautions. The facility ensured all future shifts were worked in accordance with policy. The facility ensured that linens were handled per policy upon identification of issue. The facility informed the wound care team of individuals on TBP immediately upon identification of the deficient practice. the facility ensure proper signage was in place for each TBP resident room. The facility immediately called and notified NV OPHIE to inform them of the unusual rashes. 2. The facility conducted skin checks of affected units and no additional unusual rashes or itching were identified. 3. Staff will be educated on infection control practices including, but not limited to transmission based precautions and use of PPE. The DON or designee will review changes of condition (CIC) daily at the morning clinical stand-up meeting. Any CIC that requires TPB shall be discussed and TBP will be implemented in accordance with guidelines and policy. The Infection Preventionist is currently on leave with unknown date of return. The facility DON is covering andwill be educated on the Scabies Outbreak policy, and to inform the staffing coordinator in the event of confirmed or suspected scabies in residents or staff. The staff will be educated on the proper handling of linens according to the facility scabies outbreak policy. The facility IP is currently on leave with unknown date of return. The facility DON is covering and will be educated on properly informing staff on TBP and other infection control concerns. The Facility IP is currently on leave with unknown date of return. The facility DON is covering and will be educated on proper notification of potential outbreaks or other communicable diseases per regulation	

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F 880	Continued From page 60 stated they would communicate this with the Infection Preventionist (IP). On 02/07/2024 at 8:55 AM, a contact isolation precautions signage was observed posted on R112's door. A Certified Nursing Assistant (CNA) was observed inside R112's room without required PPE. The treatment nurse confirmed the observation and indicated the CNA violated the contact precautions protocol which required donning gown, gloves, and mask prior to entering R112's room. On 02/06/2024 at 9:47 AM, the IP indicated scabies was a highly contagious skin disease and confirmed or suspected cases must be placed on contact isolation precautions. The IP indicated maintaining a rash line listing which included Resident 112. The IP accompanied surveyor during observations in the 400-Hall and confirmed there were no rooms on TBP precautions such as contact isolation precautions or enhanced barrier precautions in the 400-Hall which included the rooms of R 112. The IP verbalized contact isolation precautions were to be implemented with suspected scabies cases to prevent cross contamination. On 02/12/24 at 8:52 AM, the Consultant Pharmacist indicated it was not uncommon for providers to prescribe anti-parasitic drugs such as Permethrin cream and Ivermectin prophylactically (preventive measures) when residents were suspected to have scabies or were possibly exposed to scabies. The Scabies Management policy (undated), documented residents with confirmed or suspected scabies would be placed on contact	F 880	4. The DON or Designee will review all Changes in Condition daily at the morning clinical stand-up meetings, including new onset suspected or confirmed scabies or other infectious disease will be reviewed and appropraite information sharing, including TBP, staffing, linen handling, and/or reporting will be communicated to all required parties. The infection control surveillance report will be utilized be reported to QAPI monthly to track compliance to all protocols. 5. Date of compliance - 03/27/2024	

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F 880	Continued From page 61 isolation precautions. The Outbreak of Communicable Diseases policy (undated), documented the IP and the DON were responsible for initiating transmission-based precautions. 2. Staff member with confirmed scabies: On 02/06/2024 at 9:13 AM, CNA #1 showed surveyor bilateral forearms which revealed dark spots, flat rashes, and burrows (line formation). CNA #1 indicated being seen by a medical provider on 01/26/2024 due to possible scabies and the CNA was placed on Permethrin cream for scabies. The CNA indicated providing the IP and DON with a copy of the physician report. CNA #1 indicated reporting multiple rash cases in the 400-Hall which may be indicative of scabies to the IP and DON who indicated the skin issue was contact dermatitis. A Patient Clinical Summary report dated 01/26/2024, revealed CNA #1 was diagnosed with scabies and had orders for Permethrin cream. On 02/06/2024 at 2:30 PM, CNA #1 was seen in the 100-Hall (ventilator unit). CNA #1 explained volunteering for another shift because of staffing needs. The Daily Schedule document dated 02/06/2024, revealed CNA #1 worked in the 400-Hall during the day shift (6:00 AM to 2:00 PM) and worked in the 100-Hall on swing shift (2:00 PM to 10:00 PM). On 02/13/2024 at 2:28 PM, the DON confirmed	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 62 CNA #1 was assigned to the 400-Hall on 02/06/2024 (day shift) where there were multiple residents who were considered suspected scabies cases. The DON confirmed CNA #1 worked in the 100-Hall in the afternoon (swing shift) on 02/06/2024. According to the DON, CNA #1 should have not been permitted to work in the 100-Hall on 02/06/2024 in accordance with the facility's policy related to dedicating staff who provided care for suspected scabies cases. The Scabies Management policy (Undated), documented staff assigned to the unit on which suspected or infected residents reside should not be assigned to other units within the facility until treatments were completed. 3. Handling of laundry items: On 02/06/2024 in the morning, housekeeping staff were observed collecting dirty linen from room to room in the 400-Hall and placing the linens in one bin. On 02/12/2024 at 9:40 AM, the IP confirmed the facility did not follow its scabies management policy related to handling of linens of residents with confirmed or suspected scabies when it failed to provide instruction to nursing and housekeeping staff on how to properly handle contaminated laundry. The IP explained laundry items of residents with suspected scabies were to be bagged in individual bags and laundered separately from other linens. On 02/13/2024 at 8:28 AM, the Administrator and DON confirmed laundry items which included clothing and linens for residents with suspected scabies were not being handled in accordance	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295071	A. BUILDING _____ B. WING _____	02/09/2024

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F 880	Continued From page 63 with the facility scabies management policy because the leadership was under the impression there were no confirmed or suspected scabies cases. The Scabies Management policy (undated), documented clothing and other washable items for confirmed or suspected residents would be bagged before removing from the resident's room. Laundry staff should use a designated washer and dryer for laundering clothing or linen from residents with confirmed or suspected cases. The washer and dryer would be washed with hot water and soap after use and cleansed with disinfectant. Clothing and linen would be handled in this manner until the resident had completed treatment. 4. Wound Care team communication On 02/06/2024 at 9:26 AM, the treatment nurse and the treatment nurse assistant parked the wound cart outside R16's room and entered the resident's room holding supplies with gloved hands. The treatment nurse removed R16's brief which revealed multiple raised pink rashes diffused throughout the resident's pelvis area. After completion of treatment, the treatment nurse assistant pulled back R16's privacy curtain with contaminated gloved hands. The treatment nurse assistant acknowledged contaminating the resident's privacy curtain by touching it prior to glove removal and hand hygiene. On 02/06/2024 at 9:40 AM, the treatment nurse indicated being aware R16 had a history of scabies and stated the rashes on R16's pelvic area was dermatitis.	F 880		

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F 880	Continued From page 64 The treatment nurse indicated being aware there were several residents with rashes, but the list of residents with infections (scabies or otherwise) was not shared with the treatment team. The treatment nurse indicated the wound care team had 53 residents to treat but did not know which residents had infections. The treatment nurse indicated safe practice would be to treat all residents as if they were infected in an abundance of caution and acknowledged the wound team did not don appropriate PPE during R16's wound care. The treatment nurse indicated the wound team should don gown and gloves during care for all residents moving forward to protect themselves and other residents from cross contamination of any disease. On 02/12/24 at 9:35 AM, the IP indicated there were a total of 13 residents on the transmission-based precautions (TBP) list but only four were placed on contact precautions specifically, one resident for Clostridium difficile, two residents for Vancomycin-resistant enterococcus (VRE) and one resident for methicillin-resistant staphylococcus aureus (MRSA). The IP indicated there were currently 58 residents on the rash line listing, but scabies had not been confirmed or ruled out due to the facility's decision not to test residents by skin scrape method. The IP indicated because the wound care team did not know which residents were infected and TBP precautions were not being implemented on all potentially infectious residents, the wound team should have donned full PPE meaning	F 880		

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F 880	Continued From page 65 mask, gown and gloves on all residents receiving wound care. 5. Failure to report communicable disease On 02/12/2024 at 10:00 AM, the IP emphasized there were currently 58 residents on the facility's rash line listing. The IP indicated scabies was a communicable disease which was required to be reported whether cases were confirmed or suspected. The IP recalled rash cases were identified as early as July 2023, but due to differences in leadership's clinical judgement, the 58 resident cases were not reported. On 02/13/2024 at 8:35 AM, the DON confirmed the IP told the DON about CNA #1's potential scabies infection and the CNA's case was not reported. The DON and Administrator confirmed the facility did not follow the facility's policy on reporting communicable disease when it failed to report 58 resident rash cases along with the suspected case of CNA #1. The Scabies Management policy (undated), documented the health department would be notified of infected and suspected scabies cases. The Outbreak of Communicable Disease policy (undated), documented the Administrator was responsible for reporting reportable diseased to the health department. Complaint #NV00069831	F 880		