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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey and Complaint Investigation #161229.<br><br>This 2567 was electronically sent to the facility on 6/11/21. | F 000 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced | F 657 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/11/2021

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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by:
The facility reported a census of 58 residents with 17 selected for review. Based on observation, interview and record review, the facility failed to review and revise the care plan for Resident (R)18 to include his fear of falling during transfer/shower so frequently refused showers and R16 for lack of the planned range of motion restorative services.

Findings included:

- Review of resident (R)18's "Physician Order Sheet," dated May 2021, revealed diagnoses included acute respiratory failure with hypoxia (low oxygen level) and heart failure.

The "Admission Minimum Data Set (MDS)," dated 03/15/21, assessed the resident with normal cognitive function and required extensive assistance of two staff for bed mobility, transfer, and dressing. The resident was dependent of staff for bathing and had no functional impairment of upper or lower extremities.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA,) dated 03/23/21, assessed the resident required assistance with ADLS and with generalized weakness. The resident required assistance of two staff using the transfer pole. (an anchored pole beside the resident's bed designed for the resident to hold onto with staff assistance while turning).

The "Care Plan," dated 03/29/21, instructed staff the resident turned self from side to side in bed, and his abilities could vary. Staff instructed the

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resident preferred showers in the evenings, utilized a trapeze for self-repositioning in bed, used a transfer pole, and required staff assistance for transfers.

Review of the "Comprehensive CNA Shower Review", "Bathing Refusal Sheet" and electronic "ADL Verification Worksheet" from 03/19/21 through 06/03/21, revealed the resident received six bed baths, one shower and declined a bathing opportunities on 12 occassions. The refusals had documentation of fear of falling on two of the "Bathing Refusal Sheets."

Observation on 06/01/21 at 11:30 AM revealed the resident positioned in bed with a hospital gown on and with untrimmed beard like facial hair.

Observation, on 06/02/21 at 1:30 PM, revealed the resident positioned in bed with a hospital gown on and untrimmed beard like facial hair. The resident stated the facial hair did itch, and he was not planning on growing a beard.

Observation, 06/03/21 at 09:35 AM, revealed the resident positioned in bed with the head of the bed elevated. The resident was dressed in a hospital gown and still had the untrimmed beard like facial hair. Interview with the resident at that time revealed he preferred to be shaved on his shower day but he was afraid to get up for a shower as he required staff to assist him and the staff were small in stature. The resident stated he had several falls prior to admission to the facility and was afraid of falling again.

Observation, on 06/07/21 at 10:45 AM, revealed

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the resident partially shaved. Interview with the resident at that time revealed the resident received a bed bath over the weekend and staff attempted to shave him. He stated his face felt better without the excess facial hair.

Interview, on 06/02/21 at 11:30AM, with Certified Nursing Aide (CNA) NN, revealed the resident repositioned himself in bed with the trapeze and the resident usually refused to get out of bed. CNA NN stated the resident received a facial shave on his bath days.

Interview, on 06/02/21 at 03:26 PM, with CNA P, revealed the resident repositioned himself with the use of the trapeze and positioning rails on the sides of the bed but usually refused to get out of bed or take a shower. The staff would provide a bed bath.

Interview, on 06/03/21 at 11:30 AM, with Consultant Therapy Staff G and the resident revealed again that the resident expressed fear of transfer with nursing staff for showering.

Interview, on 06/07/21 at 03:45 PM, with Administrative Nurse D, revealed the resident frequently refused bathing and refused to get out of bed and thought the care plan addressed his refusal of care as a behavior, but did not know if it addressed his fear of falling specifically.

The undated facility policy "Preparing to Bathe an Elder (resident )," instructed staff to record on the resident's care plan any new information shared by the elder related to bathing preferences.

The facility failed to review and revise this

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dependent resident's care plan to include his frequent refusals of showers due to his fears of falling with transfers which in part led to refusal of showers.

- Resident (R) 16's electronic medical record "EMR" documented the resident had a diagnosis of Multiple Sclerosis (MS) (progressive disease of the nerve fibers of the brain and spinal cord).

The "Annual Minimum Data Set" (MDS), dated 06/26/20, documented the resident had a "Brief Interview for Mental Status" (BIMS) score of 12, indicating she had moderately impaired cognition. She had functional limitation in range of motion (ROM) on her upper and lower extremities and did not receive restorative services.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 07/07/20, documented the resident required assistance with ADLs due to her diagnosis of MS.

The quarterly "MDS," dated 03/15/21, documented the resident had a BIMS score of 15, indicating she was cognitively intact. She had functional limitation in range of motion (ROM) on her upper and lower extremities and did not receive restorative services.

The "ADL Care Plan", dated 03/19/21, instructed staff the resident was totally dependent with ADLs. The care plan lacked any restorative range of motion services to be provided to the resident by the facility staff.

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The "Restorative Nursing Program Plan", dated 04/19/21, provided by the facility, included the following restorative plan for the resident: Bilateral (both sides) range of motion to the lower extremities (legs) and to the right upper extremity (arm) with shoulder flexion (bending) and extension (straightening) one to two times daily, three to five times per week, for 90 days.

On 06/02/21 at 10:55 AM, the resident rested in her bed. Her right hand and wrist were turned downward with her knuckles difficult for her to move. Both legs were bent at the knee with a pillow placed between her knees.

On 06/02/21 at 03:11 PM, the resident stated the staff were not doing restorative cares with her. The resident stated she would like to have restorative because it would be good for her. She would like to keep as much movement as possible, but had not noticed that she had lost any movement. The resident stated her bilateral knees and the fingers on her right hand are stiff.

On 06/02/21 at 03:11 PM, Certified Nurse Aide (CNA) O stated, he does not do any ROM or restorative care with the resident.

On 06/03/21 at 12:31 PM, consulting therapy staff HH stated, therapy had put the resident on a restorative program in April to help with rigidity and contratures (the locking of a joint) due to her disease process. Staff HH stated the CNAs are responsible for completing the restorative care.

On 06/03/21 at 01:17 PM, CNA Q stated, she did not know until that day that the resident was to

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| F 657 | Continued From page 6<br>be receiving restorative care.<br><br>On 06/03/21 at 03:30 PM, Licensed Nurse (LN) E stated, the facility did not currently have a restorative aide and the resident was not receiving restorative care.<br><br>On 06/03/21 at 01:39 PM, LN I stated, if the resident had a restorative plan, the CNAs would be doing the cares. LN did not believe the resident had a restorative plan at this time.<br><br>On 06/08/21 at 07:44 AM, Administrative Nurse D stated, she would expect the restorative program to be on the resident's care plan. LN E would be the person in charge of putting restorative programs on the care plan.<br><br>The facility policy for "Restorative Activities of Daily Living Services", undated, included: The Comprehensive Care Plan will indicate individualized approaches and assistive devices.<br><br>The facility failed to review and revise this dependent resident's plan of care to include instructions to the staff to provide the resident with the planned restorative services with range of motion. | F 657 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 58 residents | F 677 | | |

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with 17 residents reviewed, including five residents selected for review of Activities of Daily Living (ADLs). Based on observation, interview, and record review, the facility failed to offer appropriate assistance for personal hygiene needs for three of the five sampled residents including Residents (R) 18 with a lack of showers with facial shaving, R43 with a lack of facial hygiene needs, and R45 who wore soiled clothes.

Findings include:

- The "Physician Order Sheet" (POS), dated 04/15/21, documented Resident (R)45 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set" (MDS), dated 01/25/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating the resident had significant cognitive impairment. He required extensive assistance of two staff for dressing.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 05/28/21, did not trigger.

The quarterly "MDS," dated 04/27/21, documented the staff assessment for cognition revealed the resident had moderately impaired cognition. He required extensive assistance of two staff for dressing.

The ADL care plan, dated 02/31/21, instructed

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staff the resident required extensive assistance with dressing.

Review of documentation from the resident's electronic medical record, EMR, revealed he required limited to total assistance with dressing from 04/06/21 through 06/06/21.

On 06/02/21 at 10:58 AM, the resident sat in his Broda (specialized wheelchair) chair in the commons area. The resident wore dark grey sweatpants and a dark grey long sleeved shirt. Both items of clothing had food crumbs and debris on the front. The resident's sleeves had a dried food substance on both wrists.

On 06/02/21 at 11:35 AM, Certified Nurse Aide (CNA) Q, fed the resident lunch which consisted of pureed pulled pork, baked beans and cherry cheesecake. As can Q fed the resident, he wiped at his face with both arms, causing food debris to transfer to his sleeves.

At 06/02/21 at 12:57 PM, the resident sat in the commons area in his Broda chair. The resident continued to wear the dark grey sweat pants and shirt which continued to have the dried food debris and crumbs.

On 06/02/21 at 03:44 PM, CNA N, confirmed the resident's clothing was dirty with food debris. CNA N stated she would change the resident's clothing following dinner. If she changed the resident's clothing before dinner, the clean clothing would only become dirty during the meal. The resident's clothing would be changed before he went to bed for the night.

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On 06/03/21 at 01:17 PM, CNA Q stated, if a resident had on dirty clothes, staff should change them.

On 06/03/21 at 01:39 PM, Licensed Nurse (LN) I stated, the resident's clothing gets dirty while he eats. He would wipe at his face with his arms as he was fed by staff. LN stated she would expect the staff to change his clothing when they became dirty.

On 06/08/21 at 07:44 AM, Administrative Nurse D stated, she would expect staff to change resident's clothing when they became soiled during a meal.

The facility policy for "Activities of Daily Living", undated, included: The facility will provide each elder with care, treatment, and services according to the elder's individualized care plan.

The facility failed to change this dependent resident's clothing when they became soiled with food following meals.

- The "Physician Order Sheet" (POS), dated 12/28/20, documented Resident (R)43 had a diagnosis of
physical debility (a limitation on a person's physical functioning).

The "Admission Minimum Data Set" (MDS), dated 12/28/20, documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating she was cognitively intact. She required limited assistance of one staff for personal hygiene.

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The "Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 01/14/21, triggered but lacked completion.

The Significant Change "MDS," dated 01/21/21, documented the resident had a BIMS score of 14, indicating she was cognitively intact. She required extensive assistance of two staff for personal hygiene.

The "ADL Care Plan", dated 05/04/21, instructed staff the resident required assistance with washing her hands and face.

Review of the staff's documentation of the resident's ADLs, supplied by the facility, revealed the resident required mostly total assistance of one staff for personal hygiene from 05/06/21 through 06/06/21.

On 06/02/21 at 10:55 AM, the resident rested in bed. Her eyes contained a greenish discharge to both eyes.

On 06/02/21 at 12:56 PM, Certified Medication Aide (CMA) T fed the resident her lunch and then left the room. The resident continued to have a greenish discharge to both eyes.

On 06/03/21 at 10:48 AM, the resident remained with a greenish discharge from both eyes.

On 06/03/21 at 01:17 PM, Certified Nurse Aide (CNA) Q stated, the resident was unable to wash her face on her own and required staff assistance with all ADLs.

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On 06/03/21 at 02:42 PM, CNA MM stated, the resident required staff to wash her face. CNA MM confirmed the resident had eye drainage and stated she would wash the resident's face before bed.

On 06/03/21 at 02:24 PM, Licensed Nurse (LN) I stated, the CNAs were responsible for washing resident's faces when they were dirty.

On 06/08/21 at 07:44 AM, Administrative Nurse D stated, she would expect the staff to wash residents faces when they were dirty.

The facility policy for "Activities of Daily Living", undated, included: The facility will provide each elder with care, treatment, and services according to the elder's individualized care plan.

The facility failed to wash the face of this dependent resident who had continued green discharge from her eyes.

- Review of resident (R)18's "Physician Order Sheet," dated May 2021, revealed diagnoses included acute respiratory failure with hypoxia (low oxygen level) and heart failure.

The "Admission Minimum Data Set (MDS)," dated 03/15/21, assessed the resident with normal cognitive function and required extensive assistance of two staff for bed mobility, transfer, and dressing. The resident was dependent of staff for bathing and had no functional impairment of upper or lower extremities.

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The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA,) dated 03/23/21, assessed the resident required assistance with ADLS and with generalized weakness. The resident required assistance of two staff using the transfer pole. (an anchored pole beside the resident's bed designed for the resident to hold onto with staff assistance while turning).

The "Care Plan," dated 03/29/21, instructed staff the resident turned self from side to side in bed, and his abilities could vary. Staff instructed the resident preferred showers in the evenings, utilized a trapeze for self-repositioning in bed, used a transfer pole, and required staff assistance for transfers.

Review of the "Comprehensive CNA Shower Review", "Bathing Refusal Sheet" and electronic "ADL Verification Worksheet" from 03/19/21 through 06/03/21, revealed the resident received six bed baths, one shower and declined a bathing opportunities on 12 occasions. The refusals had documentation of fear of falling on two of the "Bathing Refusal Sheets."

Observation on 06/01/21 at 11:30 AM revealed the resident positioned in bed with a hospital gown on and with untrimmed beard like facial hair.

Observation, on 06/02/21 at 1:30 PM, revealed the resident positioned in bed with a hospital gown on and untrimmed beard like facial hair. The resident stated the facial hair did itch, and he was not planning on growing a beard.

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Observation, 06/03/21 at 09:35 AM, revealed the resident positioned in bed with the head of the bed elevated. The resident was dressed in a hospital gown and still had the untrimmed beard like facial hair. Interview with the resident at that time revealed he preferred to be shaved on his shower day but he was afraid to get up for a shower as he required staff to assist him and the staff were small in stature. The resident stated he had several falls prior to admission to the facility and was afraid of falling again.

Observation, on 06/07/21 at 10:45 AM, revealed the resident partially shaved. Interview with the resident at that time revealed the resident received a bed bath over the weekend and staff attempted to shave him. He stated his face felt better without the excess facial hair.

Interview, on 06/02/21 at 11:30 AM, with Certified Nursing Aide (CNA) NN, revealed the resident repositioned himself in bed with the trapeze and the resident usually refused to get out of bed. CNA NN stated the resident received a facial shave on his bath days.

Interview, on 06/02/21 at 03:26 PM, with CNA P, revealed the resident repositioned himself with the use of the trapeze and positioning rails on the sides of the bed but usually refused to get out of bed or take a shower. The staff would provide a bed bath.

Interview, on 06/03/21 at 11:30 AM, with Consultant Therapy Staff G and the resident revealed again that the resident expressed fear of transfer with nursing staff for showering.

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| F 677 | Continued From page 14<br>Interview, on 06/07/21 at 03:45 PM, with Administrative Nurse D, revealed the resident frequently refused bathing and refused to get out of bed.<br><br>The undated facility policy "Preparing to Bathe an Elder (resident)," instructed staff to record on the resident's care plan any new information shared by the elder related to bathing preferences.<br><br>The facility failed to assess this dependent resident's refusals to get out of the bed for necessary bathing/facial shaving, due to his fears of falling with transfers. | F 677 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§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<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by: | F 688 | | |

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The facility reported a census of 58 residents, with 17 residents included in the sample, including three residents reviewed for rehabilitation/restorative services. Based on observation, interview, and record review, the facility failed to provide restorative services for two of the three sampled residents including Resident (R) 16, with range of motion (ROM) to maintain or prevent decline in range of motion (ROM) ability and R5 with restorative services for ambulation to maintain or prevent decline in ambulation ability.

Findings included:

- Resident (R) 16's electronic medical record "EMR" documented the resident had a diagnosis of Multiple Sclerosis (MS) (progressive disease of the nerve fibers of the brain and spinal cord).

The "Annual Minimum Data Set" (MDS), dated 06/26/20, documented the resident had a "Brief Interview for Mental Status" (BIMS) score of 12, indicating she had moderately impaired cognition. She had functional limitation in range of motion (ROM) on her upper and lower extremities and did not receive restorative services.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 07/07/20, documented the resident required assistance with ADLs due to her diagnosis of MS.

The quarterly "MDS," dated 03/15/21, documented the resident had a BIMS score of 15, indicating she was cognitively intact. She

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had functional limitation in range of motion (ROM) on her upper and lower extremities and did not receive restorative services.

The "ADL Care Plan", dated 03/19/21, instructed staff the resident was totally dependent with ADLs.

The "Restorative Nursing Program Plan", dated 04/19/21, provided by the facility, included the following restorative plan for the resident: Bilateral (both sides) range of motion to the lower extremities (legs) and to the right upper extremity (arm) with shoulder flexion (bending) and extension (straightening) one to two times daily, three to five times per week, for 90 days.

On 06/02/21 at 10:55 AM, the resident rested in her bed. Her right hand and wrist were turned downward with her knuckles difficult for her to move. Both legs were bent at the knee with a pillow placed between her knees.

On 06/02/21 at 03:11 PM, the resident stated the staff were not doing restorative cares with her. The resident stated she would like to have restorative because it would be good for her. She would like to keep as much movement as possible, but had not noticed that she had lost any movement. The resident stated her bilateral knees and the fingers on her right hand are stiff.

On 06/02/21 at 03:11 PM, Certified Nurse Aide (CNA) O stated, he does not do any ROM or restorative care with the resident.

On 06/03/21 at 12:31 PM, consulting therapy staff HH stated, therapy had put the resident on a

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restorative program in April to help with rigidity and contratures (the locking of a joint) due to her disease process. Staff HH stated the CNAs are responsible for completing the restorative care.

On 06/03/21 at 01:17 PM, CNA Q stated, she did not know until that day that the resident was to be receiving restorative care.

On 06/03/21 at 03:30 PM, Licensed Nurse (LN) E stated, the facility did not currently have a restorative aide and the resident was not receiving restorative care.

On 06/03/21 at 01:39 PM, LN I stated, if the resident had a restorative plan, the CNAs would be doing the cares. LN did not believe the resident had a restorative plan at this time.

On 06/08/21 at 07:44 AM, Administrative Nurse D stated, there had been a communication issue with the resident and the nursing staff was not aware the resident was to be on a restorative program. Administrative Nurse D stated the staff had now been educated about the need to do restorative with the resident.

The facility policy for "Restorative Activities of Daily Living Services", undated, included: All elders of the facility will achieve and maintain the highest practicable level of functionality with all Activities of Daily Living.

The facility failed to provide restorative range of motion services to this dependent resident to maintain and prevent decline in her range of motion ability.

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- Review of Resident (R)5's "Physician Order Sheet," dated May 2021, revealed diagnoses include encephalopathy (brain damage or disease,) acute respiratory failure and alcohol induced dementia (progressive mental disorder characterized by failing memory and confusion).

The "Quarterly Minimum Data Set (MDS)," dated 02/17/21, assessed the resident had severe cognitive impairment, with inattention, disorganized thinking, delusions, and wandering. The resident required limited assistance of one staff for bed mobility, transfers, personal hygiene, dressing, and toilet use. The resident's balance for walking was unsteady and was only able to stabilize with staff assistance. The resident had no impairment of the upper or lower extremities and used a wheelchair or walker for mobility.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA,) dated 05/18/20, assessed the resident had impaired balance and functional impairment in activity with generalize weakness and decreased safety awareness.

The "Care Plan," reviewed May 2021, instructed staff to maintain the resident's current level of mobility and that the resident used a wheelchair for mobility. The resident had behavioral symptoms of anxiety and agitation.

The "Care Plan Report," dated 12/15/20, contained an entry for staff to assist the resident with walking to meals daily using a gait belt with a wheelchair following the resident. An entry for ambulation indicated the resident needed one

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staff to assist him with a gait belt. Staff instructed the resident was unsafe to ambulate by himself.

The "Physical Therapy Discharge Summary," dated 06/30/20instructed staff to ambulate the resident with contact guard assistance, rolling walker and a wheelchair behind the resident to/from three meals per day.

Observation, on 06/02/21 at 1:30 PM, revealed the resident propelling himself in his wheelchair using his feet from the dining room. Observations on 06/03, and 06/07 revealed the resident propelling himself to and from meals in the dining room seated in his wheelchair.

Interview, on 06/02/21 at 01:30 PM, with Certified Nurse Aide (CNA) NN, revealed the resident moved about in his room and facility with his wheelchair and could transfer himself from his bed to his wheelchair but staff did not ambulate the resident to meals.

Interview, on 06/02/21at 03:27 PM, with CNA QQ, revealed the resident propels himself around the facility in his wheelchair. CNA QQ stated the staff did not walk to dine the resident to or from meals.

Interview, on 06/03/21 at 02:19 PM, with Administrative Nurse E, revealed the resident was not on a restorative program. Upon review of old records and the care plan, Administrative Nurse E confirmed the resident was on a restorative program for walk to dine from 07/21/20 through 10/19/20. Administrative Nurse E stated the resident frequently refused to walk, and had behavior issues. Staff transferred the

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resident to behavioral health units a couple times, and then he became COVID positive (the resident transferred to a behavioral health facility 10/19/20 and returned 11/03/20, the resident transferred to COVID unit 11/08/20 through 11/11/20, and back to behavioral health 01/11/21 through 01/27/21.) Administrative Nurse E stated the restorative programs last for 90 days, then staff incorporate restorative measures into everyday care of the resident but confirmed staff did not offer the resident ambulation opportunities.

Observation, on 06/07/21 at 10:39 AM, revealed CNA NN and Administrative Nurse F, applied a gait belt around the resident and asked the resident if he would stand and walk with them with a walker. The resident agreed and ambulated with knees in a partially flexed position with staff assistance but did become unbalanced and sat back into his wheelchair. Interview with the resident at that time revealed he would like to walk.

Interview, on 06/07/21 at 03:30 PM, with Administrative Nurse D and Licensed Nurse H, revealed the resident was mobile in his wheelchair with no change in status, but staff did not provide walk to/from dining ambulation opportunities to the resident since discharge from the restorative program on 10/19/20.

Interview, on 06/08/21 at 09:00 AM, with Consulting Therapy staff HH, confirmed the discharge plan from therapy on 06/30/20 included a walk to/from dining three times a day. Consulting Therapy staff HH stated he conducted quarterly evaluations of the resident and

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| F 688 | Continued From page 21<br>concluded the resident had no change in capabilities. Therapy staff HH stated the facility had a restorative program for 90 days after a therapy recommendation was made.<br><br>The undated facility "Restorative Policy" instructed staff to ensure residents achieve and maintain the highest practicable level of functionality with all ADLs.<br><br>The facility failed to provide staff assistance for ambulation opportunities for this resident who required contact guard assistance of staff, a walker and follow behind of a wheelchair to maintain the resident's physical walking ability. | F 688 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 58 residents with 17 selected for review which included 4 residents reviewed for accidents. Based on observation, interview and record review, the facility failed to provide safety following a shower for one resident (R)16, failed to ensure one resident R18, used his trapeze in a safe manner, and failed to ensure one resident R 22 with a history of falls had access to her call light on two occasions. | F 689 | | |

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Findings included:

- Review of resident (R)18's "Physician Order Sheet," dated May 2021, revealed diagnoses included acute respiratory failure with hypoxia (low oxygen level) and heart failure.

The "Admission Minimum Data Set (MDS)," dated 03/15/21, assessed the resident with normal cognitive function, and required extensive assistance of two staff for bed mobility, transfer, and dressing. The resident was dependent of staff for bathing and had no functional impairment of upper or lower extremities.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 03/23/21, assessed the resident used a trapeze for repositioning when in bed.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA,) dated 03/23/21, assessed the resident required assistance with ADL, with generalized weakness.

The "Care Plan," dated 03/29/21, instructed staff the resident turned self from side to side in bed, and his abilities could vary. Staff instructed the resident utilized a trapeze for self-repositioning in bed.

Observation, 06/03/21 at 09:35 AM, revealed the resident positioned in bed with the head of bed elevated and the entire bed in a high position. The trapeze was behind the resident (behind the mattress) out of reach. Licensed Nurse (LN) H and LN G lowered the resident's head of bed and

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the trapeze swung out, nearly hitting the resident's head.
The resident demonstrated how he utilized the trapeze but grabbed the frame of the trapeze which extended out above and in front of him and then reached behind himself and grabbed the back frame of the trapeze to pull himself up .

Observation, on 06/03/21 at 11:30 AM with Consultant Therapy Staff G revealed again the resident demonstrated use of the trapeze by grabbing onto the frame of the trapeze (not the actual trapeze) to repositioned himself. Interview with Consultant Therapy Staff G confirmed the resident's improper technique of using the frame of the trapeze to pull himself up as potentially hazardous. Interview with the resident at that time revealed he did not know why his bed remained in a high position, other than at meals to accommodate the over the bed tray table.

Interview, on 06/02/21 at 11:30 AM, with Certified Nursing Aide (CNA) NN, revealed the resident repositioned himself in bed with the trapeze.

Interview, on 06/03/21 at 01:23 PM with Consulting Therapy staff HH, revealed staff and resident received instruction on use of the trapeze upon placement of the trapeze per the Therapy "Discharge Summary" dated 04/08/21.

Interview, on 06/02/21 at 03:26 PM, with CNA P, revealed the resident repositioned himself with use of the trapeze and positioning rails on the sides of the bed.

Interview, on 06/07/21 at 03:45 PM, with Administrative Nurse D, revealed therapy

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instructed staff and the resident in use of the trapeze for self-positioning, but staff D did not know the resident used the trapeze improperly.

The undated facility "Fall Prevention Protocol," instructed staff to provide services and care to ensure the elder's environment remains as free from accident hazards as possible and the resident receives adequate supervision and assistive devices to prevent accidents.

The undated facility policy "Bed Mobility" instructed staff to ensure the grasps the trapeze with a strong hand.

The facility failed to ensure this resident used the trapeze for positioning in a correct manner to prevent potential accidents.

- Review of resident (R)22's "Physician Order Sheet," dated May 2021, revealed diagnoses included repeated falls, anxiety disorder and low back pain.

The "Admission Minimum Data Set (MDS,)" dated 03/19/21, assessed the resident had moderate cognitive impairment and required extensive assistance of two staff for transfers and toilet use with occasional urinary incontinence.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment " (CAA,) dated 03/25/21, assessed the resident had impaired balance during transfers, functional impairment of ADL, generalized weakness and decreased safety awareness.

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The "Falls" CAA, dated 03/25/21, assessed the resident had impaired gait and mobility, required assistance with transfers and had a history of falls prior to admission with other major/minor injuries.

The "Care Plan," revised 04/01/21, instructed staff the resident required two staff to transfer. The resident did not ambulate due to recent fracture of her left arm (fall in the facility on 04/20/21) but was independently mobile in her wheelchair. A fall intervention, dated 04/16/21 instructed staff to provide a Reacher (a long-handled device used to grab out of reach items,) an anti rollback device for the wheelchair was applied and staff instructed the resident to lock both brakes. An intervention dated 04/20/21 instructed staff to rearrange the room furnishings for safe walking, and the resident moved to a room with high staff observation.

Review of the "Accident Timeline" revealed the following:

Fall on 04/16/21 at 05:45 PM, revealed the resident reached for her Kleenex box and stood to transfer herself into her wheelchair and fell due to one unlocked brake. The interventions included to provide the resident with a Reacher, obtain an anti rollback device for the wheelchair, and staff instructed the resident to lock both brakes.

The fall on 04/20/21 at 07:00 AM, revealed the resident was found on the floor between her bed and wheelchair when she self-transferred. The resident did not use her call light and sustained a radial neck (wrist) fracture. The interventions

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included to provide a room change with higher staff observation and arrange for safe furniture walking. The resident did not always remember to call for assistance prior to transfer.

Observation, on 06/01/21 at 03:40 PM, revealed the resident seated on the edge of her recliner and then scooted herself toward her wheelchair. The resident's call light was on her bed not within reach. Interview with the resident at that time revealed she had fallen several times and could not use her left arm (in a cast from base of knuckles to mid upper arm) due to a fracture and she needed assistance to go to the bathroom. The resident demonstrated she could not reach her call light. Surveyor II notified Certified Medication Aide (CNA) R and Licensed Nurse K; the resident required assistance to toilet.

Observation, on 06/03/21 at 08:23 AM, revealed the resident seated in her wheelchair in her room facing her recliner. The foot pedals of the wheelchair rested against the recliner, and the call light was beneath the pillow on the resident's bed, and out of her reach. Interview, with the resident at that time, revealed she needed to use the toilet and demonstrated that she could not find/use her call light. Surveyor II notified CNA PP, who confirmed the resident could not reach her call light and obtained further assistance to toilet the resident.

Observation, on 06/08/21 at 08:30 AM, revealed the resident positioned on the commode in her bathroom. The resident stated her medical provider removed the cast from her left arm and it was sore, and she was not able to use it. The call light in the bathroom was located to the

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resident's left which required the resident to extend her right arm forward and across her body, with nothing to hold onto (a positioning bar was attached to the wall to the resident's left side and the call light did not have a string attached to it for the resident to pull.)

Interview, on 06/03/21 at 01:23 PM, with Consulting Therapy staff HH, revealed the resident received therapy and prior to her falls in the facility she required minimal assistance with transfers upon discharge from therapy.

Interview, on 06/07/21 at 3:30 PM, with Administrative Nurse D, revealed she would expect staff to keep the resident's call light within reach.

The facility undated "Fall Prevention Protocol" instructed staff to provide services and care that ensure the resident's environment remains as free from accident hazards as is possible and each resident receives supervision and assistive devices to prevent accidents.

The facility failed to ensure this resident had access to her call light to alert staff of the need for assistance and prevent further accidents.

- The "Physician Order Sheet" (POS), dated 04/15/21, documented Resident (R)45 had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

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The "Significant Change Minimum Data Set" (MDS), dated 01/25/21, documented the resident had a Brief Interview for Mental Status "BIMS" score of 3, indicating the resident had severe cognitive impairment. He required extensive assistance of two staff for transfers. His balance was not steady, he was only able to stabilize with human assistance, and used a wheelchair for locomotion. The resident had two or more non-injury falls since the prior assessment.

The "Falls Care Area Assessment" (CAA), dated 01/25/21, documented the resident had an impaired gait and mobility with a history of falls.

The quarterly (MDS,) dated 04/27/21, documented the staff assessment for cognition revealed moderately impaired cognition. He required extensive assistance of two staff for transfers. His balance was not steady,he was only able to stabilize with human assistance, and used a wheelchair for locomotion. The resident had one non-injury fall and one injury (except major) fall since the prior assessment.

The Falls care plan, dated 02/31/21, instructed staff the resident was at high risk for falls related to severe cognitive loss and poor safety awareness and a history of falls. The resident had a history of attempting to get up from his wheelchair, unassisted. Fall interventions included: a low bed, floor mat next to his bed, a sensor alarm on the floor mat, and a perimeter mattress on his bed.

Review of the resident's "electronic medical record" "EMR", revealed the following fall risk

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assessments which placed the resident at a high risk for falls, dated: 04/22/21, 04/20/21, 01/23/21, 12/27/20, and 12/25/20.

Review of the facility fall report, dated 04/21/21, revealed, Certified Nurse Aide (CNA) OO gave the resident a shower on 04/21/21 at approximately 11:30 PM, after the resident had an episode of bowel incontinence. Following the resident's shower, CNA OO turned his back on the resident and walked approximately five feet away from the resident to obtain another towel. While the CNA had his back turned to the resident, the resident, dressed in pants and a t-shirt, attempted to stand up from the wheelchair and fell, hitting the wall of the shower room and then falling to the floor. The resident obtained a skin tear to his left elbow, measuring 2.5 centimeters (cm) and an abrasion (a partial thickness wound caused by damage to the skin and can be superficial involving only the epidermis to deep, involving the deep dermis) to his left nostril, measuring 0.7 cm. The areas were treated per facility protocol. The staff were re-educated to take the resident with them to obtain additional supplies following a shower.

On 06/02/21 at 10:58 AM, the resident sat in his Broda chair in the commons area. He had a 1 cm area to his left nostril which was scabbed over and light green bruising above his left eye. The resident had no indications of pain or discomfort.

On 06/02/21 at 03:44 PM, CNA O and N, give cares to the resident while he was in his room. Staff transferred the resident with extensive assistance of two staff and the use of the gait belt

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from his bed to the Broda chair. The resident was able to bear minimal weight during the transfer. The resident continued to have the scabbed area to his left nostril and light green bruising above his left eye.

On 06/02/21 at 03:44 PM, CNA N stated, the resident required extensive assistance with standing. He had a history of trying to stand on his own, but he was no longer able to stand safely. His fall interventions included a low bed and a floor mat next to his bed.

On 06/03/21 at 01:17 PM, CNA Q stated, the resident required extensive assistance of two staff for transfers as he was not able to stand or transfer independently. He had a history of attempting to stand up on his own.

On 06/03/21 at 02:42 PM, CNA MM stated, the resident would try to get out of his wheelchair on his own.

On 06/07/21 at 09:05 AM, CNA OO stated, on the day of the incident, he had taken the resident into the shower after the resident had an episode of bowel incontinence in his bed. Following the shower, the resident was dressed in pants and a t-shirt, but lacked socks and shoes. CNA OO stated he turned his back on the resident and walked approximately five feet away to obtain a towel. The resident attempted to stand on his own from his wheelchair while CNA OO's back was turned. The resident was unable to maintain an upright position and fell into the wall of the shower room and then fell to the floor. CNA OO notified the Licensed Nurse (LN) J who came and assessed the resident at that time and treated

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| F 689 | Continued From page 31<br>the skin tear to the resident's elbow and the abrasion to the resident's nostril. Staff then assisted the resident up to his wheelchair and back to bed.<br><br>On 06/03/21 at 01:39 PM, LN I stated, the resident required extensive assistance with all of his cares. He had a history of attempting to get out of his wheelchair unassisted.<br><br>On 06/03/21 at 08:23 AM, Administrative Nurse D stated, she would expect the staff to not turn their backs on a resident while in the shower room. The resident had a history of attempting to get out of his wheelchair unassisted.<br><br>The facility's policy for "Fall Prevention Protocol", undated, included: Each elder residing at the facility will be provided services and care that ensures the elder's environment remains as free from accident hazards as possible and that each elder receives adequate supervision to prevent accidents.<br><br>The facility failed to provide appropriate supervision to this dependent resident during a showering opportunity which led to the resident falling to the floor and receiving a skin tear and an abrasion. | F 689 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must | F 692 | | |

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ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 58 residents. The sample contained 17 residents, with five residents selected for nutritional review. Based upon observation, interview, and record review, the facility failed to promote weight maintenance for one of five residents, Resident (R) 7, when the facility failed to provide routine consistent cueing, encouragement, and assistance with meals as per R7's nutritional plan of care.

Findings included:

- A signed "Physician Order Sheet" (POS), dated 03/17/21, documented R7 had diagnoses which included congenital stenosis and stricture of esophagus (a birth defect resulting in abnormalities of the swallowing mechanism caused by narrowing of the esophagus, the muscular tube connecting the mouth and stomach) and dysphagia (swallowing difficulty).

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An annual "Minimum Data Set" (MDS), dated 09/02/20, documented R7's "Brief Interview for Mental Status" (BIMS) score was 7, indicating severe cognitive impairment. She required supervision with set up assistance for eating.

R7's nutrition care plan, dated 09/11/20, instructed staff to provide cueing and encouragement, and to provide assistance if needed.

A signed physician order, dated 03/17/21, instructed that R7 receive a fortified puree diet, and ice cream with meals.

A "Nutritional Care Form," dated 01/11/21, documented the Registered Dietitian determined R7 had a 7% weight loss in 2 months, and recommended staff continue cueing, encouraging, and assisting R7 to eat as needed.

On 06/03/21 at 08:49 AM, R7 sat alone with her breakfast. Dietary staff BB approached, encouraged her to eat, and offered her oatmeal instead of what she was eating. R7 did not respond and did not eat anything until 09:03 AM (11 minutes later), when Activity Staff Z stopped and fed her a few bites of the puree eggs and her supplement. R7 remained in the dining room for an additional 30 minutes without further staff cueing to eat more or interaction. The resident ate nothing else for this meal.

On 06/07/21 at 08:30 AM, R7 sat alone with her breakfast. No staff approached or provided any cueing to eat to R7 until 09:10 AM (40 minutes later), when Consultant Therapy Staff HH propelled her in the wheelchair away from the

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table and out of the dining room.

On 06/02/21 at 04:10 PM, Certified Nursing Assistant (CNA) P stated R7's meal tray ticket was blue, identifying a fortified diet for weight loss. R7 refused supper and often refuses meals. When R7 is not eating, nursing staff encourage her to eat, and offer her some bites.

On 06/03/21 at 01:21 PM, Certified Medication Aide (CMA) R stated the resident had a blue dietary ticket so she should receive fortified foods. She could help some with her routine cares, and could feed herself, but she needed a lot of encouragement to do that.

On 06/03/21 at 02:27 PM, Licensed Nurse (LN) G stated R7 had weight loss and was not eating well lately. She had a history of weight loss, received a supplement with each meal, and fed herself. This morning she was not eating, so LN G sent someone to help her and to see if they could get her to eat anything.

On 06/08/21 at 09:43 AM, LN H stated R7 was not eating well and needed a lot of encouragement to eat.

On 06/08/21 09:45 AM, Administrative Nurse D stated R7 was a slow eater and required staff encouragement to eat.

An undated facility policy titled "Monitoring Weights," instructed staff to evaluate all elders for weight stabilization for timely identification of weight loss and treatment will be provided when possible. Care plan interventions will be developed and implemented that offer a

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| F 692 | Continued From page 35<br>reasonable expectation addressing all causal factors including eating environment and food preferences.<br><br>The facility failed to promote weight maintenance for this resident, when they failed to provide routine consistent cueing, encouragement, and assistance with meals as planned to maintain her weight. | F 692 | | |