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F 000	INITIAL COMMENTS The following deficiencies represent the finding of a Health Resurvey.	F 000		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed	F 636		

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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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on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 58 residents with 18 residents sampled. Based on observation, interview, and record review the facility failed to complete an accurate Minimum Data Set (MDS) for three Residents (R)15, regarding incomplete triggered Behavioral Symptoms and Psychosocial Well-Being Care Area Assessments (CAA), R 56, regarding an incomplete CAA for the triggered area of Behavioral Symptoms and R 7, regarding incomplete CAAs for all triggered areas.

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Findings included:

- Review of Resident (R)15's electronic medical record (EMR) revealed a diagnosis of neurocognitive disorder with behavioral disturbance (a condition where a person has both cognitive deficits and behavioral disturbances).

The "Admission Minimum Data Set" (MDS), dated 06/11/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive disturbance. He had didsorganized thinking behavior which fluctuated and other behaviors which disrupted the living environment of other residents. He had wandering behaivors one to three days of the assessment period and received antipsychotic (medication used to treat psychosis--any major mental disorder characterized by a gross impairment in reality perception)) and antidepressant (medication used to treat depression--a mood disorder that causes a persistent feeling of sadness and loss of interest) during the assessment period.

The "Behavioral Symptoms Care Area Assessment" (CAA) and the "Psychosocial Well-Being CAA," dated 06/11/24, both triggered, but lacked an analysis of findings.

The "Quarterly MDS," dated 09/09/24, documented the staff assessment for cognition revealed severe cognitive impairment. He had inattention and disorganized thinking behavior present during the assessment period and physical behavioral symptoms directed towards others one to three days of the assessment period. He receivced antipsychotic, antianxiety (medications used to treat anxiety--mental or

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emotional reaction characterized by apprehension, uncertainty and irrational fear) and antidepressant medication during the assessment period.

The care plan, revised 09/07/24, instructed staff the resident received antianxiety medications, antidepressant medications and psychotropic medications. Staff were to monitor the resident for adverse side effects of the medications and report any behaviors to the nurse.

Review of the resident's "Medication Administration Record" (MAR), for October 2024, included the following physician's orders:

Haloperidol (an antipsychotic medication), 1 miligram (mg), by mouth (po), every day (QD), for anxiety, ordered 06/11/24.

Seroquel (an antipsychotic medication), 50 mg, po at bed time (HS), for neurocognitive disorder with behavioral disturbances, ordered 06/04/24.

Trazodone (an antidepressant medication), 50 mg, po Q HS, as needed (PRN), for insomnia (the inability to sleep), ordered 06/04/24.

Review of the resident's October 2024 MAR, revealed the resident received all of these medications, as ordered.

On 10/30/24 at 08:53 AM, Administrative Nurse D stated it was the expectation for all triggered CAAs contain an analysis of findings.

On 10/30/24 at 10:39 AM, Administrative Nurse E confirmed the "Behavioral Symptoms" and "Psychosocial Well-Being" CAAs on the

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admission MDS, dated, triggered but lacked an analysis of findings.

The facility policy for "Care Areaa Assessments", revised November 2019, included: The care area assessments are used to help analyze data obtained from the MDS and to develop individualized care plans.

The facility failed to complete an accurate MDS for this dependent resident with behaivors by failing to complete the triggered CAAs on his admission MDS.

- Review of Resident (R)56's electronic medical record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Admission Minimum Data Set" (MDS), dated 08/09/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. She had verbal behaviors directed towards others one to three days of the assessment period with no impact on the resident or others.

The "Behavioral Symptoms Care Area Assessment" (CAA), dated 08/09/24, triggered but lacked an analysis of findings.

The care plan for behaviors, revised 10/30/24, instructed staff the resident had the potential to become verbally aggressive. Staff were to monitor the side effects of the resident's medicationns and report any ususual behaviors to the nurse.

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Review of the resident's EMR revealed the following phsyician's order:

Escitalopram (an antidepressant medication used to treat depression--a mood disorder that causes a persistent feeling of sadness and loss of interest), 20 miligrams (mg), by mouth (po), every day (QD) in the morning, for depression, ordered 08/02/24.

Review of the resident's October 2024 MAR, revealed the resident the medication, as ordered.

On 10/30/24 at 08:53 AM, Administrative Nurse D stated it was the expectation for all triggered CAAs contain an analysis of findings.

On 10/30/24 at 10:39 AM, Administrative Nurse E confirmed the "Behavioral Symptoms" and "Psychosocial Well-Being" CAAs on the admission MDS, dated, triggered but lacked an analysis of findings.

The facility policy for "Care Areaa Assessments", revised November 2019, included: The care area assessments are used to help analyze data obtained from the MDS and to develop individualized care plans.

The facility failed to complete an accurate MDS for this dependent resident with behaivors by failing to complete the triggered CAA on her admission MDS.

- Review of Resident (R)7's "Physician Orders" (POS) dated 10/08/24 documented diagnoses which included major depressive disorder (a

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mood disorder that causes a persistent feeling of sadness and loss of interest), type 2 diabetes ((DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), pain, insomnia (inability to sleep), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).

The "Admission Minimum Data Set" (MDS) dated 03/19/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 indicating the resident cognitively intact, no behavior or indication of depression. He was occasionally incontinent of urine. The resident received opiod (narcotic-controled medication) pain medication as needed (prn) and reported frequent moderate pain which interfered with his day-to-day activities and sleep. He was 71 inches tall and weighed 246 pounds. R 7 received medications which included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), and antianxiety (class of medications used to treat mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The following "Care Area Assessments" (CAA)dated 03/25/24 triggered and lacked the required analysis of findings related to the causes , contributing factors, and/or rationale:
1. " Urinary Incontinence CAA"
2. "Falls CAA"
3. "Nutritional Status CAA"
4. "Psychotropic Drug CAA"
5. "Pain CAA"

On 10/29/24 at 02:42 PM, Administrative Nurse E reviewed the residents MDS as noted above . He

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confirmed the resident's "Admission MDS" dated 03/11/24, lacked the required completion of the triggered CAAs. He stated he was aware the analysis of findings/CAA completion was necessary to meet the criteria of a completed comprehensive assessment .
Administrative Nurse E stated the facility used the "Resident Assessment Instrument Manual," (RAI) for guidance to complete the MDS.
0/30/24 at 09:13 AM, Administrative Nurse D confirmed the above findings. She confirmed the resident's "Admission MDS" lacked the required completion of the triggered CAAs. He stated he was aware the analysis of findings/CAA completion was necessary to meet the criteria of a completed comprehensive assessment . Administrative Nurse D stated the facility used the "Resident Assessment Instrument Manual," (RAI) for guidance to complete the MDS. She stated the facility used the "Resident Assessment Instrument Manual," (RAI) for guidance to complete the MDS.

The facility policy for "Care Areaa Assessments", revised November 2019, included: The care area assessments are used to help analyze data obtained from the MDS and to develop individualized care plans.

The "Resident Assessment Instrument," (R.A.I.) Manual, Section 2.7 titled "The Care Area Assessment (CAA) Process and Care Plan Completion," dated 2019, documentation included ". . . Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or

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F 636	Continued From page 8 maintain the resident's highest practicable physical, mental, and psychosocial well-being. The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based "Trigger" conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process. CAA(s) completion is required for comprehensive assessments. The facility failed to complete the "Care Area Assessment" (CAA-analysis of findings), as required related to a Comprehensive "Minimum Data Set" (MDS), comprehensive for the resident, to address the underlying cause, risk factors, and other contributing factors to ensure this resident received care based on their individual needs.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility reported a census of 58 residents with 18 sampled for review. Based on observation, interview, and record review, the facility failed to complete an accurate	F 641		

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assessment/"Minimum Data Set" (MDS) for four residents (R)7 related to antipsychotics (class of medications used to treat major mental conditions which cause a break from reality), R 33 related to rejection of care, R R5 related to hospice and R 50 related to continuous airway positive pressure (CPAP).

Findings included:

- Review of Resident (R)7's "Physician Orders" (POS) dated 10/08/24 documented diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type 2 diabetes ((DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), pain, insomnia (inability to sleep), and bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods).

The "Admission Minimum Data Set" (MDS) dated 03/19/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 indicating the resident cognitively intact, no behavior or indication of depression. He Received medications which included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality).

The "Quarterly MDS" dated 08/30/24, lacked documentation the resident received antipsychotic medication.,

Review of the POS dated 10/08/24, revealed the resident with prescribed medications which included Lurasidone Hydrochloric (HCl) tablet, 80 milligrams (MG), (Lurasidone HCl),

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(antipsychotic medication) tablet by mouth, at bedtime for bipolar disorder with moderately severe depression, ordered 03/11/2024. The resident received antipsychotic medication during the 08/20/24 Quarterly MDS look back period . The MDS lacked accurate documentation to reflect the use of antipsychotic medication.

On 10/29/24 at 10:00 AM, R 7 was lying in the bed facing the window. The room was dark. He participated in the interview appropriately without tearfulness or restlessness noted.

On 10/30/24 at 08:25 AM , R 7 was lying in the bed watching television. He reported he slept pretty well the night before and commented on his preference for watching westerns on TV. His conversation was appropriate, and his facial expressions were consistent with his conversation. He did not exhibit any signs of discomfort.

On 10/29/24 at 02:42 PM, Administrative Nurse E reviewed the residents MDS coding as noted above . He confirmed the resident's 08/20/24 "Quarterly MDS" was inaccurate. He stated the MDS lacked accurate documentation to reflect the resident's use of antipsychotic medication . Administrative Nurse E stated the facility used the "Resident Assessment Instrument Manual," (RAI) for guidance to complete the MDS.

On 10/30/24 at 09:13 AM, Administrative Nurse D confirmed the above findings. She stated the Quarterly MDS dated 08/20/ 24 should have been coded to reflect the resident's use of antipsychotic medications. Administrative Nurse D stated the facility used the "Resident

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Assessment Instrument Manual," (RAI) for guidance to complete the MDS.

The Center for Medicare and Medicaid (CMS) "RAI Manual Version 3.0," dated October 2019 documentation included the intent of the items in section N of the MDS is to record select medications received by the resident. An antipsychotic medication review has been included. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication uses, and management has important associations with the quality of life and quality of care of residents receiving these medications.

The facility failed to complete an accurate assessment/ "Minimum Data Set" (MDS) for the resident related to the use of antipsychotic medication.

- Review of Resident (R)33's medical record revealed diagnoses that included depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and unspecified dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set" (MDS), dated 09/23/24, assessed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive function. The resident received antipsychotic (class of medications used to treat psychosis and

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other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications. The MDS lacked indication of the behavior of rejection of care.

The "Behavior Care Area Assessment" (CAA), dated 09/23/24, assessed the resident had history of being verbally aggressive with threats noted.

The "Care Plan" reviewed 10/03/24, instructed staff to educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care.

Review of the Medication Administration Record (MAR) for September 2024, revealed the resident refused to the following medications from 09/16/24 through 09/23/24.

Levetiracetam (a medication for seizure prevention) 750 milligrams (mg) twice a day (BID) for seven doses.
Sinemet (a medication used to treat Parkinson's disease slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) 25/100mg three times a day for nine doses.
Sertraline (a medication given for depression) 75mg, daily for three doses.
Seroquel (class of medications used to treat psychosis and other mental emotional conditions) 150 mg daily for three doses.

Observation, on 10/28/24 at 09:00 AM, revealed the resident ambulated with his walker with a steady gait and answered questions

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appropriately.

Interview, on 10/29/24 at 03:00 PM, with Certified Medication Aide (CMA) RR, revealed the resident refused medications frequently, but had no other behaviors.

Interview, on 10/30/24 at 09:34 AM, with Licensed Nurse (LN) G, revealed the resident did refuse treatments and medications and the physician was aware of the resident's refusal of medications and behaviors.

Interview, on 10/30/24 at 10:29 AM, with Administrative Nurse D, revealed the resident refused cares and medications.

Interview, on 10/30/24 at 11:15 AM, with Administrative Nurse E, confirmed the resident refused medications during the "Significant Change MDS" dated 09/23/24, look back period and should be coded as the behavior of rejection of care.

The facility policy "Comprehensive Assessments" reviewed 07/2024, instructed staff to conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity using the Resident Assessment Instrument.

The facility failed to accurately assess this resident's behavior of refusal of medications as rejection of care on the "Significant Change MDS" as required.

- Review of Resident (R)5's electronic medical record (EMR) revealed a diagnosis of multiple sclerosis (MS- progressive disease of the nerve

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fibers of the brain and spinal cord).

The "Annual Minimum Data Set" (MDS), dated 06/28/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. She did not have a condition or chronic disease that would result in a life expectancy of less than six months and was not receiving hospice care.

The "Functional Abilities Care Area Assessment", dated 06/28/24, documented the resident rerquired staff assistanace with all activities of daily living (ADL).

The "Quarterly MDS," dated 09/18/24, documented the resident had a BIMS score of 11, indicating modereate cognitive impairment. The resident had a condition or chronic disease that may result in a life expectanccy of less than six months and was not receiving hospice care.

Review of the care plan, revised 10/17/24, instructedstaff the resident received hospice cares due to her diagnosis of MS. Staff were to ensure the resident was kept comfortable.

Review of the resident's EMR, revealed the following physician's order:

Admit to hospice care for terminal diagnosis of MS, ordered 11/24/23.

On 10/30/24 at 08:29 AM, Administrative Nurse E stated the resident originally admitted to hospice in June of 2022 with a diagnosis of MS. Administrative Nurse E stated the MDSs, dated 09/18/24 and 06/28/24, were inaccurate as the resident was on hospice at the time of both of the

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assessments.

On 10/30/24 at 08:53 AM, Administrative Nurse D stated it was the expectation for staff to complete the MDSs accurately.

The facility failed to accurately complete two MDS for this dependent resident on hospice.

The facility utilizes the Resident Assessment Instrument (RAI) manual for completion of the MDS.

- Review of Resident (R)50's Electronic Medical Record (EMR) revealed a diagnosis of obstructive sleep apnea (a common sleep disorder that occurs when the upper airway becomes blocked during sleep, interrupting breathing).

The "Admission Minimum Data Set" (MDS), dated 07/13/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The resident did not use a Continuous positive airway pressure (CPAP) during the assessment period.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 07/13/24, documented the resident had acute mental status changes and required short, simple instructions from staff.

The "Quarterly MDS," dated 10/11/24, documented the resident had a BIMS score of 10,

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indicating moderate cognitive impairment. The MDS inaccurately documented the resident did not use a CPAP during the assessment period.

The care plan, revised 09/08/24, lacked staff instruction regarding the use and care of the resident's CPAP.

Review of the resident's EMR revealed the following physician's order:

Assist and encourage the resident to utilize his CPAP throughout the night, ordered 09/13/24.

On 10/28/24 at 10:01 AM, the resident's CPAP face mask rested, uncovered, on the bed side table of his room. The inside of the face mask contained a flaky, whitish substance.

On 10/29/24 at 06:51 AM, the resident's CPAP face mask rested, uncovered, on the bed side table of his room. The inside of the face mask contained a flaky, whitish substance.

On 10/30/24 at 06:53 AM, Certified Nurse Aide (CNA) M stated the resident utilized the CPAP at night while he slept.

On 10/30/24 at 08:28 AM, CNA O stated the resident utilized the CPAP at night when he slept.

On 10/30/24 at 08:29 AM, Administrative Nurse E stated the resident did utilize a CPAP while asleep and the MDSs, dated 07/13/24 and 10/11/24, were inaccurate.

On 10/30/24 at 08:53 AM, Administrative Nurse D stated it was the expectation for staff to complete the MDSs accurately.

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F 641	Continued From page 17 The facility failed to accurately complete two MDS for this dependent resident with a CPAP machine. The facility utilizes the Resident Assessment Instrument (RAI) manual for completion of the MDS.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not 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)-	F 656		

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(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 care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 58 residents with 18 residents selected for review. Based on observation, interview and record review, the facility failed to develop comprehensive care plans for three of the 18 residents reviewed. Resident (R)50 lacked a care plan for use of CPAP (Continuous Positive Airway Pressure a device with a face mask that uses air pressure to keep breathing airways open while a person sleeps). R33 lacked a care plan for history of suicide ideation and R 54 lacked a personalized fluid restriction care plan.

Findings included:

- Review of Resident (R)33's medical record revealed diagnoses that included depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), anxiety (mental or emotional reaction characterized by apprehension,

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uncertainty, and irrational fear), and unspecified dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set" (MDS), dated 09/23/24, assessed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive function. The resident received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medications.

The "Behavior Care Area Assessment" (CAA), dated 09/23/24, assessed the resident had history of being verbally aggressive with threats noted.

The "Care Plan" reviewed 10/03/24, instructed staff to monitor the resident for adverse reactions to antidepressant therapy which included change in behavior/mood cognition and suicidal thoughts.

Review of the "Admission Summary" dated 06/28/24, revealed the resident admitted to acute care on 06/25/24 for suicide ideation. The resident returned to the facility on 06/28/24, with an order for psychiatric consult, which was subsequently cancelled by the physician.

Interview, on 10/28/24 at 09:00 AM, with the resident, revealed he would like to have his own apartment, and need a cell phone. He stated he did not attend activities and would use his computer if he had all the parts for it. The resident ambulated with his walker with a steady gait and answered questions appropriately.

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F 656	Continued From page 20 Interview, on 10/29/24 at 03:00 PM, with Certified Medication Aide (CMA) RR, revealed the resident refused medications frequently, but had no other behaviors. Interview, on 10/30/24 at 09:34 AM, with Licensed Nurse (LN) G, revealed the resident had various concerns, but did not recall a plan to commit suicide. LN G stated the resident did refuse treatments and medications, and stated to staff that he thought the staff wanted him to die. LN G stated the physician was aware of the resident's refusal of medications and behaviors. Interview, on 10/30/24 at 10:29 AM, with Administrative Nurse D, revealed staff provided a mouse for his computer and it did work, but the resident rejected the use of the mouse. Administrative Nurse D stated she did not think the resident had a plan to commit suicide and refused psychiatric consultation. Administrative Nurse D stated the resident had multiple admissions to acute care for various health concerns. Administrative Nurse D stated the care plan instructed staff to monitor for suicidal thoughts, and confirmed the plan did not include personalized interventions for the suicidal ideation voiced on 06/26/28, upon return to the facility 06/28/24. The facility policy "Care Plans, Comprehensive Person- Centered" reviewed 07/2024, instructed staff to develop interventions with careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making. Interventions	F 656		

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should address the underlying sources of the problem not just symptoms or triggers.

The facility failed to develop a comprehensive care plan to include this resident's history of suicide ideation, to ensure optimal psychosocial functioning.

- - Review of Resident (R)54's medical record revealed diagnoses that included renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

The "Significant Change Minimum Data Set" (MDS), dated 10/02/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident received dialysis.

The "Nutrition Status Care Area Assessment" (CAA), dated 10/02/24, assessed the resident required staff to monitor her body weight to help monitor trends and to monitor food and fluid intake. The Registered Dietician to meet with the resident regularly to ensure nutritional needs are being met.

The "Dehydration/Fluid Maintenance CAA" date 10/02/24 did not trigger.

The "Care Plan" reviewed 10/18/24. Instructed staff to offer small frequent feedings and the resident had a fluid restriction of 1500 milliliters (ml) per 24 hours and staff to chart every shift. The resident received dialysis on Monday, Wednesday, and Fridays. The care plan lacked instructions for staff regarding allocation of fluids and per shift and resident preferences for fluids.

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A "Physician's Order" dated 10/17/24, instructed staff the resident was to receive dialysis services three times a week and monitor the resident's dialysis port.

A "Physician's Order" dated 10/17/24, instructed staff to provide a fluid restriction of 1500ml per 24 hours and document fluid intake every shift.

Interview, on 10/30/24 at 01:15 PM, with Administrative Nurse D, confirmed the "Care Plan" lacked a personalized approach to the resident's fluid restriction.

The facility policy "The facility policy "Care Plans, Comprehensive Person- Centered" reviewed 07/2024, instructed staff to develop interventions with careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making.

The facility failed to develop a comprehensive care plan for this resident's fluid restriction to ensure optimal psychosocial functioning.

- Review of Resident (R)50's Electronic Medical Record (EMR) revealed a diagnosis of obstructive sleep apnea (a common sleep disorder that occurs when the upper airway becomes blocked during sleep, interrupting breathing).

The "Admission Minimum Data Set" (MDS), dated 07/13/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The resident did not use a Continuous positive airway pressure (CPAP) during the assessment period.

The "Cognitive Loss/Dementia Care Area

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Assessment" (CAA), dated 07/13/24, documented the resident had acute mental status changes and required short, simple instructions from staff.

The "Quarterly MDS," dated 10/11/24, documented the resident had a BIMS score of 10, indicating moderate cognitive impairment. The MDS inaccurately documented the resident did not use a CPAP during the assessment period.

The care plan, revised 09/08/24, lacked staff instruction regarding the use and care of the resident's CPAP.

Review of the resident's EMR revealed the following physician's order:

Assist and encourage the resident to utilize his CPAP throughout the night, ordered 09/13/24.

On 10/28/24 at 10:01 AM, the resident's CPAP face mask rested, uncovered, on the bed side table of his room. The inside of the face mask contained a flaky, whitish substance.

On 10/29/24 at 06:51 AM, the resident's CPAP face mask rested, uncovered, on the bed side table of his room. The inside of the face mask contained a flaky, whitish substance.

On 10/30/24 at 06:53 AM, Certified Nurse Aide (CNA) M stated the resident utilized the CPAP at night while he slept. CNA M stated the nurse was responsible for cleaning the face mask each morning after use.

On 10/30/24 at 08:28 AM, CNA O stated the resident utilized the CPAP at night when he slept.

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F 656	Continued From page 24 CNA O stated she was unsure who was responsible for cleaning the face mask. On 10/30/24 at 07:01 AM, Licensed Nurse (LN) I stated the CNAs were responsible for cleaning the resident's face masks. On 10/30/24 at 07:13 AM, Administrative Nurse D stated all nurses were able to add interventions to the care plans. Administrative Nurse D stated it was the expectation for a CPAP machine to be included on a resident's care plan. The facility policy for "Comprehensive Person-Centered Care Plans", revised March 2022, included: The comprehensive person-centered care plan describes the services that are to be frnighed to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility failed to complete a comprehensive care plan for this dependent resident who utilized a CPAP machine while he slept.	F 656		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility reported a census of 58 residents with 18 residents selected for review which included one resident reviewed for dialysis.	F 698		

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Based on observation, interview and record review, the facility failed to ensure staff accurately monitored Resident (R)54 fluid restriction as ordered by the physician.

Findings included:

- Review of Resident (R)54's medical record revealed diagnoses that included renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

The "Significant Change Minimum Data Set" (MDS), dated 10/02/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident received dialysis.

The "Nutrition Status Care Area Assessment" (CAA), dated 10/02/24, assessed the resident required staff to monitor her body weight to help monitor trends and to monitor food and fluid intake. The Registered Dietician to meet with the resident regularly to ensure nutritional needs are being met.

The "Dehydration/Fluid Maintenance CAA" date 10/02/24 did not trigger.

The "Care Plan" reviewed 10/18/24. Instructed staff to offer small frequent feedings and the resident had a fluid restriction of 1500 milliliters (ml) per 24 hours and staff to chart every shift. The resident received dialysis on Monday, Wednesday, and Fridays. The care plan lacked instructions for staff regarding allocation of fluids and per shift and resident preferences for fluids.

A "Physician's Order" dated 10/17/24, instructed

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staff the resident was to receive dialysis services three times a week and monitor the resident's dialysis port.

A "Physician's Order" dated 10/17/24, instructed staff to provide a fluid restriction of 1500ml per 24 hours and document fluid intake every shift.

Review of the residents "Dietary Menu" slip for lunch on 10/29/24 indicated the resident was to receive eight ounces (240ml) of fluid with meals.

Interview, on 10/29/24 at 08:37 AM, with the resident revealed she knew she was on a fluid restriction and stated she usually chewed ice from a 19-ounce (570ml) cup (the facility red cups measure 240 and 360 ml per posted description on the wall in the drink station in the dining room) and the kitchen kept track of how much fluid she was allowed, but often snuck in extra coffee. The resident had two large red cups on her bedside table and a coffee mug all empty. The resident stated she took a diabetic shake and a granola bar to dialysis on Mondays, Wednesdays, and Fridays.

Observation, on 10/29/24 at 01:03 PM revealed the resident seated in the dining room eating lunch. The resident stated she drank the liquid from two bowls of chicken noodle soup, as she did not like noodles. The resident had an empty 240 and two 360 ml cups in front of her which totaled 960 ml.

Interview, on 10/29/24 at 03:08 PM, with Certified Medication Aide (CMA) RR, revealed she did know the resident was on a fluid restriction, but usually used a small plastic cup of water to administer medications to the resident.

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Interview, on 10/29/24 at 03:14 PM, with Dietary Staff CC, stated the resident had choices of fluids and confirmed the "Dietary Menu" slip indicated eight ounces of fluid per meal. Dietary Staff CC stated the resident sometimes took other resident's fluids.

Interview, on 10/29/24 at 03:30PM with Licensed Nurse (LN) G, revealed she kept track of the resident's fluid intake by observation at meals and through out the day and then documented it on the "Treatment Administration Record". LN did not know if other staff were aware of the resident's fluid intake.

Interview, on 10/30/24 at 01:00PM, with CMA S, revealed he did not know the resident was on a fluid restriction, but he usually administered medications with a half full plastic cup.

Interview, on 10/30/24 at 01:15PM, with Administrative Nurse D, confirmed she would expect all staff to be aware of the resident's fluid restriction, and the recording of fluid intake was the responsibility of the charge nurse. Administrative Nurse D confirmed the "Care Plan" did not indicate the resident's preferences to include ice and her pattern of fluid intake throughout the 24-hour day.

The facility policy "Encouraging and Restricting Fluids" revised 07/2024, instructed staff to follow specific instructions encouraging fluid intake or restrictions and to be accurate when recording fluid intake.

The facility failed to ensure all staff were aware of this resident's fluid restriction and failed to

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F 698	Continued From page 28 develop a personalize plan for the fluid restriction per the resident's preferences to ensure compliance.	F 698		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		

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by:
The facility reported a census of 58 residents. Based on observation, interview, and record review the facility failed to establish a system to keep drug records in order for all controlled drugs to be maintained and reconciled.

Findings included:

- Review of the "Narcotic Count Shift Verification" sheet on 10/28/24 at 08:13 AM, the following areas of concern were noted:

1. The east hall "Narcotic Count Shift Verification" form, from October 1 through October 27, 2024, lacked a total of 63 staff signatures.

2. The west hall "Narcotic Count Shift Verification" form, from October 1 through October 27, 2024, lacked a total of 30 staff signatures.

On 10/28/24 at 08:13 AM, Certified Medication Aide (CMA) T stated staff were to count with the oncoming and off going nurse or CMA at the beginning and end of their shift. Both of the staff were expected to sign the "Narcotic Count Shift Verification" form to indicate the narcotic count was correct at the time they counted.

On 10/30/24 at 08:53 AM, Administrative Nurse D stated both nurses or CMAs were expected to count the narcotics when coming onto their shift and when leaving their shift. By signing the "Narcotic Count Shift Verification" they were documenting the narcotic count was accurate.

The facility policy for "Controlled Substances",

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F 755	Continued From page 30 revised November 2022, included: The nursing staff shall count the controlled medication inventory at the end of each shift in order to reconcile the inventory count. The nurse coming on duty and the nurse going off duty shall make the count together. The facility failed to establish a system to keep drug records in order for all controlled drugs to be maintained and reconciled.	F 755		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing	F 851		

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information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(p)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(p)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 58 residents. Based on observation, interview, and record review the facility failed to electronically submit to the "Centers for Medicare and Medicaid Services" (CMS) complete and accurate direct staffing

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information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. "Payroll Base Journal" (PBJ), when the facility failed to accurately report weekend licensed nurse staffing for the month of August 2024.

Findings included:

- Review of the "Payroll Base Journal" (PBJ) Staffing Data Report for August 2024, revealed the facility failed to accurately report weekend licensed nurse staffing for the month of August 2024.

On 08/03, Saturday (SA),

On 08/04, Sunday (SU),

On 08/10, SA,

On 08/11, SU,

On 08/17, SA,

On 08/18, SU,

On 08/24, SA,

On 08/25, SU,

On 08/31, SA,

On 10/29/24 at 01:15 PM, Administrative Nurse D stated she and Administrative Nurse F would come in and work during the weekends in August. Their hours were not counted on the PBJ for those times as they are both salaried employees.

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F 851	Continued From page 33 On 10/29/24 at 04:00 PM, Administrative Staff A stated they would look into a way for Administrative Nurse D and Administrative Nurse E to clock in so the PBJ report would be accurate. The facility lacked a policy for the completion of the PBJ reports. The facility failed to electronically submit to "Centers for Medicare and Medicaid Services" (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. "Payroll Base Journal" (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report weekend staffing for the month of August, 2024.	F 851		
F 880 SS=F	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,	F 880		

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F 880	Continued From page 34 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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; (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.	F 880		

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F 880	Continued From page 35 §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: The facility reported a census of 58 residents. Based on observation, interview, and record review the facility failed to ensure staff provided Enhanced Barrier Precautions (EBP use of personal protective equipment to prevent the spread of infections) for Resident (R)3 and R54. The staff failed to provide cleaning of R50's CPAP (Continuous Positive Airway Pressure, a device with a face mask that uses air pressure to keep breathing airways open while a person sleeps) and failed to provide urinary catheter care in a sanitary manner to prevent the spread of infections. The facility failed to ensure R19's dog maintained up-to-date vaccine status. Findings included: - Review of Resident (R)3' medical record revealed diagnoses that included Methicillin Resistive Staphylococcus Aureus (a bacteria that is resistive to multiple antibiotics also known as Multi Drug Resistant Organism, MDRO), sepsis (a systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infection which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to the medical emergency, septic shock), and cutaneous abscess (cavity containing pus and surrounded	F 880		

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by inflamed tissue).

The "Significant Change Minimum Data Set" (MDS), dated 05/01/24, revealed a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 05/01/24, revealed the resident needed help to maintain skin integrity and staff to monitor for skin issues.

The "Quarterly MDS" dated 10/07/24, assessed the resident with a BIMS of 10 which indicated moderate cognitive impairment and documented R3 had Moisture Associated Skin Damage (MASD skin damage caused by moisture).

The "Care Plan" reviewed 09/27/24 instructed staff the resident had a subcutaneous abscess to her left buttocks and required Hibiclens (an antibacterial solution) showers for infection prevention. The "Care Plan" lacked the intervention to include Enhanced Barrier Precautions (EBP).

A "Skin Assessment" dated 10/01/24, documented a chronic open area to the left gluteal crease. "Skin Assessments" dated 10/08/24, 10/15/24 and 10/22/24 documented the open are to the left buttock.

Observation on 10/29/24 at 11:06 AM, revealed Licensed Nurse (LN) J provided wound care to the wound on the resident's left buttock cheek. LN J stated the wound was an abscess (cavity containing pus and surrounded by inflamed tissue) that comes and goes, and the resident admitted to the facility with the wound. With

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gloved hands, LN G, removed the dressing on the resident's left buttock cheek and revealed an open red area approximately 1.5 by 0.5 centimeters (cm) with a small amount of serosanguinous (semi-thick reddish drainage) drainage that dripped onto the resident's brief. With gloved hands, LN J cleansed the wound, applied skin prep (a solution that protects the skin) and applied a bordered foam dressing to the wound. Neither LN J or LN G wore a gown during the procedure and did not know the resident should be in EBP.

Interview on 10/30/24 at 10:30 AM, with Administrative Nurse D, confirmed the resident had a history of MRSA in the wound and had been on antibiotics in the past, and had been on contact precautions (safeguards designed to reduce the risk of transmission of microorganisms by direct or indirect contact) at that time, and should be in EBP since the wound was chronic and open.

The facility policy "Enhanced Barrier Precautions" Reviewed 07/2024, instructed staff EBP are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization and the EBP remain in place for the duration of the resident's stay or until resolution of the wound.

The facility failed to ensure staff implemented EBP for this resident with a chronic abscess and history of MRSA to prevent the spread of infection.

- Review of Resident (R)54's medical record revealed diagnoses that included renal failure (inability of the kidneys to excrete wastes,

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concentrate urine and conserve electrolytes).

The "Significant Change Minimum Data Set" (MDS), dated 10/02/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated normal cognitive function. The resident received dialysis.

A "Physician's Order" dated 10/17/24, instructed staff the resident was to receive dialysis services three times a week and monitor the resident's dialysis port to her left chest twice daily and replace the dressing if coming off.

Observation, on 10/29/24 at 08:00 AM, revealed Certified Nurse Aide (CNA) P aided the resident with dressing without donning protective barrier precaution equipment.

Observation, on 10/29/24 at 08:37 AM, revealed the resident seated in her wheelchair in her room. The resident stated she went to dialysis three times a week and had a port on her upper left chest which was covered with a dry dressing.

Interview, on 10/29/24 at 10:00AM, with Licensed Nurse G, revealed the resident had multiple problems with her dialysis access port and had several infections, but did not know what type of infections and did not know that EBP was indicated for this resident.

Interview, on 10/30/24 at 10:30 AM, with Administrative Nursing Staff D, confirmed the resident should be on EBP due to presence of her dialysis port and frequent infections of the dialysis catheters which included multi drug resistant organisms (MDRO).

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The facility policy "Enhanced Barrier Precautions" Reviewed 07/2024, instructed staff EBP are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization and the EBP remain in place for the duration of the resident's stay or until resolution of the wound.

The facility failed to ensure staff implemented EBP for this resident with a dialysis access port, and history of MDRO infections to prevent the spread of infection.

- Observation, on 10/28/24 at 10:30 AM, revealed Resident (R)19 in her room with a dog on her bed. R19 stated the dog was her personal pet and stayed in her room with her and her roommate.

Interview, on 10/30/24 at **, with Administrative Staff A, confirmed the last rabies vaccine for R19's dog was 05/2023. Administrative Staff A stated the facility did not have a policy for ensuring staff monitored R19 for maintaining annual vaccines for her dog.

The facility lacked a policy for annual pet vaccinations.

The facility failed to ensure R19 obtained annual vaccines for her dog as required to prevent the spread of infection.

- Review of Resident (R)50's Electronic Medical Record (EMR) revealed a diagnosis of obstructive sleep apnea (a common sleep disorder that occurs when the upper airway becomes blocked during sleep, interrupting breathing).

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The "Admission Minimum Data Set" (MDS), dated 07/13/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The resident did not use a Continuous positive airway pressure (CPAP) during the assessment period.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 07/13/24, documented the resident had acute mental status changes and required short, simple instructions from staff.

The "Quarterly MDS," dated 10/11/24, documented the resident had a BIMS score of 10, indicating moderate cognitive impairment. The MDS inaccurately documented the resident did not use a CPAP during the assessment period.

The care plan, revised 09/08/24, lacked staff instruction regarding the use and care of the resident's CPAP.

Review of the resident's EMR revealed the following physician's order:

Assist and encourage the resident to utilize his CPAP throughout the night, ordered 09/13/24.

On 10/28/24 at 10:01 AM, the resident's CPAP face mask rested, uncovered, on the bed side table of his room. The inside of the face mask contained a flaky, whitish substance.

On 10/29/24 at 06:51 AM, the resident's CPAP face mask rested, uncovered, on the bed side table of his room. The inside of the face mask contained a flaky, whitish substance.

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On 10/30/24 at 06:53 AM, Certified Nurse Aide (CNA) M stated the resident utilized the CPAP at night while he slept. CNA M stated the nurse was responsible for cleaning the face mask each morning after use.

On 10/30/24 at 08:28 AM, CNA O stated the resident utilized the CPAP at night when he slept. CNA O stated she was unsure who was responsible for cleaning the face mask.

On 10/30/24 at 07:01 AM, Licensed Nurse (LN) I stated the CNAs were responsible for cleaning the resident's face masks.

On 10/30/24 at 07:13 AM, Administrative Nurse D stated the CNAs, or the nurse were responsible for cleaning the resident's face mask each morning after use.

The facility policy for "CPAP/BIPAP Support", revised March 2015, included: Staff shall clean the face mask of the CPAP machine with warm water and allow it to dry in between uses.

The facility failed to clean the resident's face mask of the CPAP each morning after use.

- Review of Resident (R) 56's Electronic Medical Record (EMR) revealed a diagnosis of neurogenic bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying).

The "Admission Minimum Data Set" (MDS), dated 08/09/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175424	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT AUGUSTA, LLC	901 LAKEPOINT DRIVE AUGUSTA, KS 67010

(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 42	F 880		

She had an indwelling urinary catheter (a catheter inserted into the bladder to drain urine) and required substantial to maximum staff assistance with toileting.

The "Urinary Incontinence/Indwelling Catheter Care Area Assessment" (CAA), dated 08/09/24, documented the resident had an indwelling urinary catheter due to a diagnosis of neurogenic bladder. Staff were to provide catheter care for the resident every shift.

The "Care Plan" for the indwelling urinary catheter, revised 10/30/24, instructed staff to always position the catheter bag and tubing below the level of the resident's bladder.

Review of the resident's EMR revealed a physician's order for staff to provide catheter care every day and night shift, ordered 08/07/24.

On 10/29/24 at 08:27 AM, the resident sat in her wheelchair at the dining room table eating breakfast. The catheter bag hung from underneath the seat of her wheelchair and the catheter tubing rested directly on the floor beneath the seat of the wheelchair.

On 10/29/24 at 08:57 AM, Certified Nurse Aide (CNA) N transferred the resident from her wheelchair to the recliner in the front commons area. The CNA tossed the catheter bag onto the floor during the transfer and left the bag and tubing on the floor following the cares.

On 10/29/24 at 09:03 AM, CNA N stated the resident's catheter bag and tubing should not be on the floor at any time. CNA N stated she forgot to pick the bag and tubing up after transferring

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	175424	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 43 the resident. On 10/30/24 at 09:37 AM, Licensed Nurse (LN) G stated catheter bags and tubing should be always kept off the floor. On 10/29/24 at 09:57 AM, Administrative Nurse D stated staff should ensure the resident's catheter bag and tubing be always kept off the floor. The facility policy for "Urinary Catheter Care", revised August 2022, included: Staff should ensure the catheter tubing and drainage bag are kept off the floor. The facility failed to always keep the catheter bag and tubing for this dependent resident off the floor.	F 880		