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	175380	A. BUILDING _____ B. WING _____	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	1021 CEDARS DRIVE MCPHERSON, KS 67460

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00186363. The 2567 was sent elctronically on 03/25/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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

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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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. The sample included 15 residents with one reviewed for dignity. Based on observation, record review, and interview the facility staff failed to treat Resident (R) 29 with dignity when staff checked his blood glucose level at the dining room table with two other residents able to view the procedure. This placed the resident at risk for an undignified experience.

Findings included:

- On 03/05/24 at 10:57 AM, observation revealed in the 300-House dining room, Certified Medication Aide (CMA) R used a glucometer (an instrument used to calculate blood glucose) to check R29's blood glucose level at the dining room table during the meal service and dining. There were two other residents present and able to view the procedure.

On 03/11/24 at 10:46 AM, Administrative Nurse D stated she expected staff to take R29 to his room or a private area when they checked his blood glucose level.

The facility's "Supporting the Resident's Right to

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F 550	Continued From page 2 Privacy and Confidentiality Policy," revised 02/2009, documented it was the responsibility of each employee of the community to ensure that the privacy and confidentiality of each resident was protected. The facility staff failed to treat R29 with dignity when staff checked his blood glucose level at the 300-House dining room table during meals. This placed the resident at risk for an undignified experience.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582		

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F 582	Continued From page 3 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 15 residents, with three reviewed for Medicare Liability Notices. Based on record review and interview, the facility failed to provide the resident (or their representative) a fully completed Advanced Beneficiary Notice (ABN) for skilled services for Resident (R) 16, R17, and R190 which included the estimated cost of services. This placed the resident at risk for uninformed care decisions.	F 582		

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Findings included:

- The "Medicare Advanced Beneficiary Notice (ABN)" informed the beneficiary that Medicare may not pay for skilled services and provided a cost estimate of continued services. The form included an option for the beneficiary to (1) receive the specified skilled services listed, and bill Medicare for an official decision on payment. The recipient understands if Medicare does not pay, the recipient is responsible for payment but can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, the recipient is responsible for payment for services. (3) the recipient does not want the listed therapy services.

The "Center of Medicare (CMS)-10055" form provided to R16 when the skilled services ended on 01/16/24, lacked the estimated costs of services.

The "Center of Medicare (CMS)-10055" form provided to R17 when the skilled services ended on 10/13/23 lacked the estimated costs of services.

The "Center of Medicare (CMS)-10055" form provided to R19 when the skilled services ended on 03/01/24 lacked the estimated costs of services.

On 03/12/24 at 10:50 AM, Administrative Nurse D and Social Services X verified there was no estimated cost of continued services on the CMS-10055.

The facility's "Medicare Coverage" policy, dated 12/2000, documented Medicare will cover 100

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F 582	Continued From page 5 percent (%) of service from one to 29 days of the resident's stay in the Skilled Nursing Unit. The resident is responsible for covering the cost of the co-pay for skilled nursing care for days 21 to 100. The amount varies from year to year. If the resident disagrees with the determination, the resident can ask for a "Demand Bill". The facility failed to provide the resident (or their representative) the completed "CMS-10055" form when discharged from skilled services for R16, R17, and R190 which included the estimated cost of continued services. This placed the residents at risk of making uninformed decisions for their skilled services.	F 582		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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.	F 657		

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(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. The sample included 15 residents, with five reviewed for accidents. Based on observation, record review, and interview, the facility failed to revise the care plan with interventions to prevent avoidable accidents. This placed the resident at risk for further accidents due to uncommunicated care needs.

Findings included:

- The Electronic Medical Record (EMR) for R7 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, macular degeneration (progressive deterioration of the retina), epilepsy (brain disorder characterized by repeated seizures), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), falls, and pain.

The "Quarterly Minimum Data Set" (MDS), dated 01/24/24, documented R7 had severely impaired cognition. R7 was dependent on staff for toileting and required substantial/maximum assistance for dressing and bathing. R7 required partial/moderate assistance for mobility and transfers and set-up assistance for eating.

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R7's "Hot Liquid Assessment," dated 01/28/24, documented R7 was cognitively impaired but was deemed safe to handle and ingest hot liquids.

R7's "Care Plan" dated 02/07/24, initiated on 09/27/23 documented R7 had impaired decision-making skills and directed staff to offer R7 simple choices and monitor for changes in her behavior, appetite, and health needs. The care plan directed staff to monitor for fatigue, weakness, altered muscle tone or strength, involuntary movements, and contractions of muscles or muscle groups related to her seizure disorder. The care plan directed staff to cut up R7's meat into bite-size pieces, provide a regular diet, and use an insulated cup.

The "Nurse's Note," dated 03/03/24 at 11:39 AM, documented R7 spilled hot tea on her lap at lunch. The note documented R7 used a Kennedy cup (an adaptable drinking cup designed to prevent spills) with a lid, but the resident removed the lid. The note further documented R7's pants were removed immediately and there was no sign of erythema (redness) or burns.

The "Nurse's Note," dated 03/07/24 at 03:02 PM, documented R7 was steeping her hot tea and she reported it was on the edge of the table and tipped onto her lap. The note documented R7 pulled at her pants to keep the warmth off her thighs and the nurse used a towel to get some of the hot water off her. A skin assessment was performed and the area to the inner right thigh was light red but blanchable (when the skin becomes white or pale in appearance). The staff applied a cool washcloth to the area.

R7's EMR lacked documentation R7 was

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assessed for safety with hot liquids after she spilled her hot tea on 03/03/24 and 03/07/24 and lacked evidence of interventions to address the hot liquid spills.

On 03/11/24 at 07:45 AM, observation revealed R7 at the dining room table with a regular coffee cup and no lid and R7 was able to drink the coffee without incident.

On 03/06/24 at 11:06 AM, Certified Nurse Aide (CNA) N stated she was unaware of any problems with R7 drinking and said she did not know of any accidents with R7 and hot liquids.

On 03/11/24 at 09:29 AM, Administrative Nurse E stated she had not completed another hot liquid assessment and did not update R7's "Care Plan" because R7 did not receive any injury with the recent hot tea incident. Administrative Nurse E further stated the cup was on the edge of the table when it fell onto R7's lap; the area on R7's inner thigh was pink and blanchable.

On 03/11/24 at 11:15 AM, Administrative Nurse D stated staff should make sure R7's cup was away from the edge of the table. Administrative Nurse D said she expected staff to complete a new hot liquid assessment and care plan interventions to prevent further incidents for R7.

The facility's "Skin and Wound Prevention Management" policy, dated 01/21, documented that skin integrity would be maintained at the optimum level for the duration of the resident's stay. The care plan would be reviewed and revised as needed to manage treatment and identify prevention approaches.

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F 657	Continued From page 9 The facility failed to revise R7's care plan with interventions to prevent further accidents with her hot beverages. This placed the resident at risk for further injury due to uncommunicated care needs.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to assess and treat Resident (R) 32's alteration in bowel movements, which placed the resident at risk of ongoing constipation and possible fecal impaction (accumulation of hardened feces in the rectum that the individual was unable to move) complications. Findings included: - R32's Electronic Medical Record (EMR) included diagnoses of acute respiratory failure with hypoxia or hypoxia (inadequate supply of oxygen), dementia (a progressive mental disorder characterized by failing memory, and confusion), and constipation. The "Admission Minimum Data Set" (MDS),	F 684		

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dated 02/03/24, documented R32 had moderately impaired cognition, disorganized thinking which fluctuated, and other behavioral symptoms not directed to others which occurred daily that significantly disrupted care or living environment. R32 required set-up and clean-up assistance with eating and partial to moderate assistance with toileting, upper and lower body dressing, personal hygiene, and mobility. The MDS further documented R32 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was always continent of bowel.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 02/09/24, documented the facility would care plan for an indwelling catheter to reduce the risk for injury and infection.

R32's "Care Plan," dated 02/15/24, documented R32 did not have continence issues and had an indwelling catheter due to bladder outlet obstruction. The care plan directed staff to monitor R32's bowel movements and treat for constipation per provider orders.

The "Physician Order", dated 01/30/24, directed staff to administer polyethylene (medication used to treat constipation) 17 grams by mouth once daily for other functional intestinal disorders.

The "Physician Order", dated 02/04/24, directed staff to administer Milk of Magnesia (MOM) 1200 mg, 30 cubic centimeters (cc) by mouth as needed (PRN) every 12 hours, with a maximum of two doses in 24 hours for constipation.

The "Physician Order", dated 02/29/24, directed

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staff to administer bisacodyl suppository 10 milligrams (mg) rectally PRN daily for constipation, if no bowel movement for three days.

On 01/30/24 at 02:31 PM the "Interdisciplinary Note" documented R32 was admitted to the facility from a hospital. The note further documented R32's last bowel movement on 01/28/24.

On 02/04/24 at 04:18 PM, the "Interdisciplinary Note" documented R32's abdomen was soft, non-tender with active bowel sounds in four quadrants. R32 had a bowel movement that morning and was on the three-day no bowel movement list so MOM was administered.

On 02/07/24 the "Physician Note" documented R32 required enemas (introduction of a solution into the rectum for cleansing or therapeutic purposes) for constipation while hospitalized from 01/19/24 to 01/30/24.

On 02/07/24 at 01:50 AM, the "Interdisciplinary Note" documented R32's abdomen was soft, non-tender with active bowel sounds in four quadrants. R32 had no bowel movement and was on the bowel movement list for day two.

On 02/10/24 at 01:38 PM, the "Interdisciplinary Note" documented R32's normal active bowel sounds and R32 had no bowel movement that evening.

On 02/11/24 at 06:58 PM, the "Interdisciplinary Note" documented R32 had normal active bowel sounds and had no bowel movement. The EMR lacked further documentation of bowel movement

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or treatment.

R32's February 2024 Bowel Movement Record revealed R32 did not have a bowel movement on February 5-9 (five days), 11-17 (seven days), 19-22 (four days), and 24-28 (five days).

R32's EMR revealed MOM had been administered on the following dates:
02/04/24
02/09/24 After five days with no bowel movement.
02/15/24 After four days with no bowel movement and again on 02/17/24 with now seven days with no bowel movement.
02/23/24 After four days with no bowel movement.

On 03/11/24 at 10:43 AM, Administrative Nurse D reported that R32 continued to decline and that the staff should utilize the use of bowel protocols and PRN medication and treatments to manage R32's bowels.

The facility's "Constipation Standing Protocols-PRN Medication and Treatment" orders reviewed 01/03/24, documented the use of:
Milk of magnesium 30 cc by mouth every 12 hours PRN, no more than two doses in 24 hours.
Senna (bowel stimulant) 8.6 one or two tablets by mouth twice a day as needed. Bisacodyl suppository per rectum if no stool for three days.
Fleets enema for distention or hard stool, repeat one time if no results. Fiber stat 15 to 30 cc as directed per nurse judgment.

The facility's "Bowel Management" policy, dated 08/01/11, documented bowel monitoring, and management will be followed to minimize any bowel problems such as constipation or fecal

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F 684	Continued From page 13 impaction by actively employing all preventative options possible. The facility failed to treat R32's lack of bowel movements which placed the resident at risk of ongoing constipation and fecal impaction complications.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 15 residents, with one reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview, the facility failed to implement nutritional interventions to promote healing for one resident, Resident (R) 11, after development of a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed)	F 686		

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pressure ulcer. This placed the resident at risk for complications from pressure injuries and delayed healing.

Findings included:

- The Electronic Medical Record (EMR for R11 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made, or the body cannot respond to the insulin), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath), pressure ulcer, and nutritional deficiency (severely reduced levels of one or more nutrients).

The "Quarterly Minimum Data Set" (MDS), dated 06/26/23, documented R11 had intact cognition and required extensive assistance from one staff for bed mobility, dressing, toileting, and personal hygiene. The MDS documented R11 was at risk for pressure ulcers and had pressure-relieving devices for his bed and chair. The MDS documented R11 had no skin breakdown.

R11's "Quarterly MDS," dated 01/20/24, documented R11 had intact cognition and was dependent on staff for toileting and transfers. R11 required substantial/maximum assistance for mobility. R11 had frequent bladder incontinence. R11 was at risk for pressure ulcers and had pressure-relieving devices for his bed and chair. R11 had two Stage 2 pressure ulcers and received pressure ulcer care.

The "Braden Scale Assessment," (a formal assessment for predicting pressure ulcer risk) dated 06/26/23, 09/21/23, and 12/21/23,

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documented R11 was at high risk for pressure ulcers.

R11's "Care Plan," dated 02/01/24, initiated on 12/31/20, directed staff to remind R11 to lie down to get off his bottom and to change positions every two hours. The plan directed R11 should wear heel protectors at night and take off his incontinence pull-up at night. The update, dated 06/25/22, directed staff to make sure his cushion was moved from chair to chair. The update, dated 09/27/23, documented R11 had two Stage 2 pressure ulcers on his right and left buttocks. The plan directed staff to assess R11's skin weekly and ensure R11 had a pressure-reducing mattress on his bed. The update dated 02/29/24 directed staff to encourage R11 to use a rolled-up towel under his hips to offload pressure, alternating sides.

The "Skin Evaluation Record," dated 09/13/23, documented R11 had an open sore on his left buttock which measured 0.4 centimeters (cm) x 0.8 cm x 0.2.

The "Physician's Order," dated 09/20/23, directed staff to apply Triad wound dressing paste (a paste that covers moist, weeping wounds), apply a small amount to the wound as needed, and leave it open to air.

The "Skin Evaluation Record," dated 10/23/23, documented R11 had a Stage 2 pressure ulcer on his left buttock that measured 0.4 cm x 0.8 cm x 0.2 cm. The note documented the pressure ulcer was macerated (prolonged exposure to moisture) and directed staff to bandage after showers.

The "Nutritional Assessment," dated 10/31/23,

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documented R11 had skin breakdown on his left buttock. The note documented the Registered Dietician (RD) recommended Vitamin C 500 milligrams (mg) twice per day, a multivitamin daily, and Arginaide (supplement to aid in wound healing) twice per day.

The EMR lacked evidence R11 was provided the recommendations from the RD and lacked evidence the physician was presented with the recommendations and /or declined the recommendations.

The "Skin Evaluation Record," dated 11/15/23, documented R11 had a Stage 2 pressure ulcer on his left buttock which measured 1.4 cm x 0.5 cm x 0.2 cm.

The "Physician's Order," dated 11/30/23, directed staff to apply Fibracol Plus Collagen (absorbent dressing with protein) and alginate (promotes wound healing) to the wound bed. Cover with a bandage and change every other day or sooner if soiled.

The "Skin Evaluation Record," dated 12/21/23, documented R11 had a Stage 2 pressure ulcer on his left buttock which measured 0.4 cm x 0.3 cm x 0.2 cm, and a new pressure ulcer on his right gluteal fold (the horizontal skin crease that forms below the buttocks, separating the upper thigh from the buttocks) which measured 0.7 cm x 0.7 cm. The evaluation documented that Fibracol Plus was applied to both wounds.

The "Skin Evaluation Record," dated 01/05/24, documented R11 had a Stage 2 pressure ulcer on his left buttock which measured 0.5 cm x 0.4 cm x 0.2 cm, and a Stage 2 pressure ulcer on his

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right gluteal fold which measured 0/7 cm x 0.5 cm.

The "Skin Evaluation Record," dated 01/25/24, documented R11 had a Stage 2 pressure ulcer on his left buttock which measured 0.8 cm x 1.3 cm x 0.2 cm, and a Stage 2 pressure ulcer on his right gluteal fold which measured 1.0 cm x 0.8 cm x 0.2 cm.

The "Nutritional Assessment," dated 01/29/24, documented R11 had skin breakdown on his left buttock and right gluteal fold and recommended Vitamin C 500 mg twice per day, a multivitamin daily, and Arginaide twice per day.

The "Physician's Order," dated 02/02/24, directed staff to administer Vitamin C 500 mg by mouth twice per day, a multivitamin daily, and Arginaide, one serving daily for wound healing.

On 03/06/24 at 07:30 AM, R11 stated he had pressure ulcers off and on. R11 stated the wounds would heal but after the treatment was finished, nothing was done to it to protect it, and it would open again. R11 further stated that he had staff place a sign on the wall to remind them to move the cushion from his wheelchair to the recliner because it was often forgotten. R11 stated he usually slept in his recliner except for on shower days, then he would lie down in bed.

On 03/06/24 at 09:30 AM, observation revealed Consultant GG and her assistant, Consultant HH, were in R11's room to provide wound care. Consultant HH sanitized her hands, gloved and cleansed the pressure ulcer with wound cleanser, and measured the wound at 1.6 cm x 1.3 cm. Further observation revealed Consultant GG

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changed places with Consultant HH to look at the wound and to measure the depth of the wound, which was 0.2 cm. Consultant HH stated the wound had improved and said it was much smaller. Consultant HH applied the antibiotic ointment, placed a foam dressing on top of the wound, and placed a bandage over the top.

On 03/06/23 at 09:45 AM Consultant GG stated the wound was avoidable and that R11 needed to make sure he was offloading several times per day.

On 03/06/24 at 10:15 AM, Certified Nurse Aide (CNA) N stated staff reminded R11 to reposition often and tried to encourage him to sit in his recliner.

On 03/11/24 at 09:31 AM, Administrative Nurse E stated she was unsure why the facility did not implement the recommendations from the RD on 10/31/23 and said it may have been overlooked.

On 03/11/24 at 11:15 AM, Administrative Nurse D stated she did not receive the email regarding the RD recommendations on 10/31/23. Administrative Nurse D said if she had the recommendations would have been implemented.

The facility's "Skin and Wound Prevention Management" policy, dated 01/21, documented that skin integrity would be maintained at the optimum level for the duration of the resident's stay. A comprehensive prevention plan would be initiated for all residents who had intact skin and were at risk. The dietician would be notified and a follow-up on any recommendations made when there was a development of skin injury.

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F 686	Continued From page 19 The facility's "Pressure Injury Prevention and Management" policy, dated 01/20, documented the facility was committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries, The facility should establish and utilize a systemic approach for pressure injury prevention and management including prompt assessment and treatment, intervening to stabilize, reduce or remove the underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as appropriate. The facility failed to implement nutritional interventions to promote healing for R11's pressure injuries. This placed the resident at risk for complications related to pressure injuries and delayed healing.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The sample included 15 residents, with five reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure an environment free from preventable accident hazards for Resident (R) 7, who spilled her hot	F 689		

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tea onto her lap twice in one week. This placed the resident at risk for injury.

Findings included:

- The Electronic Medical Record (EMR) for R7 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, macular degeneration (progressive deterioration of the retina), epilepsy (brain disorder characterized by repeated seizures), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), falls, and pain.

The "Quarterly Minimum Data Set" (MDS), dated 01/24/24, documented R7 had severely impaired cognition. R7 was dependent on staff for toileting and required substantial/maximum assistance for dressing and bathing. R7 required partial/moderate assistance for mobility and transfers and set-up assistance for eating.

R7's "Hot Liquid Assessment," dated 01/28/24, documented R7 was cognitively impaired but was deemed safe to handle and ingest hot liquids.

R7's "Care Plan" dated 02/07/24, initiated on 09/27/23 documented R7 had impaired decision-making skills and directed staff to offer R7 simple choices and monitor for changes in her behavior, appetite, and health needs. The care plan directed staff to monitor for fatigue, weakness, altered muscle tone or strength, involuntary movements, and contractions of muscles or muscle groups related to her seizure disorder. The care plan directed staff to cut up R7's meat into bite-size pieces, provide a regular

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diet, and use an insulated cup.

The "Nurse's Note," dated 03/03/24 at 11:39 AM, documented R7 spilled hot tea on her lap at lunch. The note documented R7 used a Kennedy cup (an adaptable drinking cup designed to prevent spills) with a lid, but the resident removed the lid. The note further documented R7's pants were removed immediately and there was no sign of erythema (redness) or burns.

The "Nurse's Note," dated 03/07/24 at 03:02 PM, documented R7 was steeping her hot tea and she reported it was on the edge of the table and tipped onto her lap. The note documented R7 pulled at her pants to keep the warmth off her thighs and the nurse used a towel to get some of the hot water off her. A skin assessment was performed and the area to the inner right thigh was light red but blanchable (when the skin becomes white or pale in appearance). The staff applied a cool washcloth to the area.

R7's EMR lacked documentation R7 was assessed for safety with hot liquids after she spilled her hot tea on 03/03/24 and 03/07/24 and lacked evidence of interventions to address the hot liquid spills.

On 03/11/24 at 07:45 AM, observation revealed R7 sat at the dining room table with a regular coffee cup and no lid. R7 was able to drink the coffee without incident.

On 03/06/24 at 11:06 AM, Certified Nurse Aide (CNA) N stated she was unaware of any problems with R7 drinking and said she did not know of any accidents with R7 and hot liquids.

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On 03/11/24 at 09:29 AM, Administrative Nurse E stated she had not completed another hot liquid assessment and did not update R7's "Care Plan" because R7 did not receive any injury with the recent hot tea incident. Administrative Nurse E further stated the cup was on the edge of the table when it fell onto R7's lap; the area on R7's inner thigh was pink and blanchable at first and ultimately had no injury.

On 03/11/24 at 11:15 AM, Administrative Nurse D stated staff should make sure R7's cup was away from the edge of the table. Administrative Nurse D said she expected staff to complete a new hot liquid assessment and care plan interventions to prevent further incidents for R7.

The facility's "Skin and Wound Prevention Management" policy, dated 01/21, documented that skin integrity would be maintained at the optimum level for the duration of the resident's stay. The care plan would be reviewed and revised as needed to manage treatment and identify prevention approaches.

The facility's "Accident and Incident Reporting" policy, dated 09/18, documented, that the facility strived to have the best quality of life for the residents to prevent accidents and incidents and any accident or incident would be reviewed and investigated timely. If an accident or incident that resulted in no apparent injury, or minor injury would be investigated, and the report would be reviewed with the administrator and risk team within seven calendar days.

The facility failed to ensure an environment free from preventable accident hazards for R7. This placed the resident at risk for preventable injury.

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The	F 690		

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sample included 15 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 32 with sanitary indwelling catheter (tube placed in the bladder to drain urine into a collection bag) care and treatment which placed the resident at risk for urinary tract infections (UTI).

Findings included:

- R32's Electronic Medical Record (EMR) included diagnoses of acute respiratory failure with hypoxia or hypoxia (inadequate supply of oxygen), dementia (a progressive mental disorder characterized by failing memory, and confusion), constipation (difficulty passing stools), retention of urine, delirium (sudden severe confusion, disorientation and restlessness), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid, pain, and encephalopathy (broad term for any brain disease that alters brain function or structure).

The "Admission Minimum Data Set" (MDS), dated 02/03/24, documented R32 had moderately impaired cognition, disorganized thinking which fluctuated, other behavioral symptoms not directed to others which occurred daily that significantly disrupted care or living environment, required set up and clean up assistance with eating and partial to moderate assistance with toileting, upper and lower body dressing, personal hygiene and mobility. The MDS further documented R32 had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag) and was always continent of bowel, had shortness of breath or trouble breathing with exertion and sitting at rest. R32 weighed 164 pounds, had a weight loss of five

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percent (%) or more in the last month or 10 % in six months, and was not on a physician-prescribed weight loss regimen. R32 took a diuretic (medication to promote the formation and excretion of urine) during the observation period.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 02/09/24, documented the facility would care plan for the indwelling catheter to reduce risk for injury and infection.

R32's "Care Plan," dated 02/15/24, documented R32 had an indwelling catheter due to bladder outlet obstruction. The care plan directed staff to provide catheter care twice a day (BID) and as needed (PRN), ensure tubing is secure to reduce pulling, monitor for symptoms of UTI, and notify the provider of symptoms.

The "Physician Order", dated 02/07/24, directed staff to provide R32 peri catheter care, to pull back the foreskin, and clean thoroughly BID for disorder of the skin and subcutaneous (beneath the skin) tissue.

The "Physician Order", dated 02/16/24, directed staff to apply a small amount of Nystatin (antifungal) topical cream at the end of the penis three times a day for tinea cruris (fungal infection in the skin of genitals, inner thigh, and buttocks).

On 02/16/24 at 06:14 PM an "Interdisciplinary (ID) Note" documented that staff communicated with the physician regarding R32's penis lesions that were bleeding and got worse since the order of Nystatin. The physician ordered to send R32 to the emergency room.

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F 690	Continued From page 26 On 02/18/24 at 03:46 PM an "ID Note" documented R32's physician ordered the resident to be sent to the emergency room due to the resident not eating, moaning, and unable to communicate what he needed or feeling. On 02/19/24 at 12:49 AM an "ID Note" documented R32 had returned to the facility from the emergency room with a prescription for an antibiotic for a UTI. On 03/06/24 at 07:41 AM observation revealed Licensed Nurse (LN) H provided catheter care by cleansing the catheter insertion site with disposable wipes. LN H then applied the prescribed ointment without changing gloves. On 03/11/24 at 10:43 AM, Administrative Nurse D stated LN H should have changed gloves after cleansing the catheter and before applying the medicated ointment. The facility's "Medication Administration" policy, dated 05/2020, documented that if your hands have become soiled, i.e., touching a resident's mouth, contacting saliva, if you touch their spoon or glass, you must use alcohol gel or wash your hands. The facility failed to provide R32 with sanitary indwelling catheter care and treatment, which placed the resident at risk for continued complications of UTIs and fungal skin conditions.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		

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F 695	Continued From page 27	F 695		

tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to provide appropriate respiratory care and services when staff failed to store oxygen cannula and tubing in a sanitary manner for Resident (R) 14. This placed the resident at risk for respiratory infections.

Findings included:

- R14's Electronic Medical Record (EMR) documented R14 had diagnoses of pneumonia (inflammation of the lungs), Crohn's disease (chronic inflammatory bowel disease), acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), and hypercapnia (high levels of carbon dioxide in the blood), and major depressant disorder (major mood disorder which causes persistent feelings of sadness).

R14's "Quarterly Minimum Data Set" (MDS), dated 02/20/24, documented R14 had intact cognition. R14 required partial to moderate assistance with toileting hygiene, upper and lower body dressing, rolling side to side, sitting from lying, and transfers. R14 was always incontinent of urine and frequently incontinent of bowel. R14 had two or more falls with injury and had weight

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loss. The MDS further documented R14 received an antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (medication to treat pain).

R14's "Care Plan" initiated on 08/18/23 documented R14 had oxygen therapy via nasal cannula at three liters per minute (LPM) and directed staff to administer oxygen as ordered by the medical doctor and adhere to safety as per facility protocol. The plan directed staff to maintain an oxygen saturation of 90 percent (%) or above.

The "Physician Order", dated 02/29/24, directed staff to administer oxygen continuously to keep oxygen saturations at 90% or above.

The "Interdisciplinary (ID) Note," dated 02/26/24 at 02:37 AM, documented R14 had complaints of not being able to breathe. R14 was diaphoretic (sweaty) and had tachypnea (abnormally rapid breathing) with an oxygen saturation of 67% at times. Staff administered treatments and the oxygen flow rate was increased. The note further documented R14 was sent to the emergency room.

The "ID Note," dated 02/29/24, documented R14 admitted back to the facility with oxygen at two LPM.

On 03/05/24 at 11:18 AM, observation revealed Certified Nurse Aide (CNA) M assisted R14 with morning care. R14 had oxygen via a nasal cannula which was attached to a concentrator placed in the bathroom/shower. During the shower process, CNA M removed the nasal

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cannula, which then fell to the floor in the bathroom. Once CNA M finished the showering process and assisted the resident in dressing for the day, CNA reapplied the oxygen cannula that was on the floor. Once R14 was in her wheelchair and preparing to go to the dining room for a meal, CNA M retrieved a portable oxygen machine from a bedside table where the nasal cannula was draped over the top of the machine and not stored inside a bag or other sanitary container.

On 03/06/24 at 01:40 PM, Observation revealed R14 laid in bed with oxygen via a nasal cannula from the oxygen concentrator. The portable oxygen machine sat on the overbed table with the nasal cannula draped over the side of the machine. Licensed Nurse (LN) H verified the nasal cannula should be stored in a bag when not in use and the oxygen nasal cannula should not touch the floor.

On 03/11/24 at 08:34 AM observation revealed R14 laid in bed and received oxygen administration vial nasal cannula and oxygen concentrator. The portable oxygen machine sat on the bedside table with the nasal cannula draped over the top, uncovered. LN G verified the nasal cannula should be stored in a bag when not in use.

On 03/11/24 at 10:43 AM, Administrative Nurse D verified oxygen cannulas should be stored in a sanitary bag when not in use.

The facility's "Oxygen Administration" policy, dated 11/2013, directed staff to place extra oxygen tubing on a hook on the concentrator, do not leave it on the floor if possible. Place a clean bag on the concentrator to hold the cannula when

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F 695	Continued From page 30 not in use and the cannula should not lay on furniture. The facility failed to provide appropriate respiratory care and services when staff failed to store oxygen cannula and tubing in a sanitary manner for R14. This placed the resident at risk for respiratory infections.	F 695		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced	F 803		

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by:
The facility had a census of 37 residents. The sample included 15 residents. Based on observation, record review, and interview the facility failed to prepare a nourishing well well-balanced pureed diet that followed the menu and included a vegetable for Resident (R)190, who requested vegetables. This placed the resident at risk for dissatisfaction and impaired nutrition.

Findings included:

- On 03/06/24 at 09:50 AM, observation in the main kitchen revealed Dietary Staff (DS) BB stated the facility had one resident (R190) who received a pureed diet. Observation revealed DS BB placed five half-ounce (oz) meatballs with sauce into a blender and blended to the consistency of pudding. DS BB used a spatula to transfer the pureed meatballs to a metal pan and placed the pan in the warmer. When asked how R190 would receive her vegetables, DS BB stated R190 had not requested any.

On 03/06/24 at 10:41 AM, observation of R190's noon meal dietary order sheet revealed that R190 had soft-cooked vegetables circled. DS CC verified R190 had circled soft, cooked vegetables and stated it meant she had requested them.

On 03/06/24 at 11:50 AM, Administrative Staff A stated when staff prepared R190's pureed diet, she expected staff to prepare all food items requested on R190's dietary order sheet.

The facility's " Dining-Pureed Food Policy," revised 07/2021, documented for those residents who have orders to have pureed food, the regular

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F 803	Continued From page 32 menu item that the resident chooses would be pureed in the resident dining area to allow the same options as all other residents. The facility failed to prepare R190's requested pureed diet food items. This placed the resident at risk for dissatisfaction and impaired nutrition.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 37 residents. The facility had one main kitchen and three kitchenettes. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the 37 residents who received their	F 812		

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meals from the facility's kitchens when staff stored unlabeled, undated food in the refrigerators. Staff did not sanitize the thermometer between food items when checking food temperatures and failed to ensure clean and sanitary preparation areas. This placed the 37 residents at risk for foodborne illness.

Findings included:

- On 03/05/24 at 08:05 AM, observation in the kitchen revealed the following:
An updated, unlabeled plastic bag with liquid coffee.
12 uncovered, undated, and unlabeled slices of cheese.
An undated, unlabeled plastic container of barbeque sauce.

On 03/05/24 at 08:05 AM, Dietary Staff (DS) BB verified the above finding and stated food items placed in the refrigerator should be labeled, dated, and completely covered. DS BB disposed of the food items in the trash.

On 03/06/24 at 09:55 AM, observation in the kitchen revealed DS BB checked the food temperatures of the noon food items without cleansing or disinfecting the thermometer between different food items. DS BB stated he should have cleaned the thermometer between the different food items.

On 03/06/24 at 10:00 AM, observation in the kitchen revealed the following:
Two unlabeled, undated flour containers.
Three ceiling vents had four inches of a gray-colored substance around them.
A three-quarter full 5-gallon bucket filled with a

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black greasy substance on the floor by the three-well sink in the dishwashing area.
The floor underneath the three-well sink had an area of brown substance approximately six inches by three feet long.

On 03/06/24 at 10:15 AM, DS DD verified the above findings and stated maintenance staff were responsible for cleaning the ceiling vents. DS DD said she would put in a requisition to have them cleaned. DS DD stated staff should not store the bucket of fryer grease in the kitchen, staff should take it outside every time they empty grease into the bucket after it cooled down. DS DD stated the dietary staff had a daily cleaning schedule and the floor should be clean underneath the sinks.

On 03/06/24 at 10:41 AM, observation in the 100-House kitchenette refrigerator revealed the following:
Two undated chocolate Mighty shakes.
Eight undated strawberry Mighty shakes.
One undated fast-food chocolate shake and one fast-food chocolate and vanilla shake.
An undated plastic bag with four ice cream sandwiches and another one with seven ice cream sandwiches.
An undated, unlabeled one-quarter-full bag of shredded cheddar cheese.
An undated, nine-ounce (oz) plastic container of black forest ham.
An undated package (pkg) of ham slices.
An undated, unlabeled one-quarter-full plastic bag of bacon toppings.
Two undated pkg of sliced yellow cheese.
One undated pkg of mozzarella cheese slices.
An unlabeled, undated bowl of shredded turkey.
An unlabeled, undated bowl of orange slices.
An unlabeled, undated pkg of cherry tomatoes.

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On 03/06/24 at 10:412 AM, DS CC verified the above findings in the 100-House kitchenette and stated dietary staff should label and date food when they receive it from the kitchen. DS CC discarded all food items listed above in the trash.

On 03/07/24 at 11:50 AM, Administrative Staff A stated staff should not keep a bucket of grease in the kitchen. Administrative Staff A said staff should take the bucket out and pour it into the container by the dumpster. Administrative Staff A stated the closing dietary staff were supposed to check for outdated and unlabeled food in the refrigerators daily. Administrative Staff A stated when staff obtained food items from the kitchen, they should label and date them before placing them in the refrigerator.

The facility's "Food Storage Chart Policy," revised 07/2013, documented that food must be stored in a way in which quality is preserved and in a way that ensures proper rotation. This means that food must be sealed to reduce the growth of bacteria and date marked to ensure that the oldest items are used first.

The facility's "Cleaning of Work Surfaces, Utensils, and Equipment Policy" revised 04/2013 documented utensils and equipment would be cleaned routinely to help prevent cross-contamination and food-borne illnesses.

The facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the 37 residents who received their meals from the facility's kitchen and one of three kitchenettes. This placed the 37 residents at risk for foodborne

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F 812	Continued From page 36 illness.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) 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(q)(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(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing 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	F 851		

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

§483.70(q)(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 had a census of 37 residents. Based on observation, record review, and interview, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing.

Findings included:

- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (YR) 2023 Quarter 2 indicated the facility did

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F 851	Continued From page 38 not have a Registered Nurse (RN) on 5 dates, FY 2023 Quarter 3 indicated no RN for on 91 dates and FY 2023 Quarter 4 for 26 dates. The PBJ also indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple days in FY 2023: Quarter 3 for 91 dates and Quarter 4 for 31 dates. The PBJ further indicated Fiscal YR 2024 Quarter 1 did not have an RN for 26 days and did not have a licensed nurse coverage 24 hours a day, seven days a week for 46 dates. A review of the facility licensed nurse payroll data for the dates listed on the PBJ revealed an RN for eight consecutive hours daily and a licensed nurse on duty for 24 hours a day seven days a week. On 03/06/24 at 09:30 AM, observation revealed an RN and a licensed practical nurse on duty in the facility. On 03/11/24 at 11:15 AM, Administrative Nurse D stated the facility staff were not sure how to submit the PBJ information and knew that they had submitted it incorrectly. Administrative Nurse D further stated that the facility administration would contact the appropriate people to make sure it was done correctly. Upon request a policy for PBJ was not provided by the facility. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.	F 851		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 39 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 37 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to ensure adequate infection control measures when staff did not practice appropriate hand hygiene when providing incontinence care for Resident (R) 12, or for R4 during medication administration. This placed the residents at risk for infection.

Findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175380	A. BUILDING _____ B. WING _____	03/11/2024

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- The Electronic Medical Record (EMR) for R12 documented diagnoses of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), atrial fibrillation (rapid, irregular heartbeat), and hypertension (high blood pressure).

The "Quarterly Minimum Data Set" (MDS), dated 02/14/24, documented R12 had moderately impaired cognition and was dependent upon staff for toileting, substantial/maximum assistance for dressing, personal hygiene, and transfers. The MDS documented R12 was continent of bowel.

The "Care Plan," dated 03/01/24, initiated on 02/28/24 documented R12 used incontinent products and directed staff to apply a protective skin barrier after each incontinent episode.

On 03/06/24 at 09:40 AM, observation revealed Certified Nurse Aide (CNA) N assisted R12 in the sit-to-stand lift and placed him on the toilet. CNA N applied gloves and pulled down R12's pants and incontinent brief which revealed R12 had a large, loose bowel movement (BM) that had also gotten on R12's pants. CNA N removed and discarded the soiled brief into the trash and wearing the same gloves, retrieved a new brief and clean pants. Continued observation revealed CNA put the new brief and pants on, stood R12 up in the lift, provided peri care, looked through R12's drawers for barrier cream, applied the barrier cream, and pulled up the brief and pants while wearing the same soiled gloves. CNA N transferred R12 with the sit-to-stand lift with the soiled gloves on, wiped off the toilet seat, and

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then removed the soiled gloves. CNA N removed her gloves and took the trash out of the room without washing her hands.

On 03/06/24 at 09:50 AM, CNA N stated she should have removed her gloves after she removed the soiled incontinence product and applied clean gloves.

On 03/11/24 at 03:30 PM, Administrative Nurse D stated the CNA should change her gloves multiple times during toileting and should have disinfected the lift afterward.

The facility's "Perineal Care for the Incontinent and UTI Prevention" policy, dated 10/03, directed staff to use perineal wipes over the entire soiled area of skin, wipe from front to back, repeat if necessary, allowing cleansers to further soften stool, and change gloves after working with bowel movement.

The facility staff failed to use adequate hand hygiene when she did not change gloves and wash her hands when providing R12 incontinent care. This placed the resident at risk for infection.

- On 03/06/24 at 08:00 AM, observation revealed Licensed Nurse (LN) H prepared and administered R4's morning inhalation, nasal, and ophthalmic (pertaining to the eye) treatments. LN H retrieved the medications from the locked cabinet in R4's room. LN H donned gloves and placed the medication and treatments on the overbed table in front of the resident. LN H primed the inhalation medication and handed it to the resident for inhaling, which R4 completed. LN H then removed the cover from the nasal spray and handed it to R4, who then administered the

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nasal spray to each nostril. LN H then adjusted the head of the bed from the bed controls positioned by a urinal that hung on the same rail. LN H's gloved hand touched the urinal and bed controls, without changing gloves LN H administered the ophthalmic wipes and drops to both eyes. LN H then took the treatments and placed them back into the locked cabinet.

On 03/11/24 at 10:43 AM, Administrative Nurse D verified staff should have changed gloves with different administrations of treatments.

The facility's "Medication Administration" policy, dated 05/2020, documented that if your hands have become soiled during the medication pass, i.e., touching a resident's mouth, contacting saliva, touching their personal spoon or glass, you must use alcohol gel or wash your hands.

The facility failed to ensure sanitary administration of R4's treatments which placed the resident at risk for contaminated possible infectious process.