Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Frank M. Tejeda Texas State Veteran's Home

Location: 200 Veterans Drive, Floresville, TX 78114

Onsite / Virtual: Onsite

Dates of Survey: 2/21/23 through 2/24/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 160

Census on First Day of Survey: 138

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from February 21, 2023 through February 24, 2023 at the Frank M. Tejeda Texas State Veteran's Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.100 (a) Dignity. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, record review, and review of facility policy, it was determined for one (1) of 23 sampled residents (Resident #11) the facility failed to ensure a resident was treated in a dignified manner with respect to their individuality. Resident #11 made numerous attempts to remove a long-sleeved shirt, layered over a tee shirt on their upper torso and facility staff forced the resident to leave the long-sleeved shirt on, not allowing the resident to remove it. The findings include: Review of a facility policy titled, "Statement of Resident Rights," revised 10/22, revealed Compliance Guidelines included: "The community should educate, encourage, and honor the rights of those we serve. Further, the community should assist a resident/patient to fully exercise their rights as applicable." The policy specified: "Resident/Patient Rights include: To be treated with courtesy, consideration, and respect…The community will promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing

	problems, and cognition limits) in the exercise of these rights. If a resident has been deemed incompetent, [they] will be given the opportunity to exercise these rights based on [their] degree of capability." Resident #11 was admitted to the facility on [DATE]. The resident's diagnoses included Dementia, Insomnia, Psychotic Disturbance, Adjustment disorder with mixed Anxiety, and Depressed Mood disorder. Resident #11 resided on [LOCATION]. Review of an admission Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of six (6), indicating moderate to severe impairment in cognitive skills for daily decision making. Resident #11 required the extensive assistance of one (1) person with dressing and had no range of motion limitations in upper or lower extremities. The resident was assessed to show signs and symptoms of delirium as evidenced by inattention and disorganized thinking that was present and did not fluctuate. An assessment of behavioral symptoms revealed Resident #11 exhibited verbal behaviors one (1) to three (3) days and other behaviors not directed toward others on four (4) to six (6) days during the assessment review period. Review of Resident #11's Care Plan, initiated on [DATE], revealed that the resident being resistive to activities of daily living (ADL) care related to anxiety and dementia was identified as a problem deficit. The goal was for Resident #11 to cooperate with care through the next review date. Interventions included: 1) Encourage as much participation/interaction by the resident as possible during care activities; 2) Give clear explanation of all care activities prior to, and as they occur, during each contact. Observation, on 2/22/23, at 9:45 a.m., revealed Resident #11 was seated in a wheelchair positioned in an enclosed courtyard, outside the [LOCATION] on the [LOCATION]. There were approximately 10 other residents in the courtyard, and Consultant Staff A was reading to the residents from a newspaper. Resident #11 was speaking in Spanish and attempting to remove a long-sleeved shirt from their upper torso. The resident was noted to use one hand to hold a white tee shirt down while using the other hand to raise the long-sleeved shirt over the head. When questioned regarding the resident trying to remove the long-sleeved over shirt, Consultant Staff A stated "(A [Certified Nurse Aide]) just made (them) put it back on." At approximately 9:55 a.m., Consultant Staff A pushed Resident #11 in the wheelchair into the [LOCATION], positioning the resident at a table. A cookie and glass of water was placed on the table within the resident's reach. The resident continued to

	try to remove the long-sleeved shirt while also holding an undershirt (white tee shirt) down with one hand. At 10:04 a.m., Licensed Nurse A approached Resident #11, who at that time had pulled the long-sleeved overshirt completely over their head, while leaving the white tee shirt down, covering the torso. Licensed Nurse A proceeded to pull the long-sleeved shirt back down while the resident continued to attempt to remove the shirt. Licensed Nurse A did not speak to the resident; however, stated to the surveyor, "[They have] a lot of behaviors." Licensed Nurse A was questioned regarding why Resident #11 wanted to remove the long-sleeved shirt? Licensed Nurse A responded, "[they] did this over the weekend, too. [They have] a lot of anxiety. They increased [their] medications." Licensed Nurse A was asked a second time, "But, do you know why [they want] to take the shirt off?" After being questioned, Licensed Nurse A assisted Resident #11 with removing the long-sleeved over shirt, leaving a white tee shirt in place, covering the resident's torso. Licensed Nurse A did not address Resident #11 directly throughout the incident and made no attempt to ask the resident why they were trying to remove the shirt. The resident immediately calmed down and started eating the cookie and drank from the glass of water that had been placed on the table in front of them. Resident #11 made no attempts to remove the white tee shirt. Observation, on 2/22/23, at 10:45 a.m., revealed Resident #11 continued to sit in a wheelchair, positioned at a [LOCATION] table. The resident was noted to be wearing a white tee shirt with the long-sleeved tee shirt lying on the table in front of the resident. Resident #11 was observed to be calm and quiet while independently drinking from a glass of water. An interview was conducted, on 2/23/23, at 1:00 p.m., with Consultant Staff B. They stated Consultant Staff A was also a Certified Nurse Aide. All Consultant Staff who were assigned to the [LOCATION] were required to be Certified Nurse Aides. Consultant Staff B stated they had heard about the incident regarding Resident #11 trying to remove a shirt during an outside activity the previous day. Consultant Staff B stated it was warm outside, and Consultant Staff A should have asked the resident if they wanted to remove the long-sleeved shirt before removing them from the activity. An interview was conducted, on 2/24/23, at 11:40 a.m., with Administrative Staff A. Administrative Staff A stated the expectation was that all residents would be treated with dignity. All residents should be given a choice in making daily, routine decisions.
§ 51.100 (e) Participation in other activities.	Based on observation, interview, record review, and policy review, the facility failed to provide social, religious, and

A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility management must arrange for religious counseling by clergy of various faith groups. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	community activities for one (1) of 23 sampled residents (Resident #5). The findings include: Review of the policy, dated 6/12, and titled, "Section 17-Activities Program," stated: " The community provides an ongoing, organized program of activities designed, in accordance with the comprehensive assessment to meet the interests and to maintain the physical, mental and psychosocial well-being of each resident…The activities program is an essential component of the community's fulfillment of its obligation to care for its residents in a manner and environment that maintain or enhance each resident's quality of life." The facility admitted Resident #5 on [DATE], with the following diagnoses: Hypertensive Heart Disease, Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), Type II Diabetes Mellitus, Venous Insufficiency, Atrial Fibrillation, Vascular Dementia, Polyneuropathy, and Muscle Wasting. Review of the Annual Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview Mental Status (BIMS) of 14, and the resident was able to be interviewed. Continued review of the MDS, section F0300 Daily and Activity Preferences, revealed it was very important to the resident to listen to music, be around animals, and to go outside for fresh air as the weather permitted. Continued review of section F0300 revealed it was somewhat important to participate in religious services. Review of Resident #5's Care Plan, dated [DATE], stated: "Focus- I can participate in activities of my choice within my physical and cognitive ability, Goal- I prefer to enjoy activities one (1) to three (3) weekly or as tolerated through my next review date, Interventions- …Remind and assist me to the planned activities as scheduled." Review of Resident #5's Group Activity Graph for the [DATE] revealed the resident had not participated in any group activities. Review of Resident #5's In-Room Activity Graph for the [DATE] revealed a five (5) to 10-minute activity on one (1) day, [DATE]. Review of Resident #5's Individual Activity Graph for the past [DATE] revealed the resident watched television on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].

	An interview with Consultant Staff B, on 2/23/23, at 1:06 p.m., revealed religious activities occurred every day except Friday. An interview with the resident, on 2/21/23, at 10:00 a.m., and 2/23/23, at 9:00 a.m., revealed they had not been asked by staff to participate in any activities since admission. The resident went on to state they would like to participate in the church services. Review of Resident #5's clinical record did not reveal documentation that the resident had been offered, or had declined, to participate in religious activities. An interview with Administrative Nurse A, on 2/24/23, at 10:50 a.m., revealed it was important for residents to be involved in activities that interested them because it was good for their quality of life. An interview with Administrative Staff A, on 2/24/23, at 11:45 a.m., revealed it was very important for residents to be happy with their activities because that was part of the homelike environment.
§ 51.100 (f) Accommodation of needs. A resident has the right to— (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and (2) Receive notice before the resident's room or roommate in the facility is changed. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, record review, and policy review, the facility failed to provide services in the facility with reasonable accommodation of individual needs and preferences for one (1) of 23 sampled residents. Resident #5 desired to sit up in a chair, but staff failed to accommodate their request. The findings include: Review of the policy titled; "Accommodating Resident Needs," dated 2/17, stated: "Each resident has the right to reside and receive services and reasonable accommodation of individual needs and preferences." Reasonable accommodations of individual needs and preferences was defined as the community's efforts to individualize the resident's environment. The facility admitted Resident #5 on [DATE], with the following diagnoses: Hypertensive Heart Disease, Chronic Kidney Disease (CKD), Congestive Heart Failure (CHF), Type II Diabetes Mellitus, Venous Insufficiency, Atrial Fibrillation, Vascular Dementia, Polyneuropathy, and Muscle Wasting.

	Observation of Resident #5, on 2/21/23, at 10:00 a.m., revealed the resident to be alert, awake, and lying in their bed. Observation of Resident #5, on 2/21/23, at 11:45 a.m., revealed the resident asleep in their bed. Observation of Resident #5, on 2/21/23, at 2:00 p.m., revealed the resident lying in their bed. An interview with Resident #5, on 2/21/23, at 2:01 p.m., revealed in the past they had been assisted by the staff to get up in a chair, however, they said they had not been up in the chair in quite some time. Observation of Resident #5 on 2/21/23 at 3:00 p.m. revealed the resident asleep in the bed. An interview with Certified Nurse Aide A, on 2/21/23, at 2:02 p.m., revealed they thought the resident could not get out of the bed due to a pressure ulcer. An interview with Licensed Nurse B, on 2/24/23, at 9:45 a.m., revealed Resident #5 had probably not been out of the bed and into the wheelchair for two (2) months. Review of the Care Plan, dated [DATE], stated: “Focus- I have a self-care deficit weakness, and debility, Goal- I will maintain my ability to participate in my care with activities of daily living (ADL), Interventions- I use a reclining wheelchair,” dated [DATE]. An interview with Administrative Nurse A, on 2/24/23, at 10:50 a.m., revealed each resident should be involved and make decisions regarding their own care. An interview with Administrative Nurse A, on 2/24/23, at 11:45 a.m., revealed it was their expectation that residents were able to choose to participate in their care. They stated it was the resident’s right to choose to participate in their care.
§ 51.100 (g) (1) Patient Activities. (1) The facility management must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well being of each resident.	Based on observation, interview, record review, and review of facility policy, it was determined for residents who resided on one (1) of four (4) units, a [LOCATION], a program of ongoing activities was not provided based on the planned activities calendar and in accordance with residents’ assessments and interests. The findings include: Review of a facility policy titled, “Activities Program,” revised 6/1/12, revealed the statement: “The community provides an

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Some	ongoing, organized program of activities designed, in accordance with the comprehensive assessment, to meet the interests and to maintain the physical, mental, and psychosocial well-being of each resident." The policy specified: "Activities occur at any time and are not limited to the format, scheduled activities provided by activity team members. The activities program is an essential component of the community's fulfillment of its obligation to care for its residents in a manner and environment that maintain or enhance each resident's quality of life. The activity program is designed to encourage restoration of self-care and maintenance of normal activity and is geared to meet the individual resident's needs. The activities program is a compilation and aggregation of many individualized programs that address the diverse needs and interests of the community's resident population." A tour was initiated, on 2/21/23, at 9:45 a.m., of the [LOCATION]. Licensed Nurse C, reported the census on the [LOCATION] was 30 residents. Observation of the [LOCATION], adjacent to the nursing station, revealed 10 residents were seated in wheelchairs and/or regular chairs at the [LOCATION] tables. Two (2) residents were observed ambulating in and out of the [LOCATION]. There was soft, "oldies" music playing in the background. Observation, at 9:56 a.m., revealed a variety of games and puzzles had been placed in front of some of the residents. None of the residents were observed to be using the games or puzzles. At 9:59 a.m., Consultant Staff A walked in the [LOCATION] and approached one (1) of the residents seated in the [LOCATION]. Consultant Staff A proceeded to assist the resident with playing a Velcro tabletop game. Review of a posted "[LOCATION] Calendar" for February, 2023 revealed on 2/21/23, at 9:30 a.m., an "Exercise Circle" was documented as being planned for the time of the observations on the [LOCATION]. The planned activity was not being provided. Continued observation, on 2/21/23, at 10:35 a.m., of the [LOCATION] revealed residents continued to be seated in the [LOCATION] or walking aimlessly throughout the [LOCATION]. The games and/or puzzles remained on the [LOCATION] tables with no residents actively using them. A review of the posted "[LOCATION] Calendar" for February, 2023 revealed at 10:30 a.m., "Mind Works: Picture Match" was a planned activity. The planned activity was not being provided. Review of the posted "[LOCATION] Calendar" for February, 2023 revealed on 2/21/23, at 2:30 p.m., a planned activity of "Wellness Walk in Garden" was planned for residents on the [LOCATION]. Observation on 2/21/23, at 2:50 p.m., on the [LOCATION] revealed Consultant Staff A assisted one (1) resident with exiting the [LOCATION] and entering an enclosed

	courtyard. Consultant Staff A and the one (1) resident walked around the courtyard together. Observation revealed other residents on the unit remained in the [LOCATION], ambulated in hallways, or remained in their rooms with no activity program being implemented. A tour was initiated, on 2/22/23, at 9:18 a.m., of the [LOCATION]. There were no activities being provided on the unit. Licensed Nurse A stated, "supposed to have activities back here but I'm not sure where they are." Residents on the unit were observed seated at [LOCATION] tables, ambulating, or propelling themselves in wheelchairs around the unit. Review of the posted "[LOCATION] Calendar" for February, 2023 revealed at 9:15 a.m., the scheduled activity of "Daily Chronicle" was planned but not being implemented. At 9:25 a.m., Consultant Staff A arrived on the [LOCATION]. Consultant Staff A propped open the [LOCATION] door leading into an enclosed courtyard and began to push residents in wheelchairs out into the courtyard. Ambulatory residents were observed to walk out into the courtyard. At 10:40 a.m., approximately 10 residents were observed to remain outside in the courtyard and Consultant Staff A was reading from a newspaper to the residents. A review of the planned activities calendar revealed the scheduled activities included at 9:30 a.m., "Ball Toss," 10:00 a.m., "Morning Hydration and Snack," and 10:30 a.m., "Activity Card: Ash Wednesday." The planned activities were not being provided as planned for the 10 residents in the courtyard or the remaining 20 residents on the [LOCATION]. Review of the posted "[LOCATION] Calendar" for February, 2023 revealed on 2/23/23, at 10:30 a.m., a planned activity of "Mind Works: Heart Health" was planned for residents on the [LOCATION]. Observation on the [LOCATION] on 2/23/23, at 10:35 a.m., revealed 15 residents were seated in wheelchairs or regular chairs in the [LOCATION]. Two (2) residents were observed to have games placed on the table in front of them, but neither was engaged with them. One (1) resident was holding a small tambourine, but the resident had their head down, eyes closed, and was not engaged in using the tambourine. Consultant Staff A was seated at a table with one (1) resident, coloring in a picture book, but the resident had their eyes closed and was not engaging in coloring with Consultant Staff A. A housekeeping staff member was observed mopping the [LOCATION] floor around the residents. The planned activity was not being implemented. Review of the posted "[LOCATION] Calendar" for February, 2023 revealed on 2/24/23, at 10:30 a.m., the activity of "Game Club: Black History Month Trivia" was planned for residents on the [LOCATION]. Observation of the [LOCATION] on 2/24/23,

	at 10:35 a.m., revealed 11 residents were seated at tables in the [LOCATION]. Most of the residents had their eyes closed. Five (5) residents had games/puzzles on the table in front of them, but none of the residents were engaged with the items. One (1) resident was using colored pencils to color in a book and two consultant staff members were seated at a table with three (3) residents using colored pencils to color in a book. Other residents were observed to wander throughout the unit, in hallways and wandering through the [LOCATION]. The planned activity was not being implemented and residents were not engaged in activities of interest. An interview was conducted, on 2/22/23, at 3:24 p.m., with Consultant Staff A who was assigned to provide the activities program on [LOCATION]. Consultant Staff A stated, in addition to being a consultant staff, they were a Certified Nurse Aide. Consultant Staff A stated they had not received very much training before being assigned as a consultant staff on the [LOCATION]. Consultant Staff A stated they had been shown where the games, puzzles, etc. were stored on the unit. Consultant Staff A stated the activity calendar for the [LOCATION] was created by Consultant Staff B, themself, and the other consultant staff who worked in the facility. Consultant Staff A stated they could not always follow the activities calendar because it was just them on the unit. An interview was conducted, on 2/23/23, at 1:00 p.m., with Consultant Staff B. They stated they developed the activities calendar for the [LOCATION] with input from the facility's two (2) consultant staff. Consultant Staff B stated it was difficult to do something with all residents on the [LOCATION], since it was just themself and Consultant Staff A available to implement the program. Consultant Staff B stated they spent a lot of time conducting Minimum Data Set (MDS) assessments, Care Plans, and participating in Interdisciplinary Care Plan meetings, making it difficult to find time to assist Consultant Staff A on the [LOCATION]. Consultant Staff B further stated it was difficult for Consultant Staff A to provide activities for all residents on the [LOCATION]. Consultant Staff B stated, "we don't get help from nursing when doing the activities program." According to Consultant Staff B, nursing staff were not responsible for assisting consultant staff with getting residents to activities or assisting with resident participation. Sometimes residents were brought off the [LOCATION] to attend large group events in other areas of the facility; however, it was consultant staff who were responsible for bringing the residents and assistance was not provided by nursing staff. Consultant Staff B stated the February, 2023 activity calendar for the [LOCATION] was a new program being trialed and would be evaluated at the end of the month. Consultant Staff B stated the activity calendar should be followed on the unit.

	An interview was conducted, on 2/24/23, at 10:38 a.m., with Administrative Nurse A. When questioned regarding an interdisciplinary approach to ensuring residents on the [LOCATION] attended and participated, to extent practical, in a planned activities program, Administrative Nurse A stated the nursing staff had other duties to perform and could not assist with implementing an activities program on the unit. An interview was conducted, on 2/24/23, at 11:40 a.m., with Administrative Staff A. They stated it was their expectation a planned activity program would be implemented. It was important that residents had the right to participate or not participate in an activity program, but activities of interest should be offered/provided.
§ 51.100 (i) (2) Environment. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, and facility policy, the facility failed to maintain furniture and bathroom fixtures for one (1) of 23 sampled residents (Resident #17). The findings include: Review of the facility document entitled, “Statement of Resident Rights reviewed/revised 10/22, revealed: “Resident/Patient Rights include: 2. To safe, decent and clean conditions.” In an observation and interview during the initial facility tour, on 2/21/23, at 11:30 a.m., Resident #17 showed the surveyor the foot board of their bed, which was detached on one side and hanging down. Also observed, the toilet seat of the in-room bathroom was observed with the left hinge detached from the commode due to a broken bracket, and the left side of their television had a crack in the picture of the left upper side, causing a distorted display. Resident #17 reported the crack was caused by the Hoyer lift being brought into or out of the room. In an interview, on 2/22/23, at 10:30 a.m., Administrative Nurse B, they observed and confirmed the broken accommodations in Resident #17’s room. In an interview, on 2/22/23, at 10:48 a.m., Administrative Nurse A stated that resident rooms should be cleaned daily and anything that needed repair should be reported to maintenance. In an interview, on 2/24/23, at 9:00 a.m., Administrative Staff B confirmed that each room should be cleaned daily, and that housekeeping staff was to report any issues to a nurse or the manager.

§ 51.110 (b) (1) Comprehensive assessments. (1) The facility management must make a comprehensive assessment of a resident's needs: (i) Using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 3.0; and (ii) Describing the resident's capability to perform daily life functions, strengths, performances, needs as well as significant impairments in functional capacity. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Some	Based on record review, interview, and review of facility policy, it was determined for four (4) of 23 sampled residents (Residents #2, #11, #12, and #13) the facility failed to make a comprehensive assessment that described the resident's capabilities and/or impairments. Resident #2 was not assessed on a comprehensive assessment for smoking status. Resident #11 was not assessed on a comprehensive assessment for Cognitive Loss/Dementia, Communication, Activities of Daily Living (ADLs), Urinary Incontinence, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Resident #12 was not assessed on a comprehensive assessment for Cognitive Loss/Dementia, Communication, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Resident #13 was not assessed on a comprehensive assessment for Cognitive Loss/Dementia, Vision, Mood, Behavioral Symptoms, ADLs, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. The findings include: Review of a facility policy titled, "Comprehensive Assessments," implemented 02/17, revealed: "The community uses the Resident Assessment Instrument (RAI) to develop the comprehensive resident assessment. It identifies the care, services, and treatments that each resident needs to attain or maintain [their] highest practicable mental and physical functional status." Continued review revealed the policy addressed "Accuracy of Assessment," specifying: "Each resident receives an accurate team member assessment of relative care areas that provide team members with knowledge of each resident's status, needs, strengths, and areas of decline. The initial comprehensive assessment provides baseline data for ongoing assessment of resident progress." 1. The facility admitted Resident #2 on [DATE], with the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD), Lung Nodule, Peripheral Vascular Disease, Depression, Uropathy, Anxiety, Hypertension, Type II Diabetes Mellitus, and Dementia. Review of the Annual Minimum Data Set (MDS) assessment, dated [DATE], revealed Section J1300 Current Tobacco Use-

	"no" was selected. Review of the Nursing Smoking Tool, dated [DATE], revealed the resident was a safe smoker. An interview with Resident #2, on 2/21/23, at 10:00 a.m., revealed they were a safe smoker and could independently smoke. Review of the Care Plan, dated [DATE], stated, "I am a smoker (cigarette)." An interview with Administrative Nurse C, on 2/23/23, at 2:24 p.m., revealed they assumed the previous Administrative Nurse C had overlooked that the resident smoked, and smoking should have been coded on the MDS as "yes." An interview with Administrative Nurse A, on 2/24/23, at 10:50 a.m., revealed it was their expectation that the coding on the MDS be accurate, so that the Care Plan could be accurate. An interview with Administrative Staff A, on 2/24/23, at 11:45 a.m., revealed their expectation was that the MDS was coded correctly and accurately. 2. Resident #11 was admitted to the facility on [DATE]. Review of the medical record revealed an admission Minimum Data Set (MDS) assessment was completed, with an Assessment Reference Date (ARD) of [DATE]. A review of Section V of the MDS assessment revealed Resident #11 triggered for further review of the Care Area Assessment (CAA) areas of: Cognitive Loss/Dementia, Communication, Activities of Daily Living (ADLs), Urinary Incontinence, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Section V documentation indicated the additional assessment information for the triggered CAAs would be found on CAA worksheets. A review of the CAA worksheet for each triggered care area revealed no additional assessment of the care areas was documented. The CAA worksheet for each triggered care area included a computer-generated report from the MDS, outlining the factors that caused the care area to trigger, with no evidence of the assessment of complication factors, or risks for the triggered care areas as required by the Resident Assessment Instrument (RAI) process. 3. Resident #12 was admitted to the facility on [DATE]. Review of the medical record revealed an annual MDS assessment was completed, with an ARD of [DATE]. A review of Section V of the MDS assessment revealed Resident #12 triggered for further review of the CAA areas of: Cognitive Loss/Dementia, Communication, Urinary Incontinence, Falls, Nutritional Status,

	Pressure Ulcer, and Psychotropic Drug Use. Section V documentation indicated the additional assessment information for the triggered CAAs would be found on CAA worksheets. A review of the CAA worksheet for each triggered care area revealed no additional assessment of the care areas was documented. The CAA worksheet for each triggered care area included a computer-generated report outlining the factors that caused the care area to trigger. There was no evidence of the assessment of complicating factors or risks for the triggered care areas, as required by the RAI process. 4. Resident #13 was admitted to the facility on [DATE]. Review of the medical record revealed an annual MDS assessment was completed, with an ARD of [DATE]. A review of Section V of the MDS assessment revealed Resident #13 triggered for further review for the CAA areas of: Cognitive Loss/Dementia, Vision, Mood, Behavioral Symptoms, ADLs, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Section V documentation indicated the additional assessment information for the triggered CAAs would be found on CAA worksheets. A review of the CAA worksheet for each triggered care area revealed no additional assessment of the care areas was documented. The CAA worksheet for each triggered care area included a computer-generated report outlining the factors that caused the care area to trigger. There was no evidence of the assessment of complicating factors or risks for the triggered care areas, as required by the RAI process. An interview was conducted, on 2/23/23, at 1:35 p.m., with Administrative Nurse C, who was assigned to complete comprehensive assessments on the [LOCATION]. Administrative Nurse C stated they were new to the position and were continuing to receive training. Administrative Nurse C stated they had reviewed past completed comprehensive assessments and were aware the former Administrative Nurse C had not worked the triggered CAAs as required by the RAI for residents in the facility. An interview was conducted, on 2/24/23, at 10:38 a.m., with Administrative Nurse A. They stated they were aware the previously employed Administrative Nurse C had experienced challenges in completing the RAI process and that triggered CAAs were not being worked, as required by the process. Administrative Nurse A stated the facility now had two (2) Administrative Nurses who were still in the learning process. An interview was conducted, on 2/24/23, at 11:40 a.m., with Administrative Staff A. They stated it was their expectation that all comprehensive MDS assessments be completed accurately. Further, Administrative Staff A stated it was expected that all

	resident Care Plans be updated based on an accurate assessment of the resident.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. **Level of Harm** – No Actual Harm, with potential for more than minimum harm **Residents Affected** – Few	Based on interview and record review, the facility failed to review and revise the Care Plan for one (1) of 23 sampled residents (Resident #1). The findings include: The facility admitted Resident #1 on [DATE], with the following diagnoses: Parkinson's Disease, Alzheimer's Disease, Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Hypoxemia, and chronic kidney disease (CKD). Record review of a progress note, dated [DATE], at 8:40 p.m., found: "[Certified Nurse Aide] assisting patient to bed reports to nurse patient noted with open skin area to heel. this nurse assessed right heel at this time, skin noted with raised skin area to right heel measuring three (3) centimeters (CM) x two-point five (2.5) CM, no drainage noted. skin prep applied at this time and heel offloaded with offloading boot. Primary Care Physician (PCP) notified" [sic]. Review of the Physician Order, dated [DATE], at 2:29 p.m., revealed: "Heel protectors to be in place when in bed." Review of the Care Plan on 2/21/23, and dated [DATE], revealed the Care Plan had not been reviewed and revised to address care of the right (R) heel ulcer identified by staff on [DATE]. An interview with Administrative Nurse A, on 2/23/23, at 11:00 a.m., revealed the facility did not have a policy and procedure related to the review and revision of Care Plans. An interview with Administrative Nurse A, on 2/24/23, at 10:50 a.m., revealed the purpose of the Care Plan was to keep staff informed of how to care for each resident. They revealed the Administrative Nurses or the clinical staff could update the Care Plan as needed. An interview with Administrative Staff A, on 2/24/23, at 11:45 a.m., revealed Care Plans were supposed to be reviewed daily by the Interdisciplinary Team (IDT) and updated at that time.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must—	Based on observation, interview, record review, and review of facility policy, it was determined for two (2) of 23 sampled residents (Resident #13 and #22) the facility failed to implement care planned interventions to address each resident's risk for falls.

(i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Few	The findings include: Review of a facility policy titled, "Comprehensive Assessments," implemented 02/17, revealed: "The community uses the Resident Assessment Instrument (RAI) to develop the comprehensive resident assessment. It identifies the care, services, and treatments that each resident needs to attain or maintain [their] highest practicable mental and physical functional status." Continued review of the policy revealed: "The comprehensive assessment allows for the development of plan of care that addresses all of the resident's care needs. It also identifies the interventions that may be required to overcome barriers to the provision of resident care." 1. Resident #13 was admitted to the facility on [DATE]. The resident's diagnoses included Dementia, Congestive Heart Failure, Hypertension, Bipolar Disorder, Insomnia, Major Depressive Disorder, Peripheral Vascular Disease, Anxiety, and Lack of Coordination. Resident #13 resided on [LOCATION]. Review of an annual Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate to independent cognitive skills for daily decision making. Resident #13 required supervision and set up help only with wheelchair mobility on and off the unit. The resident was assessed to have experienced two (2) or more falls without injury during the assessment review period. Review of the Care Plan, dated [DATE], revealed Resident #13 was identified to be at risk for falls and a goal established for the resident to be free from falls. The Care planned interventions included anticipating and meeting their needs, keeping needed items such as water within reach, and keeping the call light within reach. Resident #13 was observed lying in bed on 2/22/23, at 1:53 p.m.; 2/23/22, at 10:40 a.m.; and 2/23/22, at 3:05 p.m. During each observation there was no water or beverage noted within the resident's reach. Additionally, during each observation the call light was not within reach of the resident. 2. Resident #22 was admitted to the facility on [DATE]. The resident's diagnoses included Dementia, Arthritis, Adjustment Disorder with mixed anxiety, and Depressed Mood. The resident resided on [LOCATION]. Review of an admission MDS assessment, dated [DATE], revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of four (4), indicating severe impairment in

	cognitive skills for daily decision making. The resident required the extensive assistance of one (1) person walking in the room and walking in the corridor did not occur. Resident #22 was assessed as having experienced two (2) or more falls with injury that wasn't major injury during the review period. Review of a quarterly MDS assessment, dated [DATE], revealed Resident #22 had a BIMS score of two (2) indicating severe impairment in cognitive skills for daily decision making. The resident was assessed to exhibit physically aggressive behavioral symptoms toward others and to wander one (1) to two (2) days during the review period. Resident #22 required the limited assistance of one (1) staff person with walking in room and corridor. The resident experienced no falls during the review period. Review of a Care Plan, dated [DATE], revealed Resident #22 was identified to be at risk for falls. A goal was established for the resident to not sustain serious injury. Interventions to attain the goal included to anticipate and meet the resident's needs and ensure the resident wore appropriate footwear when ambulating or mobilizing in a wheelchair. Resident #22 was observed on 2/24/23, at 10:05 a.m., ambulating on the unit with an unsteady gait. The resident was wearing a white sock and slip on house shoe on the right foot. The resident's right heel was not positioned inside the house shoe, but was off the sole of the shoe, touching the floor as they walked. The resident was not wearing a shoe on the left foot but was wearing a white sock. The sock did not have a non-skid sole on the bottom. An interview was conducted, on 2/24/23, at 10:38 a.m., with Administrative Nurse A. They stated every morning the "clinical connect team" met to review anything clinical. Administrative Nurse A stated this could include a review of falls, behaviors, upcoming appointments, need for referrals, etc. Administrative Nurse A stated Care Planned interventions should be implemented for all residents. An interview was conducted, on 2/24/23, at 11:40 a.m., with Administrative Staff A. They stated residents on the [LOCATION] did create a challenge due to behaviors, but the call lights should be kept within reach in accordance with the Plan of Care. Administrative Staff A stated it was their expectation that each resident's Care Plan be updated as indicated and all planned interventions should be implemented.
§ 51.120 (d) Pressure sores. Based on the comprehensive	Based on observation, interview, record review, and policy review, the facility failed to provide one (1) of 23 sampled

assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	residents the necessary treatment and services to promote healing and prevent new pressure sores from developing. Resident #1 had an existing deep tissue injury on their right heel; however, the facility failed to consistently apply heel protectors or offload the heels. The findings include: Review of the policy titled, "Skin and Wound Management," dated 05/22, stated: "Each resident receives the care and services necessary to retain or regain optimal skin integrity to the extent possible…A plan of care should be developed based on the skin review/checks. If skin compromise occurs, the interdisciplinary team notifies the physician for any orders and those appropriate measures and additional interventions are put in place to minimize further compromising of the skin to aid in healing to extent possible." The facility admitted Resident #1 on [DATE] with the following diagnoses: Parkinson's Disease, Alzheimer's Disease, Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Hypoxemia, and Chronic Kidney Disease (CKD). Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident's Brief Interview for Mental Status to be 13, and the resident was able to be interviewed. Continued review of the MDS section M0150 revealed the resident was at risk for the development of pressure ulcers. Record review of a progress note, dated [DATE], at 8:40 p.m., stated: "[Certified Nurse Aide] assisting patient to bed reports to nurse patient noted with open skin area to heel. this nurse assessed right heel at this time, skin noted with raised skin area to right heel measuring 3cm x 2.5cm, no drainage noted. skin prep applied at this time and heel offloaded with offloading boot. Primary Care Physician (PCP) notified" [sic]. Review of the Physician Order, dated [DATE], at 2:29 p.m., stated: "Heel protectors to be in place when in bed." Observation of Resident #1, on 2/21/23, at 11:45 a.m., revealed the resident lying on their back in the bed. The resident's left heel was noted to be in direct contact with the surface of the mattress, and the right heel was noted to be partially in a heel protector with the entire heel in contact with the mattress surface. Only one (1) heel protector was noted at this time.

	Observation of Resident #1, on 2/21/23, at 12:50 p.m., revealed a heel protector in the bed with the resident, and both of their heels were in direct contact with the surface of the mattress. Observation of Resident #1, on 2/21/23, at 2:30 p.m., revealed one (1) heel protector in the bed with the resident, and both heels in contact with the surface of the mattress. Observation of Resident #1, on 2/22/23, at 8:30 a.m., revealed a heel protector on the resident's left (L) foot. The resident's right (R) foot was in direct contact with the mattress surface, and neither heel was offloaded from the surface of the mattress. Observation of Resident #1, on 2/22/23, at 10:00 a.m., revealed the resident's R heel in direct contact with the mattress surface. Neither heel was offloaded from the mattress surface. An interview with Certified Nurse Aide B, on 2/22/23, at 10:30 a.m., revealed they had no idea if the resident required a heel protector on each heel, or if the resident's heels should be offloaded from the surface of the mattress. They went onto state they were "agency," and did not get a report on each resident at the beginning of the shift. They stated they relied on the facility's Certified Nurse Aide to tell them what to do for each resident. An interview with Licensed Nurse D, on 2/22/23, at 10:40 a.m., revealed the resident should have heel protectors on both of their heels and the resident's heels should also be offloaded with a pillow to prevent pressure to the heels. Observation of a dressing change to Resident #1's right heel, on 2/22/23, with Licensed Nurse D at 10:45 a.m., revealed a two (2) centimeter (CM) by 2 CM dark red area. An interview with Administrative Nurse A, on 2/24/23, at 10:50 a.m., revealed the purpose of heel protectors and offloading was to relieve pressure from a resident's heel to prevent impaired skin integrity. An interview with Administrative Staff A, on 2/24/23, at 11:45 a.m., revealed it was their expectation that wound care interventions/orders be followed by the staff.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives	Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure the environment was as free of accident hazards as possible. Three (3) of 23 sampled residents (Residents #13, #19, and #22) were assessed to be at risk for falls. The care planned interventions were not reviewed/revised and/or implemented to address each resident's fall risk. A tour of the facility, on 2/23/23, between

adequate supervision and assistance devices to prevent accidents. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Few	1:50 a.m., and 11:30 a.m., revealed a key was left in a door lock unattended that could be used by unauthorized persons to gain access to areas where chemicals, etc., were stored. Residents #13 and #22 had care planned interventions developed but not implemented to address a risk for falls. Resident #19 experienced nine (9) falls and the facility failed to review after each fall and revise the Care Plan as indicated. The findings include: Review of a policy titled, "Falls Prevention Guideline," dated 3/28/22, revealed the policy purpose was: "To establish a process that identifies risk and establishes interventions to mitigate the occurrence of falls." The process included: "When a risk factor for falls is identified a corresponding intervention addressing that risk factor is developed. When the risk is identified and intervention determined, it is documented on the care plan and on the Kardex. The identified intervention is initiated." 1. Observation, on 2/23/23, between 10:50 a.m., and 11:30 a.m., revealed a master key left unattended in a doorknob on [LOCATION]. Further observation revealed, the keys opened all [LOCATIONS], storage rooms, cleaning rooms, and an exit door in the [LOCATION]. Maintenance Staff A indicated that they didn't know who the keys belonged to. Additionally, Maintenance Staff A stated that staff should never leave keys unattended. Later, at approximately 1:00 p.m., Consultant Staff C came in and stated the keys belonged to Maintenance Staff B and they forgot the keys in the door by accident. 2. Resident #13 was admitted to the facility on [DATE]. The resident's diagnoses included Dementia, Congestive Heart Failure, Hypertension, Bipolar Disorder, Insomnia, Major Depressive Disorder, Peripheral Vascular Disease, Anxiety, and Lack of Coordination. Resident #13 resided on [LOCATION]. Review of an annual Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate to independent cognitive skills for daily decision making. The resident was assessed to require extensive assistance of one (1) person with bed mobility and transfers and was always incontinent of bowel and bladder. Resident #13 required supervision and set up help only with wheelchair mobility on and off the unit. The resident was assessed to have experienced two (2) or more falls without injury during the assessment review period.

	Review of Resident #13's Care Plan, dated [DATE], revealed the resident was at risk for falls related to a history of falls, gait/balance problems, incontinence, and psychotropic drug use. A goal was established for the resident to be free of falls through the review date of [DATE]. Interventions planned included: 1) Anticipate and meet my needs. 2) Keep needed items, water, etc., in reach. The Care Plan for Resident #13 included a problem focus of "Call Light Use" initiated on [DATE]. The stated goal was: "(Resident) will be able to utilize appropriate use of call light as needed throughout view to promote safety awareness." The planned intervention was "Keep call light within reach and remind resident of call light location." Observation, on 2/22/23, at 1:53 p.m., revealed Resident #13 was lying on their left side in bed. The resident's eyes were closed, and they appeared to be resting quietly. There was no water or other beverages within reach of the resident. Additionally, the call light was not within reach of Resident #13. The call light cord was noted to be running against the wall behind the head of the resident's bed, with the call light button positioned on the floor behind the bed. A wheelchair was positioned beside the resident's bed. Observation and interview, on 2/22/23, at 2:05 p.m., revealed Resident #13 was up in a wheelchair propelling themself in the hallway outside the resident's room. The resident was asked if they received assistance with getting out of bed, to which Resident #13 replied "no, I got up by myself." Observation, on 2/23/22, at 10:40 a.m., revealed Resident #13 was lying on their right side in bed. A wheelchair was positioned at the side of the bed. There was a sandwich in plastic wrap on a bedside table, within reach of the resident. There was no water or other beverages within the resident's reach. The call light was observed to be lying across a bedside chest of drawers and was not within the resident's reach. Observation and interview, on 2/23/22, at 3:05 p.m., revealed Resident #13 was lying in bed on their right side. The call light was positioned on the floor behind the head of the bed and was not within reach of the resident. The resident was awake and asked, "What's wrong with me?" The surveyor asked Resident #13 if they needed to see the nurse, and the resident responded "yes." The surveyor went to the nursing station where Licensed Nurse A was working and reported Resident #13's request to see the nurse. Licensed Nurse A accompanied the surveyor back to the resident's room where it was pointed out that the call light was not within the resident's reach. Licensed Nurse A positioned the call light within the resident's reach stating, "staff should make sure the call lights are within reach."

	An interview was conducted, on 2/24/23, at 10:38 a.m., with Administrative Nurse A. They stated every morning the "clinical connect team" met to review anything clinical. Administrative Nurse A stated this could include a review of falls, behaviors, upcoming appointments, need for referrals, etc. Administrative Nurse A stated Care planned interventions should be implemented for all residents. 3. Record review revealed Resident #19 experienced nine (9) falls and the facility failed to review and revise the Care Plan after each fall, as indicated. Record review revealed Resident #19 was admitted to the facility on [DATE]. The resident's diagnoses included: Dementia, Disorientation, Dissociative/Conversion Disorder, Peripheral Vascular Disease, Localized Lower Extremity Edema and Absence of Right Great Toe. Resident #19 expired on [DATE], under hospice care. Review of Resident #19's progress notes revealed that the resident sustained falls on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Review of risk management progress notes revealed the following information regarding the falls: -[DATE], revealed that Resident #19 was found on the floor and did not have proper footwear. Review of interdisciplinary team notes dated, [DATE], revealed a root cause analysis: "episodes of contusion and non-compliance with care plan… proper footwear was not being worn…interventions; therapy to screen, offer assistance to toilet before dinner." -[DATE], revealed that Resident #19 was found sitting on floor, new interdisciplinary interventions modified; therapy to screen…remind resident to use call light. Review of a Nursing Progress Note, dated [DATE], revealed that Resident #19 was found on the floor… interdisciplinary team note, dated [DATE], revealed interventions that included therapy to screen… educate resident on wheelchair safety and locking brakes, trial period using wheelchair with therapy. -[DATE], revealed that Resident #19 refused wheelchair. No interdisciplinary team or risk management notes to discuss alternate interventions were found in the health record.

	-[DATE], revealed that Resident #19 was found lying on the floor. Interdisciplinary team note, dated [DATE], stated interventions therapy to screen. -[DATE], recorded that Resident #19 was found on the floor in their room. Interdisciplinary team meeting note, dated [DATE], charted root cause analysis. Resident #19 attempted self-transfer to use bathroom; interventions included therapy to screen… educate team on residents non weight bearing status…increase rounds. Review of summary for providers, dated [DATE], reported change in condition with orders to admit to hospice. -[DATE], charted Resident #19 was found sitting on floor. Interdisciplinary team meeting note, dated [DATE], included interventions… therapy to screen…resident educated on locking brakes on wheelchair…encouraged to use call light. -[DATE], revealed Resident #19 was found sitting on floor. Interdisciplinary team note, dated [DATE], listed interventions therapy to screen…encouraged non-skid socks. An interview was conducted, on 2/24/23, at 9:10 a.m., with Licensed Nurse E. They stated that the interdisciplinary team met after each fall and current interventions were discussed and new interventions were determined, and care planned. Licensed Nurse E stated that Resident #19 had multiple falls and that some planned interventions had inadvertently not been updated on the Care Plan. Licensed Nurse E stated care planned interventions should be documented on the Care Plan to guide staff on implementation or required care for the residents. An interview was conducted, on 2/24/23, at 10:38 a.m., with Administrative Nurse A. They stated care planned interventions should be implemented for all residents. An interview was conducted, on 2/24/23, at 11:40 a.m., with Administrative Staff A. They stated it was their expectation that each resident's Care Plan be updated as indicated and all planned interventions should be implemented. Administrative Staff A stated residents on the [LOCATION] did create a challenge due to behaviors, but the call lights should be kept within reach in accordance with the Plan of Care. Administrative Staff A stated it was their expectation that each resident's Care Plan be updated as indicated and all planned interventions should be implemented. 4. Resident #22 was admitted to the facility on [DATE]. The resident's diagnoses included Dementia, Arthritis, Adjustment

	Disorder with mixed anxiety, and Depressed Mood. The resident resided on [LOCATION]. Review of an admission MDS assessment, dated [DATE], revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of four (4), indicating severe impairment in cognitive skills for daily decision making. Resident #22 was assessed to exhibit physical and verbal behavioral symptoms that impacted self and others. The resident was assessed to require the extensive assistance of one (1) person with walking in room and walking in the corridor did not occur. Resident #22 was assessed as having experienced two (2) or more falls with injury that wasn't major injury during the review period. Review of a quarterly MDS assessment, dated [DATE], revealed Resident #22 had a BIMS score of two (2), indicating severe impairment in cognitive skills for daily decision making. The resident was assessed to exhibit physically aggressive behavioral symptoms toward others and to wander one (1) to two (2) days during the review period. Resident #22 required the limited assistance of one (1) staff person with walking in room and corridor. The resident experienced no falls during the review period. Review of Resident #22's Care Plan, dated [DATE], revealed the resident was at risk for falls related to gait/balance problems, exit seeking, and use of psychotropic medications. The established goal was for the resident to not sustain serious injury through the review date of [DATE]. Interventions planned to address Resident #13's fall risk included to anticipate and meet the resident's needs and ensure the resident wore appropriate footwear when ambulating or mobilizing in a wheelchair. Observation, on 2/24/23, at 10:05 a.m., revealed Resident #22 was ambulating independently on the [LOCATION] where the resident resided. Resident #22 walked past the nursing station and down a hallway, adjacent to the [LOCATION]. The resident was observed to be within the line of sight of staff at the nursing station and in the [LOCATION]. Resident #22 was observed wearing one, open back, slip on house shoe on the right foot. The resident was wearing a white sock. The resident's right heel was noted to be off the sole of the shoe and touching the floor as the resident walked. Resident #22 was noted to have a white sock on the left foot and was wearing no shoe. The resident was observed to walk with an unsteady gait. Consultant Staff A was observed to approach Resident #22 and offer a bag of potato chips. The resident accepted the chips and started eating from the bag as they turned and continued to walk down the hallway. A Certified Nurse Aide approached the resident after Consultant Staff A walked away, and was holding

	the resident's left, matching house shoe. The Certified Nurse Aide placed the house shoe on the floor in front of Resident #22 and instructed the resident to step into the house shoe. The resident did not comply and continued to walk down the hallway wearing one house shoe on the right foot, with the right foot heel hanging out of the shoe. The resident was not wearing the appropriate footwear and was walking with an unsteady gait. There were no staff staying near the resident as they ambulated unsteadily while wearing one (1) house shoe. An interview was conducted, on 2/24/23, at approximately 10:10 a.m., (during the timeframe of Resident #22 ambulating with one house shoe on) with Licensed Nurse A. They stated a Certified Nurse Aide had attempted to get Resident #22 to put the left house shoe on, just before the observations of the resident ambulating without it on. The resident had resisted wearing the left house shoe and Licensed Nurse A stated they had instructed the Certified Nurse Aide to back away due to the resident's resistance. Licensed Nurse A was asked if instructions had also been given to nursing staff to remain within proximity to the resident due to the increased risk for falls? Licensed Nurse A responded "no," because the resident had a history of being aggressive. However, during the observations of Resident #22, Consultant Staff A and a Certified Nurse Aide were observed to approach the resident with no aggression exhibited by Resident #22. An interview was conducted, on 2/24/23, at 10:38 a.m., with Administrative Nurse A. They stated they had been on the [LOCATION} that morning when Resident #22 had refused to allow staff to put the left house shoe on their left foot. Administrative Nurse A stated the staff were doing a good job "back there" [LOCATION] in providing care. When questioned about a potential missed opportunity to have Resident #22 sit down to enjoy the snack provided by Consultant Staff A, Administrative Nurse A stated the nursing staff had other duties and could not sit down to do activities with the residents. Administrative Nurse A stated care planned interventions should be implemented for all residents. An interview was conducted, on 2/24/23, at 11:40 a.m., with Administrative Staff A. They stated residents on the [LOCATION] did create a challenge due to behaviors, but the call lights should be kept within reach in accordance with the Plan of Care. Administrative Staff A stated it was their expectation that each resident's Care Plan be updated as indicated and all planned interventions should be implemented.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved	Based on facility policy, observation, and interview, the facility failed to follow accepted practice for use of hair restraints by

or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	dietary staff while handling food in one (1) of four (4) [LOCATIONS]. The findings include: Review of facility policy entitled, "Employee Sanitation," revised 5/10/18, revealed: "Policy: The [Dietary Staff] will monitor each facility to ensure that the facility uses good sanitation practices in accordance with the state and Federal Food Codes…Guidelines: 3. B. Hair restraints such as hats hair coverings or nets, caps and beard/moustache restraints (snoods) or other effective hair restraints are worn to keep hair from contacting food and food-contact surfaces." A dining observation, on 2/22/23, at 12:10 p.m., revealed a dietary staff member serving food from the steam table with a baseball cap turned backwards that did not restrain/cover their hair, along with a second server with their hairnet pulled back to expose their hair to the ear line. Both dietary staff left the serving area and entered the [LOCATION]. In an interview on 2/22/23, at 12:20 p.m., Dietary Staff A, supervisor for the day, confirmed that both staff were not wearing proper hair restraints.
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Some	**Smoke Barriers and Sprinklers** 1. Based on observation and interview, the facility failed to ensure fire alarm boxes were visible and accessible. The deficient practice affected two (2) of 11 smoke compartments, staff, and 23 residents. The facility had a capacity for 160 beds with a census of 138 on the day of the survey. The findings include: Observation during the building inspection tour, on 2/23/23, at 10:49 a.m., revealed a fire alarm box was not accessible and blocked by a high blood pressure machine on [LOCATION], as prohibited by section 19.3.4.2.2 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 2/23/23, at 10:49 a.m., revealed the facility was not aware the fire alarm box was blocked at the end of [LOCATION]. Observation during the building inspection tour, on 2/23/23, at 11:00 a.m., revealed a fire alarm box was not accessible and blocked by a decorative plant in the [LOCATION], as prohibited by section 19.3.4.2.2 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 2/23/23, at 11:00 a.m., revealed the facility was not aware the fire alarm box was blocked in the [LOCATION].

	Observation during the building inspection tour, on 2/23/23, at 11:05 a.m., revealed a fire alarm box was not accessible and blocked a popcorn machine in the [LOCATION], as prohibited by section 19.3.4.2.2 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 2/23/23, at 11:05 a.m., revealed the facility was not aware the fire alarm box was blocked in the [LOCATION]. The census of 138 was verified by Administrative Staff A on 2/23/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 2/23/23. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** 19.3.4.2.2 Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other continuously attended staff location, provided that both of the following criteria are met: **(1)** Such manual fire alarm boxes are visible and continuously accessible. (2) Travel distances required by 9.6.2.5 are not exceeded. **Electrical Systems** 2. Based on observation and interview, the facility failed to prohibit the improper use of electrical equipment. The deficient practice affected one (1) of 11 smoke compartments, staff, and zero (0) residents. The facility had a capacity for 160 beds with a census of 138 on the day of the survey. Observation during the building inspection tour, on 2/23/23, at 10:15 a.m., revealed a power strip used in lieu of fixed wiring to power a mini refrigerator and microwave, in the [LOCATION], as prohibited by sections 400.8 and 590.3 of NFPA 70, National Electric Code. An interview, on 2/23/23, at 10:15 a.m., with Maintenance Staff A revealed the facility was not aware that a power strip was used in lieu of fixed wiring to power a mini refrigerator and microwave in the [LOCATION]. Observation during the building inspection tour, on 2/23/23, at 10:18 a.m., revealed a power strip used in lieu of fixed wiring powering a coffee pot, in the [LOCATION], as prohibited by sections 400.8 and 590.3 of NFPA 70, National Electric Code. An interview, on 2/23/23, at 10:18 a.m., with Maintenance Staff A revealed the facility was not aware that a power strip was used in lieu of fixed wiring to power a coffee pot in the [LOCATION].

	Observation during the building inspection tour, on 2/23/23, at 10:36 a.m., revealed a power strip used in lieu of fixed wiring powering a large refrigerator, coffee pot, and microwave in the [LOCATION], as prohibited by sections 400.8 and 590.3 of NFPA 70, National Electric Code. An interview, on 2/23/23, at 10:36 a.m., with Maintenance Staff A revealed the facility was not aware that a power strip was used in lieu of fixed wiring to power a large refrigerator, coffee pot and microwave in the [LOCATION]. The census of 138 was verified by Administrative Staff A on 2/23/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 2/23/23. **Actual NFPA Standard: NFPA 101, (2012) Life Safety Code** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1 Utilities.** **9.1.2 Electrical Systems**. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 70 (2011) National Electric Code** **400.8 Uses Not Permitted.** Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure