STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555130	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAYWOOD SKILLED NURSING & WELLNESS CENTRE	6025 PINE AVE MAYWOOD, CA 90270

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat 10 of 24 residents (8, 9, 21, 27, 28, 38, 71, 82, 103, 122), with dignity and respect by: Resident 38, who needed assistance with the meal, the staff was observed standing over while assisting the resident Resident 8, 9, 21, 27, 28, 71, 82, and 103, the residents were called and their diet card was labeled feeder. Resident 122, who was alert and oriented stated she was treated with disrespect by a certified nursing attendant (CNA 6), who was later terminated. These failures had the potential to affect Resident 8, 9, 21, 27, 28, 38, 71, 82, 103, 122's psychosocial well-being that could result in a negative outcome such as fear, depression, and isolation for the residents. Findings: a. During an observation on 3/9/20 at 11:32 a.m., Certified Nurse Assistant (CNA 2) was standing up while feeding Resident 38. CNA 2 stated Resident 38 can not eat by himself. A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool dated 1/23/20, indicated Resident 38 had an impaired cognition for daily decision making, required extensive assistance with eating and personal hygiene. The MDS assessment indicated the resident's [DIAGNOSES REDACTED]. b. During an observation on 3/9/20 at 11:38 a.m., CNA 3 was observed preparing Resident 8's food standing up. CNA 3 stated Resident 8 was a Feeder. CNA 3 stated she knew with a Feeder I will need to sit while feeding, but with Resident 8 she had to stand up because it was hard, and had to put a towel near the resident's mouth when she drank. c. During an observation in the kitchen on 3/10/20 at 11:43 a.m., the lunch card for Residents 8, 9, 21, 27, 28, 71, 82, 103 were labeled Feeders. During an interview on 3/11/20 at 1 p.m., Dietary Supervisor (DS) brought a copy of the printed meal cards that labeled Feeder for Resident 8, 9, 21, 27, 28, 71, 82, 103. During a review of the latest quarterly MDS assessments, indicated Residents 8, 9, 21, 27, 28, 71, 82, 103 had impaired cognitive skills with daily decision making. During a review of the MDS assessment dated [DATE], indicated Resident 8 had a moderate cognitive impairment with daily decision making. During a review of the clinical records the care plan indicated Resident 8 had cognitive deficit, communication impairment, poor decision making and lack of safety awareness and judgment. During an interview on 3/11/20 at 2:06 p.m. Restorative Nurse Assistant (RNA 1) stated For patients who are completely feeders, I have to feed them. We call them feeders. I have to be seated while feeding them. I need to be facing them at eye level, so they don't get scared and think I'm the boss. It is a problem if you don't sit while feeding. I don't know what they told me, but so that I don't scare them. During an interview on 3/11/20 at 2:14 p.m., Licensed Vocational Nurse (LVN 1) stated When staff are feeding the residents, they must sit down at eye level of the patient, so they are able to see the residents clearly and not hover over the residents. If they are standing, the residents might feel uncomfortable. It is a dignity issue. LVN 1 was asked if it was acceptable for the staff to call the residents who need assistance at mealtimes a Feeder and label each meal card a Feeder. LVN 1 shook her head and stated We will take it off and change it to the level of assistance needed. It is an issue of dignity. During an interview on 3/12/20 at 10:48 a.m., LVN 6 stated Staff feeding the residents should be sitting on the chair so that they will be at the eye level of the resident so they won't feel they are being rushed and so it won't hurt their back. It is not acceptable for staff to call residents feeder because it is unnecessary labeling and does not show respect to the residents. d. On 03/10/20 at 12:45 p.m., Resident 122 was in bed awake and able to communicate. Resident 122 stated sometime last year, Certified Nursing Attendant (CNA 6) answered to her call light in a very rude way. Resident 122 stated CNA 6 came into the room, pointing her two fingers at the resident, saying why the call light was always turned on. A review of Resident 122's Admission Record (Face Sheet) indicated the facility readmitted Resident 122 on 10/18/19 with [DIAGNOSES REDACTED]. A review of Resident 122's Minimum Data Set (MDS), a standardized assessment and care-screening tool dated 1/17/20 indicated Resident 122 had the ability to make herself understood, understand others, and make decisions. Resident 122 required supervision with bed mobility, transfers, and eating. A review of the Nursing Progress notes dated 10/22/19 timed at 11:05 a.m., indicated Director of Staff Development (DSD) and Director of Nursing (DON) met with Resident 122 about her complaint regarding CNA 6 being very rude to her. Resident 122 stated during the 3 p.m., to 11 p.m., shift (on 10/21/20) she had her call light on, and CNA 6 went in her room and in a rude manner gesturing told her, Why are you always on your light I told you they are not here! They are not here. A review of CNA 6's employee file indicated she was suspended on 10/22/19 and terminated on 10/25/19.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete each resident's discharge, reentry, and quarterly Minimum Data Set ((MDS) a standardized assessment and care planning tool) assessments was not completed no later than 14 calendar days after the Assessment Reference Date ((ARD) the date that signifies the end of the look back period of MDS assessment), for seven of 7 residents, (1, 2, 5, 6, 12, 38, 101). This failure had the potential for critical indicators of gradual change in a resident's status would not be identified, monitored timely, and addressed, which could affect Resident 1, 2, 5, 6, 12, 38, 101's plan of care. Findings: During an interview on 3/13/20 at 9:45 a.m., Licensed Vocational Nurse (LVN 2) stated quarterly MDS assessment should be completed within 14 days from the ARD date. During a concurrent record review of the clinical records with LVN 1, the following residents quarterly MDS assessments had not been completed within 14 days from the ARD date: 1. Resident 2, had a quarterly MDS (a non-comprehensive assessment that must be completed at least every 92 days) dated 12/20/19 but was completed on 2/11/20. LVN 2 stated It should have been completed within 14 days. 2. Resident 6, had a quarterly MDS dated [DATE] that was completed on 3/5/20. LVN 2 stated It should have been completed within 14 days. 3. Resident 12, had a discharge MDS dated [DATE] that was completed on [DATE]. LVN 2 stated It should have been completed within 14 days. 4. Resident 1, had a quarterly MDS dated [DATE] that was completed on 2/3/20. LVN 2 stated It should have been completed within 14 days. 5. Resident 5, had a quarterly MDS dated [DATE] that was completed on 2/3/20. LVN 2 stated It should have been completed within 14 days. 6. Resident 101, had a quarterly MDS dated [DATE] that was completed on [DATE]. LVN 2 stated It should have been completed within 14 days. 7. Resident 38, had a reentry MDS dated [DATE] that was completed on 2/20/20. LVN 2 stated It should have been completed within 14 days. During an interview on 3/13/20 at 9:45 a.m., Registered Nurse 3 stated I am not sure if it will affect the quality measure or payment. MDS assessment has to be completed within 14 days from the ARD date.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 1 resident (38), who was on hospice services (end of life care), received the assistance to attend activities of interest according to acceptable standards of

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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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) clinical practice. This failure had the potential to deprive Resident 38 of activities previously liked, in order to improve the quality of life, and enhance the resident's psychosocial well-being. Findings: During an observation on [DATE] at 8:10 a.m., Resident 38 was observed on bed. Resident 38 was nonverbal and unable to answer questions. During an observation on [DATE] at 10:07 a.m., Resident 38 was observed on bed. During an observation on 3/11/20 at 11:35 a.m., Resident 38 was on bed. A review of the face sheet indicated Resident 38 was originally admitted to the facility on [DATE], and re-admitted on [DATE]. A review of the Minimum Data Set (MDS), a standardized assessment and care planning tool dated 1/23/20, indicated Resident 38 had an impaired cognition with daily decision making, preferred doing things with groups of people, and participating in favorite activities. The MDS assessment indicated the resident required extensive assistance with bed mobility, transfer, and used a wheelchair as mobility device. A review of Resident 38's face sheet indicated [DIAGNOSES REDACTED]. During an observation and concurrent interview on 3/12/20 at 11:52 a.m., Certified Nurse's Assistant (CNA 3) stated Resident 38 used to go out in the patio, now he stays in bed. He was more active before, he usually participates with activities, he listens to music, he plays bingo. It had been a month that he stayed on bed. He doesn't get up. I did not see him get up in my shift. His family only comes once a week. During a review of the clinical records for Resident 38, the physician order dated 1/16/20 indicated Resident 38 had been enrolled under hospice care, to be out of bed with assistance, and could attend activity as tolerated. A review of a care plan dated 12/31/19 indicated Resident 38 was at risk for development of skin breakdown or pressure sore (injury to skin and underlying tissue resulting from prolonged pressure on the skin). One of the interventions indicated to encourage patient to get out of bed as tolerated. A review of the psychosocial well-being care plan for Resident 38 dated 1/2/20, indicated to encourage activities according to the resident's choices and preferences. A review of the recreational/activity care plan for Resident 38 dated 1/2/20 indicated an intervention to encourage out of bed/ room to participate in activities that interests the resident. A review of the mood state care plan for Resident 38 dated 1/2/20, indicated one intervention to encourage socialization and participation in activities. A review of the hospice care plan for Resident 38 dated 1/16/20 did not indicate that Resident 38 had restrictions to get out of bed or participate in activities. A review of another care plan for Resident 38 dated 1/16/20 indicated the resident had preference to stay in bed, however, there was no intervention as to how to address the preference. A review of the cognitive loss care plan for Resident 38 dated 1/23/20, indicated an intervention to encourage participation in activities. During an interview on 3/12/20 at 12:11 p.m., Licensed Vocational Nurse (LVN 6) stated Resident 38 had [MEDICAL CONDITION] (a sudden, uncontrolled electrical disturbance in the brain) at the end of January 2020, but he was never out of bed after the [MEDICAL CONDITION]. During an interview on 3/12/20 at 3:30 p.m., Activity Assistant (AA 1) stated Since Resident 38 had been on hospice, he had been in bed. Resident 38 had been non-responsive. During an interview on 3/12/20 at 3:43 p.m., Activity Director (AD) stated Activities department is a very important department for the residents in this facility. Aside from the cognitive and sensory stimulation, we also provide emotional support to the residents and we provide the sense of community. We make them feel that this is home for them. AD also stated that the activities each resident has are based on my assessment. I also go by what the physician's order say. AD confirmed the physician order and stated, With the order to get him out of bed with assistance, activity as tolerated, our role in the activity is we ask the nurses to have him get up. AD also stated that since January, Resident 38 had been on room visits and never been out. However, with the resident's preference to be on bed, the physician's order should have been clarified or changed. Resident 38 used to be very active outside the room, he smokes in social activity until he was confined in his room due to his medical condition. But his condition should not make him be confined on his bed, in his room. I don't know if Resident 38 had been offered or encouraged to get out of his room for activities and stimulation. During an interview on 3/13/20 at 8:48 a.m., Registered Nurse (RN 4) stated Physicians orders should be followed. However, we can question a physician order sometimes. RN 4 also stated with hospice residents, we try to get them up and take them to activity, but if the resident does not want to and he is content with where he is at, we should still encourage them to get up, like the care plan indicated. If they continue to refuse, it has to be documented and notify the physician of the situation, especially that Resident 38 had an order. RN 4 stated the risks involved for not getting him up and out of the room could deprive the resident of socialization and at risk for pressure ulcers. RN 4 stated just because the resident was receiving hospice services and they should not just be in their rooms. During a concurrent record review, RN 4 confirmed the physician's orders for Resident 38 indicated for the resident to be out of bed with assistance and attend activity as tolerated. However, RN 4 confirmed licensed and non-licensed personnel did not indicate Resident 38 had been offered and assisted to get out of bed and if the resident attended activities as tolerated. A review of an undated facility's policy titled Activities Program, indicated the care plan should be reviewed with the resident and/ or the resident's family to ensure that the resident approves of and understand the plan. The resident's activity plan will be reviewed and updated at least quarterly and with any change of condition, no less than quarterly: The resident's attending physician reviews and approves the activity plan for the resident; When a resident is considered unable to participate in the activity program, the attending physician and the Director of Activities will document the reasons for that determination in the resident's record; The Director of Activities will review the resident's Attending Physician orders for any changes in condition or changes to the orders that would affect the resident's participation in activities. A review of the facility policy titled Hospice Care of Residents, dated 1/1/12, indicated nursing staff will be informed of any changes recommended by the hospice staff.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide enough incontinent briefs (pull-ups) for one of 24 residents (67), who was incontinent, needed assistance with toileting and hygiene, but had been left all night in a soiled pull-up that was emanating foul odor. The deficient practice potentially resulted in Resident 67 sustaining rash, redness, and skin excoriation (skin comes off) underneath the scrotum (a pouch of skin containing the testicles), which could create pain, and low self-esteem. Findings: A review of Resident 67's Admission Face Sheet indicated the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 67's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated [DATE] indicated Resident 67's had mild cognitive (ability to understand and be understood by others) impairment with daily decision making. The MDS indicated Resident 67 required extensive assistance from staff with activities of daily living (ADLs) such as bed mobility, transfer, dressing, toileting, and personal hygiene. A review of Resident 67's Care Plan dated 2/17/20 titled ADL Functional indicated the resident required assistance for self care deficit and physical functioning including bed mobility, transfers, toilet use, personal hygiene, and bathing. The Care Plan interventions indicated to assist resident with toileting as indicated, observe skin for redness and breakdown, assist with ADLs, provide clean clothing to wear, maintain good personal hygiene, and neat appearance. On [DATE] at 8:58 a.m., during observation Resident 67 stated last night, I begged the charge nurse on duty to give me a pull up and she never give me one. I wore one pull up brief all day. smelling, stinky and wet. I got a rash on my scrotum. I can help myself. I only needed the pull up brief, sometimes I goes out to target to buy my own. They just brought these three in my draw this morning, I have been wet and stinking up. I hate to be treated this way. I do not like it. On [DATE] at 12:36 p.m., during observation of Resident 67's skin condition along with Certified Nursing Assistant (CNA 4), the resident's skin around the scrotum was red, excoriated, there were rashes. CNA 4 stated skin around the scrotum was dry and red. On 3/11/20 at 3:46 p.m., during interview Registered Nurse (RN 1) stated 'I work 3-11 p.m., shift 2 days on, and two days off. LVN 8 and LVN 9, worked with me on 3/8/20 and LVN 2 was the charge nurse for the resident. I was the one resident asked for the pull -ups. Resident asked me can I have additional pull ups, because he told me that they took lots of his pull ups away, because he hoards things under the bed by his draw tables. Resident had only 1 pull up but, he goes to the bathroom by himself and whenever he goes he changes himself. I told resident to ask the charge nurse for pull ups whenever he needs. I told resident we are open to service 24 hours a day, seven days a week. Because resident hoards, I did not provide additional pull up to resident. A review of facility's undated policy and procedure titled A,M. Care indicated to assist the resident to do as much independence as possible. The policy indicated to provide for cueing, verbal reminders, as needed, keep all equipment within reach of the resident.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Based on observation, interviews and record review, facility failed to provide one of 24 residents (56), activities of interest, log the attendance, conclude the result of the participation, and offer alternative activities when refused. Resident 56, who was alert and oriented, was not assisted to attend activities of interest or provided with in room activities, the results of participation offered, and alternative activities when refused, were not documented. These deficient practices had the potential of limiting the ability for Resident 56 to maintain and/or improving the physical, mental, and psychosocial well-being, by offering activities of interest. Findings: A review of Resident 56's Admission Record (Face Sheet) indicated the resident was initially admitted to the facility on [DATE] and re-admitted [DATE] with [DIAGNOSES REDACTED]. A review of Resident 56's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 12/21/19, indicated the resident had intact cognition (ability to make decisions, understand, learn) for daily decision making. The MDS assessment indicated the resident required total dependence for activities of daily living (ADLs) such as bed mobility, transfer, locomotion on unit and off unit, dressing, eating, toileting, and personal hygiene. A review of Resident 56's activity log dated 1/2020- [DATE], indicated the resident have not been participating in outdoor programs, sensory stimulation group, and outings out of the facility. A review of Resident 56's Care Plan dated 11/28/19, indicated activity participation challenged by; the needs ongoing reminders and encouragement to participate in activities. The Care Plan goal indicated the resident will participate in group activities 3 times a week. The interventions indicated the resident will participate in group activities on a daily basis, identify lifestyle ADLs, allow to attend activities related lifestyle ADL, encourage the resident to participate in activities of interest arts/crafts, cooking, reminiscing, exercise/sports, gardening, outing/shopping, spiritual, travel, walking, crossword/cards/table games, current events/educational, word games, music, reading, and watching television. A review of Resident 56's Physician order [REDACTED]. On 3/09/20 at 08:52 a.m., during facility tour and observation Resident 56 stated I have not been out of bed for a long time. When asked what happened, Resident 56 stated No one comes to get me up from the bed for activities. During observation there was no in room activities provided to the resident such as magazines, puzzles, and arts/crafts. On 3/12/20 at 03:52 p.m., during interview Activity Assistant (AA) stated Resident 56 did not attend activities sometimes, but not always. AA stated We do room visits, then when asked if any activity is provided during room visit, staff stated resident refuses but I don't have any documentation of resident's refusal. I do not document resident's refusal. Residents need activity because sometimes, they do not have family members, activity help to keep their sensory running, and get them to socialize with others and enjoy the environment. On 3/12/20 at 4:00 p.m., during interview Activity Director (AD) stated Resident 56 was independent, liked outings, fashion magazines, and came to out doors. During record review witnessed by AD, the log for outdoor program participation for Resident 56 showed it had not been marked. There was no indication if Resident 56 was involved in the outings and social group activities and what was the result of the attendance. A review of facility's policy and procedure titled Activity Program. dated 11/1/13, indicated the purpose of activity include to encourage residents to participate in activities to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent, and to enable the resident to maintain the highest attainable social, physical and emotional functioning.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure needed care and services for one of 1 residents (29), was provided in accordance with the comprehensive-person centered care plan goals. Resident 29, who needed assistance with activities of daily living, had to lay in a soiled incontinent brief (diaper) because the call pad (means for a resident to directly contact caregivers) that was broken, and as a result, staff were unaware the resident needed assistance. This deficient practice did not meet Resident 29's needs, which potentially could cause skin breakdown, infections, and accidents when the call light was not answered in a timely manner. Findings: A review of Resident 29's admission form indicated the resident was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/10/20, indicated Resident 29's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was moderately impaired with daily decision making. The MDS indicated the resident required total assistance with transfer, dressing, toileting and extensive assistance with bathing and limited assistance with eating. A review of Resident 29's nursing admission assessment, dated 1/21/20, indicated the resident was not continent (had control) of bowel or bladder, had [MEDICAL CONDITION] (a severe loss of motor function, on one side of the body) on the left side and required total assistance. A review of Resident 29's bladder incontinence (lack of control over urine and bowel) evaluation and bowel assessment, both dated 1/22/20, indicated the resident was incontinent of both bladder and bowel and dependence on staff for assistance. A review of Resident 29's care plan, dated 1/21/20, indicated the resident's call light would be within easy reach and answered promptly, the resident was incontinent of bowel and bladder and staff would provide assistance needed when toileting. The Resident 29's care plan also indicated: -the staff would assess the resident for bowel and bladder patterns -monitor bowel movements for amount and consistency -observe for signs and symptoms of bowel and bladder discomfort -check every 2 hours for soiling or wetness -keep skin clean and dry as possible to prevent skin breakdown During an observation and interview on 3/09/20 at 11:15 a.m., Resident 29 stated he had pressed his call pad, but no one had come in the room yet. Resident 29 stated his diaper was soiled and needed to be changed. Then Resident 29 stated, I can feel a ball of poop just sitting there. When asked how long he had been trying to call for help, Resident 29 was not sure, but stated he had pressed his call pad several times. Resident 29 stated he was kind of embarrassed to talk right now because he was worried that there might be an odor. When asked if his call light was working, Resident 29 stated he did not know and then reached up to the call pad (which was wrapped around a trapeze bar, directly over the resident's head) and began to press the call pad. However, the light outside Resident 29's room did not light up. During the same time, Licensed Vocational Nurse (LVN 1), walked by Resident 29's room and when asked if she could see the call light (outside the resident's room door) light up, as Resident 29 pressed the call pad again, LVN 1 looked up at the light and stated, No. We need to call maintenance. On [DATE] at 11:19 a.m., Certified Nursing Assistant (CNA 1) walked into Resident 29's room and stated he did not know the call pad was not working. CNA 1 stated he had checked on the resident earlier that day, but did not know the resident needed his diaper changed, or that call pad was pressed for assistance. CNA 1 stated, I will clean him up now. On [DATE] at 11:27 a.m., Maintenance Personnel (MP 1) entered Resident 29's room and replaced the call pad. MP 1 tested the new call pad and stated, It's working now. MP 1 stated he was not aware Resident 29's call pad was not working and no one had told him about it until now. A review of the facility's policy and procedure titled, Incontinence Care, dated 9/1/2014, indicated incontinence care was provided when the resident was wet or soiled and the purpose of the policy was to enable the resident to retain their dignity. The policy indicated that residents who were incontinent of urine, feces, or both, would be kept clean, dry and comfortable. A review of the facility's undated policy and procedure titled, Call Light, indicated it was the facility's policy to ensure use of a call light and assess the resident for ability to use call light.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure two of 24 residents (47, 121), received necessary services by: Resident 121, had a timely and appropriate documented assessment to support its use of an indwelling catheter (catheter drains urine from bladder into a bag outside the body), an ongoing reassessment for the need and removal of the catheter and provide the appropriate care and services to prevent recurrence of urinary tract infection. This failure had placed Resident 121 at an increased risk of further catheter associated urinary tract infections (CAUTI, infection in the urine), including the risk [MEDICAL CONDITION] (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death), and complications such as blockage of the catheter, expulsion, pain and discomfort, the presence of blood in the urine that could have been caused by trauma during insertion. Resident 47, who

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) had an order for [REDACTED]. Findings: a. During an observation on [DATE] at 7:58 a.m., Resident 121's indwelling catheter was observed with sediments (crystals found in urine caused possibly by urinary tract infection) in the catheter tubing. Resident 121's urine output was cloudy yellow to amber color and the drainage bag had around 400 cubic centimeter (cc) of output. On 3/11/20 at 11:49 a.m., during an interview, Registered Nurse (RN 1) stated When we went to the room, the tubing of the indwelling catheter was cloudy and had a lot of sediments and in the bag was 400 cc of urine that was cloudy. It wasn't reported to me. We called the physician and ordered urine and culture test. During a review of the Minimum Data Set (MDS), a standardized assessment and care planning tool dated 1/26/20, indicated Resident 121 had a moderate cognitive impairment, required extensive assist with toileting and personal hygiene. During an interview and concurrent record review on 3/12/20 at 10:25 a.m., Licensed Vocational Nurse (LVN 6) stated Our responsibilities for residents with catheter is we made sure that it is intact, draining correctly and report to the problem right away to the doctor. The presence of sediments makes the residents at risk for urinary tract infection. It will be an issue to resident's health. LVN 6 also stated The presence of the catheter puts any residents at risk of bladder issues, infections, injury like if they pull it out or if they are laying on it for too long, it could cause bleeding. During a concurrent review of the clinical record with LVN 6, the admission notes dated 1/19/20 did not indicate Resident 121 had an indwelling catheter. However, Resident 121 had been receiving intravenous antibiotics for urinary tract infection from acute hospital and the skin condition on admission did not indicate that an indwelling catheter had been present. During a concurrent review of the clinical record with LVN 6, the licensed progress notes dated 1/21/20 indicated foley catheter was inserted on 1/21/20 due to abdominal distention and fecal impaction, with no hematuria and no sediments noted. When asked, LVN 6 stated If you are retaining urine, your bladder would be distended, not the abdomen. If an abdomen is distended, I would be suspecting constipation and not urine retention. LVN 6 also stated that basing on the licensed nurses' documentation, it did not justify the use of an indwelling catheter. When asked if there had been attempts made to remove the indwelling catheter, LVN 6 stated No, because the next day, he had hematuria (blood in urine), then they scheduled Resident 121 for ultrasound of the kidneys and bladder. During an interview on 3/13/20 at 12:48 p.m., LVN 1 stated Indwelling catheters are used for [MEDICAL CONDITION]. Not for abdominal distention or for fecal impaction. During a concurrent review of the clinical record, the physician order [REDACTED]. During a concurrent review of the clinical record, the care plan for Resident 121 indicated a need for foley catheter due to [MEDICAL CONDITION]. The care plan goals indicated was Resident 121 will have no signs and symptoms of urinary tract infections. The care plan interventions indicated to assess the need or continued need of the catheter, monitor urine for color, sediments, and amount and to report any of the above or fever promptly to MD, follow foley care per protocol, and to attempt to discontinue the catheter. A review of an undated facility's policy titled Foley/Indwelling Catheter, indicated the licensed nurses shall monitor resident's urine output for color, cloudiness, sediments, hematuria, odor, etc. A review of an undated facility's policy titled Indwelling Catheter, indicated a purpose is to relieve bladder distention. Indwelling catheters will be used only when medically indicated and a licensed nurse will assess the need for continued use of a catheter. b. A review of Resident 47's admission form indicated the resident was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/1/20, indicated Resident 47's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was severely impaired. The MDS indicated the resident required total assistance with transfer, dressing, toileting and extensive assistance with bathing and eating. A record review of Resident 47's physician order [REDACTED]. A review of Resident 47's care plan, dated [DATE], indicated to assess the need or continued need of the catheter and attempt to discontinue the catheter. A review of Resident 47's physician order, dated 3/2/20, indicated to use bladder scan to check post (after) void residual (amount of urine left in the bladder after urinating). During an observation on [DATE] at 11:10 a.m., Resident 47 was lying in bed and appeared to be sleeping. The resident had an indwelling urinary catheter with light clear yellow urine in the tubing. During an interview and record review on [DATE] at 10:12 a.m., when asked what were the results of Resident 47's bladder scan, Registered Nurse (RN 1) reviewed the resident's medical record, then stated, I don't see any nurses notes that he ever went out for a scan. On [DATE] at 10:24 a.m., RN 1 returned and stated, It was not done. When asked what is supposed to happen when a test was ordered for Resident 47, RN 1 stated , that normally the nurses endorse it to the next shift if it was not done. When asked if the facility had any process in place to check if all orders were transcribed, RN 1 stated nurses working 11 p.m. - 7 a.m. shift do chart reviews and sometimes medical records staff also alert them when an order was missed. RN 1 stated each nurses' station had a desk nurse and that person also is supposed to review telephone orders. Then RN 1 stated, I'm not aware of this one, no one told me. RN 1 stated they have a communication book they write new orders and laboratory test to be done. When asked if the order for the bladder scan was written in the communication book, RN got up to look at the book, then stated, No, it was not communicated. RN 1 stated in the future, they should gather all the telephone orders for each shift and review them during shift report, so they don't miss any orders. On [DATE] at 10:32 a.m., Licensed Vocational Nurse (LVN 3) stated she would put the order in for the bladder scan and call Resident 47's doctor to see when he wanted the test done. A review of Resident 47's physician order, dated [DATE], indicated clarification order for bladder scan revealed pelvis ultrasound after post void residual urine. There was also another clarification order written on 3/11/20 to confirm the pelvis ultrasound. A review of the facility's undated policy and procedure, titled, Physician Orders, indicated it would be the facility's policy to provide care and services to the resident in accordance with physician orders. A review of the facility's undated policy and procedure, titled, Physician Order, Transcribing, indicated x-ray orders would be transferred to the order slip and physician's orders [REDACTED]. The policy also indicated that all new orders were to be documented in the nursing notes and families were to be notified of all new orders and documented. A review of the facility's undated policy and procedure, titled, Appointments, Clinic, indicated all orders must be verified by resident's attending physician before they are written on the physician's orders [REDACTED]. Also record verification in nurses' notes.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review for one of 24 residents (21), the facility failed to ensure that the resident was free from unnecessary [MEDICAL CONDITION] medications (a drug taken that affects the chemical make-up of the brain and the nervous system) when a physician ordered [MEDICATION NAME], (a medication that changes the actions of chemicals in the brain that is often used to treat [MEDICAL CONDITION] disorder) prescribed for aggressive behavior but records did not indicate the specific behaviors for monitoring. Findings: A review of the face sheet (a document that gives a patients brief medical history) for Resident 21 indicated the resident was diagnosed with [REDACTED]. A review of the physician order [REDACTED]. The care plan also indicated to monitor and record episodes of behavior as ordered. On [DATE] at 11:18 a.m., an interview and concurrent record review was conducted with Licensed Vocational Nurse (LVN 7). LVN 7 reviewed the physician order [REDACTED]. LVN 7 was asked to describe Resident 21's behavior. LVN 7 stated, labile, but it could change and then (Resident 21) could show signs of aggressiveness. When asked to describe what aggressiveness meant, LVN 7 stated, Not physical. When asked what the physician order [REDACTED]. (the resident) is on [MEDICATION NAME] (a prescription medication used to treat depression.) as well, for being verbally abusive and cussing at staff. LVN 7 stated the order for [MEDICATION NAME] was more specific then the order for [MEDICATION NAME]. LVN 7 also reviewed the Medication Administration Record, [REDACTED]. When asked if the staff could monitor the resident for aggressive behavior without knowing the specific behaviors to monitor for, LVN 7 stated, No. On 3/13/20 at 9:55 a.m. and interview was conducted with the Director Of Nursing. When asked what Resident 21's aggressive behavior meant, the DON stated, aggressive behavior means cursing and yelling, or striking out. When asked which behaviors staff should look for when completing the behavior monitoring, the DON stated if the resident was aggressive toward staff, striking out, or cursing and yelling, then they would note the number of times in the MAR. The DON also stated the behavior monitoring was done every shift. When asked if

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) the [MEDICATION NAME] order for Resident 21 gave staff enough information for monitoring, the DON stated, It should be more specific because I know this resident and he strikes out for no reason. When asked why it was important for the order to be more specific, the DON stated staff needed to be able to monitor for a specific behavior to document the information in the MAR. When asked what the staff should do if they see an order that is not specific enough for behavior monitoring, the DON stated that the staff should call the psychiatrist and get clarification for the order so that it could be updated. On 3/13/20 at 10:08 a.m. an interview was conducted with the Social Services Director, (SSD). When asked to describe what aggressive behavior meant, SSD stated it meant a resident could be angry, irritated, or mad. When asked to describe Resident 21's aggressive behaviors, the SSD stated, The resident can not understand and make decisions, or make simple needs known. He is usually mad or shows verbal aggression by cursing.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observations, interviews, and record reviews, the facility failed to ensure the room temperature monitoring records were not missing the times for the room temperature readings, for medications requiring routine room temperature monitoring, in one (1) medication storage room out of one (1) total medication storage room at the facility. This deficient practice had the potential for harm to residents due to potential undetected temperature excursions, the potential loss of strength of the medications, and the potential for the residents to receive ineffective medication dosages. Findings: During an observation, on [DATE] at 8:29 a.m., of the IV Room North Station Medication Room, the room thermometer temperature reading was 72 degrees Fahrenheit (F). During an interview, on [DATE] at 8:29 a.m., the licensed vocational nurse (LVN 4) confirmed the room thermometer reading of 72 degrees F. A review of the room temperature monitoring record (log) indicated columns for the date, shift, temperature, and signature. The spaces in the Date column were pre-filled with the numerical day of the month, the Shift column contained spaces for the 7-3 (7 a.m. to 3 p.m. shift), 3-11 (3 p.m. to 11 p.m. shift), and 11-7 (11 p.m. to 7 a.m.). The Temp column contained blank, fillable spaces corresponding to the shifts, and the Signature column also contained fillable spaces corresponding to the shifts. However, there was no Time column with fillable spaces corresponding to the shifts for recording when temperature readings were taken. In contrast, a review of the refrigerator temperature monitoring records indicated a different format that included spaces for recording the time. The Date column contained blank fillable spaces. The Time column contained designated spaces with pre-printed times every two (2) hours, starting at 12 a.m. and ending at 10 p.m. for a total of twelve spaces per day. The Temperature column contained blank fillable spaces, and the Comment column contained blank fillable spaces. During an interview, on [DATE] at 8:51 a.m., LVN 4, regarding the absence of fillable spaces for documenting the times of room temperature readings on the room temperature monitoring record, stated, that the temperatures were taken, Per shift, anytime during the shift. That's the way we always have been doing it. LVN 4 acknowledged the inconsistency with the refrigerator temperature monitoring record regarding time documentation every two hours around the clock. LVN 4 acknowledged that recording the room temperatures without the times compromised the integrity of the temperature monitoring record as a tool for monitoring medication storage conditions, including pinpointing the times of temperature fluctuations or excursions outside of the required room temperature range. A review of the facility's pharmacy policy and procedures, titled, Storage of Medications, date not listed, indicated, Procedures .Medications requiring storage at 'room temperature' are kept at temperatures ranging from .59 degrees F to .86 degrees F.Medication storage areas are kept .free of .extreme temperatures.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 3 kitchen staff assisting food tray line, washed the hands after removing used gloves, before putting on a new pair of gloves, and before going back to the food tray line. This deficient practice had the potential for cross contamination of bacteria to the prepared food in the kitchen and to the residents eating from the kitchen. Findings: During a tray line/ kitchen observation on [DATE] at 12:40 p.m., Kitchen Helper (KH 1) placed an emptied lasagna container to the sink, removed gloves, then put on new pair of gloves without washing the hands, before going back to assist the cooks preparing lunch plates. During an interview on 3/11/20 at 7:56 a.m., KH 1 stated I wear gloves when I help in the kitchen. I should wash hands before putting on gloves. After I remove my gloves and when I put on new gloves, I also wash my hands for infection control and for the security of the residents and the workers. If I don't wash hands, bacteria [MEDICAL CONDITION] can be present. During an interview on 3/12/20 at 11:07 a.m., Dietary Supervisor (DS) stated the policy before putting on and after removing of gloves was to wash the hands because of potential contamination. A review of an undated facility's policy titled Infection Control for Dietary Employees, indicated proper handwashing by personnel will be done before initially donning gloves for working with food and after engaging in any other activities that contaminate the hands.
F 0880 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure infection control and prevention standards were abided by for two of 18 residents (15, 116) by: The laundry room barrels of soiled linens were transported in front of clean linen, a barrel of dirty linen was uncovered, and the tile floor in the laundry room was cracked and broken. Resident 15 and 116, facility also failed to provide accurate infection control surveillance when the Infection Control Nurse was not aware Resident 15 had an active infection and was taking antibiotics, and when Resident 116 had a portacath (a small chamber that sits under the skin at the end of a central line or intravenous line that is inserted into a large vein of the heart). and staff were not sure why it was inserted or how long it had been in place. These failures had the potential to result in the spread of infectious agents, (an organism such as bacteria, viruses, and parasites invades the human body and can cause disease) and cause illness in the facility's resident population. Findings: a. On 3/11/20 at 11:37 a.m. an interview and concurrent record review was conducted with Licensed Vocational Nurse 4, (LVN4). When asked to describe the process for infection control and surveillance, LVN 4 stated that there was a surveillance binder located at each nurse's station. LVN 4 also stated each binder contained surveillance forms that were color coded by body systems like respiratory, urinary, and GI. LVN 4 explained the Charge nurse at each station was responsible for filling out the surveillance forms in the binder whenever an infection was suspected or when antibiotics were ordered for a resident. LVN 4 stated Charge Nurses would then call the primary physician and write in orders or prescriptions on the form and put the form in the infection surveillance binder. LVN 4 stated the Infection Control Nurse was responsible for checking for and Change of Condition for each resident, and that was done at least 3 times a day. LVN 4 stated infection control binder was checked at least 3 times a day. When asked how often infection surveillance information should be updated, LVN 4 stated that it should be done on a daily basis. When asked if there was any system in place to catch infections that may be missed by the charge nurses, LVN 4 stated Infection Control Nurse would just check all the binders for infections and changes of condition. When asked if Resident 15 was a part of the current infection surveillance that was being conducted in the facility, LVN 4 checked the surveillance binder, and stated that the resident was not. LVN 4 reviewed the Antibiotic stewardship binder and did not locate any information for Resident 15. A review of the Change of Condition binder was conducted, and LVN read the following aloud: Antibiotic [MEDICATION NAME] 1 gram Q (every) 24 hours times 7 days. When asked if this information was included in the current infection surveillance of the facility, LVN 4 stated the information was missed and not included. When asked why it was important active infections in the facility were not missed, LVN 4 stated it was important so staff were aware of the infection, it would help to limit the spread of infections, and to reduce the inappropriate use of antibiotics. LVN 4 stated once antibiotics were started by a resident, the Infection Control nurse would follow up and check the residents for signs and symptoms of infection. When asked what was done with the information collected, LVN 4 stated on the 3rd Tuesday of the month, the percentages of infections (from inside the facility and those obtained from the outside community) were calculated for the month and presented to the Medical Director. LVN 4 stated Medical Director would

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F 0880 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 5) review the information that was discussed with the supervisors of each department. On 3/12/20 at 2:59 p.m. an interview was conducted with the Director of Nursing. When asked if the pharmacy was involved in keeping track of infections at the facility, the DON stated pharmacy did not keep track of antibiotic stewardship. The DON stated it was the responsibility of the Infection Control Nurse to catch any missed cases of infections. The DON also stated Infection Control nurse would speak with the Charge nurses about any changes of condition, or antibiotic use. The DON stated facility would use a log to ensure that there were no missed infections and all antibiotics were documented in the surveillance binder. b 1. During an observation of the laundry room on [DATE] at 1:46 p.m., the soiled linen was kept in large barrels in a separate room from the clean linens. However, one of the soiled barrels (full of dirty linen) was uncovered. Laundry Personnel (LP 1) called out to Laundry Personnel (LP 2) to cover the barrel. LP 2 stated, Sorry, it's supposed to be covered. A review of the facility's policy and procedure, titled, Laundry-Route and Process, revised 1/1/12, indicated soiled laundry was to be covered at all times. b 2. During an observation and interview on [DATE] at 2:01 p.m., the Maintenance Supervisor, Housekeeping Supervisor ([CONDITION]HS) confirmed the laundry staff roll the dirty soiled linen barrels past the clean laundry area and folding area in order to get to the washers and dryers. When asked if the soiled laundry was supposed to be transported past the clean laundry, stated, Not really. [CONDITION]HS stated the staff try to pull the curtain, however there was only one curtain on one side of the clean areas, the other side was exposed. [CONDITION]HS stated staff try to put away all the clean laundry before they brought in the dirty barrels, however, that was not always possible. When asked if the barrels could be contaminated on the outside of the barrel when they are brought in from the nursing units, [CONDITION]HS stated, Yes, and acknowledged it was possible the barrels might rub against clean linen or the curtain. [CONDITION]HS stated, I will talk to administration about what we can do to make it better, even though it is a small space; maybe the facility could install another curtain on the other side to protect the clean linen on that side. b 3. During an observation of the laundry room on [DATE] at 2:08 p.m., the floor around the washer and dryers had cracks, crevices, and portions that were peeling, with visible black and brown substances forming. When asked what could happen with the floor tiles torn and cracked open, the Maintenance Supervisor, Housekeeping Supervisor ([CONDITION]HS) stated bacteria could grow in the cracks. [CONDITION]HS stated the facility had plans to replace the floor. [CONDITION]HS stated, I know we need a new floor. On [DATE] at 3:30 p.m., [CONDITION]HS stated he had begun to replace a portion of the floor in the laundry room. A review of the facility's policy and procedure titled, Laundry-Route and Process, revised 1/1/12, indicated that laundry staff were responsible for keeping the laundry room clean and maintaining a safe environment. c. A review of Resident 116's admission form indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/1/20, indicated Resident 116's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was severely impaired. The MDS indicated the resident required extensive assistance with transfer, dressing, toileting, bathing and limited assistance with eating. The MDS indicated the resident was always incontinent (unable to control urine or bowel movement) of bowel and bladder, and indicated the Resident was not receiving [MEDICAL CONDITION] or Intravenous (IV) medications. A review of Resident 116's physician's orders [REDACTED]. There was no clinical indication for the portacath. A review of Resident 116's care plan, dated [DATE], indicated the Resident had potential for infection related to long term venous access and also the potential for inflammation of the veins, blood clot formation, catheter migration (catheter can move to other parts of the body) and catheter occlusion or breakage. A review of Resident 116's interdisciplinary team care conference notes ((IDT), a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient) (a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident) , dated 2/520/20 and 12/14/2019 indicated the Resident's portacath was not mentioned. On 3/09/20 at 11:39 a.m., an attempt was made to interview Resident 116, however, the resident answered inappropriately with words and phrases not related to the conversation. During an a concurrent observation and interview on [DATE] at 8:42 a.m., Resident 116 had an implanted device (portacath) under his skin on the upper right chest, below the shoulder. When asked why the Resident had a portacath, Registered Nurse (RN 1) stated she was not sure and would have to check on the reason. On [DATE] at 8:45 a.m. RN 1 reviewed Resident 116's medical record and was not able to locate any documentation as to why Resident 116 had a portacath. RN 1 stated that she thought the Resident had received intravenous (IV) antibiotics back in December 2019, but was not sure. RN 1 stated that she would check with medical records to see if there was any documentation as to why the Resident still had a portacath. When asked what could happen if a portacath is left in a resident for a long time, RN 1 stated, Infection. On [DATE] at 9:46 a.m., RN 1 stated that she had just talked to Resident 116's doctor and the doctor had advised her to consult with the Resident's dermatologist and order an oncologist consult to see if there was any reason they thought the Resident would need the portacath in the future, before they discontinue it. RN 1 stated she would make the referral to the oncologist today. During an interview on 3/12/20 at 10:40 a.m., when asked if Resident 116 was receiving nay medications or treatments through his portacath, Licensed Vocational Nurse (LVN 3) stated, No and then stated that she was not sure why Resident 116 had a portacath. LVN 3 stated that the Resident had [MEDICAL CONDITION] and that maybe they were thinking that he might need the catheter down the road, like if it turned [MEDICAL CONDITION]. A review of Resident 116's physician's orders [REDACTED]. A review of Resident 116's physician's orders [REDACTED].
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a working call light/pad (means for a resident to directly contact caregivers) for one of 1 residents (29). Resident 29, who needed assistance with activity of daily living, the resident's call pad was not working and did not have any means to contact caregivers. This deficient practice had the potential to delay care and assistance for Resident 29. Findings: A review of Resident 29's admission form indicated the resident was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/10/20, indicated Resident 29's cognition (mental capacity to make decisions, ability to remember, learn, and understand) was moderately impaired with daily decision making. The MDS indicated the resident required total assistance with transfer, dressing, toileting and extensive assistance with bathing and limited assistance with eating. During an observation and interview on 3/09/20 at 11:15 a.m., Resident 29 stated he had pressed his call pad, but no one had come in the room yet. Resident 29 stated he needed his incontinent brief (diaper) changed. When asked if his call light was working, Resident 29 stated he did not know and then reached up to the call pad (which was wrapped around a trapeze bar, directly over the resident's head) and began to press the call pad. The light outside the Resident 29's room did not light up. During the same time, Licensed Vocational Nurse (LVN 1), walked by the Resident 29's room and when asked if she could see the call light (outside the resident's room door) light up, as Resident 29 pressed the call pad, LVN 1 looked up at the light and stated, No. We need to call maintenance. On [DATE] at 11:19 a.m., Certified Nursing Assistant (CNA 1) walked into Resident 29's room and stated he did not know the call pad was not working. CNA 1 stated he had checked on the Resident 29's earlier that day, but did not know the resident needed his diaper changed or that call pad was pressed. On [DATE] at 11:27 a.m., Maintenance Personnel (MP 1) entered Resident 29's room and replaced the call pad. MP 1 tested the new call pad and stated, It's working now. MP 1 stated he was not aware Resident 29's call pad was not working and no one had told him about it until now. A review of the facility's undated policy and procedure, titled, Call Light, indicated it was the facility's policy to ensure use of a call light and assess the resident for ability to use call light.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an effective pest control program by for two of 18 residents (33, 118) and other residents by: Resident 33, and 118, used the same shower room where there was two live, and three dead, adult cockroaches The facility did not follow recommendations made by the pest control company that

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0925 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) serviced the facility. These failures had the potential to result in the spread of infectious disease from pests to residents and cause increased cases of infections for Resident 33, and 118 and others within the facility. Findings: On 3/11/20 at 3:06 p.m., an observation was conducted inside the shower room for Resident 33 and Resident 118. During the observation, there was two live cockroaches, and 3 dead cockroaches seen inside of the shower room. An interview was immediately conducted with Certified Nurse Assistant (CNA 5). When asked to describe what was inside the shower room, CNA 5 stated there were bugs, 3 dead and 5 total roaches. When asked if any bugs had been observed in the shower room before, CNA 5 stated, I have used this shower for residents before, but never saw roaches inside until now. When asked if there was anything else inside the shower, CNA 5 stated there was a plastic cup filled with soap for resident showers. When asked if that was the proper place to store soap for resident use, CNA 5 stated that the soap should be stored in the soap dispenser to avoid and infection control issue. CNA 5 also stated there were roach droppings inside the cup of soap. When asked why the soap for residents should not be stored in an open cup inside the shower, CNA 4 stated it was infection control issue. CNA 5 stated the issue should be reported to the maintenance department. On 3/11/20 at 3:29 p.m., an interview was conducted with the Maintenance/Housekeeping Supervisor, ([CONDITION]HS). When asked how often the facility was treated for [REDACTED]. When asked if maintenance recently received any other complaints of live cockroaches found in the facility, [CONDITION]HS stated that there had been no previous complaints. On 3/11/20 at 3:41 p.m., an interview was conducted with the administrator (ADMIN) of the facility. The ADMIN stated the pest control service came out 3 times a month and sprayed for all types of insects and rodents. On 3/11/20 at 3:45 p.m., a telephone interview was conducted with a representative from the extermination company that serviced the facility. During the interview, the representative stated a service inspection report was provided to the facility each time a treatment was done. The representative also stated that the treatment included a spray to treat ants, roaches, mice, and rats. The representative stated that the facility had not called for any additional service requests outside of the prescheduled monthly visits since 2018. The representative explained that the last service was performed on 2/3/2020 and that the technician sent to the facility indicated the following: Treat and inspect all accessible areas. Please address all open conditions to help reduce and eliminate a variety of potential pest issues. On 3/11/20 at 4:20 p.m., an interview was conducted with Maintenance Personnel (MP 1). When asked what service the exterminator company provided for the facility, MP 1 stated the company sprayed poison outside and sometimes inside the building. The MP 1 stated that there had been no previous complaints of pests in the building. When asked if the extermination company ever provided any reports or recommendations after service was provided, MP 1 stated that the reports were provided tot he maintenance supervisor. The MP 1 also stated that the company did make a recommendation to cut trees in the past but was not aware of any other recommendations. A review of the document titled, Service Inspection Report, dated 8/14/2019, indicated the following: Doors have gaps on the bottom and between. Side door has gaps on bottom which creates a possible pest entry point. Repair door to prevent gaps to keep pests from entering the structure. On 3/12/20 at 3:35 p.m. an interview was conducted with the Maintenance/Housekeeping Supervisor ([CONDITION]HS). When asked if the recommendations the extermination company made had been followed, the [CONDITION]HS stated that each recommendation was carried out. The glass, double doors at the entry of the facility were observed with a gap in between them. When asked if the gaps had been filled according the Service Inspection Report, the [CONDITION]HS stated maintenance department was unable to find a way to fill the gaps. When asked how the facility could imply with the recommendations from the extermination company, [CONDITION]HS stated maintenance department would find a way to follow up on it.