STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105323	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks of Clearwater, The	420 Bay Ave Clearwater, FL 33756

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(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 - Few	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** 41015 Based on observation, record review and interview the facility failed to ensure one resident (#209) of six residents observed for in-room dining and two residents (#4 and #26) of nine residents observed for communal dining received a dignified dining experience. Findings included: 1. An observation, on 09/18/23 at 4:43 p.m. showed Resident #209 sat in her wheelchair at a bedside table and stated, I am hungry. Resident #209's roommate was observed with a dinner tray eating as Resident #209 watched her roommate eat dinner. Resident #209 stated her tray always came late and on a different cart. Resident #209 stated she had been receiving her tray later, after her roommate was served, since being admitted to the facility three days ago. (Photographic Evidence Obtained) During an interview on 09/18/23 at 4:45 p.m. Staff A, Licensed Practical Nurse (LPN) stated the tray pass was a problem around here. Staff A, LPN stated food should be delivered to roommates together but that did not always happen because the trays came on different carts at different times. An observation on 09/18/23 at 5:01 p.m. showed Resident #209 received her dinner tray at 5:01 p.m. A review of Resident #209's Admission Record showed Resident #209 was admitted to the facility on [DATE] with diagnoses of cellulitus of lower left leg, urinary tract infection, left hip pain and an unspecified open wound. A review of the Minimum Data Set (MDS), dated [DATE], showed in Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). Review of an active physician order, dated 09/15/23, showed, Regular diet, regular texture, thin consistency. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An observation on 09/19/23 at 11:58 a.m. showed Residents #22, #40, #26 and #4 were all seated together at a table in the dining room. Resident #22 and Resident #40 were observed with their lunch trays eating while Resident #26 and Resident #4 had no lunch tray. Resident #26 and Resident #4 were observed watching Resident #22 and #40 eat while they waited on lunch trays. An empty tray cart was sat in the dining room where all the lunch trays had been distributed from. At approximately 12:06 p.m. a second tray cart arrived in the dining room and Resident #26 and Resident #4 were then served their lunch trays. (Photographic Evidence Obtained) During an interview on 09/20/23 at 12:56 p.m. Staff B, Certified Nursing Assistant (CNA) stated staff served food trays off the tray carts based on availability. Staff B, CNA stated the kitchen puts the resident trays on the cart and we serve them as they come. Staff B, CNA stated there are times when residents are not served at the same time because that is how the kitchen sent the trays up. Staff B, CNA stated sometimes residents have to wait on their trays when others, at the same table or their roommates, would be served and already eating. During an interview on 09/20/23 at 1:05 p.m. Staff C, CNA stated the facility's policy was for all residents to be served per table or room together (at the same time). A review of the facility's policy, Dining Room Audits, revised date 01/2009, showed, Policy Statement Our facility audits food service department regularly to ensure that residents needs are met and that dining is a safe and pleasant experience for residents. The auditor will assess: d. If residents at each table are served together.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 49227 Based on observation, interview, and record review, the facility failed to maintain confidentiality of Protected Health Information (PHI) related to a bulletin board located in one of one nurses' station for a census of 52 residents related to having Do Not Resuscitate (DNR), mobility, tube feeding, and dialysis status being visible and accessible to visitors, residents, and staff members. The information was displayed at the nurse's station and the East Wing hallway bulletin board. Findings included: An observation on 09/19/23 at 9:00 a.m., behind the nurses' station located between the east and west wing, revealed a cart that contained all of the resident charts that showed the resident's name, room number and status of Do Not Resuscitate (DNR) for twenty-eight residents. (Photographic Evidence Obtained) An additional observation on 09/19/23 at 9:00 a.m. revealed a bulletin board located on the East Wing hallway with a sign titled, 11-7 Get Up List and displayed two columns labeled as Dependent and Independent. This list showed resident room numbers, their first names and last names. In addition, a document titled, Master Diet Type 9/18/2023 was observed on the bulletin board and contained pages of information listing resident names with their room numbers, diet type, diet texture, fluid consistency, and additional directions (identifying tube feeds and dialysis status). (Photographic evidence obtained) During an interview on 09/20/23 at 3:52 p.m. Assistant Director of Nursing/Unit Manager (ADON/UM) stated the facility protects resident PHI by locking computer screens and turning papers with PHI upside down when not in use. ADON/UM confirmed information regarding a resident's DNR, mobility, dialysis and enteral feeding statuses is considered confidential. During an interview on 09/20/23 at 4:22 p.m. the Director of Nursing (DON) stated all staff receive Health Insurance Portability and Accountability Act (HIPAA) training at the beginning of their employment and confidentiality of PHI is emphasized. The DON confirmed a resident's DNR, mobility, dialysis and tube feeding status are PHI. Immediately following the interview, an observation was conducted with the DON of the cart with resident charts and of the bulletin board on the East Wing hallway with the 11-7 Get Up List and Master Diet Type 9/18/2023 document. The DON immediately removed the 11-7 Get Up List from the bulletin board. A review of a policy titled, Resident Respect, Dignity, and Confidentiality approved January 26, 2016, revealed: Confidentiality: Treat Resident information as confidential by all staff members and do not disclose without first obtaining permission from the resident/ responsible party. Procedures: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Staff will receive training on HIPAA and resident information confidentiality requirements. A review of facility policy titled, Staff Education, approved January 26, 2016, revealed: Orientation Process All employees of [facility Name] are trained in the initial orientation process with human resources covering a minimum but not limited to the following: M. HIPAA.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, record review and interview the facility failed to ensure a safe, clean and homelike environment for six resident rooms (#200, #202, #207, #212, #213, and #224) of 22 rooms in the facility. Findings included: 1. An observation on 09/18/23 at 3:34 p.m. of Resident room [ROOM NUMBER] revealed: (Photographic Evidence Obtained) - Multiple ceiling tiles throughout the room were separate or disconnected from the rest of the ceiling. - The air vent located near the door had dust build up in the vent. - Wallpaper was torn and missing around the air vent. - Ceiling tiles had bio growth that discolored areas of the tiles. - A white garbage bag with multiple gnats flying in and around the bag was located on the top of a clothing armoire. During an interview on 09/20/23 at 2:00 p.m. the Director of Nursing (DON) and Assistant Director of Nursing/Unit Manager (ADON/UM) observed the bag of gnats in Resident room [ROOM NUMBER]. ADON/UM looked at the bag of gnats and stated, .I hate bugs. The DON stated this bag of gnats would need to be disposed of and she would go get a garbage bag for proper disposal. ADON/UM stated someone must have left food or something in that bag and it must have been up there for a while. The DON was unaware of how long the bag had been stored on top of the armoire. During an interview on 09/20/23 at 5:08 p.m. the Central Service Director (CSD) stated housekeeping should be checking and cleaning high and low areas of resident rooms daily. The CSD stated housekeeping would also be responsible for dusting the air vents in resident rooms. The CSD toured Resident room [ROOM NUMBER] and stated, room [ROOM NUMBER] was not very pretty. The CSD stated the area around the air vent needed to be replaced, the tiles needed to be replaced and the area around the air vent would also need to be disinfected. The CSD stated room [ROOM NUMBER] would also need maintenance to look at why the ceiling was slipping and replace the defective tiles and fix the slipping issue. The CSD stated housekeeping would need to be dusting the vents and the wallpaper around the air vent would need to be replaced. 46234 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An observation was made on 9/18/23 at 7:09 a.m. in Resident room [ROOM NUMBER] of a sheet spread on the floor just inside the doorway. The sheet was completely soaked with water. An unnamed staff member passed and said the air conditioning vent had been leaking there for a couple of days. On 9/18/23 at 7:17 a. m. the sheet on the floor had been replaced with a dry blanket and trash can to catch the water. On 9/20/23 at 11:51 a.m. maintenance was observed to be in Resident room [ROOM NUMBER] working on the air conditioning vent leak. The two residents in room [ROOM NUMBER] had just been served their lunch trays and were eating while maintenance was continuing to work. At this time the DON was in the room and she observed maintenance working while residents were eating lunch. She confirmed the work should have stopped when it was time for the residents to eat. (Photographic Evidence Obtained) 3. An observation was made on 9/18/23 at 7:11 a.m. of items including a bed, two chairs, two shelves, boxes, wheelchair, and a prosthetic leg piled in the hallway. On 9/18/23 at 8:22 a.m. those items were observed to be in Resident room [ROOM NUMBER]. On 9/19/23 while eating lunch, the resident in room [ROOM NUMBER] said he wished they would move the stuff out of his room, pointing to the shelves, boxes, and prosthetic leg piled on the bed across from him. (Photographic Evidence Obtained) 4. An observation was made on 9/18/23 at 1:16 p.m. in Resident room [ROOM NUMBER] of a hole in the wall with a water stain. The water stain has bio-growth on it. This hole and stain are just to the right as you walk in the resident's room. (Photographic Evidence Obtained) An interview was conducted on 9/20/23 at 4:58 p.m. with the CSD. She confirmed the vent in Resident room [ROOM NUMBER] had been leaking for four days and they were trying to figure out the problem. She said it should have never been set up with a sheet/blanket and can to catch the water. The CSD said it was brought to her attention that maintenance was working in the room while residents were eating. She said that should not have happened and she would be educating staff. 46498 5. During a facility tour on 09/18/23 at 10:00 a.m. Resident room [ROOM NUMBER] was observed with loose toilet rails attached to the resident's toilet inside the bathroom. 6. During a facility tour on 09/18/23 at 10:15 a.m. Resident room [ROOM NUMBER] was observed with an extension cord with other electronics plugged into the cord on a resident's bed while the resident was resting in bed. During an interview on 09/20/23 at 4:47 p.m. the CSD confirmed managing both the facility's housekeeping and maintenance departments and that she was unaware the toilet grab bars in the bathroom of Resident room [ROOM NUMBER] were loose. She said it was a safety issue for the facility and the residents. The CSD said the maintenance worker was expected to make rounds in the facility and check to make sure things, like resident grab bars, ceiling tiles, etc., are in good functioning order. The CSD said residents should not have power cords in their bed because it was a safety issue. A review of the facility policy titled, Physical Environment, undated, revealed: It is the policy of the facility to provide care and services related to Physical Environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Resident Rooms, undated, revealed: It is the policy of the facility to provide areas large enough to comfortably accommodate the needs of the residents who usually occupy this space, in accordance to State and Federal regulations. 3. The facility will provide each resident with: d. Functional furniture appropriate to the resident's needs. A review of the facility policy, titled, Safe Environment, undated, revealed: It is the policy of the facility to provide a safe environment in accordance to State and Federal regulation. 1. The facility will be designed, constructed, equipped and maintained to protect the health and safety or residents, personnel, and the public.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review and interview the facility failed to accurately assess a discharge on the Minimum Data Set (MDS) for one resident (#56) of three residents reviewed for transfer and discharge. Findings included: A review of Resident #56's Admission Record showed Resident #56 was admitted to the facility with diagnoses of Parkinson's Disease, dysphasia, pneumonitis and dysphonia. A review of the Discharge Return Not Anticipated MDS, dated [DATE], showed in Section A 2100 Discharge Status that Resident #56 was discharged to an Acute hospital. Review of a physician order, dated 07/19/23, showed, discharge to apartment in Assisted Living Facility. Review of a Plan of Care Note, dated 6/28/2023, showed, Care plan meeting held with IDT (interdisciplinary team), [spouses] they are both residents at facility, plan for residents to transition back to ALF (assisted living facility). Review of a Discharge Summary, dated 07/19/23, showed, Resident discharged to upstairs apartment. Resident assisted by CNAs (certified nursing assistants). All personal effects given. Medications sent upstairs. During an interview on 09/20/23 at 10:40 a.m. Staff F, MDS Coordinator (MDSC) stated Resident #56 was discharged upstairs to an assisted living apartment on 07/20/23. Staff F, MDSC reviewed Resident #56's MDS Discharge Return Not Anticipated, dated 07/20/23. Staff F MDSC stated Section A 2100 showed Resident #56 was discharged to an acute hospital which was wrong. Staff F MDSC stated, Oh that is an error, it must be a computer glitch, as Resident #56 was discharged upstairs to the assisted living community. Staff F, MDSC was observed immediately modifying Resident #56's MDS Discharge Return Not Anticipated, dated 07/20/23, during the interview.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review and interview and facility failed to refer three residents (#18, #30 and #45) of four residents for a Level II Pre-Admission Screening and Resident Review (PASARR) upon a significant change in status assessment. Findings included: 1. A review of Resident #30's Admission Record showed Resident #30 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, neurocognitive disorder with Lewy Body Dementia, generalized anxiety disorder and major depressive disorder, single episode. Resident #30 was later diagnosed with schizoaffective disorder on 06/09/23. Review of Resident #30's Level I Pre-Admission Screening and Resident Review (PASARR), dated 01/02/20 showed, Resident #30 had Lewy Body Dementia and was marked No diagnosis or suspicion of Serious Mental illness or intellectual disability indicated. There was no PASARR referral for a Level II PASARR upon new diagnosis of schizoaffective disorder on 06/09/23. 2. A review of Resident #45's Admission Record showed Resident #45 was admitted to the facility on [DATE] with diagnoses of dysphagia, paralysis of vocal cords and larynx, and chronic atrial fibrillation. Resident #45 was later diagnosed with major depressive disorder, recurrent, mild on 08/16/21 and dementia, unspecified severity with agitation on 02/20/23. Review of Resident #45's Level I PASARR, dated 08/10/21, showed, Resident #45 had a psychotic disorder with multiple questions marked yes in Section II for decision making. There was no PASARR referral for a Level II PASRR upon new diagnosis of dementia, unspecified severity with agitation on 02/20/23. 46498 3. A review of Resident #18's Admission Record revealed she was admitted to the facility on [DATE], with diagnoses to include major depressive disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of the PASARR Level I Screen, dated 6/30/21, Section I - Decision Making A. and B, revealed it was not completed to reflect Resident #18's mental illness. During an interview on 09/19/23 at 3:00 p.m. Director of Nursing (DON) stated that Residents #18, #30 and #45's PASARRs should have been updated to show the new diagnosis of serious mental illness after admission and submitted for a Level II. The DON stated the facility had never really had a process for PASARRs before besides just reviewing them upon admission, but the facility will now develop a PASARR process. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the policy title, Coordination-Pre-admission Screening and Resident Review, undated showed, 2. b. Referring all Level II residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for Level II resident review upon a significant change in status assessments.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review and interview the facility failed to revise the person centered care plan to reflect the use of the word mama to communicate and identify the needs by one resident (#37) with communication limitations of thirty-two residents sampled. Findings included: On 9/18/2023 at 7:00 a.m. Resident #37 was observed laying down in bed dressed in her nightgown, with her bedside table next to her bed. Resident #37 was not able to communicate when she was asked questions. On 9/20/2023 at 3:45 p.m. Resident #37 was observed laying down in bed dressed in her nightgown, trying to express herself, but was unable to communicate her needs. A review of the Admission Record revealed Resident #37 was admitted to the facility on [DATE], with diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, altered mental status, unspecified and adult failure to thrive. A review of the Minimum Data Set (MDS), dated [DATE], Section C - Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of no score recorded in Section C0500. Further review of the MDS Section C100 - Cognitive Skills for Daily Decision Making revealed a score of 3 indicating Resident # 37 was severely impaired. A review of a care planned Focus, dated 4/13/2023, revealed Resident #37 had a communication problem r/t (related to) Expression Aphasia post Cerebral Vascular Accident, CVA. A review of the care plan goal was documented as staff would anticipate and meet needs of Resident #37. Interventions included to encourage resident to make needs known through nonverbal communication as able. Pointing at objects, nodding head, Observe for verbal and nonverbal s/s (signs/symptoms) of pain or discomfort i.e. facial expression, crying out, moaning, grimacing, restlessness, protective body. During an interview on 9/20/2023 at 9:00 am., Staff B, Certified Nursing Assistant (CNA) said when she was distributing breakfast trays to resident rooms, she overheard Resident #37 shouting out for her mama from her room. When she went to check on the resident, she said Resident #37 was lying in bed soaking wet from the night shift. Staff B said Resident # 37 was unable to communicate her needs, but she calls out for her mama and that's how she knows something is wrong. She stated if she was not a regular staff member, she wouldn't know the resident needed help when she calls out for her mama. During an interview on 9/20/2023 at 11:25 p.m. with Staff G, CNA said she's takes care of Resident #37 and she's able to understand what the resident wants most of the time, and especially when she uses the word mama. She said if she never worked with the resident before she would not know the resident needed something when she calls out for her mama. Staff G said she doesn't get the resident out of bed because she knows the resident doesn't like to get up. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/20/2023 at 2:45 p.m. the Assistant Director of Nursing/Unit Manager (ADON/UM) said Resident #37 calls out for her mama whenever she needs something. The ADON/UM said the word mama should be care planned because they use agency staff a lot and it would help them to identify Resident #37 has a need. A review of the facility policy, titled, Care Plan, Comprehensive Person- Centered, revised December 2016, showed: Policy Statement - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident . 8. The comprehensive, person - centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observation, interview, and record review the facility failed to ensure accommodations were in place related to visual impairment for one resident (#47) out of thirty-two sampled residents. Findings included: An observation was made on 9/19/23 at 4:59 p.m. of Resident #47 sitting in her wheelchair next to her bed. The resident's dinner tray was in front of her, and the drinks were open, but the resident said she didn't know what she was served. The resident also said she did not know where her drink was on the tray and wanted to be told where it was located, she said she was unable to see what was on her tray. Review of Admission Record showed Resident #47 was admitted on [DATE] with diagnoses including unspecified glaucoma, and age-related physical debility. Review of Resident #47's quarterly Minimum Data Set (MDS,) dated 6/16/23, Section C - Cognitive Patterns, showed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating she has moderately impaired cognition. Section B - Hearing, Speech and Vision showed the resident had impaired vision. Section G - Functional Status showed the resident needs set up help for meals. Review of Resident #47's Dehydration Risk Evaluation, dated 9/17/23, showed the resident was at risk for dehydration due to decreased oral intake, among other causes. Review of Resident #47's Quarterly Activities Review, dated 9/15/23, noted the resident is brought too [sic] activities but she never really participates minimal and she wants to go back to her room. Review of Resident #47's care plans showed a focus plan in place for impaired visual function related to Glaucoma with risk for additional decline, difficulty seeing large print, sees objects. The focus plan was initiated on 10/13/22. The actions/tasks listed were the following: -Take care with activities/care to provide for safety and promote independence. -Eye exam on 9/20/23. -Arrange a consultation with eye care practitioner as required. -Medications per orders. -Monitor/document/report PRN (as needed) any s/sx [signs/symptoms] of acute eye problems: Change in ability to perform ADLs [activities of daily living], decline in mobility, sudden visual loss, pupils dilated, gray or milks, c/o [complaints of] halos around lights, double vision, tunnel vision, blurred or hazy vision. -Tell the resident where you are placing their items. Be consistent. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders showed an order in place for an eye exam follow-up appointment for Resident #47 due to legally blind/macular degeneration related to UNSPECIFIED GLAUCOMA The order was entered on 8/23/23. An observation was made on 9/18/23 at 2:07 p.m. of Resident #47 sitting in a chair beside her bed with a family member by her bedside. The resident stated she would like her family member to explain her concerns. The family member stated the resident has been losing vision for a while and the facility staff are not accommodating things for her. The family member said Resident #47 used to go to activities and now just sits in bed. The family member said the resident doesn't even know what she eats each meal. The family member said staff told her someone would go with the resident to help with bingo and other activities, but no one ever does. The family member said they don't feel like the resident is eating very good because she cannot see what she is eating, and staff do not tell her. An observation was made on 9/19/23 at 11:45 a.m. of the resident being assisted to the bathroom with an aide. At 12:05 the resident had returned to her chair located beside her bed and no staff members were present. Resident #47 was observed reaching to her left, leaning over, and feeling around on her bed. When asked what she was looking for, the resident said she couldn't find her oxygen tubing. She said it was taken off when she went to the bathroom, and she couldn't see where it was to put it back on. The nasal cannula was observed to be out of reach of the resident. The resident's call light was also out of her reach so she could not call for assistance. The resident said she didn't really like her lunch, but she didn't know what she was eating. The nutrition shake and lemonade were unopened on the tray, and the condiments for the meal, salsa and sour cream, were stacked up and unopened. When the resident was told she also had a piece of cake that looked good she stated, Oh, where is that. (Photographic Evidence Obtained) An observation was made on 9/20/23 at 12:00 p.m. of lunch being delivered to Resident #47. A staff member assisted the resident to her wheelchair and placed the food tray in front of her. She opened the resident's juice but did not tell the resident what was served for lunch or where items were placed on her tray. The staff member exited the room. At 12:02 p.m. the resident was observed using a spoon unsuccessfully trying to scoop her food. When asked if she knew what she had for lunch, the resident said she didn't know. She asked where her nutrition shake was and said she knew she needed to drink that first. The resident again began trying to use her spoon to scoop her food. The resident was unable to see that her lunch was a sandwich, and this was not explained to her. When told she had a sandwich, she said that it would have been nice to know she could have picked it up. When told she also had peaches on her tray she said Oh, where are those? The resident also asked if someone could get her a towel due to her not being able to see and spilling food on herself. She said she didn't want to get food on her clothes. When the resident finished eating and her tray was removed, her mashed potatoes and beans had not been touched and her sandwich bun was broken to pieces. (Photographic Evidence Obtained) (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/20/23 at 2:13 p.m. with Staff J, Certified Nursing Assistant (CNA.) Staff J, CNA said she knew Resident #47 well. Staff J, CNA said the resident is blind and had been needing more help in the last week or two. She added the resident is alert and oriented but occasionally goes to the wrong bed. Staff J, CNA said for eating, the resident is able to eat on her own, but does need help, cutting up her food, opening containers and setting up. Staff J, CNA said she tells the resident counterclockwise where things are, and the resident always asks what she is having. Staff J, CNA said the resident is able to use her call bell and if she can't find it, she will wait until someone comes in the room and ask them. Staff J, CNA said there are no other special accommodations in place related to Resident #47's visual impairment. She said the resident has anxiety and will panic sometimes. Staff J, CNA confirmed the resident is able to pick up a sandwich and eat it if she knew what it was. Staff J, CNA also said the resident will sometimes go to activities but will disturb others by asking what are we doing. An interview was conducted on 9/20/23 at 2:41 p.m. with the Assistant Director of Nursing/Unit Manager (ADON/UM.) The ADON/UM said Resident #47 does often feel around for things and ask for assistance. The ADON/UM said she tells the resident where things on her plate are like a clock. The ADON/UM said she needed to educate staff on using the clock method with the resident. The ADON/UM said Resident #47 had not been looked at for needing more assistance with eating or care. The ADON/UM said she wasn't aware the resident's visual impairment had advanced. The ADON/UM said she did go in the resident's room on 9/18/23 and the resident was feeling around and couldn't find her call light. The ADON/UM said the call light was out of reach from the resident. When asked if the resident had any accommodations for her blindness she said, Not that I know of. An interview was conducted on 9/20/23 at 6:20 p.m. with the Director of Nursing (DON.) The DON said staff did not notify her Resident #47's vision had gotten worse. The DON said the resident needed a change of condition and full assessment completed. The DON said they needed to do education with the staff. Review of a facility policy titled ,Quality of Life-Accommodation of Needs, reviewed August 2009, showed the following: Policy Statement: Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and or achieving independent functioning, dignity, and well-being. Policy and Interpretation and Implementation 1. The residents individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other individuals would be. 2. The residence individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis . 4. In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the resident in maintaining independence, dignity, and well-being to the extent possible and in accordance with the resident's wishes. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Staff shall interact with the resident in a way that accommodates the physical or sensory limitations of the resident, promotes communication, and maintains dignity.

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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** 46498 Based on observation, record review and interview the facility failed to provide nail care related to trimming and cleaning fingernails for one resident (#7) of thirty-two residents. Finding included: On 09/18/2023 at 10:00 a.m. and 3:00 p.m. Resident #7 was observed lying down in bed dressed in a nightgown, hair disheveled, facial hair on his face and long fingernails. On 9/19/2023 and 9/20/2023 at 11:00 a.m. and 4:00 p.m. Resident #7 was observed lying down in his bed, hair disheveled, facial hair on his face and long fingernails. A review of Resident #7's Admission Record revealed he was admitted to the facility on [DATE] with diagnoses to include but not limited to hepatic encephalopathy, unspecified macular degeneration, anxiety disorder, and depression. A review of the Minimum Data Set (MDS), dated [DATE], Section C- Cognitive Patterns showed a Brief Interview for Mental Status score of 13 indicating Resident #7 was cognitively intact. Further review of the MDS Section G- Functional Status revealed Resident #7 was totally dependent for personal hygiene with one-person physical assist. A review of the Activities of Daily Living (ADLs) care plan initial and revision date of 4/10/2023, revealed Resident #7 required staff assistance with ADLs and is at risk for decline and complications. Review of the care plan goals, initial date of 8/23/2023, revealed Resident #7 will have his care needs meet as evidenced by being clean, dressed and well-groomed daily through next review. A review of the care plan interventions, dated 4/10/2023, revealed to check Resident #7's nail length and trim and clean nails on bath days and as necessary, report any changes to nurse. During an interview on 9/19/2023 at 4:00 p.m. Resident #7 said he had not received his showers and he would like to have his face shaved and his nails cut. Resident #7 said he has asked staff to bring him a nail clipper so he can cut his nails himself, but staff has not answered his request. During an interview on 9/20/2023 at 5:00 p.m. Assistant Director of Nursing/Unit Manager (ADON/UM) said Resident # 7 nails are too long and staff should have trimmed Resident #7 nails and shaved him during ADL care. The (ADON/UM) said she would have to pay more attention to the residents when she does her walking rounds to make sure staff are providing ADL care to residents as care planned. A review of the facility policy titled, Care Planning - Interdisciplinary Team, revised September 2013, revealed: Policy Statement - Our facility's Care Planning/ Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. 2. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/ Interdisciplinary Team which includes but is not necessarily limited to the following personnel: j. Nursing Assistant responsible for the resident's care: and k; Others as appropriate or necessary to meet the needs of the resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, record review and interview the facility failed to ensure one resident (#41) of two residents reviewed for respiratory services was administered oxygen at the physician ordered flow rate. Findings included: An observation, on 09/18/23 at 10:35 a.m. showed Resident #41 was alone in her room sitting up in bed and looked distressed with a frown on her face. Resident #41 was observed being administered oxygen via a nasal cannula. During an immediate interview on 09/18/23 at 10:35 a.m. Resident #41 shook her head no (side to side) when asked if she was ok. Resident #41 shook her head yes (up and down) when asked if she was short of breath. Resident #41's oxygen concentrator was observed to be set for an oxygen flow rate of one liter per minute. (Photographic Evidence Obtained) During an interview on 09/18/23 at 10:37 a.m. Staff A, Licensed Practical Nurse (LPN) stated Resident #41 had COPD (chronic obstructive pulmonary disease) and when Resident #41 gets short of breath she gets anxious. Staff A, LPN immediately grabbed Resident #41's breathing treatment from the medication cart and went straight the Resident #41's room to administer Resident #41's breathing treatment. During an additional interview on 09/18/23 at 10:38 a.m. Staff A, LPN stated Resident #41 was ordered oxygen administration at a flow rate of two liters per minute and confirmed the one liters per minute flow rate Resident #41 was receiving was not correct. Staff A, LPN stated Resident #41should be on two liters per minute not one liter per minute. Review of Resident #41's Admission Record showed Resident #41 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure unspecified with hypoxia and anxiety disorder. Review of an active verbal physician order, dated 11/09/22, showed, O2 (oxygen) at 2 liters per minute via nasal cannula frequency: continuous. The care plan, dated 01/04/23, showed Resident #41 had COPD with an intervention of oxygen per MD (medical doctor) orders. The Quarterly Minimum Data Set (MDS), dated [DATE], showed in Section O - Special Treatments that Resident #41 received oxygen therapy. During an interview on 09/20/23 at 8:53 a.m. Staff K Contracted Respiratory Therapist (CRT) stated Resident #41 had a ventilation problem. Staff K, CRT stated Resident #41's oxygen concentrator should be set to the physician order at all times. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Oxygen Administration and Storage, revised date October 2010 showed, Preparation 1. Verify that there is a physician order for this procedure. Steps in the Procedure 8. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41015 Based on observation, record review and interview the facility failed to ensure food was labeled and dated when stored in the walk-in refrigerator, the walk-in refrigerator log was completed daily and the dishwasher was functioning properly in accordance with professional standards for food service safety in one of one kitchen with the potential to affect 51 of census of 52 residents. Findings included: An observation on 09/18/23 7:00 a.m. revealed food items located in the kitchen's walk-in refrigerator were not labeled and dated. The food items not labeled or dated included: (Photographic Evidence Obtained) - metal container of white thick gravy - metal container of brown thick gravy - A bag of 10 eggs - A bag of six rolls - A bag of cut broccoli - A bag of approximately 12 hot dogs - A wrapped up cucumber - Two heads of lettuce. During an interview on 09/18/23 at 7:05 a.m. Staff D, Dining Room Manager (DRM) confirmed the food items were not labeled or dated. Staff D, DRM stated that all food should be labeled and dated before being stored in the walk-in refrigerator. An observation on 09/18/23 at 7:07 a.m. showed the walk-in refrigerator temperature monitoring log was not completed for 09/17/23. (Photographic Evidence Obtained) During an interview on 09/18/23 at 7:08 a.m. Staff D, DRM stated, The refrigerator temp (temperature) log should have been completed for yesterday, and confirmed the log was incomplete. An observation on 09/18/23 at 7:15 a.m. revealed steam rising up from the floor around the dishwasher. The hot water from the dishwasher was observed not draining down the designated hole below the dishwasher and was flooding the floor. The hot water was observed flooding the floor from the clogged designated drain and flowing down another drain located in front of the dishwasher. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/18/23 at 7:20 a.m. Staff E, Dietary Staff (DS) stated, It doesn't normally overflow, but maintenance continues to try to fix it. Staff E, DS was observed turning down the water flow to the dishwater with a water valve above the dishwasher on the wall. Staff E, DS stated he turned down the water flow to the dishwasher to help keep it from flooding the floor. A review of the facility's policy titled, Food Receiving and Storage, revised date July 2014, showed, 7. All foods stored in the refrigerator or freezer will be covered, labeled, and dated. 13c. Refrigerators must have a working thermometers and be monitored for temperatures according to state specific guidelines.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observation, interview, record review and policy review the facility failed to ensure proper infection control practices were implemented for two (#42 and #209) out of two residents on isolation precautions out of a total of thirty-two residents sampled. Findings included: 1. An observation was made on 9/18/23 at 7:18 a.m. of a Contact Precautions sign on the door of Resident #42. There was no personal protective equipment (PPE) cart placed outside the door. On 9/18/23 at 8:35 a.m. an unknown staff member was observed in the resident's room without PPE. An observation was made on 9/18/23 at 4:25 p.m. of Staff I, Licensed Practical Nurse (LPN) standing at Resident #42's bedside with no PPE on. The Contact Precaution sign was still posted on the door. Upon exiting the room an interview was conducted with Staff I, LPN. Staff I, LPN confirmed there was no PPE cart outside the room and no PPE set up inside the room. When asked if staff were not wearing PPE to go in Resident #42's room he said, No not really. Staff I, LPN said Resident #42 had clostridium difficile colitis (c-diff,) but he doesn't think he has it anymore. Staff I, LPN said the facility hadn't gotten official word or orders to take him off precautions. A review of the Admission Record showed Resident #42 was admitted to the facility on [DATE] with diagnoses to include enterocolitis due to clostridium difficile. A review of Resident #42's physician orders on 9/18/23 at 4:38 p.m. showed an active order for Contact Isolation Precautions with an order date of 9/17/23. A review of Resident #42's care plan showed a focus plan in place for Infection- C-diff. Initiated on 8/11/23. Interventions included ISOLATION PRECAUTIONS PER MD ORDERS, initiated on 9/8/23. An interview was conducted on 9/18/23 at 4:58 p.m. with the Assistant Director of Nursing/Unit Manager (ADON/UM). The ADON/UM said Resident #42 had come back from the hospital the previous day and was currently on isolation precautions. The ADON/UM was observed looking up the resident's orders. She then verified an active order for contact precautions was in place. The ADON/UM said there should have been a PPE cart placed outside the resident's room when he returned to the facility. The ADON/UM also said all staff and visitors should have been wearing PPE to go in the room. An interview was conducted on 9/18/23 at 5:30 p.m. with the Director of Nursing (DON.) The DON said Resident #42 is on precautions for c-diff and she didn't know why a PPE cart was not outside the door. She said she would speak to the nurse (Staff I, LPN) and see if he heard anything about the resident coming off precautions. When she was shown there was an active order in place for contact precautions she said, Oh. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An observation was made on 9/18/23 at 8:30 a.m. of Resident #209 sitting in a chair beside her bed. Resident #209 said she currently had MRSA (Methicillin-resistant Staphylococcus aureus) in her leg and arm and the facility doesn't have supplies to cover it. There was no contact precaution sign placed on the resident's door and no PPE cart outside the door. The resident was in a semi-private room with a roommate. An observation was made on 9/18/23 at 9:23 a.m. of Resident #209 sitting in the hall outside of her door. The resident had a gauze bandage on her left leg with discharge coming out from under the bandage and running down her leg. Review of the Admission Record showed Resident #209 was admitted on [DATE] with admission diagnoses including cellulitis of left lower limb, unspecified open wound. Review of Resident #209's Brief Interview for Mental Status (BIMS) Evaluation, dated 9/19/23, showed the resident had a BIMS score of 15, indicating she was cognitively intact. Review of Wound Culture results showed Resident #209 had heavy growth of MRSA on the final report, dated 9/14/23. The results and fax cover sheet showed the results of the wound culture were faxed to the facility on [DATE] at 9:46 a.m. A review of Resident #209's baseline care plan, dated 9/15/23, showed the resident was admitted on IV (intravenous) antibiotics. The care plan also showed the resident had a wound on her left leg. An interview was conducted on 9/18/23 at 5:33 p.m. with Staff A, LPN. Staff A, LPN confirmed she was assigned as the nurse for Resident #209. When asked about Resident #209 having MRSA and not being on precautions she said generally they would use contact precautions, but the resident's wound is self-contained and she thinks they do it different here. Staff A, LPN said Resident #209 just sits in her wheelchair in her room. When asked about the resident being observed in the hall earlier that day she said that was the first time she had seen the resident out. Staff A, LPN then stated they don't have a contact precaution sign on the door because it is a HIPAA (Health Insurance Portability and Accountability Act) violation, and they don't use the signs in this facility. When told another resident had a precaution sign on their door she said, I don't know then. Staff A, LPN was observed going to the resident's physical chart and reviewing the wound culture results. She confirmed Resident #209 had a positive culture for MRSA in her wound. An interview was conducted with the DON on 9/18/23 at 5:30 p.m. When asked about Resident #209 not being on precautions while being treated for MRSA in her wound, she said they would need to put her on precautions. The DON said when the resident was admitted they didn't know the resident had MRSA because she came from the assisted living upstairs and the hospital records had to be requested. The DON said they did not get the resident's hospital records until the morning of 9/18/23. The DON was shown the faxed records were received on 9/15/23 at 9:47 a.m. and she said she didn't know, but she just found out about the MRSA earlier that day (on the morning of 9/18/23) When asked why the resident was still not on precautions at 5:30 p.m. when she found out that morning about the resident having MRSA in her wound, she said, It has just been busy with everything today. An observation was made on 9/18/23 at 6:20 p.m. of a maintenance worker going in and out of Resident #209's room. The contact precaution sign was on the door, but the maintenance worker did not have on any PPE. (Photographic Evidence Obtained) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made on 9/20/23 at 2:05 p.m. of Staff I, LPN entering Resident #209's room without putting any PPE on. The precaution sign was on the door and the PPE cart was outside the room. Upon exiting the room Staff I, LPN confirmed he saw the contact precaution sign and said, I should have had a gown on and I didn't. An interview was conducted with the ADON/UM on 9/20/23 at 3:04 p.m. The ADON/UM confirmed the staff thought they did not need to wear a gown if they were not directly caring for the resident. She confirmed all staff should be wearing a gown any time they are entering a contact precaution room. Review of a facility policy titled, Infection Control-Standard and Transmission-Based Precautions, undated, showed the following: Intent: It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of communicable disease and infections in accordance with State and Federal Regulations, and national guidelines. Transmission-based Precautions: . 6. All staff including environmental services staff are to comply with transmission-based precautions. 7. To designate a room for transmission-based precautions, a sign will be placed in the pocket caddy of the door and is yellow in color for all infections except c-diff. Staff will be notified of the type of transmission-based precautions a resident is placed on and the reason. Staff are notified during shift report. 8. An isolation caddy with personal protective equipment and other supplies will be placed at the entrance of the resident room. At a minimum, this caddy will include appropriate personal protective equipment and disinfecting wipes . 12. Contact precautions are implemented most often for residents who have an infection due to an epidemiologically important organism such as a multi-drug resident organism (MDRO.) a. Staff are to put on gowns and gloves upon room entry and remove gowns and gloves upon exit of resident room. 13. Residents with C. difficile infection will be placed on special contact precautions. a. Special contact precautions require the use of gowns and gloves upon entry to room, soap and water for hand hygiene after contact with the resident of their care environment. Gowns and gloves should be removed and discarded at room exit.

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	105323	A. Building B. Wing	09/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks of Clearwater, The	420 Bay Ave Clearwater, FL 33756

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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** 46234 Based on observation, interviews, and policy review facility did not ensure the call bell system was accessible to eleven residents (#28, #47, #13, #16, #15, #41, #54, #40, #26, #5, #4) out of thirty-two residents sampled and did not ensure a call system was accessible at one toilet out of twenty-two toilets in resident rooms. Findings included: 1. An interview was conducted on 9/18/23 at 1:30 p.m. with Resident #28. The resident was sitting in a wheelchair on the left side of her bed. The resident said her call light was on the other side of the curtain by her roommate and she couldn't reach it when she needed to. She said she needed help previously and wasn't able to call and just had to wait for someone to come in. Resident #28's call light was observed to be past the curtain on the right side of her bed without a string. (Photographic Evidence Obtained) Review of the Admission Record showed Resident #28 was admitted to the facility on [DATE]. Review of Resident #28's annual Minimum Data Set (MDS), dated [DATE], Section C - Cognitive Patterns, showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. Section G - Functional Status showed the resident needed extensive assistance for bed mobility and transfers and limited one-person physical assist for walking in her room. 2. An observation was made on 9/19/23 at 11:45 a.m. of Resident #47 being assisted to the bathroom by an aide. At 12:05 p.m. the resident returned to her chair beside her bed and no staff members were present. Resident #47 was observed reaching to her left, leaning over, and feeling around on her bed. When asked what she was looking for, the resident said she couldn't find her oxygen tubing. She said it was taken off when she went to the bathroom, and she couldn't see where it was to put it back on. The nasal cannula was observed to be out of reach of the resident. The resident's call light was also out of her reach so she could not call for assistance. Review of the Admission Record showed Resident #47 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, history of falling, unspecified glaucoma, and age-related physical debility. Review of Resident #47's quarterly MDS, dated [DATE], Section C - Cognitive Patterns showed the resident had a BIMS score of 10, indicating she has moderately impaired cognition. Section B - Hearing, Speech and Vision showed the resident had impaired vision. 3. An observation was made on 9/18/23 at 1:31 p.m. of Residents #13 and #16 in bed sleeping with both of their call lights hanging down the wall between their beds, out of reach for either one of the residents. Review of the Admission Record showed Resident #13 was admitted on [DATE] with diagnoses including Parkinson's disease, transient cerebral ischemic attack, dementia, and muscle wasting and atrophy. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's latest MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was 4, indicating severely impaired cognition. Section G - Functional Status showed the resident required one-person physical assist for bed mobility and two-person physical transfers. Review of the Admission Record showed Resident #16 was admitted on [DATE] with diagnoses including dementia, and muscle wasting and atrophy. Review of Resident #16's latest MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was 11, indicating she had moderately impaired cognition. Section G - Functional Status showed the resident required one-person physical assist for bed mobility and transfers. 4. The bathroom of Residents #28, #47, #13, and #16 were observed to not have a call light pull cord in the bathroom next to the toilet on 9/18, 9/19, and 9/20/23. (Photographic Evidence Obtained) 5. An observation was made on 9/18/23 at 1:48 p.m. of Resident #15 in bed with her call light hanging down the wall on the other side of her table, out of her reach. (Photographic Evidence Obtained) Review of the Admission Record showed Resident #15 was admitted on [DATE] with diagnoses including epilepsy, adult failure to thrive, major depressive disorder, dementia, and osteoarthritis. Review of Resident #15's latest MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was 5, indicating severely impaired cognition. Section G - Functional Status showed the resident required extensive assistance for bed mobility and transfers. 6. An observation was made on 9/18/23 at 1:48 p.m. of Resident #41 in bed with her call light on her bedside table, out of reach of the resident. (Photographic Evidence Obtained) Review of the Admission Record showed Resident #41 was admitted on [DATE] with diagnoses including respiratory failure, chronic obstructive pulmonary disease (COPD,) anxiety disorder, dementia, and depression. Review of Resident #41's latest MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was 4, indicating severely impaired cognition. Section G - Functional Status showed the resident required one-person physical assist for bed mobility and transfers. 7. An interview was conducted on 9/19/23 at 2:30 p.m. with Resident #54. The resident was trying to help her roommate and needed assistance. Resident #54 said she didn't know where the call light was to pull it to get help. A follow-up interview was conducted on 9/20/23 at 4:46 p.m. with Resident #54. The resident said she figured out where the string was for the call light but had a hard time seeing it because it is white. The call light was observed to be a red string hanging down the wall out of reach of the resident's bed. The white string was to the light above the resident's bed. (Photographic Evidence Obtained) Review of Admission Record showed Resident #54 was admitted on [DATE] with diagnoses including traumatic hemorrhage of the cerebrum, spinal stenosis, post concessional syndrome, and difficulty walking. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #54's admission MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was 13, indicating she was cognitively intact. Section G - Functional Status, showed the resident required supervision and one-person physical assist for bed mobility and set up help for walking in room and transfers. 8. An observation was made on 9/18/23 at 1:14 p.m. of Resident #40, #26, #5, and #4 all in bed with call lights not in reach of the residents. All four residents share a room at the end of the hall, furthest from the nurses' station. Each of their call light strings was tied to a stuff animal and sitting on the tables between their beds. Review of the Admission Record showed Resident #40 was admitted on [DATE] with diagnoses including muscle wasting and atrophy, Alzheimer's disorder, open angle glaucoma, dementia, and difficulty walking. Review of Resident #40's quarterly MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was unable to be obtained due to resident rarely/never being understood. Section G, Functional Status, showed the resident required two-person physical assist for bed mobility and transfers. Review of the Admission record showed Resident #26 was admitted on [DATE] with diagnoses including muscle wasting and atrophy, syncope and collapse, dementia, psychotic disturbance, and difficulty walking. Review of Resident #26's latest MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was 5 indicating severely impaired cognition. Section G - Functional Status, showed the resident required two-person physical assist for bed mobility and transfers. Review of the Admission Record showed Resident #5 was admitted on [DATE] with diagnoses including muscle wasting and atrophy, dementia, muscle weakness, and autonomic neuropathy. Review of Resident #5's latest MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was unable to be obtained due to resident rarely/never being understood. Section G - Functional Status showed the resident required two-person physical assist for bed mobility and transfers. Review of the Admission Record showed Resident #4 was admitted on [DATE] with diagnoses including muscle wasting and atrophy, , Alzheimer's disease, weakness, major depressive disorder, and anxiety disorder. Review of Resident #4's latest MDS, dated [DATE], Section C - Cognitive Patterns showed her BIMS score was unable to be obtained due to resident rarely/never being understood. Section G - Functional Status, showed the resident required one-person physical assist for bed mobility and transfers. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/20/23 at 6:07 p.m. with the Director of Nursing (DON.) The DON said staff are educated on ensuring call lights are in reach of residents. She said she had not heard complaints about not having call lights in reach. The DON confirmed there should be a call light pull cord in every resident bathroom. She said Resident's #40, #26, #5, and #4 all have dementia. The DON said she doesn't think they have the mental capacity to use a call light, but they would have to do an evaluation to see. She said she is not sure if the residents are able to use the call light strings tied to the stuffed animals. The DON said if residents can not pull the string for the call light, they would have to get a different method. A facility policy titled, Call Lights-Use of, approved February 2023, showed the following: Procedure: . 8. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light. 9. Orient all new residents to the call light at the bedside as well as the call light in the bathroom and in the shower rooms. Have the resident demonstrate the use of the call light to be sure he/she understands your instructions. 11. Be sure all call lights are placed on the bed at all times, never of the floor or bedside stand.