STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105443	A. Building B. Wing	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Venice	1026 Albee Farm Rd Venice, FL 34285

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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 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** 25618 Based on observations, record review and staff interview the facility failed to ensure they applied and removed an AFO (ankle-foot orthosis) device for 1 (Resident #66) of 1 out of 6 residents coded as having an AFO. The use of an AFO is to improve standing, transfers, and/or walking patterns by reducing, preventing, or limiting the movement of the lower leg and foot and by supporting weak muscles. The findings included: On 10/03/23 at 9:10 a.m., Resident #66 was observed sitting in her wheelchair in the doorway to her room. During the observation, Resident #66 was noted to be dragging her right foot and her right arm and her hand appeared to be contracted. Resident #66 stated she had a cerebral vascular accident (CVA) causing her weakness on the right side of her body. She said she used to have a right foot splint, but therapy took it away a long time ago and she didn't know why. Review of Resident #66's medical record revealed diagnoses included a medical history of Multiple Sclerosis (disorder marked by decreased nerve function), Hemiplegia (paralysis of one side of the body), and Hemiparesis (weakness of one side of the body) following a Cerebral Infarction affecting the Right Dominant Side, Weakness, Unsteadiness on Feet, and a History of Falls. Resident #66's plan of care, dated 1/9/23 and revised 9/7/23, noted the resident had an activity of daily living (ADL) self-care performance deficit related to the disease process of Multiple Sclerosis, Vision Impairment, and Right Lower Leg/Extremity (RLE) Impairment and wore an AFO. Under interventions, it stated staff was to assist the resident with applying and removing the RLE AFO daily. The Certified Nursing Assistant (CNA)'s plan of care (KARDEX) for Resident #66, noted in the Resident Care section to assist Resident #66 with applying and removing her RLE AFO daily and observe for discoloration and bruising at least daily. On 10/4/23 at 9:15 a.m., CNA Staff K, said she was normally assigned to work with Resident #66. She said Resident #66 was independent but due to CVA she was very weak on her right side and had an unsteady gait. She said she had never seen or applied any splinting device to Resident #66's right foot. She said she was never told or aware the CNA's KARDEX stated they had to assist Resident #66 with applying and removing her RLE AFO daily and check for any discoloration to her leg. (continued on next page)

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

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/23 at 9:30 a.m., the Rehabilitation Director, said she had conducted an Occupational Therapy (OT) evaluation on Resident #66 on 9/7/23 because the resident was referred to them due to worsening vision, falls, decreased strength, impaired endurance, anxious behaviors and decreased quality of life. She said via her OT evaluation of Resident #66, she determined to start OT sessions with Resident #66, four times a week for four weeks. She said during her evaluation of Resident #66 on 9/7/23 she noted the resident did not have any splinting devices. The Rehabilitation Director said on 9/11/23 the Minimal Data Set (MDS) Coordinator gave her a list of 11 residents that had a splint/orthotics device and asked her to determine if the residents were using their splints/orthotics and to determine if they still needed them. The Rehabilitation Director confirmed Resident #66 was on the list for a right AFO to be worn out of bed. She said she did not have any documentation the therapy department had conducted the evaluation of Resident #66's RLE for use of AFO as requested by the MDS Coordinator on 9/11/23. By observation of Resident #66 and a search of Resident #66's room, the Rehabilitation Director confirmed Resident #66 was not wearing the RLE AFO as ordered, and she was unable to find the RLE AFO in Resident #66's room. On 10/4/23 at 10:06 a.m., the MDS Coordinator, said Resident #66 was admitted on [DATE] and the physician had ordered on 12/13/22 for a RLE AFO to be worn daily when Resident #66 was out of her bed. She said Resident #66 had a care plan created on 1/09/23 and revised on 9/7/23 for her to wear the RLE AFO because of her vision impairment, history of Multiple Sclerosis, and falls. The MDS Coordinator said she had given the therapy department a list of residents on 9/11/23 to conduct an evaluation of their splints/orthotics to determine if the residents still needed the splints/orthotics, including Resident #66. The MDS Coordinator said she had no documentation the therapy department had conducted an evaluation of Resident #66's RLE AFO as requested on 9/11/23. By observation the MDS Coordinator confirmed Resident #66 was not wearing the RLE AFO and the AFO was not in Resident #66's room. Resident #66 told the MDS Coordinator she had not worn the AFO in months. The MDS Coordinator said she was not informed Resident #66 was not wearing the RLE as ordered by the physician and written in Resident #66's ADL plan of care.

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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 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** 41155 Based on observation, review of the clinical record, review of facility policies and procedures, and staff interviews, the facility failed to provide the necessary care and services to maintain personal hygiene for 2 (Resident #19, and #68) of 3 residents reviewed for activities of daily living (ADLs). The findings included: The facility policy, N-1130 Bathing/Showering effective 11/30/2014 (revised 9/1/17) documented, Assistance with showering and bathing will be provided at least twice a week and as needed to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. 1. Review of the clinical record revealed Resident #19 had an admitted [DATE] with diagnoses including Alzheimer's disease, paranoid schizophrenia, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 8/16/23 documented Resident #19 required extensive physical assistance of one person for personal hygiene and was dependent on staff for bathing. The MDS assessment noted Resident #19's cognitive skills for daily decision making were severely impaired. On 10/2/23 at 3:08 p.m., Resident #19 was observed sitting at a table in the dining room of the secured Memory Care Unit. Her fingernails were very long extending approximately half inch in length and had a brown substance under the nail beds. Resident #19's hair was flat, uncombed, and greasy. On 10/3/23 at 8:06 a.m., Resident #19 was observed being assisted from her room dressed in her own clothing. Her hair was combed and appeared greasy. Resident #19's fingernails remained untrimmed with a brown substance under the nail beds. Review of the Certified Nursing Assistant (CNA) documentation for August 2023 and September 2023 revealed Resident #19 was scheduled for showers on the day shift on Tuesdays and Fridays. The CNA documentation lacked evidence Resident #19 received her scheduled shower on 8/8/23, 8/15/23, 8/18/23, 8/25/23, 9/1/23, 9/15/23, 9/22/23 and 9/29/23. On 9/12/23 the documentation reported a partial shower was provided. There was no documentation Resident #19 received assistance with personal hygiene during the day shift on 8/6/23, 8/8/23, 8/10/23, 8/11/23, 8/25/23, 8/28/23, 9/1/23, 9/2/23, 9/3/23, 9/15/23, 9/17/23, 9/22/23, 9/23/23, 9/24/23 and 9/29/23. There was no documentation Resident #19 received assistance with personal hygiene during the evening shift on 8/3/23, 8/4/23, 8/5/23, 8/9/23, 8/11/23, 8/18/23, 8/22/23, 8/23/23, 8/25/23, 8/26/23, 8/28/23, 8/31/23, 9/1/23, 9/3/23, 9/7/23, 9/8/23, 9/10/23, 9/15/23, 9/17/23, 9/19/23, 9/22/23, 9/23/23, 9/24/23, 9/26/23, 9/27/23, 9/28/23 and 9/29/23 . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation of assistance with personal hygiene for the night shift on 8/9/23, 8/12/23, 8/16/23, 8/19/23, 8/21/23, 8/22/23, 8/26/23, 8/27/23, 9/3/23, 9/6/23. 2. Review of the clinical record revealed Resident #68 had an admitted [DATE] with diagnoses including Alzheimer's disease, dementia, psychotic disturbance, mood disturbance, and anxiety. The Quarterly MDS assessment dated [DATE] documented Resident #68 required extensive physical assistance of one person with dressing, personal hygiene and was dependent on staff for bathing. The MDS noted Resident #68's cognitive skills for daily decision making were severely impaired. Review of the CNA documentation for August 2023 and September 2023 revealed Resident #68 was scheduled for showers on the 3-11 shift on Mondays and Thursdays. There was no documentation Resident #68 received her scheduled shower on 8/3/23, 8/28/23, 8/31/23, 9/11/23, and 9/14/23. A bed bath was provided on 9/7/23. The CNA documentation showed Resident #68 received no assistance with personal hygiene as follows: The day shift on 8/6/23, 8/8/23, 8/10/23, 8/11/23, 8/14/23, 8/15/23, 8/25/23, 8/28/23, 9/1/23, 9/2/23 , 9/7/23, 9/17/23, 9/18/23, 9/22/23 and 9/29/23. The evening shift on 8/3/23, 8/4/23, 8/5/23, 8/9/23, 8/11/23, 8/18/23, 8/22/23, 8/23/23, 8/25/23, 8/26/23, 8/28/23, 8/31/23, 9/2/23 9/5/23, 9/8/23, 9/9/23, 9/11/23, 9/15/23, 9/16/23, 9/22/23, 9/23/23, and 9/30/23. The night shift on 8/9/23, 8/12/23, 8/16/23, 8/17/23, 8/19/23, 8/22/23, 8/23/23, 8/25/23, 8/26/23, 9/3/23, 9/6/23, 9/7/23, 9/11/23, 9/17/23, 9/18/23, 9/21/23, 9/23/23, 9/26/23 and 9/29/23. On 10/02/23 at 12:14 p.m., Resident #68 was observed in the dining room at the table for the noon meal, dressed in a hospital gown. The gown was opened on the left side exposing her incontinent brief, upper thigh, and abdomen as she sat eating lunch. Three staff members were present in the dining room and did not adjust the resident's gown to cover her thigh, abdomen, and exposed brief. On 10/2/23 at 3:16 p.m., Resident #68 was observed sitting at a table in the dining room dressed in her own clothing. Her fingers nails were long with a brown substance under the nail beds. Her hair was messy and uncombed. On 10/4/23 at 8:12 a.m., Resident #68 was observed seated at the dining room table dressed in her own clothing. Her nails remained long with a brown substance under the nails. On 10/4/23 at 11:00 a.m. in an interview, CNA Staff A said if a resident refuses a shower, she will leave and approach the resident again. She said, I have a three-time process, if they decline after 3 times, I ask another staff member to try. If the resident continues to refuse a shower, I document it and I notify the nurse. Review of the Resident Council Minutes showed the following repeated concern with residents not receiving showers as scheduled. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/23, 14 residents attended the meeting and reported showers were not given. On 6/18/23, eight residents attended the meeting and reported the shower schedule was not being kept. On 7/11/23, nine residents attended the meeting and reported showers were getting better. On 8/12/23, nine residents attended the meeting and reported showers are sometimes being provided. On 10/5/23 at 10:00 a.m., Registered Nurse Staff J said the nurse was responsible to ensure the residents showers are completed. Staff J said sometimes, if the resident doesn't want to take a shower, she goes and ask them to please take a shower. She will try three times and if they say no, she documents the resident refused.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observations, review of the clinical record, review of the facility policies and procedures, and staff interviews the facility failed to develop and implement a program of meaningful activities to meet the needs of 6 of 16 residents in the memory care unit. The facility failed to implement meaningful individualized activities to meet the interest and wellbeing of 1 (Resident #58) of 1 resident in the memory unit sampled for individualized activities. The lack of an individualized activity program has the potential to cause social isolation, boredom, agitation, and frustration. The findings included: The facility policy, MC-200 Activity-Intensive Program effective date 11/30/14 (revised 3/19/19) documented, A structured activity intensive program shall be the focus of the memory care unit to minimize the confusion residents with dementia and related disorders experience as they attempt to cope with difficulties in short term memory, attention span, comprehension, learning, conceptualization, judgment, reasoning, abstract thought, perception and psychosocial well-being . Procedure: The activity intensive program shall provide a minimum of 12 hours per day, 84 hours per week of structured activity programming . A review of the clinical record revealed Resident #58 was admitted on [DATE] with diagnosis including dementia, anxiety, and major depressive disorder. The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date of 7/6/23 documented Resident #58's cognitive skills for daily decision making were severely impaired. The care plan initiated on 9/30/21 and revised on 7/11/23 documented Resident #58 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. The goal for Resident #58 was to attend and participate in community life activities of choice three to five times. The care plan noted, She loves company. She loves music and BINGO, she loves chocolate. The interventions included assisting with arranging community activities. Ensure that the activities the resident is attending are compatible with physical and mental capabilities. Compatible with known interest and preferences, adapted as needed such as large print. Compatible with individual needs and abilities. The activity calendar listed Exercise for 10/2/23 at 10:00 a.m. On 10/2/23 at 10:20 a.m., Resident #58 was observed seated at the dining room table with her forehead resting on the table. No music was playing, and no activity program was in progress. On 10/2/23 at 12:21 p.m., Resident #58 was observed at the same table in the dining room resting her forehead on the table. The activity calendar for 10/3/23 listed News at 9:00 a.m., and Rosary at 10:00 a.m. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/23 Resident #58 was observed sitting at a table in the dining room from 10:00 a.m. to 10:30 a.m., and on 10/3/23 at 11:21 a.m. During both observations, Resident #58 was staring at the wall. There was no activity in progress, no television or music playing. There were no staff in the dining room during the observations. On 10/4/23 at 8:13 a.m., Resident #58 was observed in a wheelchair in the unit dining room. There was no group or individual activity in progress and no music playing. On 10/4/23 at 8:23 a.m., Registered Nurse (RN) Staff D said there were no activities provided to the Memory Care Unit residents. Staff D said the unit used to have an activity aide who was wonderful, but she was no longer here. Staff D said, The CNAs (Certified Nursing Assistants) try to do little things for the residents, but they have patient care to do and can only do so much. I have not seen the Activity Director come back here to do any activities during the day when I am working. On 10/4/23 at 8:36 a.m., CNA Staff A said, No one comes to the memory care unit to do activities. We have this large activity calendar on the wall and, if we have time, we do something with the residents. The residents back here are not able to do most of the things on the calendar, they use the same one as the main unit and the activities listed, most of the residents are not able to do. We are not allowed to take the residents from the unit for the general activities in the main area of the facility. The CNA said, The calendar says to do news at 9:00 a.m. The residents don't read the newspaper and if I try, they can't participate. Karaoke is at 10:00 a.m., today but they don't have the equipment here and the residents can't read along. On 10/4/23 at 9:01 a.m., the Activity Director (AD) said she tries to go back to the unit as often as she can, but with the COVID outbreak on the unit it is harder. The AD said she was the only activity person for the facility and the CNAs were to provide the activities on the Memory Care Unit. The AD said she goes back to the unit daily to ensure the activities are being provided. The AD said she does not place individual activity calendars in resident rooms because the residents cannot read it. The AD said she only placed a large calendar on the unit wall by the television (TV). The AD said she had provided education to all the staff who work on the memory care unit on how to do each activity and said everything is on the unit for the activities. The AD said she makes sure the CNAs are providing the activities and completing the charting. The AD provided a copy of the same general population calendar for the Dementia residents, and said the calendar was the same one used for the Memory Care Unit residents. On 10/4/23, during observation of the Memory Care Unit from 10:00 a.m. to 10:27 a.m., Resident #58 remained at the table facing a wall with no activity in progress. The Calendar specified Karaoke at 10:00 a.m. No music was playing. No activity of any kind was in progress. On 10/4/23 at 10:20 a.m., CNA Staff B said there was no Karaoke machine on the unit. Staff B said she had not received in-service education on providing activities on the unit and said, The residents wander, and you have to stop and redirect them frequently, you can't be in two places at the same time, and we can't do our patient care and do activities at the same time. On 10/4/23 at 10:31 a.m., during observation in the main dining room of the general population, Karaoke was in progress. No residents from the memory care unit were in attendance. The Activity Director was present. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/4/23 at 11:03 a.m., an observation on the Memory Care Unit, one resident was wandering the halls, three residents were in the dining room unattended. Resident #58 was seated at the table, with crayons and a paper to color, but the resident had pushed them to the other side of the table. Resident #58 responded when greeted but did not respond appropriately to questions. There was no structured activity in progress and no music was playing. One CNA was observed in the TV area attending to other residents. On 10/4/23 at 1:59 p.m., the activity calendar specified nails to be done at 2:00 p.m. Observation of the unit noted five residents sleeping in the TV area, while the TV was on. One resident was wandering in the dining room. The CNAs were observed providing toileting and care to the residents. On 10/4/23 at 2:03 p.m., RN Staff D said, The Activity Director came back here this afternoon and told the staff they were to do nail care, I told her we had no supplies back here on the unit. The AD left and returned with a caddy that had a few nail polishes in it. On 10/4/23 at 2:16 p.m., CNA Staff B said no one from activities had come to the unit to provide nail care. The CNA said, if we have time, we try and do an activity with the residents, but we are always busy. On 10/4/23 at 2:22 p.m., CNA Staff A said, We toilet everyone back here every two hours, I take that very seriously. If they need to be changed or put to bed, I do it. My main concern is with the resident's care and if I have time, I don't mind doing the activity with them. I love to spend time with them doing appropriate activities for them but some days there is no time. On 10/5/23 at 8:30 a.m., the Activity Director confirmed the activity calendar for the Memory Care Unit was the same as the general population and the residents did not leave the secured unit to attend activities in the main area of the facility. The Activity Director said the residents like Karaoke, and they sing along to it but confirmed the activity did not occur on the memory unit as listed on the calendar. The Activity Director said she was aware the residents on the Memory Care Unit required activities to meet their cognitive level and said she was doing her best, but she was the only person in the facility for activities. I used to have an assistant, but she left suddenly and had not been replaced yet. The Activity Director confirmed the activities on the general population calendar were not provided to the memory care residents.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observations, interviews, and record review the facility failed to provide care and services to prevent reduction in range of motion (ROM) for 1 (Resident #78) of 2 residents reviewed for limitation in ROM. The findings included: Review of the facility policy for Contracture Prevention revised 8/22/17 revealed the purpose is to prevent contracture of extremities for those residents who no longer have full use of their extremities. Each resident must be evaluated for the need of contracture prevention procedure on admission and readmission as needed. Review of the clinical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including paralysis of right side due to cerebral vascular accident (CVA). The physician's orders dated 8/12/23 included an Occupational and Physical Therapy evaluation and treatment. The physician's History and Physical progress note dated 8/14/23 at 5:47 p.m., noted Resident #78 had a right hand contracture. Physical Therapy (PT) and Occupational Therapy (OT) to assess and treat. The clinical record lacked documentation of an Occupational Therapy evaluation and treatment as per the physician's order. On 10/02/23 at 10:37 a.m., Resident #78 was observed in his room. The resident's right hand was in a closed fist. The resident was not wearing an orthotic device such as a splint to the right hand. Resident #78 was not able to speak and shook his head no when asked if the facility had evaluated and was treating his right hand. On 10/4/23 at 11:35 a.m., observed Resident #78 in his room, nothing in the right hand, closed fist position. On 10/4/23 at 1:09 p.m., Resident #78 was observed in his room with his daughter. The daughter said Resident #78 had a CVA on 2/14/23. His right hand became paralyzed. She retrieved a splint from a box in the closet which she said was for Resident #78's right hand. On 10/4/23 at 1:29 p.m., the Director of Rehabilitation Services said Resident #78 was not evaluated or treated by Occupational Therapy and was not receiving services to prevent a decline in the range of motion of the right hand. The Director of Rehabilitation said Resident #78's payor source was Private Pay, the daughter wanted to start with Physical Therapy, therefore, he did not receive Occupational Therapy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/23 at 2:16 p.m., Certified Nursing Assistant (CNA) Staff X said she takes care of the resident regularly, no one told her to do any range of motion (ROM) for Resident #78. On 10/4/23 at 3:58 p.m., the Minimum Data Set (MDS) Coordinator said the Rehabilitation Department should have addressed the right-hand fist and applied a rolled-up towel or something to keep the hand from closing. After reviewing the clinical record, she said Resident #78 was not receiving restorative nursing for his right hand to prevent a decline in the range of motion. On 10/5/23 at 9:11 a.m., the Director of Rehabilitation Services attempted to open Resident #78's right hand. The Rehabilitation Director said she cannot open the fist. She said she could not tell if the hand was contracted or hypertonia (abnormal muscle tone), both of which indicate a ROM decline. She said without treatment the hand would get worse. She said that is what happens when the hand is paralyzed. On 10/5/23 at 9:29 a.m., the Director of Nursing (DON) went to the room and confirmed the right hand was closed in a fist, and she could not open it. On 10/5/23 at 9:48 a.m., the Business Office Manager (BOM) said OT should have evaluated and treated per the physician's orders, regardless of the payor source.

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Aspire at Venice	1026 Albee Farm Rd Venice, FL 34285

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on record review, and staff interviews the facility failed to ensure they maintained communication between the nursing facility and the dialysis center related to the ongoing assessment of dialysis resident before and after each dialysis treatment for 2 (Residents #7 and #24) of 2 residents receiving dialysis. The findings included: The facility policy titled, Coordination of Hemodialysis Services N-1359, with an effective date of 11/30/2014 and a revision date of 7/2/2019, stated residents that required an outside ESRD (End Stage Renal Disease) facility would have services coordinated by the facility. The Dialysis Communication form would be initiated by the facility and sent to the ESRD center. The nurse would collect and complete the information regarding the resident to send to the ESRD center and upon the resident's return to the facility, the nurse would review the Dialysis Communication form and the information sent by the ESRD center and complete the post dialysis information on the Dialysis Communication form and file it in the resident's medical record. 1. Review of Resident #7's medical record revealed he was admitted to the facility on [DATE] with a medical diagnosis of End Stage Renal Disease. Resident #7 had a physician's order for hemodialysis (Treatment to filter wastes and water from the blood) every Tuesday, Thursday and Saturday related to ESRD. On 10/4/23 at 4:38 p.m., Licensed Practical Nurse (LPN) Staff F confirmed Resident #7 went to the dialysis center every Tuesday, Thursday and Saturday. She said the nurses were responsible to fully fill out the prior to dialysis section on the Dialysis Communication Record form and send it to the dialysis center. When the resident returned from the dialysis center, the receiving nurse was required to review the Dialysis Communication Record form for any new orders and/or concerns the dialysis center documented on the form. The receiving nurse then was responsible to complete the return from dialysis section of the form to show they had completed a full assessment of the dialysis port site to check for any bleeding and/or possible infection and to complete a full set of vital signs to indicate the resident was stable and not in any distress. Staff F searched Resident #7's dialysis communication logbook and Resident #7's medical record and she said she was unable to find any of Resident #7's Dialysis Communication Record forms. On 10/4/23 at 5:00 p.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed Resident #7 went to the dialysis center every Tuesday, Thursday and Saturday. They said the nursing staff were required to complete the pre and post assessment on the Dialysis Communication Record form. The ADON said all of Resident #7's Dialysis forms were kept in the medical records office. Resident #7's Dialysis Communication Records forms for September and October 2023 were reviewed with the ADON. The ADON verified the post return section of the dialysis communication form was not completed on September 2, 19 and 21. The ADON said she was not able to find the dialysis communication form for September 7, 9, 14, 16, 23, 26, 30, and October 2, 2023. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/5/23 at 8:30 a.m., in an interview, the Charge Nurse at the Dialysis Center confirmed Resident #7 came to their facility every Tuesday, Thursday and Saturday for hemodialysis service. She said the facility did not always send the Dialysis Communication Record form with Resident #7 as required. She said even though the facility did not always send the Dialysis Communication Record form, they always faxed their Information Exchange form to the facility for their records. She said their main concern was Resident #7 came to their facility without a dressing covering the left chest dialysis port site which could lead to an infection. She said they had written this information on the Dialysis Communication form as required but Resident #7 still came to the facility without a dressing to his dialysis port site. On 10/5/23 at 10:00 a.m., the ADON said she was unable to find Resident #7's Dialysis Communication form for September 7, 9, 14, 16, 23, 26, 30, and October 2, 2023. The ADON confirmed the dialysis center had written on their Information Exchange form dated 9/19/23 Resident #7's dialysis port dressing was missing. She said she had identified on 9/26/23, the nursing staff were not completing the pre and post assessments on the Dialysis Communication form but had not conducted staff education with the nursing staff to ensure they completed the required components on the Dialysis Communication Record form and making sure Resident #7's dialysis dressing remained intact at all times. 38570 2. On 10/5/23 at 4:10 p.m., Resident #24's dialysis communication book located in the dialysis bag in the resident's room was reviewed. The dialysis communication form dated 10/5/23 did not document the resident's name and was not filled out by the facility prior to going to dialysis at 6:30 a.m. On 10/05/23 at 4:18 p.m., Registered Nurse (RN) Staff J stated when she received the resident back from dialysis today, the pre dialysis part of the form dated 10/5/23 was not filled out, and the form did not have the resident's name.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on observation, record review and interview, the facility failed to have documentation of alternatives attempted prior to use of side rails, review the risks and benefits of side rails, and obtain consent prior to the use of side rails for 1 (Resident #44) of 1 resident observed with side rails on the bed. The findings included: Review of the facility policy for Side Rail/Bed Rail dated 4/19/18 indicated the facility will attempt alternative interventions and document in the medical record, prior to the use of side rail/bed rail. 1. Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. 2. Review the risks and benefits with residents. 3. Obtain consent from the resident. 4. Obtain physician order for side rail/bed rail. Review of Resident #44's Quarterly Minimum Data Set assessment dated [DATE] Section P for restraints, documented side rails used for 0 days. Review of the Order Summary Report that included physician orders revealed there was no order for side rails/bed rails. Review of the Care Plan for activities of daily living (ADLs) self-care performance revealed interventions for bilateral quarter rails used for bed mobility and turning and repositioning initiated on 6/15/23. On 10/2/23 at 10:41 a.m., observed Resident #44's bed with quarter side rails in the up position. On 10/04/23 at 5:51 p.m., the Nursing Home Administrator (NHA) said it is necessary to obtain consents for side rails and then the therapy department evaluates for appropriateness. She said Resident #44's evaluation for appropriateness was completed on 10/4/23 and that was the only one she could find in the medical record. She acknowledged Resident #44 was using side rails prior to evaluation for appropriateness and attempts for alternatives. On 10/05/23 at 2:00 p.m., review of the resident's medical record including paper chart and electronic health record revealed a side rail evaluation form completed on 10/4/23. The clinical record lacked documentation of a consent for side rail use, and no alternative interventions attempted prior to the use of side rails as initiated in the care plan on 6/15/23. On 10/5/23 at 3:27 p.m., the Director of Nursing acknowledged the facility lacked the proper documentation including consents, evaluations, and attempts for alternative interventions prior to the use of side rails.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 25618 Based on staff interviews and staff record reviews, the facility failed to ensure 3 Certified Nursing Assistants (CNA) (Staff A, H, and I) of 3 sampled records reviewed had a performance review completed at least once every 12 months. The facility failed to ensure staff had in-service education based on the outcome of the employee annual performance/competency evaluations. The findings included: On 10/3/23, a review of the facility's Employee Guidebook stated on page 25 and 26, all employees would have a performance evaluation completed upon hire, and on their yearly anniversary date or on their promotion date. On 10/3/23, a review of CNA Staff A's employee file revealed a hire date of 11/2/1992. There was no documentation Staff A had an employee performance/competency review in 2022 or 2023. The last performance/competency review in the employee record was dated 11/26/13. On 10/3/23, a review of CNA Staff H's employee file revealed a hire date of 4/11/1991. There was no documentation Staff H had an employee performance/competency review in 2022 or 2023. The last performance/competency review in the employee record was dated 4/30/13. On 10/3/23, a review of CNA Staff I's employee file revealed a hire date of 7/11/1995. There was no documentation Staff I had an employee performance/competency review in 2022 or 2023. The last performance/competency review in the employee record was dated 7/29/13. On 10/5/23 at 3:17 p.m., the Administrator confirmed their Employee Guidebook stated all employees would have a performance evaluation completed upon hire, on their yearly anniversary date or on their promotion date. The Administrator said prior to 10/3/23 the last time Staff A, Staff H and Staff I completed their annual performance/competency evaluation was in 2013. The Administrator confirmed she was unable to find documentation Staff A, Staff H and Staff I had their annual competencies/performance review completed on an annual basis and in-service education based on the outcome of their competency/performance reviews.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41155 Based on observation, clinical record review and staff interviews, the facility failed to administer medications according to physician's orders for 2 (Residents #18 and #30) of 4 residents observed for medication administration. Three licensed nurses on the morning shift with 29 opportunities were observed. Two medication errors were observed resulting in a 6.9% error rate. The findings included: The facility policy Administering Medications (revised 4/19) documented, Medications are administered in a safe and timely manner and as prescribed.Medications are administered in accordance with prescriber orders including any required time frame. 1. On 10/3/23 at 8:31 a.m., Registered Nurse (RN) Staff C was observed administering eight different medications to Resident #18. RN Staff C said she was not able to administer Duloxetine 40 milligrams (mg) as ordered medications. She said the medication was not available and was not included in the emergency drug kit. Review of the clinical record revealed a physician's order dated 9/3/23 to administer Duloxetine HCL (Hydrochloride) 40 milligrams (mg), one capsule by mouth daily related to Recurrent Major Depressive Disorder. On 10/3/23 at 4:00 p.m., RN Staff C documented in a progress note she notified the Advanced Practice Registered Nurse the medication will be given late as it will be sent STAT (immediately) from the pharmacy. On 10/4/23 at 12:15 p.m., Review of the Medication Administration Record failed to show documentation Resident #18 received the Duloxetine 40 mg as ordered on 10/3/23. On 10/4/23 at 12:32 p.m., the Assisted Director of Nursing (ADON) said Resident #18 did not receive the Duloxetine on 10/3/23 because it was not here. On 10/4/23 at 12:46 p.m., review of the Pharmacy Delivery Slip showed the Duloxetine 40 mg capsule was delivered and available on 10/3/23 at 12:48 p.m. 2. On 10/3/23 at 9:39 a.m., Licensed Practical Nurse (LPN) Staff E was observed administering seven different medications to Resident #30, including one chewable tablet of Aspirin 81 mg. LPN Staff E crushed all the medications and administered them to the resident. Review of the clinical record revealed a physician's order dated 1/20/23 to administer Aspirin EC (enteric coated) tablet delayed release, one tablet by mouth one time a day related to atrial fibrillation. On 10/3/23 at 11:00 a.m., LPN Staff E said she did not know what enteric coated was. She verified Aspirin 81 mg enteric coated was not available in the medication cart.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy and procedures and staff interviews, the facility failed to ensure medications were appropriately labeled in 3 (Carts #1, #2, and #3) of 3 medications carts reviewed. Without an open date on the medication there was no way to know when it would expire. This had the potential for residents to receive medications that could create hazardous health consequences. The facility also failed to secure medication and treatment carts were secured when not in view of the licensed nurse. The findings included: The facility policy, Administering Medications (revised 4/19) documented, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. 1. On 10/2/23 at 10:39 a.m., during an observation of medication cart identified by Licensed Practical Nurse (LPN) Staff F as cart #1 (rooms 204-208), the following was observed: One Novolog insulin flex pen without an open date on the package. The directions on the pharmacy label instructed to discard 28 days after opening. Photographic evidence obtained. One Novolin R flex pen for without an open date recorded. The directions on the pharmacy label instructed to discard after 28 days. The findings were verified by LPN Staff F. 2. On 10/2/23 at 11:30 a.m., during an observation of medication identified as Cart #3 with LPN Staff E, the following was observed: One Levemir Flex Pen without an open date. Photographic evidence obtained. One Novolog Flex pen in a clear plastic bag with a date opened of 8/15/23. The plastic bag did not have a pharmacy label. The instructions specified to discard 28 days after opening. The Novolog flex pen should have been discarded on on 9/12/23. Photographic evidence obtained. One Levemir Flex Pen dated 8/15/23 on the insulin pen and a date of 9/1/23 on the pharmacy label. The label instructed to discard after 28 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN Staff E confirmed she did not know which date was the actual open date of the insulin. Staff E confirmed the findings in the medication cart. 3. On 10/2/23 at 11:45 a.m., during an observation of medication cart identified as cart #2 with Registered Nurse (RN) Staff D the following was observed: One Lispro Insulin Pen without an open date. The pharmacy label instructed to discard the medication 28 days after opening. RN Staff D confirmed the findings in the medication cart. On 10/4/23 at 1:38 p.m. in an interview, the Assistant Director of Nursing (ADON) said the expectation was when you open an insulin you date it. The ADON confirmed the opened insulin should be dated when the nurse opens the medication. 4. On 10/2/23 at 12:11 p.m., during an observation, RN Staff D unlocked medication cart #3 to retrieve medications. The cart was against the wall in front of the nursing station. RN Staff D walked away from the unsecured medication cart and went down the hallway to the other nursing unit. There were residents and staff in the hall. RN Staff D returned to the unit and confirmed the medication cart had been left unlocked and unattended. Photographic evidence obtained. 5. On 10/2/23 at 1:17 p.m., on the secured Memory Care Unit the medication room was left unlocked and the door was open. The medication cart was in the room and was unlocked. There were residents wandering by past the open medication room. The nurse was not present for five minutes and the medication cart was unsecured. LPN Staff F returned to the open medication room and verified she had left the medication room and the medication cart unsecured and unattended. Photographic evidence obtained. 6. On 10/3/23 from 8:56 a.m. to 9:06 a.m., a medication cart labeled cart #2 was observed unlocked at nursing station 1. A treatment cart located in the hallway across from nursing station 1 was unlocked. The treatment cart contained medications and wound care supplies. Residents and staff were observed walking by the unlocked medication and treatment carts. On 10/3/23 at 9:06 a.m., LPN Staff E verified the medication and treatment carts were unlocked and unattended. 7. LPN Staff E walked away from an unlocked cart in the hallway in front of room [ROOM NUMBER]. On 10/3/23 at 9:11 a.m., LPN Staff E returned to the unsecured medication cart in front of room [ROOM NUMBER] and confirmed the medication cart was unlocked with the contents easily accessible. Photographic evidence obtained. On 10/4/23 at 11:08 a.m., the Director of Nursing said the carts were to be locked when not in view of the nurse.