STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555658	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Walk Care Center	1100 West Morton Avenue Porterville, CA 93257

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 32946 Based on interview, and record review, the facility failed to follow the facility's policy and procedure (P&P) titled, Advanced Directives, when 26 of 30 sampled residents (Resident 292, Resident 63, Resident 341, Resident 49, Resident 17, Resident 50, Resident 32, Resident 61, Resident 46, Resident 52, Resident 2, Resident 12, Resident 5, Resident 4, Resident 65, Resident 15, Resident 85, Resident 60, Resident 56, Resident 35, Resident 31, Resident 23, Resident 57, Resident 69, Resident 78, and Resident 39) did not have an Advance Directive, including the right to accept or refuse medical or surgical treatment, in the residents' medical record. This failure had the potential for the facility to provide treatment and services against multiple residents wishes. Findings: During an interview on 10/15/24 at 12:51 p.m. with Admission Coordinator, (AC), AC stated, it was very important for Resident 341 to have Advance Directive. AC stated, the Advanced Directive allowed the facility to know the resident's wishes. During an interview on 10/15/24 at 4:17 p.m. with Resident 292, Resident 292 stated he did not remember signing an Advanced Directive or being asked to sign an Advanced Directive. During an interview on 10/15/24 at 4:18 p.m. with Family Member (FM) 1, FM 1 stated she did not remember the Advance Directive being offered in the paperwork. During an interview on 10/16/24 at 8:48 a.m. with Resident 63, Resident 63 stated she had been admitted to the facility back in March of this year [2024], Resident 63 stated she and her daughter had completed the paper work when she was admitted to the facility. Resident 63 reviewed a copy of her Advance Directive and verified her initials on the document. She stated she did not remember completing the form. Resident 63 stated, I don't remember anything. Resident 63 stated she did not remember what she wanted on the Advance Directive. Other than the resident's initials and name, the Advance Directive did not indicate Resident 63's wishes. During a concurrent interview and record review on 10/17/24 at 9:55 a.m. with the AC, AC stated the Advance Directive was completed when the admission packet is completed. AC reviewed the following residents' medical records for the Advance Directive: 1. Resident 341- AC stated, No, I don't believe there is an Advance Directive. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Resident 49 - Advance Directive not found in medical record. 3. Resident 2 - Advance Directive not found in medical record. 4. Resident 12 - Resident had an advance directive form that was not completed or signed by the Resident or Responsible party. 5. Resident 292 - Advance Directive not found in medical record. 6. Resident 52 - Advance Directive not found in medical record. 7. Resident 46 - Advance Directive not found in medical record. 8. Resident 61 - Advance Directive not found in medical record. 9. Resident 32 - Advance Directive not found in medical record. 10. Resident 50 - Advance Directive not found in medical record. 11. Resident 17 - Advance Directive not found in medical record. 12. Resident 5 - Advance Directive not found in medical record. 13. Resident 4 - Advance Directive not found in medical record. 14. Resident 65 - Advance Directive not found in medical record. 15. Resident 15 - AC confirmed Resident 15's Advance Directive was not filled out, and only had resident name (Resident signature only) with none of the boxes checked to indicate Residents 15's wishes. 16. Resident 85 - Advance Directive not found in medical record. 17. Resident 60 - Advance Directive not found in medical record. 18. Resident 56 - Advance Directive not found in medical record. 19. Resident 35 - Advance Directive not found in medical record. 20. Resident 31 - Advance Directive not found in medical record. 21. Resident 23 - Advance Directive not found in medical record. 22. Resident 57 - Advance Directive not found in medical record. 23. Resident 69 - Advance Directive not found in medical record. 24. Resident 78 - Advance Directive not found in medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	25. Resident 39 - Advance Directive not found in medical record. 26. Resident 63 - Advance Directive not found in medical record. AC confirmed the above findings and stated when she started working at the facility as AC the form [Advance Directive] had not been available. AC stated the facility process was to ask the Resident or Resident representative if they had an Advance Directive or if they would like to have one. AC stated, we, meet, with social services and set up the Advance Directive, we don't have any documentation. During a review of the facility's policy and procedure (P&P) titled, Advanced Directives dated 2022, the P&P indicated, Policy Statement, The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance Directives are honored in accordance with state law and facility policy. Definitions 1. The facility define the following in accordance with current OBRA definitions and guidelines: a. Advance care planning - process of communication between individuals and their healthcare agents to understand, reflect on discuss and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. b. Advance Directive a written instruction, such an living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to provisions of health care when the individual is incapacitated . 42344 42744 45654 47095

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45654 Based on observation, interview, and record review the facility failed to follow their policy and procedure (P&P) titled, Laundry and Bedding, Soiled, when one of eight sampled residents (Resident 60) was observed with brown stains on the bed linen. This failure had the potential for Resident 60 to be exposed to infectious disease. During a concurrent observation and interview on 10/14/24 at 10:34 a.m. with Family Member (FM) 2 in Resident 60's room, an unoccupied bed had multiple brown spots on the bed linen. FM 2 stated the bed linen has been dirty for 2 days. FM 2 stated she did not want to sit in a room with dirty bed linen. During a concurrent observation and interview on 10/14/24 at 10:40 a.m. with House Keeping (HK) 1 in Resident 60's room, HK 1 confirmed there were dried brown colored spots on the bed linen. HK 1 stated dirty bed linen should be changed. HK 1 stated it was the responsibility of the Certified Nursing Assistant (CNA) to change the bed linen. During a concurrent observation and interview on 10/14/24 at 10:46 a.m. with CNA 6, in Resident 60's room, CNA 6 stated the brown colored spots looked like poop (feces) on the bed linen. CNA 6 stated the linen on the bed needed to be changed. During an interview on 10/15/24 at 11:43 a.m. with Infection Preventionist (IP), IP stated the bed linen should have been changed immediately and that dirty bed linen was not acceptable. During a review of the facility's P&P titled, Laundry and Bedding, Soiled, dated 9/22, the P&P indicated, Soiled laundry/bedding shall be handled, transported, and processed according to best practices for infection prevention and control. 1. All used laundry is handled as potentially contaminated using standard precautions. Moisture -resistant mattress covers are cleaned and disinfected using EPA-registered disinfectants between uses by different residents. Fabric mattress covers are laundered between uses by different residents.

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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. 42744 Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, when oral care was not provided for one of eight sampled residents (Resident 51). This failure had the potential to result in oral discomfort or infections and dental cavities. Findings: During a review of Resident 51's Minimum Data Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 51 had a diagnosis of a stroke (brain attack when blood flow to the brain is disrupted causing brain cell death) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), was fed via a gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and was dependent (required another person to perfom task) for oral hygiene. During a review of Resident 51's Order Care Summary (OCS), dated 10/16/24, the OCS indicated, Enteral Feed Order every shift Ensure Oral Care is provided. During a concurrent observation and interview on 10/15/24 at 10:01 a.m. with Licensed Vocational Nurse (LVN) 2 in Resident 51's room, Resident 51's lips and teeth were covered with a brown film. Resident 51's lips were dry and cracked. LVN 2 stated Resident 51's oral care should have already been done this morning. During an interview on 10/15/24 at 10:10 a.m. with Resident 51's Family Member (FM) 3, FM 3 stated, Every time I come in here his mouth is all crusted up. During an interview on 10/17/24 at 2:05 p.m. with Director of Nursing (DON), DON stated oral care should be done multiple times a day for a resident who is not taking anything by mouth. DON stated the resident's mouth should be moisturized at least every two hours. During a review of the facility's P&P titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, the P&P indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordace with the plan of care .a. hygiene (bathing, dressing, grooming, and oral care) .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38993 Based on interview and record review, the facility failed to follow its policy and procedure on Care Plans, Comprehensive Person-Centered for one of three sampled residents (Resident 341) to reduce the risk of falls and minimize injuries. This failure resulted in Resident 341 falling multiple times in six months and sustaining a fracture (broken bone) to his left hip and left shoulder requiring surgical repair. Findings: During a review of Resident 341 Admission Record (AR) dated 4/2/24, the AR indicated, Resident 341 was admitted on [DATE]. Resident 341 diagnosis including metabolic encephalopathy (brain dysfunction caused by a chemical im-balance in the blood that affects the brain) difficulty in walking, and muscle weakness (generalized). During a review of Resident 341 Minimum Data Set (MDS- a resident assessment tool) dated 04/2/24, the MDS indicated, Resident 341 had significant cognitive impairment (problem with a person's ability to think, learn, remember, use judgement, and make decisions) with a Brief Interview for Mental Status (BIMS-assesses mental processes) score of 7 (score of 0-7 [significant impairment]). During a review of Resident 341 Fall Risk Evaluation (FRE) dated 4/4/24, the FRE indicated, Fall Risk Evaluation Score: 11.High Fall Risk. During a review of Resident 341 MDS dated [DATE], the MDS indicated, Resident 341 required partial /moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for chair/bed-to-chair transfer and toilet transfer. A. During a concurrent interview and record review on 10/14/24 at 12:44 p.m. with Director of Nursing (DON), Resident 341 Progress Notes (PN), dated 7/12/24 was reviewed. The PN indicated, IDT (group of professionals with different areas of expertise who work together to achieve a common goal).On 7/11/24 @ (at) 1:45 p.m. licensed nurse was notified by CNA (Certified Nursing Assistant) that (Resident 341) was observed on the floor in tv (television) room in front of sofa and w/c (wheelchair) was beside him. Recommendations: 72-hour nursing post fall review.72-hour neuro (neurological- to assess the function of the brain) checks, pharmacy IMRR (Interim Medication Regimen Review).rehabilitation post fall review.New Fall interventions: Physical Therapy (PT) to review (Resident 341) wheelchair brake management. There was no updated care plan noted on this fall incident (7/11/24). DON confirmed the findings and stated the care plan should have been updated after the fall incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 10/14/24 at 12:44 p.m. with DON, Resident 341 IMRR dated 7/12/2024, was reviewed. The IMRR indicated, Type of Review: Change of Condition.Fall. Recommendation.BMP (basic metabolic panel-a common blood test that can be used to screen for, diagnose, or monitor health conditions).TSH (thyroid stimulating hormone-blood test that measures the amount of TSH in the blood).BP (blood pressure).HR (heart rate).Check orthostatic (blood pressure taken when standing up from a sitting or lying position) BPS (blood pressures) Q (every) Shift X (times) 3 days. Notify MD (Doctor of Medicine) if resident experiences orthostasis (drop in blood pressure when standing). There was no evidence of the recommendations being implemented. DON confirmed the findings and stated the IMRR recommendations should have been implemented. B. During a concurrent interview and record review on 10/14/24 at 12:44 p.m. with DON, Resident 341 Care Plan (CP) dated 7/18/24 was reviewed. The CP indicated, (Resident 341) had an unwitnessed fall with no injury on 7/18/24.Interventions.Monitoring for 72 hrs (hours) for any delayed injuries.Pharmacy IMMR.Rehab (Rehabilitation post fall evaluation) .Staff advised to do frequent (frequency not indicated) rounds on resident. There was no IDT noted and no evidence of the frequent rounds being implemented. DON confirmed the findings and stated there should have been an IDT conducted and DON was unable to provide evidence of frequent rounding. C. During a review of Resident 341 IDT-Interdisciplinary Post Event Note (IDT) dated 8/23/24 was reviewed. The IDT indicated, Two staff members notified this writer that resident was on his buttock on the ground floor of his restroom with noted urine on the floor.Date and Time of Event 8/22/24 7:45 p.m .New Interventions. neuro-check.Rehab (rehabilitation) Referral.Care Plan Revision. During a concurrent interview and record review on 10/14/24 at 12:44 p.m. with DON, Resident 341 CP dated 8/23/24 was reviewed. The CP indicated, Resident sustained an unwitnessed fall w/o (without) injury on 8/22/24.Continue s/p (status post-shorthand term used to describe a patient's condition after a specific event or procedure) neuro check monitoring.monitor for any delay injuries & or pain.Notify MD of any changes. There were no new interventions implemented after the fall. The interventions indicated were the same as the fall incident on 7/18/24. DON confirmed the findings and stated the facility should initiate new interventions after the fall incident on 8/22/24. D. During a concurrent interview and record review on 10/14/24 at 12:44 p.m. with DON, Resident 341 IDT dated 9/18/24 was reviewed. The IDT indicated, On 9/16/24 @ 2145 (9:45 pm) license nurse was notified of an observed fall and rushed to his side. He (Resident 341) was asked what happened and stated in that he did not know, and his back and head were hurting.CNA stated (Resident 341) was walking out of his room, his shoes were unbuckled, he started stumbling and lost his balance and before the CNA could intervene (Resident 341) fell and hit his head on the tile.Date and time of event 9:45 p.m.Injury Present.Yes.Indicate Injury.Resident noted to have two staples to his R (right) upper eyebrow, report also determined a contusion (bruise) to right elbow.New Interventions.Neuro-Check.Medication Review.Rehab referral. There was no CP developed or new interventions implemented after the fall incident on 9/16/24. DON confirmed the findings and stated there should have been a care plan developed and new interventions implemented after the fall incident on 9/16/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 10/14/24 at 12:44 p.m. with DON, Resident 341 IMRR, dated 9/23/24 (Medication review from fall incident on 9/16/24) was reviewed. The IMRR indicated, Type of Review: Change of condition.Fall.Recommendation.BMP.BP.HR.Check orthostatic BPS Q Shift X3 days. Notify MD if resident experiences orthostasis. There was no evidence of the recommendations being implemented. DON confirmed the findings and stated the IMRR recommendations should have been implemented. E. During a concurrent interview and record review on 10/14/24 at 12:44 p.m. with DON, Resident 341 CP dated 9/22/24 was reviewed. The CP indicated, Resident had an unwitnessed fall with no suspected injuries on 9/22/24.Interventions.Assist resident to the restroom as needed.Maintain bed at a low safe position. provide pain management as needed.report abnormal vital signs and any complications to MD. There was no IDT completed after this fall incident on 9/22/24. DON confirmed the findings and stated there should have been an IDT completed after the fall incident on 9/22/24. F. During a concurrent interview and record review on 9/14/24 at 12:44 p.m. with DON, Resident 341 Change in Condition Evaluation (COCE) dated 9/28/24 was reviewed. The COCE indicated, The change in condition.Falls.9/28/24.Resident attempts to self-transfer from bed to chair and chair to bed. Resident should be monitored for attempting to transfer without assistance. The CP was not revised, there were no new interventions implemented and there was no IDT completed after the fall incident on 9/28/24. DON confirmed the findings. G. During a review of Resident 341 PN dated 10/4/24, the PN indicated, IDT.On 10/1/24 @ 9 p.m. this nurse heard a low cry for help. (Resident 341) was observed laying on the ground floor on his right side near the entrance to (Resident 341) room. He was wearing sweatpants that were around his knees and he was not wearing any shoes.@ 2300 (11 pm) (Resident 341) was receiving care and cried out in pain.was reassessed and observed guarding his left arm.Dr (Doctor). notified and directed he be sent to the ER (emergency room) due to SP (status post) fall with pain to left upper extremity.Contacted ER.who stated that he is admitted with a fracture to the left femur (bone of the thigh) and left shoulder. During a review of Resident 341 History and Physical Report (H&P) (completed at hospital 1) dated 10/2/24, the H&P indicated, Patient is .year-old male with.history of recurrent fall who presented to the emergency room via EMS (emergency medical services) from SNF (skilled nursing facility) for unwitnessed fall. Assessment and Plan.Left shoulder displacement (not in alignment) & hip fracture.Recurrent unwitnessed fall. During a review of Resident 341 Imaging Report (IR) (completed at hospital 1) dated 10/2/24, the IR indicated, Patient fell today with injury to the left hip, left hip pain.Findings: acute (severe and sudden in onset) impacted (lodged or wedged) left sub-capital (fracture in the neck of the thigh bone) hip fracture. During a review of Resident 341 IR (completed at hospital 1) dated 10/2/24, the IR indicated, Left shoulder pain today.Impression: Impacted comminuted (bone broken into more than two pieces) fractures proximal (near the center) humerus (the bone of the upper arm). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 341's Consultation (CS) (completed at hospital 1) dated 10/2/24, the CS indicated, X-ray of the left shoulder was obtained. It revealed a fracture of the upper shaft of the left humerus with little impaction and mild displacement. X-ray of the left hip revealed subcapital fracture. Recommendations: Left hip surgical procedure was discussed. I explained that I will put a screw and the plate. During an interview on 10/14/24 at 12:44 p.m. with DON, DON stated after a fall incident It was the responsibility of the nurse to put in a short-term care plan and then within one business day an IDT should be held to discuss the root cause of the fall and determine an intervention to address the cause of the fall. DON stated a new intervention should be implemented after each fall and the recommendations from the IMRR should be implemented. During a review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered dated 3/22, the P&P indicated, Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.When possible interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met. During a review of the facility's policy and procedure (P&P) titled Falls-Clinical Protocol dated 3/18, the P&P indicated, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation.The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling.and also reconsider the current interventions.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42744 Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled, Enteral Feedings - Safety Precautions, for one of four sampled residents (Resident 51) when: 1. Enteral nutrition feeding bottle was not labeled. This failure had the potential for old, spoiled, or expired nutritional feedings to be administered to Resident 51. 2. Enteral tubing was disconnected from gastrostomy (G-tube - a surgical inserted tube that provides direct access into the stomach) site a three-way-valve. The three-way-valve was not closed, and stomach contents were leaking onto Resident 51's abdomen and clothing. This failure had the potential for Resident 51's skin to develop sores. Findings: During a review of Resident 51's Minimum Data Set (MDS- resident assessment tool), the MDS indicated Resident 51 had a diagnosis of a stroke (brain attack when blood flow to the brain is disrupted causing brain cell death) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and was fed via a G-tube. 1. During a review of Resident 51's Order Summary Report (OSR), dated [DATE], the OSR indicated, Enteral Feed Order two times a day Glucerna [nutritional supplement] 1.5 via gtube @70ml/hr . Off at 0800 [8 a.m.] On 1200 [12 a.m.] or infused until volume completed. During a concurrent observation and interview on [DATE] at 9:53 a.m. with Licensed Vocational Nurse (LVN) 3 in Resident 51's room, Resident 51's Enteral Nutrition feeding bottle was not labeled with the resident's name, date or time. LVN 3 stated the bottle should have been labeled. LVN 3 stated, We don't know when it was hanging. During an interview on [DATE] at 2:06 p.m. with the Director of Nursing (DON), DON stated the enteral nutrition feeding bottle should be labeled with the resident's name, date, time started, and rate. During a review of the facility's P&P titled, Enteral Feedings- Safety Precautions, dated ,d+[DATE], the P&P indicated, Preparation 1. All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilites. 2. The facility will remain current in and follow accepted best practices in enteral nutrition. d. Use closed enteral nutritional systems when possible. 2. Maintain strict adherence to storage conditions and timeframes. 3. Maintain strict adherence to maximum hang times. 4. Administration set changes: a. Change administration sets for open-systerm enteral feedings at least every 24 hours . Preventing errors in administration. 2. On the formula label document initials, date and time the formula was hung, and initial the label was checked against the order. (continued on next page)

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River Walk Care Center	1100 West Morton Avenue Porterville, CA 93257

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on [DATE] at 9:53 a.m. with LVN 3 in Resident 51's room, Resident 51's G-tube three-way-valve was open with stomach contents flowing directly onto his abdomen and brief (underpants). LVN 3 stated, That's stomach acid on his skin and it will alter his skin integrity (undamaged skin). During an interview on [DATE] at 2:06 p.m. with DON, DON stated whenever the feeding tube is disconnected, the three-way-valve should be closed. During a review of the facility's P&P titled, Enteral Feedings- Safety Precautions, dated ,d+[DATE], the P&P indicated, Preventing errors in administration. 2. On the formula label document initials, date and time the formula was hung, and initial the label was checked against the order. Preventing misconnection errors . 2. Notify all non-clinical staff, residents and visitors not to reconnect any tubing or lines, but instead to notify a nurse if tubing becomes disconnected. 3. Regularly inspect tubing for proper and secure connection. Preventing skin breakdown 1. Keep the skin aroudn the exit site clean, dry and lubricated (as necessary). 2. Assess for leaking around the gastrostomy . frequently during the first 48 hours after tube insertion, and then with each feeding or medication administration. 3. Observe for signs of skin breakdown, infection, and irritation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38993 Based on interview and record review, the facility failed to implement pharmacy recommendations for one of 19 sampled residents (Resident 341) after multiple falls. This failure had the potential for staff to be unaware of Resident 341 experiencing adverse consequences from medication and Resident 341 to experience subsequent falls. Findings: During a review of Resident 341's Interim Medication Regimen Review (IMRR), dated 5/11/2024, the IMRR indicated, Type of Review: Change of Condition.Fall.Recommendation.BMP (basic metabolic panel-a common blood test that can be used to screen for, diagnosis[sic], or monitor health conditions).TSH (thyroid-stimulating hormone-blood test that measures the amount of TSH in the blood).BP (blood pressure). HR (Heart Rate).Check orthostatic BPS (blood pressure taken when standing up from a sitting or lying position) Q (every) Shift X (times) 3 days. Notify MD if resident experiences orthostasis (drop in blood pressure when standing). During a review of Resident 341's IMRR, dated 7/12/2024, the IMRR indicated, Type of Review: Change of Condition.Fall.Recommendation.BMP.TSH.BP.HR.Check orthostatic BPS Q Shift X3 days. Notify MD if resident experiences orthostasis. During a review of Resident 341's IMRR, dated 9/23/2024, the IMRR indicated, Type of Review: Change of condition.Fall.Recommendation.BMP.BP.HR.Check orthostatic BPS Q Shift X3 days. Notify MD if resident experiences orthostasis. During a concurrent interview and record review on 10/14/2024 at 12:44 pm with Director of Nursing (DON), Resident 341's IMRR's were reviewed. DON was unable to provide evidence that the recommendations were implemented. DON stated, the IMRR recommendations should have been implemented. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review and Reporting dated 9/18, the P&P indicated, Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. More frequent medication regimen reviews may be deemed necessary. This may include when the resident experiences an acute change of condition, or the resident is experiencing an acute change of condition. Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician.The nursing care center follows up on the recommendations to verify that appropriate action has been taken.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 42344 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, for providing services for maintaining independence in activities of daily living (ADLs - routine tasks/activities such as eating, bathing, dressing) for one of three sampled residents (Resident 52) when Resident 52 did not have an adaptive device to enable her to drink water independently. This failure resulted in Resident 52 to be dependent upon facility staff. Findings: During a concurrent observation and interview on 10/14/24 at 9:30 a.m. with Resident 52, Resident 52's water cup was on the bedside table out of Resident 52's reach. Resident 52 had contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) in both hands. Resident 52 stated she was not able to reach her water. Resident 52 stated when she can reach her water cup, it was very difficult to drink without spilling the water. During a concurrent observation and interview on 10/15/24 at 8:15 a.m. with Resident 52, Resident 52's water cup was on the bedside table. Resident 52 stated she was not able to reach her water cup and she was thirsty. During a concurrent observation and interview on 10/16/24 at 8:45 a.m. with Certified Nursing Assistant (CNA) 7 and Resident 52, Resident 52's water cup was on the bedside table and out of Resident 52's reach. CNA 7 stated Resident 52 was not able reach her water and due to the contractures in her hands, it was difficult for Resident 52 to drink water independently. During a concurrent interview and record review on 10/16/24 at 10:11 a.m. with Minimum Data Set Nurse (MDSN), Resident 52's MDS (MDS - a federally mandated resident assessment tool), dated 9/16/24 was reviewed. The MDS, Section GG- Functional Abilities and Goals, indicated Resident [52] needed partial assistance from another person to complete any activities. Upper extremity (shoulder, elbow, wrist, hand). MDS stated Resident 52 would have difficulty drinking water with hand contractions and should have an adaptive device. During a concurrent interview and record review on 10/16/24 at 10:11 a.m. with MDSN, Resident 52's Care Plan (CP), revised on 10/1/24, was reviewed. The CP indicated, [Resident 52] is at risk for. dehydration. [right] hand contracture. MDSN stated Resident 52 should have an assistive device so she could drink water without assistance from another person. During a concurrent interview and record review on 10/16/24 at 3:02 p.m. with Occupational Therapist (OT), Resident 52's OT Evaluation & Plan of Treatment (OTEPT), dated 8/31/22, OTEPT indicated, bilateral hand contractions. OT stated Resident 52 should have been evaluated for adaptive devices. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, revised March 2018, the P&P indicated, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the servises necessary to maintain good nutrition. 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living do not diminish.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 38993 Based on interview and record review, the facility failed to ensure staff were in-serviced on the elopement binder. This failure had the potential for staff to be unaware of residents that were at risk for elopement. Findings: During a review of the Elopement Binder (EB), the EB indicated, Resident 40, Resident 69, Resident 74, Resident 75, Resident 76, and Resident 294 were high risk for elopement. During a review of the facility's ETP Attendance Roster (ETPAR), dated 2/8/24, the ETPAR indicated, Course Title(s): Elopement Risk/Charge Nurse responsibilities. There were 19 staff that attended the in-service. During an interview on 10/14/24 at 3:35 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was unaware of the residents that were at risk for elopement. During an interview on 10/14/24 at 3:44 p.m. with CNA 2, CNA 2 stated the residents at risk for elopement always had a staff with them and all the residents at the facility were elopement risk. During an interview on 10/14/24 at 4:16 p.m. with Administrator, Administrator stated there was an elopement binder located at the nurse's station that indicated the residents that were at high risk for elopement. During an interview on 10/15/24 at 2:46 p.m. with CNA 3, CNA 3 stated there was no way to know who was an elopement risk unless there was a meeting or an in-service. CNA 3 stated there was no elopement binder or list available. During an interview on 10/15/24 at 2:52 p.m. with CNA 4, CNA 4 stated she was made aware of the residents that were elopement risk by word of mouth. During an interview on 10/15/24 at 3:08 p.m. with CNA 5, CNA 5 stated she would have to ask the other staff which residents were at risk for elopement. During an interview on 10/15/24 at 3:12 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when a resident was admitted to the facility, the staff were made aware of the residents that were an elopement risk and it was documented in the resident's care plan. During an interview on 10/15/24 at 3:27 p.m. with Administrator, Administrator stated staff were educated on the elopement binder during orientation and the annual in-service. Administrator stated at the time of the last annual in-service there were approximately 100 employees working at the facility and only 19 attended the in-service. Administrator stated this was unacceptable and staff were expected to know where to locate the elopement binder. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Elopements and Wandering Residents dated 6/1/22, the P&P indicated, The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. During a review of the In-service training program for certified nurse assistants, (ITPCNA) (undated), the ITPCNA indicated, The content of the in-service training program shall enhance knowledge and skills learned in the certification training program and shall also address areas of weakness as determined by a nurse assistant's performance reviews, areas of special needs of the patients, including those with cognitive needs, and areas wherein the facility received deficiencies related to patient care following the last licensing survey. the facility must provide a minimum of 24 hours of varied in-service training every year.course title. Wandering/Elopement.