STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435036	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENKIN'S LIVING CENTER	215 SOUTH MAPLE STREET WATERTOWN, SD 57201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/20/24 through 3/21/24 and again from 4/3/24 through 4/4/24. The areas surveyed were quality of care that included oral care, assistance with toileting, and prevention and care of pressure ulcers and moisture associated skin damage. Jenkin's Living Center was found not in compliance with the following requirements: F550, F600, F609, F677, and F686.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550	1.Resident 3 identified having a working window current in the room to be used while providing care. Residents 2 and 1 provided their desired wake times and added them to their care plan. Residents 2 and 13 provided their preference for the proper name they would like to be called. Resident 3 was supplied with an additional call light device for ease of use. 2.Education provided by DON, ADON, and designee to nursing staff about the use of residents' preferred names need to be used. Resident call lights must be within reach of the resident when you exit a room. Residents' privacy curtains must be closed during care to ensure privacy. When assisting residents in getting up for the day, ask them if they prefer to sleep in or would be okay to start getting them ready and honor their choice. 3. During the admission process, the resident's proper name that they would like to be called and an estimated wake-up time that they prefer will be determined. This will be communicated by social services to the IDT team and added to their care plan.	4/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kasey Klapprodt	President / CEO	04/30/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, electronic medical record review (EMR), and policy review, the provider failed to ensure staff interactions and services were provided in a manner that maintained a sense of dignity and respect for the following: *One of one sampled resident (3) by maintaining privacy during personal care. *Two of two sampled resident (2 and 1) resident in honoring their preference for wake time. *Two of two sampled residents (2 and 13) by using their proper name. *One of nine sampled residents (3) who needed a call light to call for assistance. Findings include: 1. Observation on 3/21/24 at 6:45 a.m. of resident 3 revealed: *He was yelling "help me" and motioning with his hands for assistance. *He stated his scrotum was itching and he	F 550	The facility policy and procedure regarding identified cares in tag F550 were reviewed and revised. Education was provided in nursing staff meetings on 04/24/2023 and 04/25/2023. If a staff member misses the scheduled meeting, DON, ADON, or designee conducts 1:1 education with that staff member prior to their next working shift. 4.The DON, ADON, or designee will conduct audits on the Resident/ Exercise of Rights identified in the tag twice a week for three weeks, then once a week for two months. 5. Results of initial and ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for two months.	

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needed a salve put on it.
*He had his hand inside his incontinent brief and appeared to be scratching at his scrotum.
*Licensed practical nurse (LPN) L entered his room and without closing his window curtain before completing the care she:
-Provided his perineal care.
-Applied salve to his scrotum.

Interview on 3/21/24 at 7:25 a.m. with LPN L confirmed she did not pull the window curtain before providing perineal care to resident 3.

Interview on 4/4/24 at 9:01 a.m. with licensed social worker (LSW) K confirmed it was not appropriate to leave window-curtains or doors open when providing personal cares to residents.
-Privacy was to have been provided by all staff members when providing personal care to residents.

Review of the provider's August 2023 A.M. Care policy revealed there was no guidance on providing privacy when completing resident care.

Review of the provider's August 2022 Oral Cares/hygiene policy revealed staff members were to close the privacy curtain when providing care to residents.
-There was no reference to the window curtain.

2. Observation and interview on 3/20/24 at 7:40 a.m. with resident 2 and nurse aide (NA) E revealed the following:
*NA E was assisting getting resident 2 up for the day.
*Resident 2 kept repeating she did not want to get up, and "I was sleeping so good".

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3. Observation and interview on 3/21/24 at 8:02 a.m. with resident 1 revealed she:
*Was seated in her recliner.
*Stated, "They got me up at 5:30 a.m. this morning, never in my life have I gotten up at 5:30. Maybe 6:00 [a.m.] but never 5:30."
-Was unsure as to why the staff had woken her up at 5:30 a.m.
-"They did not turn on the lights while getting me up or when I was in the bathroom brushing my teeth and washing my face. I have to tell them to set up the things so I can brush my teeth. They always have different staff; I have to tell them where everything is at."

Review of resident 1's EMR revealed the following:
*She was admitted on 5/4/12.
*Her 1/17/24 Brief Interview on Mental Status (BIMS) score was an 11, indicating she had mild cognitive impairment.
*Her diagnoses included: hemiplegia affecting her right side, scoliosis, anxiety disorder, history of poliomyelitis, urge incontinence, macular degeneration, mild cognitive impairment, and hearing loss.
*Review of resident 1's 3/21/24 care plan revealed the following:
-She liked to be in control of a situation.
-She was "very specific regarding the times she wants her cares completed, she has at times voiced concern with waiting for staff to complete care for other res [residents]."
-She "is usually alert & [and] orientated but may get details mixed up or forget at times & require reminders/cueing. She has a diagnosis of dementia with anxiety. Sudden changes or new situations may exacerbate altered cognition."

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4. Observation and interview on 3/20/24 at 7:40 a.m. with resident 2 and NA E revealed the following:
*NA E called the resident "honey, sweet pea, and sweetheart," while providing morning care.
*CNA Q entered the room at approximately 8:04 a.m. and then called resident 2 "mama and honey," while providing morning care and stated, "what you feeling today girl?" while looking in the closet for a shirt.

Review of resident 2's 3/20/24 care plan revealed there was no documentation of her preferred name to have been used by the staff.

5. Observation on 3/21/24 at 8:50 a.m. of resident 13 and NA E revealed the following:
*NA E called resident 13 "honey and sweetheart," during morning cares.

Review of resident 13's 3/21/24 care plan revealed there was no documentation of her preferred name to have been used by staff.

6. Interview on 3/21/24 at 8:55 a.m. with NA E and CNA Q revealed:
*They were aware they should not call residents "sweetheart, honey, or mama."
-They both stated it was hard to stop calling residents by those names.
*They agreed they were to use a resident's proper name unless the resident preferred an alternate name.

Interview on 4/4/24 at 9:01 a.m. with licensed social worker (LSW) K revealed:
*She stated, "as a rule, it is not allowed for staff to call residents sweetheart, mama, honey, and sweet pea, it should be kept respectful, and they

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should use their names."
*If a resident wanted staff to use something other than their proper name it was recorded on their care plan.

7. Observation on 4/3/24 at 8:20 a.m. of resident 3 revealed his call light was draped over the side of a rolling bedside table that was not within his reach.

Observation on 4/3/24 at 11:03 a.m. of resident 3 revealed:
*He was seated in wheelchair.
-There was a bedside rolling table behind him with a call light push button on it.
-The corded call light was draped over the side of the bedside table approximately 3 feet behind him.
*Resident 3 required the use of a full-body mechanical lift and one staff member to transfer.
*He was unable to reach either of the call lights.

Interview on 4/3/24 at 11:30 a.m. with CNA Q revealed the following, she:
*Confirmed he did not have access to a call light at this time.
*Confirmed resident 3 was able to use both the corded call light and the push call light button.
-She did not go into his room and ensure his call light was within his reach.

Review of the provider's 8/23 A.M. Care policy revealed the following:
*"11. Place call light within easy reach of resident and instruct resident to push call light for assistance as needed."

8. Interview on 4/4/24 at 9:03 a.m. with LSW K regarding resident rights revealed the following:

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F 550	Continued From page 6 *Staff education related to resident rights and dignity was provided by online training, nurse's meetings, and departmental meetings. *Resident preferences were recorded on the baseline care plan upon admission. -That included the resident's preference for wake times and times to go to bed. Interview on 4/4/24 at 11:33 a.m. with administrator (ADM) A, director of nursing (DON) B, and assistant director of nursing (ADON) C revealed: *They were working on a new software program that would ask residents what their preferences were for when to get up and when to go to bed. -The program was to start of April 2024. -Preferences for those residents who were admitted before the implementation of baseline care plans were not known. --They were not certain when the baseline care plans had been implemented but thought it was a couple of years ago. *DON B stated, "We ask the residents do you want to get up? Some [residents] get up early and some don't. Sometimes if they are wet and need to be changed, we ask if they care to get washed up and dressed at that time. Previously we used agency staff, and we identified early risers in the building for them."	F 550		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600	1. Resident 1 was identified in the 2567 with upper suitable leg abrasion monitored and healed on 4/9/24. The call light was ensured to be in working order and function properly. The resident can communicate her needs and use the call light. Staff will assist the resident in the bathroom when requested and anticipate her needs.	4/26/24

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F 600	Continued From page 7 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, observation, and policy review, the provider failed to ensure one of one sampled resident (1) was free from an injury caused by the use of a mechanical lift sling. Findings include: 1. Interview on 3/21/24 at 8:14 a.m. with resident 1 revealed the following: *She was left in a mechanical lift sling in her bathroom for "at least two to three hours". *She stated, "I cried, prayed, tried to holler, but no one heard me. I could hear them (staff members) laughing and talking." -The lift sling was pressing into her leg and "really hurt", and her leg was still hurting her on the day of the interview. -She thought it was Monday (3/18/24), as the staff members were getting "everyone ready for BINGO". Review of resident 1's electronic medical record revealed the following: *She was admitted on 5/4/12. *Her 1/17/24 Brief Interview on Mental Status score was an 11, indicating she had mild cognitive impairment. *Her diagnoses included: hemiplegia affecting her right side, scoliosis, anxiety disorder,	F 600	2. An audit was completed with residents using a full-body lift to ensure that no bruising or injuries from transfers were noted. With none noted. 3. Education regarding identifying redness from sling use on residents, as well as the proper procedure for assisting residents in the bathroom that uses a mechanical lift, was provided in nursing staff meetings on 04/24/2023 and 04/25/2023. If a staff member misses the scheduled meeting, DON, ADON, or designee conducts 1:1 education with that staff member before their next working shift. The DON, ADON, or designee will conduct an audit reviewing any skin impairment from using a mechanical lift twice a week for three weeks, then weekly for two months. The facility policy and procedure for mechanical lift use were reviewed and revised. 4.Results of initial and ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for two months.	

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constipation, back pain, hallux valgus (a complex deformity of the forefoot), history of poliomyelitis, urge incontinence, macular degeneration, mild cognitive impairment, and hearing loss.
*Review of resident 1's 3/21/24 care plan revealed the following:
-She required the use of mechanical total lift and assistance of two staff members to transfer her onto the toilet.
-She had physical impairments due to a history of Polio.
-She liked to be in control of a situation.
-She was "very specific regarding the times she wants her care completed, she has at times voiced concern with waiting for staff to complete care for other res (residents)."
-She "is usually alert & [and] orientated but may get details mixed up or forget at times & require reminders/cueing. She has a diagnosis of dementia with anxiety. Sudden changes or new situations may exacerbate altered cognition."
-"Be aware she has a pattern of being incontinent around 1 pm [p.m.] and then again around 9 pm [p.m.]so please toilet as close to these times as possible to help reduce her incontinence."
*Review of her progress notes revealed that there was a 3/18/24 nurse note completed by registered nurse (RN) R that noted, "Noted upon assessment of resident's skin during HS [bedtime] care; a darkish purple pink line running from mid R) [middle of right] upper thigh surrounding leg around to back of this thigh. Area is 1 cm [centimeter] in width. No open area. Rest of buttocks and skin is clear."

Interview on 3/21/24 at 8:35 a.m. with director of nursing (DON) B revealed the following:
*On 3/18/24 resident 1 had made an allegation of being left in a mechanical lift sling while in her

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bathroom.
-She had reported it to administrator (ADM) A and thought he had talked to resident 1.
-She was not aware of an investigation into the allegation that was initiated.
-She had instructed registered nurse (RN) R to do a skin check and make a note in resident 1's EMR.

Interview on 3/21/24 at 8:49 a.m. with ADM A and DON B regarding the allegation of resident 1 revealed the following, ADM A:
*Was notified on Tuesday (3/19/24), after the noon meal, about the incident and had:
-Talked to resident 1 and she told him that she did not want to yell because her heart was beating too fast.
-Confirmed her call light was working.
-Reviewed the call light log, her call light had not been on for any extended length of time.
-Had not considered the allegation a reportable event to the South Dakota Department of Health.
-Had not investigated the allegation.

Observation and interview on 3/21/24 at 9:45 a.m. during resident 1's skin assessment with DON B revealed the following:
*Resident 1 had an of upper right leg abrasion that measured approximately 2 cm wide and 9 inches long starting at the top front of the resident's right leg just below the hip bone and ran down around the back of her right leg.
-The abrasion was dark pink in color about 6 inches at the top and faded to light pink at the bottom behind the leg.
*Resident 1 stated the area was painful.
-She thought there was a steel bar on the lift that was digging into her skin during the incident.
-She stated she had hollered for help for "three

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hours, I could hear them giggling and laughing. I was praying."
*DON B confirmed the cause of the abrasion was consistent with where the edge of the lift sling would have met her skin when she was seated in the sling on the toilet.

Continued interview on 3/21/24 at 10:15 a.m. with ADM A and DON B revealed the following:
*ADM A clarified resident 1's allegation of being left on the mechanical lift sling in the bathroom occurred on 3/18/24 and he was notified that same day.
-He stated that he had reviewed the facility's recording cameras in the hallways on 3/21/24 and confirmed that on 3/18/24 from 12:36 p.m. to 2:17 p.m. resident 1 had been left in the mechanical lift sling in her bathroom.
-That was one hour and 41 minutes.
*The process was to have wound care nurse (WCN) D assess at the wounds.
-They had not had WCN D assess the wound.

Interview on 3/21/24 at 10:46 a.m. with registered nurse (RN) revealed the following:
*DON B had asked her to look at resident 1's leg and document her findings.
-She documented her findings in resident 1's EMR.
-She stated her measurements for the wound were completed by visualizing with her eyes and hand.
*She had not communicated with any staff except DON B regarding the wound.
*The process for when a wound was identified was to measure it and the WCN.
-She had not notified WCN D.

Review of the provider's revised 10/2023

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F 600	Continued From page 11 Mechanical Lift Policy revealed the following: *"16. Prior to leaving the resident confirm the resident is in a comfortable and safe position. Check that the resident's call light is within reach." Review of the provider's revised 12/2019 Abuse/Neglect/Exploitation of Residents revealed the following: *"Policy: Residents must not be subjected to verbal, sexual, physical and mental abuse, corporal punishment, involuntary punishment, involuntary seclusion or misappropriation of property by anyone, including, but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies, family members, legal guardians, friends or other individuals." *"Responsibility: All staff" -IV. Identification: Any injury or event is communicated to at least one member of the QAPI [Quality Assurance and Performance improvement] team followed by investigation if abuse/neglect is suspected. Alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown source, will be reported to your immediate supervisor and to other officials in accordance with State law. -V. Investigation: DON/Designee will review events of suspected abuse/neglect." -"VII. Reporting/Response: The DON or Designee will report results of investigation to State Department of Health and other official in accordance with the law. Reporting is done per State Department of Health requirements."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609	1. Resident 1, identified in 2567, had a reportable event submitted to the DOH with acceptance. The resident had a skin abrasion on the right leg, which was monitored and resolved.	4/30/24

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F 609	Continued From page 12 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure an allegation of neglect made by one of one sampled resident (1), was reported to the South Dakota Department of Health (SDDOH) within twenty-four hours from the time that the provider was made aware of the allegation. Findings include:	F 609	2. An audit was completed for possible reportable incidences that were not reported appropriately from the previous three months; none were noted. 3. Education material from DOH to the administrator, Don, and ADON on proper reportable events and timely reporting was received on 3/22/24. Audits will be conducted by reviewing possible reportable incidences and timely reporting weekly for three weeks and then monthly for two months by the administrator, DON, and designee to ensure proper reporting of events and time frames. Education was provided by the administrator, DON, and ADON to nursing staff on reportable events and adequate protocol for notification of an event through nursing staff meetings on 04/24/2023 and 04/25/2023. If a staff member misses the scheduled meeting, DON, ADON, or designee conducts 1:1 education with that staff member before their next working shift. The facility policy and procedure for notification and timely incidence reporting were reviewed and revised. 4. Results of initial and ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for two months.	

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1. Interview on 3/21/24 at 8:14 a.m. with resident 1 revealed the following:
*She was left in a mechanical lift sling on the toilet in her bathroom for "at least two to three hours".
*She stated, "I cried, prayed, tried to holler, but no one heard me. I could hear them (staff members) laughing and talking."
-The lift sling was pressing into her leg and "really hurt", and her leg was still hurting her on the day of the interview.
-She thought it was Monday (3/18/24), as the staff members were getting "everyone ready for BINGO".

Interview on 3/21/24 at 8:35 a.m. with director of nursing (DON) B revealed the following:
*On 3/18/24 resident 1 had made an allegation of being left in a mechanical lift sling while in her bathroom.
-She had reported it to administrator (ADM) A and thought he had talked to resident 1.
-She had instructed registered nurse (RN) R to do a skin check and make a note in resident 1's EMR.
-She had not initiated an investigation into the allegation.
-She had not reported the event to the SDDOH.

Interview on 3/21/24 at 8:49 a.m. with ADM A and DON B regarding the allegation of resident 1 revealed the following, ADM A:
*Was notified on Tuesday (3/19/24), after the noon meal, about the incident and he had:
-Talked to resident 1 and she had told him that she did not want to yell for help because her heart was beating too fast.
-Confirmed her call light was working.
-Reviewed the call light log, and her call light had

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not been on any extended length of time.
-Not completed a thorough investigation into that allegation..
-Not considered the incident a reportable event to the SDDOH.

Continued interview on 3/21/24 at 10:15 a.m. with ADM A and DON B regarding the allegation from resident 1 revealed the following:
*He clarified the allegation had occurred 3/18/24.
*He confirmed that on 3/18/24 from 12:36 p.m. to 2:17 p.m. resident 1 had been left in the mechanical lift sling on the toilet in her bathroom.
-That information was based on his review of the facility's recording cameras and interviews conducted with staff on 3/21/24.

Review of the provider's revised 12/2019 Abuse/Neglect/Exploitation of Residents revealed the following:
*"Policy: Residents must not be subjected to verbal, sexual, physical and mental abuse, corporal punishment, involuntary punishment, involuntary seclusion or misappropriation of property by anyone, including, but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies, family members, legal guardians, friends or other individuals."
*"Responsibility: All staff"
-IV. Identification: Any injury or event is communicated to at least one member of the QAPI team followed by investigation if abuse/neglect is suspected. Alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown source, will be reported to your immediate supervisor and to other officials in accordance with State law.
-V. Investigation: DON/Designee will review

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F 609	Continued From page 15 events of suspected abuse/neglect." -"VII. Reporting/Response: The DON or Designee will report results of investigation to State Department of Health and other official in accordance with the law. Reporting is done per State Department of Health requirements." Refer to F600.	F 609		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure oral care was consistently performed and accurately documented for nine of nine sampled residents (16, 17, 18, 19, 20, 2, 3, 4, and 5). Findings include: 1. Observation on 3/20/24 at 7:17 a.m. of morning care for resident 16 provided by certified nurse aide (CNA) N revealed that oral care was not completed before placing her dentures in her mouth. 2. Observation on 3/20/24 at 7:30 a.m. of morning care for resident 17 provided by CNA N revealed that oral care was not performed before to placing her dentures in her mouth. 3. Observation on 3/20/24 at 7:45 a.m. of morning care for resident 18 provided by CNA N revealed:	F 677	1.The identified residents 16,17, 18, 19, 20, 2, 3, 4, and 5 reviewed oral care needs with the care plan reviewed and revised by IDT for resident needs and preferences. 2. All residents were reviewed for proper oral care needs. Their care plans were reviewed and revised. Education is given by DON, ADON, and designee to nursing staff regarding appropriate oral care. Staff is to assist residents with set up, encouragement, or physical help with oral care for each resident. Documentation of the completed task will be in POC charting by nurse aides if the resident refuses oral care to be documented in POC as well. Education was provided by DON, ADON, and the designee for licensed and unlicensed staff on training about their role and responsibility for ensuring quality oral care and quality of life. Education was provided by the administrator, DON, and ADON to nursing staff through nursing staff meetings on 04/24/2023 and 04/25/2023. If a staff member misses the scheduled meeting, DON, ADON, or designee conducts 1:1 education with that staff member before their next working shift. DON, ADON, the administrator, and MD reviewed and revised the policy regarding oral care for residents.	4/30/24

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F 677	Continued From page 16 *The resident's dentures were not in the denture cup container and CNA N stated, "They must still be in her mouth." *It was confirmed by CNA N that the resident's dentures were still in the resident's mouth. *When asked if the resident had slept with her dentures in, CNA N stated that the resident will sometimes refuse to let staff remove her dentures and that her dentures had been left in her mouth all night. *The dentures were not removed during morning care and oral care was not completed. *CNA N was unable to determine how long the resident's dentures had been left in her mouth without any oral care. 4. Observation and interview on 3/20/24 at 9:00 a.m. with CNA O and CNA N who were assisting resident 19 to bed revealed: *When asked when do residents get their teeth brushed, CNA O stated that the staff would have brushed the resident's teeth when they got up for the day or after breakfast depending on the staff. *When asked if resident 19 had his teeth brushed that morning, CNA O stated that she did not know. *When she went to look for resident 19's toothbrush, she could not find a toothbrush for him in his room and stated that she would normally use a disposable toothette for his oral care. *When asked if the resident had his teeth or wore dentures, CNA O was not aware if the resident had his teeth or wore dentures. *CNA N could not locate the resident's toothbrush and stated that she would use a disposable toothette. 5. Interview on 3/20/24 at 10:20 a.m. with	F 677	3. Audits are to be conducted by DON, ADON, charge nurses, or designees to ensure oral care is appropriately completed and documented. Audits are to be completed two times a week for three weeks, then once weekly for two months. 4. Results of initial and ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for two months.	

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licensed practical nurse (LPN)/nurse manager P revealed:
*She would normally use a disposable toothette and water when completing oral care for resident 20.
*She would not use resident 20's toothbrush due to the resident grinding her teeth and she was afraid that the resident would swallow the mouth rinse solution.
*When asked if resident ever got her teeth brushed, she said sometimes.
*She stated that oral care was usually completed when the resident got up for the day or after breakfast.

6. Observation on 3/20/2024 from 7:30 a.m. to 10:30 a.m. on the Pine Village unit revealed:
*Every toothbrush that was examined was dry and appeared to have not been used that morning.
*Residents who had the 4 ounce (oz) mouth rinse bottles in their rooms were all dated "12/6" and appeared to be full.
7. Observation on 3/20/24 at 7:40 a.m. of morning care for resident 2 provided by nurse aide (NA) E revealed her dentures were in her mouth and no oral care was provided.

Observation on 3/20/24 at 9:56 a.m. of resident 2's bathroom revealed the following:
*Her toothbrush was dry and was lying in the emesis basin.
*There was a 4 oz. size bottle of mouthwash dated 1/11/24 that contained approximately 3 ounces of mouthwash.

Observation on 4/3/23 at 8:10 a.m. of resident 2 and her bathroom revealed her dentures were in her mouth and her toothbrush bristles were dry

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and hard.

Review of resident 2's EMR revealed the following:
*Her BIMS score was a 9, meaning she had mild cognitive impairment.
*Her care plan revealed she:
-Wore a full set of dentures.
-Needed total assistance of one staff member with her personal care and oral hygiene.

Interview on 3/20/24 at 10:05 a.m. with NA E regarding oral care for resident 2 revealed:
*Oral care was usually completed by whomever assisted the resident when getting up in the morning.
*Resident 2 already her dentures in that morning before she assisted her in getting up.
-The dentures should have been removed from resident 2's mouth last night before bed.
--Sometimes the day shift removed the dentures.
*The night shift had not notified her that resident 2's oral care had been completed.
*She confirmed she had not completed oral cares on any residents she assisted that morning.

8. Observation and interview on 3/20/24 at 9:55 a.m. with resident 4 revealed the following:
*She had a partial denture that the staff brushed and then she would brush her own bottom teeth.
*Her oral care had not been performed that morning.
*She stated, "They had been done the evening before, but they are not always done daily."
*At 10:25 a.m. her partial denture remained in her cup in the bathroom.

Interview on 3/21/24 at 11:16 a.m. with resident 4 revealed:

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*Last night she slept with dentures in her mouth.
-Her oral care was provided last evening.
*No oral care was completed by staff that morning.

Review of resident 4's EMR morning care documentation for resident 4 revealed
*Her 3/11/24 BIMS score was a 14, that meant her cognition was intact.
*Her physician orders included that her oral cares be completed twice a day.

9. Observation on 3/20/24 at 10:00 a.m. of resident 5 revealed her toothbrush was dry and had hard firm bristles.

10. Observation on 3/20/24 at 10:21 a.m. resident 3 revealed a battery-operated toothbrush in his bathroom that was dry with hard bristles and appeared to have been unused.

Review of resident 3's EMR revealed the following he required total assistance of a staff member for personal hygiene.

11. Interview on 3/20/24 at 3:30 p.m. with director of nursing (DON) B and the assistant director of nursing (ADON) C regarding resident's oral care revealed that the expectation was that oral care would have been completed every morning with every resident during morning care, but that it was still at the resident's discretion on when that would have been completed.

12. Review of the provider's 4/2023 Care Plan, Resident-Centered Facility Standards of Care Policy revealed:
*Staff would provide resident oral cares daily and as needed.

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F 677	Continued From page 20 *Staff would monitor oral mucosa and integrity. Review of the provider's 8/22 Oral Hygiene policy revealed the following: *"Policy: -Residents will be assisted with oral hygiene with a.m. and p.m. care and as necessary. The mouth will be cleansed for personal hygiene and to lessen the occurrence of mouth infections. Oral Hygiene will be provided when the resident able to assist or per the resident's preferences. *Responsibility: -RN/LPN - Assess oral health of residents regularly, monitor oral care procedure done by NA. -CNA Assist residents with oral hygiene twice daily and as necessary. Observe for problems and report same to nurse." *"Care of residents with dentures:" -"2. Request resident to remove dentures and place them in an emesis basin or denture cup." "4. Place dentures in cup with fresh solution of an effervescent denture tablet and cool water or plan water during p.m. care. Clean denture cup after a.m. care. -5. Clean inside of mouth thoroughly with mouthwash diluted with 4 parts of water to 1 part of mouthwash and rinse with water. May use toothettes to clean soft tissues."	F 677		
F 686 SS=H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686	1.Residents 15, 14, 13, 5, and 2 reviewed care plans for pressure injuries. Interventions and individualized review of regular toileting, checking and changing incontinence briefs, and repositioning reviewed and updated care plans initiated by IDT.	4/30/24

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F 686	Continued From page 21 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure interventions of regular toileting, checking and changing incontinent briefs, or repositioning were consistently implemented for six of six sampled residents (15, 14, 13, 5, 12, and 2) who developed pressure ulcers after their admission to the facility. Finding include: 1. Observation on 3/20/24 at 10:53 a.m. of resident 15 lying in her bed with the head of bed in the upright position. Observation on 3/20/24 at 1:55 p.m. of resident 15 lying in the same position as when she was observed above at 10:53 a.m. that morning. Interview on 3/21/24 at 11:22 a.m. with resident 15 stated: *After meals she would sometimes had to wait up to five hours before staff would get her back to her room. *Last night she requested to use the bathroom and staff told her that they did not have time to put her on the toilet and told her to urinate in her brief and they would come back and clean her up. *She preferred to use the toilet and not have to be incontinent.	F 686	2. Skin assessments for all residents were completed on 4/30/24 to identify any new MASD or pressure injury. Education was provided by DON, ADON, and designee to licensed and unlicensed nursing staff about their role and responsibility for ensuring quality of care and quality of life. The floor nurse, wound nurse, or designee will complete weekly skin assessments for all residents. Staff were educated in proper repositioning of residents and adequate repositioning methods. Where to document repositioning in POC. The pocket care plan will have to identify information for residents who require alternative measures regarding individualized interventions to prevent or treat pressure injuries related to regular toileting and checking incontinent briefs. The collaboration skin committee and IDT will review residents' individualized positioning schedules, toileting plans, personal hygiene, and bathing at risk for skin impairment based on the Breaden scale for appropriate interventions and skin assessments completed. They will also review interventions in place for effectiveness with consultation from Gentell for treatment. Gentell will also be doing facility rounding in the building for consultation on the treatment of residents. If a staff member misses the scheduled meeting, DON, ADON, or designee conducts 1:1 education with that staff member before their next working shift. The facility pressure injury policy and procedure were reviewed and revised to reflect the updated protocol for residents identified with MASD / Pressure injury. DON, ADON, the administrator, and MD reviewed and revised the policy regarding the new procedure.	

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F 686	Continued From page 22 Telephone interview on 3/21/24 at 12:30 p.m. with resident 15's daughter revealed: *There had been times that her mother's call light would not be answered and recalled that one time it took forty minutes for staff to respond to her mother's call light. *During one visit, the call light across the hall from her mother's room went off for an hour before it was answered by the staff. *There had been issues with her mother receiving showers. Her mother had gone two to three weeks without a shower. *That had improved since her mother started receiving care at the wound clinic. *She received a call from her mother last night and told her that staff refused to put her on the toilet and just told her to go in her brief. Interview on 4/3/24 at 8:00 a.m. with resident 15 revealed: *On 4/1/24 resident asked to use the bathroom around supper time and was told by unknown certified nursing assistant (CNA) that she did not use the bathroom implying to resident that she did not use the toilet. *On many occasions she would put her call light on, and staff would come in, shut the call light off, and would tell her that they would be right back after they assist another resident. When that happened, she was usually incontinent before they had come back to the room to assist her. *Resident stated that she had an appointment with her wound physician and was now supposed to be repositioned at least every 4 hours. *She stated that she was not repositioned last night. She had gone to bed around 8:30 p.m. on 4/2/24 and was not repositioned until she got up for the day on 4/3/24 at 7:00 a.m. *Staff did not check to see if she needed to have	F 686	3. Audits are to be conducted by wound nurses, DON, ADON, or designees to ensure proper measures are in place for residents with pressure injuries or MASD to treat or prevent further complications. Audits will be conducted two times a week for three weeks, then weekly for two months, moving forward with the skin committee. 4. Results of initial and ongoing audits will be reviewed weekly by the interdisciplinary team and via the QAPI process monthly for two months.	

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been changed or to use the toilet during the night.

Review of resident 15's electronic medical record (EMR) revealed:
*Her 2/20/24 BIMS (Brief Interview of Mental Status) score was a 15, which meant her cognition was intact.
*Resident has a stage III pressure ulcer (Full thickness tissue loss. Fat tissue might be visible, but bone, tendon, or muscle was not exposed) on her sacrum.
*A wound vac was placed on 03/07/24.
*A 1/25/24 wound care clinic note stated "Patient's daughter voices a lot of frustration with care patient is receiving from [provider's name] staff, states she hasn't received a shower in two weeks. Patient's daughter also voices concerns with nursing home never removing the sling under the patient while in bed."

Review of resident 15's April 2024 Treatment Administration Record (TAR) revealed:
*Resident needed to take two weekly showers per wound care orders.
*Resident should have been repositioned every one to two hours.

Review of resident 15's 10/5/23 care plan revealed:
*The resident used incontinent briefs.
*Staff were to assist resident to the toilet per care plan standard.
*Staff should reposition the resident frequently.
*The resident would at times refuse repositioning and had requested she only be repositioned once at night.

2. Observation and interview on 4/3/24 at 7:50 a.m. with resident 14 revealed:

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*She had just returned from the dining room after breakfast and was not offered the use of the bathroom by the staff.
*She got out of bed at approximately 6:00 a.m. that morning and that was the last time her incontinent brief was changed.
*Observation until 9:45 am of the resident was in the same position in her wheelchair.

Interview on 4/3/24 at 9:15 a.m. with CNA Q revealed:
*Staff had no place to document the frequency a resident would have been toileted or when the resident was checked or changed.
*Staff would document if a resident was checked or changed on the "End of Shift Report" sheet located at the Center Oak nurses station.
*When asked specifically about resident 14 and the above observation that she had not been repositioned or checked since 6:00 a.m. She stated that she would probably get checked and changed before lunch.
*Resident 14 would sometimes refuse to be repositioned or get out of her wheelchair. When asked how she would document a refusal she said it would be documented in the behavior section in the EMR.

Review of resident 14's EMR revealed:
*Rejection of care was last documented on 3/27/24 at 13:59 (1:59 p.m.). Rejection of care was only documented twice in March 2024.
*There was a history of a recent pressure ulcer that was identified on 3/12/24 and healed on 3/25/24.
*Resident's 3/4/24 Braden scale assessment score was 13 which meant the resident was at moderate risk for developing pressure ulcers.

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Review of resident 14's 3/5/24 care plan revealed interventions included staff would encourage frequent repositioning.

3. Observation on 4/3/24 at 9:45 a.m. of morning care for resident 13 provided by CNA Q and a staff member who requested to remain anonymous revealed:
*The resident had a suprapubic catheter.
*She was incontinent of urine and the incontinent brief was saturated with urine.
*When asked about the last time she was checked or changed, resident 13 stated she could not remember.
*CNA Q and anonymous staff member were not aware when resident 13 was last checked and changed.
*There were two open areas on her coccyx that were covered with a Mepilex dressing that was saturated with urine.
*An anonymous staff member stated that many of the residents do not get checked and changed on the overnight shift and residents were often soaked in urine and would need to have their entire bedding changed.
*The resident had one reddened area the size of a quarter on her right buttock and another reddened area the size of a dime on the left buttock.
*When asked if staff applied a moisture barrier after an incontinent episode. CNA Q stated that they have moisture barrier cream at the nurse's station that they could use.
*There was no barrier cream applied during the observation.

Interview on 4/3/24 at 9:50 a.m. with licensed practical nurse (LPN) H regarding resident 13's treatment for the open areas on her coccyx and

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the reddened areas on her buttocks revealed:
*The open areas were covered with a Mepilex dressing daily and as needed and a Triad cream was applied three times a week to the areas on her buttocks.
*When asked about resident 13's incontinence, LPN H stated that would happen after her suprapubic catheter was flushed in the morning. LPN H stated that the resident's urologist was notified of the incontinence.

Observation and interview on 4/4/24 at 7:32 a.m. during resident 13's wound care that was provided by wound care nurse (WCN) D revealed:
*The two open areas on resident 13 coccyx were facility acquired pressure ulcers.
*She stated the two reddened areas on the buttocks were moisture-associated skin damage (MASD).
*When asked if the dime size reddened area on the left buttock was a new sore, as that sore was not present at an earlier observation. She stated that the area on the left buttock was a new MASD.

Review of resident's 13's 4/3/24 progress note stated, "during assessment, writer removed existing mepilex dressing to coccyx to assess skin integrity underneath the mepilex [Mepilex] and the writer did find 2 small PI's [pressure injuries] - see wound assessment for more information."

Review of residents 13's 4/3/24 weekly skin assessment tool revealed that the resident acquired two new pressure injuries on the coccyx one measuring 5 millimeters (mm) x 5 mm x 1 mm and the other measuring 20 mm x 10 mm

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and unable to determine the depth.

Review of resident 13's 3/8/24 care plan revealed:
*She was at risk for skin breakdown.
*She had MASD to her right inner buttocks related to occasional incontinence.
*She had a history of a healed pressure ulcer to her coccyx.
*Interventions included:
-Encourage good nutrition and hydration.
-Pressure-reducing cushion to the wheelchair and a low air loss (LAL) mattress.
-Staff would monitor skin with all cares and report any new red or open areas.
-Staff would reposition resident per care plan standard.
4. Observation and interview on 4/3/24 at 8:24 a.m. with resident 5 revealed the following:
*She was in her room sitting in her wheelchair.
-The wheelchair had a pressure relieving cushion placed in the seat.
*She stated she was "nervous" as she had been "sitting a long time".
-She wanted to sit in her recliner.
*Dietary aide G assisted resident 5 to her recliner.

Continued interview on 4/3/24 at 8:28 a.m. with resident 5 revealed the following:
*She got up at 6:00 a.m. that morning.
-She normally would not up until 7:00 a.m.
-She was not sure as to why she had gotten up at 6:00 a.m.
*She knew how to use her call light but did not know why it took "so long" to get help.
*Stated that she needed help now, as she had to go to the bathroom, and the person that assisted her into her recliner had not helped her to the bathroom.

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Continued interview with resident 5 on 4/3/24 at 10:57 a.m. revealed the following:
*She wore incontinent briefs but was not incontinent.
*She had a sore on her "butt, that sometimes hurts."
-That area had been there for "about a month."
-The staff put an "ointment of some kind on them [referring to her sore butt], two to three times a day".
-Staff members assisted her to the bathroom during the night but had not put ointment on her bottom.

Review of resident 5's EMR revealed the following:
*She was admitted on 3/16/23.
*Her diagnoses included: weakness, stiffness of left hip, diarrhea, anxiety, pain, and depression.
*Her BIMS score was a 13, that meant her cognition was intact.
*Her 2/27/24 Minimum Data Set (MDS) indicated the resident had functional bladder incontinence r/t [related to] impaired mobility.
*Her CNA task documentation for the last thirty days included the following:
-Her behavior monitoring was all marked none or not applicable.
-She was continent of urine and stool.
*Her 2/23/24 Bowel and Bladder Program Scanner assessment indicated the following:
-She was never incontinent of urine or stool.
-She needed assistance of one staff member to transfer into the bathroom.
-She was always aware of her need to use the toilet.
-The condition of her skin on the genital perineal, and buttocks was marked as some blanchable

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redness. (pre-Stage I).
--A Stage I pressure ulcer is an observable, pressure-related alteration of intact skin with non-blanchable redness.
-Had no predisposing factors such as diabetes, stroke, bladder and prostrate, frequent urinary tract infections, spinal cord, injuries, cerebral palsy.
*A 3/15/24 skin/wound care progress note that noted, "Resident continues with current MASD to bilateral inner buttocks. Bilateral inner buttocks is red and blanchable with scattered open areas noted. Writer continues to believe that these open areas are not pressure related but MASD. Reddened areas and open areas are blanching and areas are moist upon assessment. Resident is incontinent and does wear and incontinence product. These areas have shown signs of healing since last assessment."
*Her 3/21/24 revised care plan revealed:
-She had functional bladder incontinence related to impaired mobility.
-On 3/20/24 she had current MASD to her bilateral inner buttocks due to her impaired mobility and incontinence.
-She was at risk for additional skin issues.
-She had a pressure reducing cushion in her wheelchair and a pressure reducing mattress on her bed to help prevent PU's.

Interview on 4/3/24 at 8:35 a.m. with LPN R revealed:
*She had known that the night shift staff assisted residents in getting up in the morning.
-The night shift usually finished at 7:00 a.m.
-She was not sure who assisted resident 5 in getting up on the morning of 4/3/24.

Interview on 4/3/24 at 11:06 a.m. with a CNA who

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wished to remain anonymous regarding resident 5 revealed the following:
*Resident 5 was up, dressed, and in her recliner when she arrived at work at 6:00 a.m. on 4/3/24.
*Resident 5 was usually continent of her urine.
*She was aware that resident 5's had MASD on her buttocks.

5. Review of resident 12's EMR revealed:
*She was admitted on 2/28/24.
*Her diagnoses included stroke, dysphagia, anxiety, and hemiplegia and hemiparesis affecting her left side.
*Her 2/29/24 Braden Scale assessment (for predicting pressure ulcer risk) score was a 17 that meant she was at risk for developing pressure ulcers.
*A 3/1/24 physician wound care referral for a possible infection of her G (gastrostomy)-tube (feeding tube) site.
*On 3/4/24 she was started on Rocephin (an antibiotic) for the G-tube infection.
*On 3/7/24 she had gone to the wound clinic to assess her G-tube site.
-While at the wound clinic, they identified an unstageable PU to her right lateral foot.
*WCN D measure the wound upon the residents return from the wound clinic.
-WCN D's measurements for the wound were 4 mm (millimeters) by 4 mm and an undetermined depth.
*On 3/12/24 resident 12 was admitted to hospice for an acute physical decline related to a recent stroke.
*A 3/12/24 physician order for, "PU Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Right lateral foot topically one time a day every Mon, Wed, Sat for unstageable pressure ulcer secure with mepilex [Mepilex]."

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-The order was started on 3/13/24.

6. Observation on 3/20/24 at 7:40 a.m. with resident 2 and NA E during a transfer with a total mechanical lift revealed:
*There was an alternating air-pressure mattress on the bed.
*Resident 2 was lying on her back in her bed.
*NA E placed a mechanical lift sling under resident 2.
-She transferred resident 2 to her Broda chair and left the lift sling underneath her.
*An unidentified CNA entered the room and assisted NA E to get resident 2 get dressed.
*Resident 2 started to slide out of her Broda chair.
-An unidentified CNA and NA E repositioned her in the Broda chair.
-The lift sling underneath resident 2 was not repositioned and it had bunched up behind resident 2's back where Mepilex covered.
-NA E assisted resident 2 to the dining room.

Review of resident 2's EMR revealed the following:
*On 1/5/24 her Braden scale score was an 8 that meant she was at a very high risk for developing a pressure ulcer.
*A 2/11/24 progress that noted she had redness to her spine.
-Mepilex was applied to the area and WCN D was notified.
*On 2/14/24 a wound assessment was completed by WCN D.
-That assessment indicated she had a pressure ulcer to her mid-back spine that measured 15 mm by 10 mm with an undetermined depth.
--Interventions included a low air loss mattress, pressure relieving cushion in her wheelchair and

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frequent repositioning.
*On 2/15/24 a nurse progress note that indicated the physician was informed of the "PI" (pressure ulcer) to her mid-back and the facility was awaiting a reply from the physician.
*On 2/19/24 at 13:02 (1:02 p.m.) the physician ordered:
-The PU to have been cleansed with soap and water and patted dry.
-To apply Santyl ointment daily to the wound bed and cover with a dressing.
--That order was started on 2/20/24.
*A 2/22/24 Nutrition/Dietary progress note had noted, "[(Resident 2)] has an unstageable new wound nursing is treating..."
*On 3/6/24 a nurse progress note indicated the PU was healed and requested the physician to discontinue the treatment.

The provider's undated CNA's pocket care plan (a form with limited resident information that CNA's used when providing care to residents) noted resident 2:
-Was incontinent.
-Required the use of a full body mechanical lift for transferring.
-Had a pressure ulcer to her mid (middle) back.
--Interventions for pressure ulcers included the use of heel protectors, to have been laid down right after meals, and needed frequent turning and repositioning.

Interview on 3/20/24 at 3:44 p.m. with DON B and ADON C regarding resident 2's PU revealed the following:
*The wound was healed, and the area was covered with Mepilex as a preventative measure for a future PU in the same area.
*Resident 2 preferred to spend most of her time

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in bed.
*Interventions to prevent the PU had included a low air loss mattress and repositioning.

7. Interview on 4/4/24 at 8:00 a.m. with administrator A, director of nursing (DON) B, and WCN D revealed:
*The expectation was that residents would be repositioned approximately every two hours.
*Weekly skin assessments were only completed on residents with current pressure ulcers.
*The follow up for residents with MASD were at the WCN D's discretion and would have been reassessed when appropriate.
*There was no specific timeframe on when she would reevaluate the interventions and their effectiveness. It was at WCN D's discretion when that follow up occurred.
*Interdisciplinary team (IDT) meets three times a week and they would discuss the residents skin issues.
*WCN D would have weekly skin meetings with the nurses.
*DON B was made aware of the concern regarding the staff working overnights not checking residents and the urine saturated beds and an internal investigation was currently being conducted.

8. Review of the provider's April 2023 Care plan, Resident-Centered Facility Standards of Care Policy stated:
*All residents were to have been offered toileting frequently while awake unless otherwise specified by the resident's preferences or documented on their individualized care plan.
*All residents admitted were offered frequent repositioning unless otherwise specified on the individualized care plan.

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F 686	Continued From page 34 Review of provider's August 2009 Perineal Care for the Incontinent policy revealed: *Staff would apply a barrier cream or ointment to all areas that may come in contact with urine and/or stool. Pay particular attention to denuded [loss of the surface area of the skin] areas. *Staff would reapply ointment or barrier cream following each incontinent episode. Review of provider's 3/2020 Pressure Sores: Prediction and Prevention Policy revealed: *Nursing staff would identify residents at risk, initiate prevention measures, and exercise early identification and treatment when noted. *The provider would identify specific residents at risk by using the Braden Scale and/or an initial assessment would have been done with each admission and interventions put in to place as indicated.	F 686		