STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195176	A. BUILDING _____ B. WING _____	C 01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTHCARE, LLC	**535 COMMERCE STREET GRETNA, LA 70056**

(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 Complaint #LA00056544 - F760 and F808 cited as a result of this complaint. Complaint #LA00056727 - F760 cited as a result of this complaint.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure a resident did not potentially receive the wrong dose of insulin for 1 of 2 sampled residents reviewed during medication administration in a total sample of 5 (Resident #4). This failed practice had the potential to affect any of the 77 residents residing in the facility who are administered medications as documented on the facility's Matrix. Findings: Review of the facility's In-service dated 10/12/2020 on How to Properly Use an Insulin Prefilled Syringe, attended by S4LPN (Licensed Practical Nurse), revealed, in part: to clear the air from the needle, look at the dose window, turn the dosage knob to one or two units; hold the pen up with the needle pointing upwards, then press the injection button all the way until you see a drop of insulin at the needle tip; the dosage knob should be back at zero after completing this step; then turn the dosage knob to dial the number of units of insulin you need. Review of Resident #4's January 2021 Physician	F 760	1. A.) Upon surveyor notification on 1/14/2021, S4LPN administered the correct dose of insulin to resident #4. B). On 1/14/2021, S4LPN was re-educated on proper insulin pen administration. 2. All residents prescribed insulin Flex Pen could be affected. DON or designee will in-service license nursing staff on Flex Pen insulin administration. 3. A.) Reviewed and revised facility policy and procedure for insulin administration regarding Flex pen. . B). DON or designee will in-service license nursing staff on Flex Pen insulin administration. C.) Develop and complete Insulin Flex Pen competency with license nursing staff.	2/12/21

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

Electronically Signed | 01/29/2021

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F 760	Continued From page 1 Orders revealed an order for Humalog (insulin used to treat diabetes) 100 units/ml (milliliter) administer 5 units subcutaneously (in the fatty portion of the skin) three times a day before meals. Observation on 01/14/2021 at 11:45am revealed S4LPN prepared to administer medications to Resident #4. S4LPN obtained Humalog 100 units/ml pen, dialed the pen to two units, and expressed the two units of insulin and air. S4LPN then proceeded to dial the pen to seven units. S4LPN then stated she was ready to administer the medication. Surveyor then stopped S4LPN and asked to confirm the orders. S4LPN stated the resident was to receive five units of Humalog insulin, and since she dialed two units and expressed it then she needed to dial the seven units to get five units of insulin. Surveyor then asked to verify this with S1DON (Director of Nursing) prior to administration. Upon the surveyor returning with S1DON, S4LPN stated she now understood this would have been seven units and would need to express all the insulin and then redial the pen to five units.	F 760	4. Facility will develop a QAPI monitoring tool to ensure accurate insulin dosage administrator via Flex Pen. DON or designee will conduct random visual observations of Insulin Flex Pen administration on 2 nurse three times weekly. Monitoring will occur for 8 weeks then as deemed necessary by the QAPI team observation finding will be documented on the QAPI monitoring tool. Any issues identified will be addressed at time of discovery. Re-education will be conducted as deemed necessary. Results of monitoring will be reviewed weekly in the QA meeting for review of process efficiency.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced	F 808		2/12/21

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	195176	A. BUILDING _____ B. WING _____	C 01/14/2021

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PARK PLACE HEALTHCARE, LLC	**535 COMMERCE STREET GRETNA, LA 70056**

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F 808	Continued From page 2 by: Based on observation, interview, and record review, the facility failed to provide a therapeutic diet as prescribed by the physician for 1 (Resident #2) of 3 sampled residents of a total sample of 5. This deficient practice had the potential to affect any of the 77 residents who reside in the facility, as per the facility's Resident Census and Conditions of Residents Form (CMS-Form 672), who may be prescribed a therapeutic diet. Findings: Review of Resident #2 record revealed a diagnoses in part, Diabetes Mellitus with Hyperglycemia and Hypertension. In observation 01/12/2021 at 12:40pm lunch meal ticket dated 01/12/2021 revealed no concentrated sweets (NCS), special notes - double portions, and regular texture. Further observation of Resident #2's lunch tray revealed he was served pot roast, mashed potatoes with gravy, vegetables, dinner roll, a slice of cake, and sugar free lemonade. Further observation revealed Resident #2 ate 95% of his lunch except the dinner roll. Record Review 01/12/2021 at 3:40pm of Physician's Orders dated 12/28/2020 revealed an order for regular, no concentrated sweets (NCS), and no added salt (NAS) diet. In an interview 01/12/2021 at 4:09pm, S3Dietary Manager (DM) acknowledged the cake served on Resident #2's lunch tray was not sugar free. Record review of the facility's Diet Order & Communication slip dated 08/16/2020 revealed	F 808	1. Corrective actions taken for Resident #2 identified to be affect by Alleged deficient practice were: a. Diet clarification order received from MD. b. Diet communication slip completed, and diet entered correctly in menu matrix (Dietary Computer Software for meal tickets). c. Dietary staff educated on following menus for therapeutic diets. 2. All current residents had the potential to be affected by the alleged deficient practice corrective actions taken for these residents were: a. An audit was conducted of MD diet orders and diets entered in Menu Matrix. b. Any identified issues were corrected by obtaining a clarification physician order. c. Diet communication slips were completed and entered in Menu Matrix. d. Dietary staff was educated on following menus for therapeutic diets. 3. The measures put in place to ensure that the alleged deficient practice will not recur are: a. In-service was conducted with dietary staff on following menus for therapeutic diets. b. In-service was conducted with nursing staff on proper completion of Dietary communication slips. c. In-service was conducted with	

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	195176	A. BUILDING _____ B. WING _____	C 01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 808	Continued From page 3 the following: Diet order: regular; Restrictions/modification: no concentrated sweets (NCS); and Texture - regular/easy to chew. Record review of telephone orders dated 12/28/2020 revealed order clarification NAS/NCS diet. In an interview on 01/12/2021 at 4:27pm, S3DM acknowledged the last facility's Diet Order & Communication slip received was dated 08/16/2020 which indicated Resident #2 was to have no concentrated sweets (NCS) diet and regular texture. In an interview 01/12/2021 at 4:53pm, S1Registered Nurse/Director of Nursing (RN/DON) acknowledged resident #2 should had been served a NCS/NAS diet on 01/12/2021 as prescribed by the physician. In an interview 01/13/2021 at 10:11am, S3DM acknowledged Resident #2 did not receive the therapeutic diet prescribed by the physician for lunch on 01/12/2021. S3DM further stated she had not received the new dietary order dated 12/28/2020 for Resident #2. In an interview 01/13/2021 at 11:11am, S2RN/Corporate Nurse acknowledged Resident #2 had not received the therapeutic diet prescribed by the physician for lunch on 01/12/2021.	F 808	Dietary Manager in entering therapeutic diets in Menu Matrix. 4. The facility plans to monitor its performance to make sure solutions are sustained by: a. The administrator/designee will monitor meal service to ensure meal served matches therapeutic diet ordered. Monitoring will occur 3x/week for 6 weeks then as deemed necessary by QAPI team. b. DON/designee will audit diet orders against Menu Matrix diet entries to ensure compliance. Audits will be conducted 3x/week for 6 weeks then monthly. c. Results of monitoring will be reviewed weekly in QA meeting. Any identified issues will be addressed with re-education, plan modification and progressive discipline.	

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	195176	A. BUILDING _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTHCARE, LLC	535 COMMERCE STREET GRETNA, LA 70056

(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 A COVID-19 Focused Infection Control Survey was conducted on 01/26/2021. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 60	F 000		

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

Electronically Signed | 01/29/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195176	A. BUILDING _____ B. WING _____	C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTHCARE, LLC	**535 COMMERCE STREET GRETNA, LA 70056**

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F 000	INITIAL COMMENTS Complaint #LA00057015. No deficiencies cited as a result of this complaint. Complaint #LA00057081. No deficiencies cited as a result of this complaint.	F 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195176	A. BUILDING **01** B. WING _____	**03/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTHCARE, LLC	**535 COMMERCE STREET** **GRETNA, LA 70056**

(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
K 000	INITIAL COMMENTS Park Place Healthcare, llc is in compliance with the requirements of Title 42 Code of Federal Regulations, Part 483.70(a) (Life Safety Code). The facility is sprinklered, licensed for 128 beds and a census of 98 residents at time of survey.	K 000		
K 222 SS=C	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222		4/30/21

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

Electronically Signed | 04/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195176	A. BUILDING **01** B. WING _____	**03/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTHCARE, LLC	**535 COMMERCE STREET** **GRETNA, LA 70056**

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K 222	Continued From page 1 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the exterior Exit door with hospital special locking hardware would release when the fire alarm is activated into alarm status. In cases of a fire alarm emergency the exterior Exit doors provide safe passage to all occupants in need of egress by releasing the magnetic hospital special healthcare locking and remaining unlocked for	K 222	1) The exterior exit door with hospital special locking hardware will be repaired so that the exit door will release when the fire alarm is activated into alarm status. 2) All residents in the facility have the potential to be affected in the event of an emergency. 3) The Maintenance Supervisor will	

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K 222	Continued From page 2 the duration of the emergency. The deficient practice had the potential to affect 49 of 98 residents. During the facility tour on March 18, 2021, between the hours of 9:15 a.m. to 4:00 p.m. it was observed the magnetic door locks located at the front star corridor double door exterior exit discharge door failed to release when the fire alarm was activated. Louisiana State Fire Marshal Health Care Special Locking Memo 2019-02 dated March 30, 2019 states, " A. UNLOCKING (EMERGENCY RELEASE) shall be accomplished by all of the following: 1. Loss of power to any part of the system that controls locks or the emergency releasing mechanisms; and 2. Activation of the fire alarm system; and 3. Remote release at approved, constantly attended location(s) within the smoke compartment containing specialized care locking arrangements. Furnish a floor plan showing the location of required exits, all locked doors (existing and new), nurses' station(s), control station(s) and remote release location(s). -The remote control functions must be identified at the remote release location(s) with permanent legible signage and responsible staff must be trained on system control and emergency operations, -Total (complete) automatic smoke detection installed in accordance with NFPA 72 throughout all occupiable areas within the locked area is permitted to release the locks in lieu of remote release; and 4. A means of manual mechanical unlocking must be provided at each door that is not in direct view	K 222	check all exterior exit doors with special locking hardware monthly to ensure the exit doors release when alarm is activated into alarm status as a part of a preventative maintenance program. These checks will be documented in the preventative maintenance log book. 4) The administrator will check the preventative maintenance log book monthly to ensure checks are completed as scheduled. 5) Completion Date 4/30/21	

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K 222	Continued From page 3 of the remote release location. Doors must be keyed alike and be provided in accordance with ONE of the following conditions; - The key must be carried by the staff responsible for patient evacuation whenever the locking system is operational and in use, or - The key must be firmly affixed at the locked door location, so that it cannot be readily removed AND visual inspection shall be performed and recorded by the responsible nursing staff at appropriate periodic time intervals to insure that the key is in place and has not been removed, or - The key must be placed in a container equipped such that an audible alarm is provided at the locked door location, that can be heard or otherwise indicated at the remote release location, when opened for key removal/use, or - The key must be placed in a glass container that must be broken for emergency access. NOTE: Keypads, card readers, and other electrical devices are not acceptable as means of mechanically unlocking doors during emergency conditions. B. "AUTOMATIC" RE-LOCKING, after remote release shall be PROHIBITED. A specific separate human action dedicated for re-locking doors is required and shall be permitted to occur at the remote control location or at each locked door location. Relocking shall be a distinctly separate action/operation and shall NOT be part of, or associated with, the releasing operation." The interview with the Administrator revealed the facility were not aware that the magnetic locks were not functioning in accordance with the Special Locking Healthcare memo. A one-time waiver is approved for this K-tag due to the COVID -19 emergency pandemic. This one	K 222		

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K 222	Continued From page 4 time waiver is effective until Louisiana Department of Health and Hospitals licensure expiration of September 30, 2021.	K 222		
K 521 SS=C	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on visual observation the facility failed to assure that the heating, ventilation and air conditioning system was installed in accordance with NFPA 90A. The system could re-circulate smoke originating from one part of the building into other parts of the building otherwise unaffected. The deficient practice had the potential to affect 98 of 98 residents with two of two corridors smoke compartments being deficient by being used as a return air plenum. Findings: During the facility tour on March 18, 2021 between the hours of 9:15 a.m. to 4:00 p.m. it was observed the corridors lacked the proper height requirements and had been approved via a waiver for three years beginning on July 16, 2019. The interview with the Administrator revealed the	K 521	1) Facility has a waiver K-067 pertaining to means of egress in corridor height. Waiver is approved for three years from 7/16/2019. Facility will request waiver before expiration date 7/16/2022.	4/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PARK PLACE HEALTHCARE, LLC	**535 COMMERCE STREET** **GRETNA, LA 70056**

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K 521	Continued From page 5 facility was aware on the corridor height requirements lacking the proper height requirements in the means of egress. A waiver had been approved dated July 16, 2019 for three years.	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195176	A. BUILDING _____ B. WING _____	03/18/2021

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F 000	INITIAL COMMENTS Park Place Healthcare, LLC. is in compliance with the requirements of 42CFR, Part 483, Subpart B, Requirements for Long Term Care Facilities. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended Practices to prepare for COVID-19. Total Residents: 93	F 000		

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

Electronically Signed | 03/25/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195176	A. BUILDING _____ B. WING _____	C 04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE HEALTHCARE, LLC	535 COMMERCE STREET GRETNA, LA 70056

(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 Complaint #LA00057414. F677 cited as a result of this complaint. Complaint #LA00057445. F677 cited as a result of this complaint Complaint #LA00057476. No results cited as a result of this complaint. Complaint #LA00057477. F677 Cited as a result of this complaint.	F 000		
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 observations, interviews, and record reviews, the facility failed to ensure dependent residents received showers or baths as scheduled. This deficient practice was identified for 3 (Resident #3, Resident #4, and Resident #5) of 5 sampled residents reviewed for Activities of Daily Living (ADL) care, and had the potential to affect any of the 96 residents who required assistance or were totally dependent with bathing as documented on the facility's Resident Census and Conditions of Residents Form CMS-672. Findings: Review of the facility's shower aide schedule revealed, in part, residents who resided in the "A" bed were to receive showers or baths on Mondays, Wednesdays, and Fridays. Residents who resided in the "B" bed were to receive showers or baths on Tuesdays, Thursdays, and Saturdays.	F 677	1. Corrective action was obtained for the residents identified as being affected by the alleged deficient practice (Resident #3, Resident #4, and Resident #5) by providing them with a shower or bath. 2. All residents have the potential to be affected by the alleged deficient practice. Corrective action was accomplished for them by providing a bath/shower according to the bath/shower schedule. 3. The measures put in place to ensure the deficient practice doesn't recur are: a. Developed and implemented a bath/shower log. b. In-service was conducted with CNA staff on providing bath/shower as scheduled and documenting on bath/shower log.	5/30/21

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

Electronically Signed | 05/03/2021

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	195176	A. BUILDING _____ B. WING _____	C 04/21/2021

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F 677	Continued From page 1 Resident #3: Review of the record revealed Resident #3 was admitted to the facility on 08/31/2015 with diagnoses which included, in part, Abnormal Gait and Mobility, Heart Failure, Hypertension, Muscle Weakness, and Morbid Obesity. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/2021 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. Resident #3 was totally dependent with bathing, with one person physical assistance. Review of Resident #3's record revealed a care plan was developed which identified Resident #3 with self-care deficit with bathing, hygiene, dressing, and grooming. One approach included shower 3 times per week per schedule; sponge bath on alternate days and PRN (as needed). The next goal date was 05/07/2021. Review of the facility's alphabetical census revealed Resident #3 resided in a "B" bed. Review of the facility's shower schedule revealed she was to have showers on Tuesdays, Thursdays, and Saturdays, with a Sunday shower upon request. Review of Resident #3's April 2021 Certified Nursing Assistant (CNA) flowsheet regarding bathing revealed she received no documented shower or bath on Thursday, April 1, 2021. In an interview on 04/19/2021 at 1:00pm, Resident #3 stated she does not always get bathed on her assigned days. Resident #3 further stated that if the shower team is not there,	F 677	4. The facility plans to monitor to make sure the solutions are sustained by: a. The DON/designee will monitor Bath/Shower Log to ensure compliance with bath/shower schedule. Monitoring will occur 5 times weekly for 8 weeks and then as deemed necessary by the QAPI Committee. b. Administrator/DON/Designee will conduct resident interviews/observations to ensure residents are receiving baths/showers as scheduled and/or needed. Interviews/observations will be conducted 5 times weekly for 8 weeks and then as deemed necessary by the QAPI Committee. c. Results of monitoring and interview/observations will be reviewed weekly in the QA meeting. Ay identified issues will be addressed with plan revision, re-education and progressive discipline.	

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the CNAs are supposed to shower the residents they are assigned to, but that doesn't always happen. Resident #3 stated she has reported this to S3CNA Supervisor, but nothing ever gets done about it.

Resident #4:
Review of the record revealed Resident #4 was admitted to the facility on 02/25/2021 with diagnoses which included, in part, Cancer, Anemia, Deep Vein Thrombosis, and Weakness.

Review of the MDS with an ARD of 03/25/2021 revealed, in part, Resident #4 was totally dependent with bathing and personal hygiene, and required one person physical assistance.

Review of Resident #4's record revealed a care plan was developed which identified him as requiring assistance with ADLs. One approach included to shower 3 times a week per schedule, sponge bath on alternate days and as needed, wash hair weekly and as needed.

Review of the facility's alphabetical census revealed Resident #4 resided in a "B" bed. Review of the facility's shower schedule revealed he was to have showers on Tuesdays, Thursdays, and Saturdays, with a Sunday shower upon request.

In an interview on 04/19/2021 at 11:30am, Resident #4 stated he did not receive showers consistently. Resident #4 stated it depended on which CNA was assigned to him.

Observation on 04/21/2021 at 9:00am revealed Resident #4 was lying in bed. Further observation revealed Resident #4's hair was

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matted and Resident smelled of urine.

In an interview on 04/21/2021 at 9:47am, Resident #4 stated he was showered twice since his admission date. Resident #4 stated he just washes himself in the sink. When asked, Resident #4 stated he did not know the facility had a whirlpool bath.

Observation on 04/21/2021 at 12:30pm revealed Resident #4 eating his lunch meal. Resident #4 confirmed he had no shower or bath. Resident #4 smelled of urine, and his hair was dirty and uncombed. When asked, Resident #4 stated his hair has only been washed twice since admission, with the 2 showers he received.

Review of Resident #4's April 2021 CNA flowsheet regarding his baths or showers revealed documentation that he received no shower or bath from 04/06/2021 through 04/09/2021. There was a documented "W" on 04/10/2021. Review of the legend revealed "W" meant Whirlpool. Further review revealed no documented shower or bath on his scheduled Saturday (04/17/2021).

Resident #5:
Review of the record revealed Resident #5 was admitted to the facility on 01/04/2016 with diagnoses which included, in part, Pain, Arthritis, Muscle Weakness, and Age Related Physical Debility.

Review of the MDS with an ARD of 02/12/2021 revealed Resident #5 required physical assistance in part of bathing activity, with one person physical assistance.

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Review of Resident #5's record revealed a care plan was developed which identified a self-care deficit with bathing, and one approach included she required assistance from one person.

Review of the facility's alphabetical census revealed Resident #5 resided in an "A" bed. Review of the facility's shower schedule revealed she was to have showers on Mondays, Wednesdays, and Fridays, with a Sunday shower upon request.

Review of Resident #5's April 2021 CNA flowsheet regarding bathing revealed the following blocks were filled in as:
Sunday 04/18/2021 - "S" - Review of the legend revealed "S" meant Shower;
Monday 04/19/2021 - "N" - Review of the legend revealed "N" meant not given; and
Tuesday 04/20/2021 - "R" - Review of the legend revealed "R" meant refused.

In an interview on 04/19/2021 at 1:00pm, Resident #5 stated she missed her bath on Monday, April 12, 2021, but did not report this to anyone. Resident #5 stated that this morning, April 19, 2021, a staff member came into her room and informed her that no one was going to get a bath today. Resident #5 stated she did not report this to anyone.

In an interview on 04/20/2021 at 10:55am, Resident #5 stated the last shower she received was on Friday (04/16/2021). Resident #5 stated she had not received a shower on Monday (04/19/2021) or Tuesday (04/20/2021). Resident #5 denied having a shower or bath on Sunday (04/18/2021).

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F 677	Continued From page 5	F 677		

In an interview on 04/20/2021 at 1:10pm, Resident #5 stated no one offered her a shower or bath this morning until S1Administrator offered her one about 20-30 minutes ago. Resident #5 stated she was already dressed and waiting for lunch, and did not want to shower at that time of day. Resident #5 denied ever having refused a shower or bath.

In an interview on 04/20/2021 at 1:15pm, S1Administrator stated she went to offer Resident #5 a bath and was told by the resident that she was already dressed and did not want a shower at that time. When asked, S1Adminstrator stated Resident #5's preferences were to be bathed in the morning.

In an interview on 04/20/2021 at 1:17pm, S4CNA reviewed Resident #5's April 2021 CNA flowsheet regarding bathing, and confirmed Resident #5 did not receive a shower on her scheduled bath day of 04/19/2021. S4CNA stated when she reported to work on 04/19/2021, she was unaware that Resident #5 was assigned to her until later in the day, and at some point, it became too late for her to shower the resident.

In an interview on 04/20/2021 at 2:00pm, S2Director of Nursing (DON) reviewed Resident #5's CNA flowsheet and stated it was possible that S4CNA did not check the daily schedule and was not aware she was assigned to Resident #5. S2DON confirmed there was no documented evidence that Resident #5 had a shower on her scheduled day of 04/19/2021.

In an interview on 04/20/2021 at 10:05am, S5Corporate Nurse stated the facility has had a hard time with staffing, especially during March

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F 677	Continued From page 6 2021. S5Corporate Nurse stated they used to have a shower team, but due to staffing issues, they had to utilize the shower team for floor CNAs. At that point, it became the assigned CNA's responsibility to ensure residents were showered and/or bathed on their scheduled days. S5Corporate Nurse reviewed the above referenced CNA flowsheets and confirmed some scheduled dates for showers were missing.	F 677		