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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 05/04/2021 through 05/12/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 5/4/21 through 5/12/21. Four (4) complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 180 certified bed facility was 135 at the time of the survey. The survey sample consisted of 27 current resident reviews and 3 closed record reviews. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to | F 578 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/02/2021

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inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to ensure the resident's right to formulate an advanced directive by failing to ensure the correct code status for 1 of 27 residents, Resident #116.

The findings included:

For Resident #116, facility staff failed to ensure the correct code status.

Resident # 116's diagnosis list indicated diagnoses, which included, but not limited to

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COVID-19, Schizophrenia Unspecified, Bipolar Disorder Current Episode Manic Severe with Psychotic Features, Unspecified Dementia with Behavioral Disturbance, Unspecified Convulsions, Unspecified Atrial Fibrillation, and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 4/02/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns.

Resident #116's clinical record included an active physician's order dated 3/26/21 stating "Do Not Resuscitate (DNR)". The Facility was unable to provide a completed DNR form for Resident #116.

On 5/06/21, the administrator provided surveyor with a copy of a verbal physician's order dated 5/06/21 stating "Resident is Full Code". A nursing progress note dated 5/06/21 3:32 pm states "Spoke with (physician name omitted) re full code status for this resident at this time verbal order obtained".

On 5/11/21 at 9:16 am, surveyor spoke with the DON (director of nursing) who stated the resident was admitted with a DNR order but did not have a completed DNR form. DON stated they spoke with the nurse that wrote the order and the nurse said they must have seen it somewhere. DON stated that on 5/06/21, the facility contacted Resident #116's adult sibling who stated they did not want the resident to be a DNR and the order was changed to full code.

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| F 578 | Continued From page 3<br>Surveyor requested and received the facility policy entitled "Do Not Resuscitate Order" which states in part:<br>"2. A Do Not Resuscitate (DNR) order form must be completed and signed by the Attending Physician and resident (or resident's legal surrogate, as permitted by State law) and placed in the front of the resident's medical record.<br>a. Use only State-approved DNR forms.<br>b. If no State form is required, use facility-approved form."<br><br>On 5/12/21 at 12:30 pm, surveyor notified the administrator, DON, nurse consultant #1, and nurse consultant #2 of the concern of Resident #116 having an order for DNR without a completed DNR form.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 5/12/21. | F 578 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, | F 580 | | |

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a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and clinical record review, the facility failed to notify providing and/or RP (responsible party) for medication not available and a weight loss for one of

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twenty-seven residents (#121).
1. For Resident #121, facility staff failed to notify the medical provider and the resident representative of a significant weight loss identified on 12/03/20, failed to notify the psychiatric nurse practitioner and psychologist of the resident's suicide attempt on 4/30/21, and failed to notify the physician of the ER's decision to send the resident back to the facility following suicide attempt on 4/30/21.

Resident #121's diagnosis list indicated diagnoses, which included, but not limited to Mood Disorder due to Known Physiological Condition, Schizoaffective Disorder Unspecified, Major Depressive Disorder Recurrent Unspecified, Unspecified Dementia with Behavioral Disturbance, Dysphagia following Unspecified Cerebrovascular Disease, Vitamin B12 Deficiency Anemia Unspecified, and Type 2 Diabetes Mellitus with Diabetic Neuropathy Unspecified.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/02/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. In section K, Swallowing/Nutritional Status, Resident #121 was coded as having a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months while not on a physician-prescribed weight-loss regimen.

A review of Resident #121's clinical record revealed the following documented weights: 10/01/20 120.0 lbs., 12/03/20 95.0 lbs., 1/04/21 94.0 lbs., 2/03/21 94.0 lbs., 3/03/21 98.0, and 4/01/21 99.0. A November 2020 weight was not

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obtained due to a facility COVID-19 outbreak.

A dietician progress note dated 12/22/20 5:14 pm states in part, "(He/she) is receiving Prostat 30 ml BID (twice a day) and Medpass 120 ml QID (four times a day). (He/she) is on a regular mechanical soft diet with ground meat. CBW (current body weight): 95# 12/3 which is a significant loss x 90 and 180 days. Supplements remain appropriate. Will monitor for additional needs".

Surveyor was unable to locate documentation of provider or resident representative notification of the 25 lb. weight loss from 10/01/20 to 12/03/20.

On 5/12/21 at 10:36 am, surveyor spoke with the DON (director of nursing) who stated they could not find physician or responsible party notification of the weight loss.

Surveyor requested and received the facility policy entitled, "Weight Assessment and Intervention" which states in part "Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the Physician, nursing staff, the Dietitian, the Consultant Pharmacist, and the resident or resident's legal surrogate".

A nursing progress note dated 2/04/21 8:48 pm states "this nurse was notified by cna (certified nursing assistant) when (he/she) went in to answer call bell call bell was pulled out of the wall and was laying behind and across res (resident) neck when asked about this res stated (he/she) didn't know it was that way."

A subsequent nursing progress note dated 2/04/21 9:06 pm states "this nurse went in to talk

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to res about (him/her) going to er where (he/she) had call bell around neck res stated (he/she) didn't want to hurt (himself/herself) that (he/she) didn't know it was that way I explained to res were [sp] (he/she) had previously said (he/she) wanted to hurt (himself/herself) that (he/she) needs to go to er res stated (he/she) didn't even remember saying that that I'm libel to say anything just because I say it doesn't mean I need it".

Resident #121 was readmitted to the facility on 2/27/21 following inpatient psychiatric care at (facility name omitted).

A nursing progress note dated 4/11/21 7:46 pm states "this nurse was setting at desk was told by cna that res roommate had told (him/her) that res had put call bell around (his/her) neck when this nurse spoke with res (he/she) stated (he/she) was trying to kill herself but (he/she) stopped when it started to hurt". Addendum dated 4/11/21 9:44 pm states "Upon assessment of res o [sp] injuries noted by this nurse". Resident #121 was transported to the local ER at 7:58 pm.

The After Visit Summary from (facility name omitted) Emergency Department dated 4/11/21 states in part, "Follow-up with behavioral medicine on an outpatient basis. Maintain suicidal precautions".

Resident #121 was seen by the psychiatric NP (nurse practitioner) the following day on 4/12/21, the progress note states in part, "Per nursing patient had made a suicide attempt by wrapping call bell around (his/her) neck and was sent out to E.R. r/t suicide attempt and was returned back to the facility from (facility name omitted) with a diagnosis of memory problem. Subjective: Lying

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in bed (patient currently constant observation by CNA). Discussed with patient (his/her) attempt at suicide yesterday. Pt verbalized, 'I don't remember that, I'm glad I don't.' Denies thoughts of self harm/suicidal ideations. Endorses depressed; denies anxiety". Recommendations include "continue constant observation".

Resident #121 was seen by the licensed psychologist via telehealth on 4/14/21, progress note from the visit states in part, "Approached Resident with progress note report of 4/11/21, 7:46 pm, finding Resident with call bell cord around (his/her) neck. However, no evidence of intent or plan or strength to tighten cord. When confronted, Resident said (he/she) had no recall of doing that" ...."(He/she) said (he/she) still wanted to die but denied intent or plan" ...."It is requested that with each shift change, a staff person be appointed, who would spend 10 mins. for a one on one with Resident for positive attention and support. Incident of 4/11 appears to be a suicide gesture w/o intent or plan to carry out".

A nursing progress note dated 5/01/21 12:33 am states in part "Late note for 2158 (9:58 pm): Resident was found in room laying in bed with eyes closed with call light tied tightly around neck. Resident was turning blue and when released and untied call light cord, resident stated (he/she) wished to die and that I had not found (him/her) so soon. Vitals were taken B/P 118/76, Pulse 84, O2 96, Resp 18, Temp 98.4. Placed aide 1 on 1 while calling transport and notifying doctor and family". Subsequent progress note dated 5/01/21 12:39 am states in part "late note for 2232 (10:32 pm) transport arrived ...As resident was leaving (he/she) stated (he/she) didn't remember tying

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call light cord around (his/her) neck and (he/she) didn't know why (he/she) would do something like that".

The After Visit Summary from (facility name omitted) Emergency Department dated 4/30/21 states in part, "Patient is not truly 'suicidal' due to the severity of (his/her) dementia. ((He/she) can't really decide to commit suicide). And (he/she) is so disabled (bed bound) that (he/she) is not able to act on a suicidal impulse even if (he/she) did have one. There is no known treatment for (his/her) acting out and having another psych evaluation and treatment would not do (him/her) any good. (He/she) does not need protective custody at a psych facility to prevent suicide. There is just no value in this. Please remove the call cord from (his/her) reach. (Facility name omitted) is a safe and good place for (him/her) to stay".

Resident #121 was seen for their weekly telehealth visit with the licensed psychologist on 5/05/21, the progress note states in part, "(He/she) added 'I'm depressed out of my mind. I don't want to live'.. ...(He/she) continues to express low will to live in terms of praying for god to take (him/her), which is differentiated from active suicidal ideation, intent, or plan at this time." The progress note does not include any documentation of the incident on 4/30/21 when the resident wrapped the call bell cord around their neck. Surveyor could not locate documentation that the psychologist was notified of the 4/30/21 incident.

Surveyor attempted to contact the licensed psychologist by leaving voice messages on 5/06/21 and 5/10/21, however, as of survey exit

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on 5/12/21 the calls had not been returned.

Surveyor was unable to locate documentation in the resident's clinical record of the psychiatric NP being notified following the 4/30/21 incident. The last documented progress note from the psychiatric NP was dated 4/28/21. Surveyor attempted to contact the psychiatric NP on 5/05/21, 5/06/21, and 5/10/21, however, the voice mailbox was full each time and surveyor was unable to leave a message.

On 5/06/21 at 2:59 pm, surveyor spoke with the administrator and asked if the facility had discussed the resident's current situation with the resident's physician or the medical director for assistance, administrator stated "maybe the DON has but I haven't". At 3:15 pm, the DON stated they had just spoken with the medical director and they are okay with the resident being here now but if it happens again and the ER will not provide services then discharge (him/her). A progress note written by the DON dated 5/06/21 3:16 pm states "This nurse spoke with (name omitted), Medical Director of this facility in regards to resident's multiple discharges to ER d/t resident being found with cord wrapped around resident's neck. (Name omitted) advised that at this time (he/she) is comfortable with resident being in facility, however, if resident is discharged to ER from this facility for this or any other attempt to harm self and ER does not provide crisis services for resident that (name omitted) will request discharge from this facility d/t facility not being able to provide the extra services resident seems to need".

Surveyor could not locate documentation of physician notification following the resident's

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return from the ER on 5/01/21 without a mental health evaluation. Surveyor could not locate documentation that the resident's physician had assessed (him/her) following the incident on 4/30/21. On 5/10/21 at approximately 3:30 pm, surveyor spoke with Resident #121's physician via telephone. The physician stated they had been in the facility in the last 2 weeks, they stated they were aware of the three suicide attempts by Resident #121. Physician stated they have a problem with the ER and have no control over them. The physician further stated it is almost impossible to get an appointment with a psychiatrist. Surveyor asked the physician if they feel that Resident #121 is safe in the facility and they stated "that's a tough one" but it is a "guarded yes" and "overall I think it is".

On 5/10/21 at 1:20 pm surveyor spoke with the facility medical director concerning Resident #121's history of suicide attempts. The medical director stated that he was not very familiar with Resident #121 as (he/she) is (name omitted) patient but the facility did notify them when the resident was sent out on 5/01/21. The medical director stated that they do not think the ER called in the crisis team for the resident on 5/01/21. The medical director also stated that it is "very unlikely that an outpatient psychiatrist would see (him/her)". They also stated that the facility could watch (him/her) carefully, remove things out of reach, continue to see the psychiatric nurse practitioner, and set something up with nursing to check on (him/her).

On 5/12/21 at 12:30 pm, surveyor informed the administrator, DON, nurse consultant #1, and nurse consultant #2 that the resident's medical record did not include documentation of physician

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| F 580 | Continued From page 12<br>and resident representative notification of Resident #121's 25 lb. weight loss from October to December 2020 and of the concern of the facility failing to follow-up and coordinate care with the physician, psychologist, psychiatric NP, and the medical director.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 5/12/21. | F 580 | | |
| F 607 SS=E | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, employee record review and facility documentation review, the facility staff failed to obtain verification of licensure from the Department of Health Professions prior to hire for 1 (Employee # 8) of 8 Registered Nurses, for 1(Employee # 20) of 6 Certified Nursing Assistants and failed to re-verify licensure after expired dates on three (Employees # 6, # 17 and # 19) of 8 Registered Nurses and failed to re-verify the expired license of one (Employee # 24) of 6 Licensed Practical Nurses. And the | F 607 | | |

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facility staff failed to obtain a Criminal Background Check for one (Employee # 22) of 4 Unlicensed Nurses Aide and one (Employee # 24) of 6 Licensed Practical Nurses to obtain a Criminal Background Check prior to hire.

The Findings included:

1. For Employee # 8, the facility staff failed to obtain licensure verification prior to hire.

On 5/5/2021- 5/7/2021, a review was conducted of employee records.

Review of the personnel file for Employee # 8 was conducted and revealed Employee # 8 was hired on 12/7/2020 as the Director of Nursing. Employee # 8's Registered Nurse license was not verified by the facility staff with the Department of Health Professions until 12/8/2020 at 13:38 (1:38 p.m.), after her date of hire.
.

On 5/10/2021 at approximately 3:58 p.m., an interview was conducted with the Human Resources Director who confirmed that the license for Employee # 8 was verified after the date of hire. She stated the expectation was that licenses would be verified and current prior to hire. An interview was conducted with the facility Administrator (Employee A) who stated the expectation was for licenses to be verified prior to hire and re-verified upon expiration.

On 05/10/2021 at 4:30 p.m., an interview was conducted with the facility Administrator who was informed of the issue. A copy of the facility's policy on Hiring, Background Checks, Personnel

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Files and Terminations was requested. The Administrator stated he would submit a copy of the facility's policy. The Administrator stated background checks should be completed on all new employees prior to the hire date.

The facility policy on Abuse, Neglect, Exploitation and Reporting, Revised 11/2016 was reviewed on 05/11/2021. On page 2 of 5 under the topic was written:
" The components of the facility's abuse prohibition plan, The Facility Must:

3. Not employ or otherwise engage individuals who:
a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law;
b. Have had a finding entered the State nurse aide registry concerning abuse, neglect, exploitation, misappropriation of property.
c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of abuse, neglect, exploitation, misappropriation of property.
d. Background, references, and credentials' checks should be conducted on employees prior to or at the time of employment, by facility administration, in accordance with applicable state and federal regulations . Any person having knowledge that an employee's license or certification is in question should report such information to the Administrator."

The Administrator was informed again of the findings during the end of day debriefing on 5/11/2021.

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| F 607 | Continued From page 15<br>No further information was provided.<br><br>2. For Employee # 20, the facility staff failed to have a license verification check with the Department of Health Professions (DHP) prior to hire.<br><br>Employee # 20 was hired on 9/25/2020 as a Certified Nursing Assistant. A copy of the license verification at the time of hire was not in the list of documents presented to the surveyor. Review revealed Employee # 20's license was not verified by the facility staff with the Department of Health Professions until 5/5/2021 at 18:39 (6:39 p.m.) according to the "License Look up" document.<br><br>On 5/10/2021 at 3:58 p.m., an interview was conducted with the Human Resources Director who stated she could not locate any license verification document from prior to the hire date. The Human Resources Director stated she looked in a binder where the previous Human Resources Director kept copies of some documents but was unable to find the missing documentation.<br><br>The Human Resources Director stated the expectation was that licenses would be verified and current prior to hire. An interview was conducted with the facility Administrator (Employee A) who stated the expectation was for licenses to be verified prior to hire and re-verified upon expiration. | F 607 | | |

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On 05/10/2021 at 4:30 p.m., an interview was conducted with the facility Administrator who was informed of the issue. A copy of the facility's policy on Hiring, Background Checks, Personnel Files and Terminations was requested. The Administrator stated he would submit a copy of the facility's policy. The Administrator stated background checks should be completed on all new employees prior to the hire date.

The facility policy on Abuse, Neglect, Exploitation and Reporting, Revised 11/2016 was reviewed on 05/11/2021. On page 2 of 5 under the topic was written:
" The components of the facility's abuse prohibition plan, The Facility Must:

3. Not employ or otherwise engage individuals who:
a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law;
b. Have had a finding entered the State nurse aide registry concerning abuse, neglect, exploitation, misappropriation of property.
c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of abuse, neglect, exploitation, misappropriation of property.
d. Background, references, and credentials' checks should be conducted on employees prior to or at the time of employment, by facility administration, in accordance with applicable state and federal regulations . Any person having knowledge that an employee's license or certification is in question should report such information to the Administrator."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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On 5/12/2021 at 11:05 a.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated he had no questions about the findings.

No further information was provided.

3. For Employee # 6, the facility staff failed to re-verify the license after the date of expiration.

Review of the personnel file for Employee # 6 revealed that Employee # 6 was hired on 1/21/2020 as a Registered Nurse in the position of the Staff Development Coordinator. At the time of hiring, Employee 6's Registered Nurse license was listed as expiring on 1/31/2021. Her license was not re-verified by the facility staff with the Department of Health Professions until 5/5/2021 at 18:39 (6:39 p.m.).

The issue was reviewed with the Human Resources Director on 5/10/2021 at 3:58 p.m. She stated that she did not see any documentation that the license had been verified after the date it was listed to expire so she verified the license when she compiled the list of employee records for review.

The findings were reviewed with the Human Resources Director who stated that she had been in that position for a couple of months. She stated she had developed some procedures to make sure the verification of all of the licenses were renewed on time.

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The Human Resources Director stated the Human Resource department would send a notice every month of employees whose licenses were due to expire. The notice would be readily visible for employees to view. The Unit Managers/supervisors would be informed as well of employees who needed to renew their licenses. The Human Resources Director would verify the renewal, print out a new copy, and place a copy in the Personnel Binder and in the employee's file.

On 05/10/2021 at 4:30 p.m., an interview was conducted with the facility Administrator who was informed of the issue. An interview was conducted with the facility Administrator (Employee A) who stated the expectation was for licenses to be verified prior to hire and re-verified upon expiration.

On 5/12/2021 at 11:05 a.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated he had no questions about the findings.

No further information was provided.

4. For Employee # 17, the facility staff failed to re-verify the license after the date of expiration.

Review of the personnel file for Employee # 17 revealed:

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Employee # 17 was hired on 3/27/2020 as a Registered Nurse. At the time of hire, her license was listed as expiring on 3/31/2021. Her license was not re-verified by the facility staff with the Department of Health Professions until 5/5/2021 at 18:39 (6:39 p.m.).

The issue was reviewed with the Human Resources Director on 5/10/2021 at 3:58 p.m. She stated that she did not see any documentation that the license had been verified after the date it was listed to expire so she verified the license when she compiled the list of employee records for review.

The findings were reviewed with the Human Resources Director who stated that she had been in that position for a couple of months. She stated she had developed some procedures to make sure the verification of all of the licenses were renewed on time.

The Human Resources Director stated the Human Resource department would send a notice every month of employees whose licenses were due to expire. The notice would be readily visible for employees to view. The Unit Managers/supervisors would be informed as well of employees who needed to renew their licenses. The Human Resources Director would verify the renewal, print out a new copy, and place a copy in the Personnel Binder and in the employee's file.

On 05/10/2021 at 4:30 p.m., an interview was conducted with the facility Administrator who was informed of the issue. An interview was conducted with the facility Administrator

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(Employee A) who stated the expectation was for licenses to be verified prior to hire and re-verified upon expiration.

On 5/12/2021 at 11:05 a.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated he had no questions about the findings.

No further information was provided.

5. For Employee # 19, the facility staff failed to re-verify the license after the date of expiration.

Review of the personnel file for Employee # 19 revealed:

Employee # 19 was hired on 3/27/2020 as a Registered Nurse. At the time of hire, her license was listed as expiring on 4/30/2021. Her license was not re-verified by the facility staff with the Department of Health Professions until 5/5/2021 at 18:39 (6:39 p.m.).

The issue was reviewed with the Human Resources Director on 5/10/2021 at 3:58 p.m. She stated that she did not see any documentation that the license had been verified after the date it was listed to expire so she verified the license when she compiled the list of employee records for review.

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The findings were reviewed with the Human Resources Director who stated that she had been in that position for a couple of months. She stated she had developed some procedures to make sure the verification of all of the licenses were renewed on time.

The Human Resources Director stated the Human Resource department would send a notice every month of employees whose licenses were due to expire. The notice would be readily visible for employees to view. The Unit Managers/supervisors would be informed as well of employees who needed to renew their licenses. The Human Resources Director would verify the renewal, print out a new copy, and place a copy in the Personnel Binder and in the employee's file.

The Administrator was notified of the issue at 4:30 p.m. on 5/10/2021. An interview was conducted with the facility Administrator (Employee A) who stated the expectation was for licenses to be verified prior to hire and re-verified upon expiration.

On 5/12/2021 at 11:05 a.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated he had no questions about the findings.

No further information was provided.

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6. For Employee # 24, the facility staff failed to re-verify the license after the date of expiration.

Review of the personnel file for Employee # 24 revealed:

Employee # 24 was hired on 12/31/2019 as a Licensed Practical Nurse. Her license was verified prior to hire and listed as expiring on 1/31/2021. Her license was not re-verified by the facility staff with the Department of Health Professions until 5/5/2021 at 18:49 (6:49 p.m.). Employee # 24 worked for over 3 months without verification of license renewal by facility staff.

The issue was reviewed with the Human Resources Director on 5/10/2021 at 3:58 p.m. She stated that she did not see any documentation that the license had been verified after the date it was listed to expire so she verified the license when she compiled the list of employee records for review.

The findings were reviewed with the Human Resources Director who stated that she had been in that position for a couple of months. She stated she had developed some procedures to make sure the verification of all of the licenses were renewed on time.

The Human Resources Director stated the Human Resource department would send a notice every month of employees whose licenses were due to expire. The notice would be readily visible for employees to view. The Unit

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Managers/supervisors would be informed as well of employees who needed to renew their licenses. The Human Resources Director would verify the renewal, print out a new copy, and place a copy in the Personnel Binder and in the employee's file.

The Administrator was notified of the issue at 4:30 p.m. on 5/10/2021. An interview was conducted with the facility Administrator (Employee A) who stated the expectation was for licenses to be verified prior to hire and re-verified upon expiration.

On 5/12/2021 at 11:05 a.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated he had no questions about the findings.

No further information was provided.

Based on staff interview, employee record review, and facility documentation review, the facility staff failed to ensure a criminal background check was completed for two (Employees # 22 and # 24) of 29 employees in the Employee Records Check sample.
The findings included:

7. For Employee # 22, the facility staff failed to

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ensure a criminal background check was completed at the time of hire.

On 05/5/2021- 05/07/2021, Employee Record Reviews were conducted.

Review of the personnel records revealed Employee #22 was hired on 02/10/2020 as an Unlicensed Aide and enrolled in the Certified Nursing Assistant class. According to the Human Resources Director, the entire personnel file was empty for Employee # 22.

Further review of the facility documentation of the spreadsheet list of all employees hired since 2019 revealed Employee # 22 was hired twice and disposition listed as "termination" twice during 2020. The two dates of hire were listed as 02/10/2020 and 10/15/2020.

An interview was conducted with the Human Resources Director on 05/10/2021 at 3:58 p.m. The Human Resources Director stated Employee # 22's Personnel file was empty and did not have any documents for the dates of employment at the facility.

The Human Resources Director stated she had been in her position for only a couple of months. She stated she contacted the previous Human Resources Director to inquire about what happened to Employee 22's record and was informed "the entire file was sent" to their sister facility when Employee 22 transferred there.

According to the Human Resources Director, she was informed by the sister facility's staff that there was no record of any records being sent there. The sister facility sent copies of documents from

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Employee 22's employment at their facility. The Human Resources Director stated she knew those forms would not suffice for the current survey but did want to show what was sent.

The facility Administrator was informed of the findings on 5/10/2021 at 4:30 p.m.

On 5/12/2021 at 11:05 a.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated he had no questions about the findings.

No further information was provided.

8. For Employee # 24, the facility staff failed to ensure a Criminal Background Check was completed at the time of hire.

Review of the employee file revealed that Employee # 24 was hired as a Licensed Practical Nurse on 12/31/2019.

Employee # 24's Criminal Background Check was performed prior to hire on 12/27/2019 with the search results documented as "transaction is being processed." There was no documentation of the facility staff contacting the State Police to determine the status of the search. As of the end of survey, there was no final result of the search.

On 5/10/2021 at 3:58 PM, an interview was conducted with the Human Resources Director who stated she double checked and found there were no other records in the personnel file about the Criminal Background Check results being

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finalized. The Human Resources Director stated "normally the State Police would mail a copy results to the facility." She stated she did not see a mailed copy of a result for Employee # 24.

At the time of survey, no further documentation showing that the facility rechecked the status of Employee # 24's criminal background search was found in Employee #24's Human Resources (HR) File.

On 05/10/2021 at 3:58 p.m., an interview was conducted with the Human Resources Director who stated she double checked the personnel file and found there were no other records about the Criminal Background Check results being finalized. The Human Resources Director stated normally the State Police would mail a copy of the results to the facility. She stated she did not see a mailed copy of a final result for Employee # 24.

On 05/10/2021 at 4:30 p.m., an interview was conducted with the facility Administrator who was informed of the issue. A copy of the facility's policy on Hiring, Background Checks, Personnel Files and Terminations was requested. The Administrator stated he would submit a copy of the facility's policy. The Administrator stated background checks should be completed on all new employees prior to the hire date.

The facility policy on Abuse, Neglect, Exploitation and Reporting, Revised 11/2016 was reviewed on 05/11/2021. On page 2 of 5 under the topic was written:
" The components of the facility's abuse prohibition plan, The Facility Must:

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| F 607 | Continued From page 27<br>3. Not employ or otherwise engage individuals who:<br>a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law;<br>b. Have had a finding entered the State nurse aide registry concerning abuse, neglect, exploitation, misappropriation of property.<br>c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of abuse, neglect, exploitation, misappropriation of property.<br>d. Background, references, and credentials' checks should be conducted on employees prior to or at the time of employment, by facility administration, in accordance with applicable state and federal regulations . Any person having knowledge that an employee's license or certification is in question should report such information to the Administrator."<br><br>The Administrator was made aware of findings.<br><br>During the end of day debriefing on 5/11/2021, the facility Administrator was informed there was no documentation of a final result of the Criminal Background check or evidence of the facility staff contacting the State Police to determine the status of the search.<br><br>On 5/12/2021 at 11:05 a.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated he had no questions about the findings.<br><br>No further information was provided. | F 607 | | |
| F 609 SS=D | Reporting of Alleged Violations | F 609 | | |

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| F 609 | Continued From page 28<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, facility document review and Adult Protective Service (APS) report, facility staff failed to notify Office of Licensure and Certification of possible misappropriation of property (narcotic pain medication) for 1of 27 residents in the survey sample (Resident #124). | F 609 | | |

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| F 609 | Continued From page 29<br><br>Resident #124 was admitted to the facility with diagnoses including hypertensive heart disease, paraplegia, cauda equina syndrome, spina bifida, back and wrist pain, and major depression. On the quarterly minimum data set assessment with assessment reference date 4/6/21, the resident scored 12/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.<br><br>The Office of Licensure and Certification received an adult protective service report that the resident's Percocet was missing and not available for administration on 2/14/2020 for the midnight and 6 AM doses. The report indicated that 52 doses of the medication were missing. OLC did not receive a facility reported incident concerning possible abuse related to this resident"s misappropriatio of property.<br><br>When the surveyor interviewed the resident on 5/10/2021, the resident reported always receiving medication and generally having pain under control.<br><br>The surveyor discussed the issues with the administrator and director of nursing during daily summary meetings over the course of the survey. | F 609 | | |
| F 646 SS=D | MD/ID Significant Change Notification<br>CFR(s): 483.20(k)(4)<br><br>§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. | F 646 | | |

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This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview and clinical record review, facility staff failed to notify the state mental health authority following a significant change in the mental condition of a resident who has mental illness for review for 1 of 27 residents, Resident #121.

The findings included:

For Resident #121, the facility staff failed to refer the resident to the state mental health authority for a Level II PASARR screening following expression of suicidal ideations resulting in three separate suicide attempts requiring transfer to a higher level of care following each incident.

Resident #121's diagnosis list indicated diagnoses, which included, but not limited to Mood Disorder due to Known Physiological Condition, Schizoaffective Disorder Unspecified, Major Depressive Disorder Recurrent Unspecified, Unspecified Dementia with Behavioral Disturbance, Dysphagia following Unspecified Cerebrovascular Disease, Vitamin B12 Deficiency Anemia Unspecified, and Type 2 Diabetes Mellitus with Diabetic Neuropathy Unspecified.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/02/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. Resident #121 was coded as requiring supervision only for eating, extensive assistance with bed mobility, dressing, personal hygiene, and being totally dependent in transfers.

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On 5/04/21 at approximately 2:45 pm surveyor observed Resident #121 sitting up in a reclining chair in the common area with other residents watching television. Surveyor introduced self and asked the resident how they were doing, Resident #121 immediately responded "depressed". The resident further stated "I'd rather be dead" and "I pray every day that I will die". On 5/04/21 at 6:34 pm, surveyor again spoke with the resident in the presence of Surveyor #2 and asked the resident if this surveyor could look at their neck. Resident #121 stated "what's wrong with my neck, oh I tried to choke myself" and resident further stated (he/she) "turned it loose when it started to hurt". Resident then became tearful and stated they were tired of living.

A nursing progress note dated 2/04/21 8:48 pm states "this nurse was notified by cna (certified nursing assistant) when (he/she) went in to answer call bell call bell was pulled out of the wall and was laying behind and across res (resident) neck when asked about this res stated (he/she) didn't know it was that way."

A subsequent nursing progress note dated 2/04/21 9:06 pm states "this nurse went in to talk to res about (him/her) going to er where (he/she) had call bell around neck res stated (he/she) didn't want to hurt (himself/herself) that (he/she) didn't know it was that way I explained to res were [sp] (he/she) had previously said (he/she) wanted to hurt (himself/herself) that (he/she) needs to go to er res stated (he/she) didn't even remember saying that that I'm libel to say anything just because I say it doesn't mean I need it".

Resident #121 was transported to the local ER

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and admitted on 2/04/21. The (hospital name omitted) Discharge Summary dated 2/09/21 states in part, "75-year-old (male/female) brought in for suspected suicidal intent. The nursing home reports that they found (him/her) with (his/her) nurse call light cord wrapped around (his/her) neck. The patient states that (he/she) does not remember this nor does (he/she) remember any intent to hurt (himself/herself). (He/she) admits to being depressed but states (he/she) has no intention of harming (himself/herself). In the ER (he/she) was found to have acute blood loss anemia with AKI (acute kidney injury) with UTI (urinary tract infection). (He/she) was admitted to the ICU with one-to-one"; "Crisis was consulted and initially recommended (he/she) go back to (facility name omitted) that can consult psychiatry NP (nurse practitioner), but (facility name omitted) declined. Today (he/she) was coordinate [sp] a bed with (facility name omitted) for inpatient psych, but require [sp] COVID 19 was positive today, after being negative (antigen and 4plex 2/05/21). Nursing home was notified and stated that patient had previously been COVID positive November 6th. Because of new COVID positive status patient was transferred to (facility name omitted). Patient is not able to make (his/her) own medical decisions with (his/her) confused status, continued suicidal ideations/depression/dementia".

Resident #121's Physician Discharge Summary from (facility name omitted) dated 2/11/21 states in part, "Patient was also seen by psychiatry. (He/she) is still actively suicidal/homicidal. (He/she) should continue full psych precautions"; "Patient is now medically stable for discharge. I have discussed with hospitalist at (facility name

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omitted) who agrees to accept patient in transfer and will assist in getting patient to (facility name omitted) inpatient psych as previously planned". Resident #121 was admitted to (facility name omitted) for inpatient psych care on 2/13/21 and discharged on 2/27/21.

Resident #121 was readmitted to the facility on 2/27/21 following inpatient psychiatric care at (facility name omitted).

A nursing progress note dated 4/11/21 7:46 pm states "this nurse was setting at desk was told by cna that res roommate had told (him/her) that res had put call bell around (his/her) neck when this nurse spoke with res (he/she) stated (he/she) was trying to kill herself but (he/she) stopped when it started to hurt". Addendum dated 4/11/21 9:44 pm states "Upon assessment of res o [sp] injuries noted by this nurse". Resident #121 was transported to the local ER at 7:58 pm.

The After Visit Summary from (facility name omitted) Emergency Department dated 4/11/21 states in part, "Follow-up with behavioral medicine on an outpatient basis. Maintain suicidal precautions".

Resident #121 was seen by the psychiatric NP the following day on 4/12/21, the progress note states in part, "Per nursing patient had made a suicide attempt by wrapping call bell around (his/her) neck and was sent out to E.R. r/t suicide attempt and was returned back to the facility from (facility name omitted) with a diagnosis of memory problem. Subjective: Lying in bed (patient currently constant observation by CNA). Discussed with patient (his/her) attempt at suicide yesterday. Pt verbalized, 'I don't remember that,

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I'm glad I don't.' Denies thoughts of self harm/suicidal ideations. Endorses depressed; denies anxiety". Recommendations include "continue constant observation".

Resident #121 was seen by the licensed psychologist via telehealth on 4/14/21, progress note from the visit states in part, "Approached Resident with progress note report of 4/11/21, 7:46 pm, finding Resident with call bell cord around (his/her) neck. However, no evidence of intent or plan or strength to tighten cord. When confronted, Resident said (he/she) had no recall of doing that" ...."(He/she) said (he/she) still wanted to die but denied intent or plan" ...."It is requested that with each shift change, a staff person be appointed, who would spend 10 mins. for a one on one with Resident for positive attention and support. Incident of 4/11 appears to be a suicide gesture w/o intent or plan to carry out".

Resident #121 was seen by the licensed psychologist on 4/28/21 via telehealth and progress note states in part, "Staff consult prior to session indicated that Resident keeps saying 'I don't want to live'" ... "at end of session (he/she) started to cry saying (he/she) could not do it and (he/she) did not want to live. Resident has expressed in prior session (he/she) has no plan and no way or strength to do it. What Resident is expressing is not suicidal ideation but no will to live". Current risk factor for suicidal/self injury was documented as none.

A nursing progress note dated 5/01/21 12:33 am states in part "Late note for 2158 (9:58 pm): Resident was found in room laying in bed with eyes closed with call light tied tightly around neck.

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Resident was turning blue and when released and untied call light cord, resident stated (he/she) wished to die and that I had not found (him/her) so soon. Vitals were taken B/P 118/76, Pulse 84, O2 96, Resp 18, Temp 98.4. Placed aide 1 on 1 while calling transport and notifying doctor and family". Subsequent progress note dated 5/01/21 12:39 am states in part "late note for 2232 (10:32 pm) transport arrived ...As resident was leaving (he/she) stated (he/she) didn't remember tying call light cord around (his/her) neck and (he/she) didn't know why (he/she) would do something like that".

The After Visit Summary from (facility name omitted) Emergency Department dated 4/30/21 states in part, "Patient is not truly 'suicidal' due to the severity of (his/her) dementia. ((He/she) can't really decide to commit suicide). And (he/she) is so disabled (bed bound) that (he/she) is not able to act on a suicidal impulse even if (he/she) did have one. There is no known treatment for (his/her) acting out and having another psych evaluation and treatment would not do (him/her) any good. (He/she) does not need protective custody at a psych facility to prevent suicide. There is just no value in this. Please remove the call cord from (his/her) reach. (Facility name omitted) is a safe and good place for (him/her) to stay".

On 5/06/21 at 12:33 pm, the DON (director of nursing) stated the facility does not have a policy addressing what triggers a PASARR to be done.

The administrator provided with surveyor with Resident #121's Level I PASARR dated 10/12/18, which stated the resident met nursing facility criteria.

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| F 646 | Continued From page 36<br><br>On 5/11/12 at 4:54 pm, surveyor informed the administrator, assistant administrator, DON, nurse consultant #1, nurse consultant #2, and the VP of Operations of Resident #121 not being referred for a Level II PASARR screening following three separate suicide attempts.<br><br>Surveyor spoke with the administrator and DON on 5/12/21 at 10:45 am, administrator stated they did not know why the resident was not referred for a Level II PASARR but (he/she) has now been referred. Administrator further stated that the social worker is brand new and they are "ironing some things out".<br><br>A progress note dated 5/11/21 6:02 pm states in part, "SSD left a message with Ascend to call (him/her) back, so (he/she) can schedule a PASARR for the res at this time".<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 5/12/21. | F 646 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, | F 689 | | |

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clinical record review, and during the course of a complaint investigation, facility staff failed to ensure the resident environment remained as free of accident hazards related to call light cord availability for 1 of 27 residents, Resident #121 and failed to include investigation of an elopement with identifying how the resident was able to exit the building for one (1) of 27 sampled current residents (Resident #64).

The findings included:

1. For Resident #121, the facility staff failed to remove the resident's call light cord following three separate incidents in which the resident had the call light cord wrapped around their neck. Two incidents resulted in transfer to a higher level of care following incidents occurring on 2/04/21 and 4/11/21. In the 5/1/21 attempt, the resident was found in room laying in bed with eyes closed with call light tied tightly around neck. The resident was turning blue and when released and untied call light cord, resident stated (he/she) wished to die. This is harm.

Resident #121's diagnosis list indicated diagnoses, which included, but not limited to Mood Disorder due to Known Physiological Condition, Schizoaffective Disorder Unspecified, Major Depressive Disorder Recurrent Unspecified, Unspecified Dementia with Behavioral Disturbance, Dysphagia following Unspecified Cerebrovascular Disease, Vitamin B12 Deficiency Anemia Unspecified, and Type 2 Diabetes Mellitus with Diabetic Neuropathy Unspecified.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of

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4/02/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. Resident #121 was coded as requiring supervision only for eating, extensive assistance with bed mobility, dressing, personal hygiene, and being totally dependent in transfers.

On 5/04/21 at approximately 2:45 pm surveyor observed Resident #121 sitting up in a reclining chair in the common area with other residents watching television. Surveyor introduced self and asked the resident how they were doing, Resident #121 immediately responded "depressed". The resident further stated "I'd rather be dead" and "I pray every day that I will die". The resident had a hand-held looped strap with jingle bells attached within reach, surveyor asked what the bells were for and resident stated "to get the nurses when I need them". On 5/04/21 at 6:34 pm, surveyor again spoke with the resident in the presence of Surveyor #2 and asked the resident if this surveyor could look at their neck. Resident #121 stated "what's wrong with my neck, oh I tried to choke myself" and resident further stated (he/she) "turned it loose when it started to hurt". Resident then became tearful and stated they were tired of living.

A nursing progress note dated 2/04/21 8:48 pm states "this nurse was notified by cna (certified nursing assistant) when (he/she) went in to answer call bell call bell was pulled out of the wall and was laying behind and across res (resident) neck when asked about this res stated (he/she) didn't know it was that way."

A subsequent nursing progress note dated 2/04/21 9:06 pm states "this nurse went in to talk

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to res about (him/her) going to er where (he/she) had call bell around neck res stated (he/she) didn't want to hurt (himself/herself) that (he/she) didn't know it was that way I explained to res were [sp] (he/she) had previously said (he/she) wanted to hurt (himself/herself) that (he/she) needs to go to er res stated (he/she) didn't even remember saying that that I'm libel to say anything just because I say it doesn't mean I need it".

Resident #121 was transported to the local ER and admitted on 2/04/21. The (hospital name omitted) Discharge Summary dated 2/09/21 states in part, "75-year-old (male/female) brought in for suspected suicidal intent. The nursing home reports that they found (him/her) with (his/her) nurse call light cord wrapped around (his/her) neck. The patient states that (he/she) does not remember this nor does (he/she) remember any intent to hurt (himself/herself). (He/she) admits to being depressed but states (he/she) has no intention of harming (himself/herself). In the ER (he/she) was found to have acute blood loss anemia with AKI (acute kidney injury) with UTI (urinary tract infection). (He/she) was admitted to the ICU with one-to-one"; "Crisis was consulted and initially recommended (he/she) go back to (facility name omitted) that can consult psychiatry NP (nurse practitioner), but (facility name omitted) declined. Today (he/she) was coordinate [sp] a bed with (facility name omitted) for inpatient psych, but require [sp] COVID 19 was positive today, after being negative (antigen and 4plex 2/05/21). Nursing home was notified and stated that patient had previously been COVID positive November 6th. Because of new COVID positive status patient was transferred to (facility name omitted). Patient is not able to make (his/her) own medical

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decisions with (his/her) confused status, continued suicidal ideations/depression/dementia".

Resident #121's Physician Discharge Summary from (facility name omitted) dated 2/11/21 states in part, "Patient was also seen by psychiatry. (He/she) is still actively suicidal/homicidal. (He/she) should continue full psych precautions"; "Patient is now medically stable for discharge. I have discussed with hospitalist at (facility name omitted) who agrees to accept patient in transfer and will assist in getting patient to (facility name omitted) inpatient psych as previously planned".

Resident #121 was admitted to (facility name omitted) for inpatient psych care on 2/13/21 and discharged on 2/27/21. Surveyor requested the resident's clinical records on 5/10/21, however, as of 5/18/21 the records had not been received.

Resident #121 was readmitted to the facility on 2/27/21 following inpatient psychiatric care at (facility name omitted).

A nursing progress note dated 4/11/21 7:46 pm states "this nurse was setting at desk was told by cna that res roommate had told (him/her) that res had put call bell around (his/her) neck when this nurse spoke with res (he/she) stated (he/she) was trying to kill herself but (he/she) stopped when it started to hurt". Addendum dated 4/11/21 9:44 pm states "Upon assessment of res o [sp] injuries noted by this nurse". Resident #121 was transported to the local ER at 7:58 pm.

The After Visit Summary from (facility name omitted) Emergency Department dated 4/11/21 states in part, "Follow-up with behavioral

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medicine on an outpatient basis. Maintain suicidal precautions". Surveyor requested the resident's clinical records from (facility name omitted) emergency department on 5/05/21, however, as of 5/18/21 the records had not been received.

A nursing progress note dated 4/11/21 11:58 pm states "res back from (facility name omitted) er only order is verbal order from hospital to follow up with (name omitted) on 4/12/21 res in bed with eyes closed".

Resident #121 was seen by the psychiatric NP (nurse practitioner) the following day on 4/12/21, the progress note states in part, "Per nursing patient had made a suicide attempt by wrapping call bell around (his/her) neck and was sent out to E.R. r/t suicide attempt and was returned back to the facility from (facility name omitted) with a diagnosis of memory problem. Subjective: Lying in bed (patient currently constant observation by CNA). Discussed with patient (his/her) attempt at suicide yesterday. Pt verbalized, 'I don't remember that, I'm glad I don't.' Denies thoughts of self harm/suicidal ideations. Endorses depressed; denies anxiety". Recommendations include "continue constant observation".

Resident #121 was seen by the licensed psychologist via telehealth on 4/14/21, progress note from the visit states in part, "Approached Resident with progress note report of 4/11/21, 7:46 pm, finding Resident with call bell cord around (his/her) neck. However, no evidence of intent or plan or strength to tighten cord. When confronted, Resident said (he/she) had no recall of doing that" ...."(He/she) said (he/she) still wanted to die but denied intent or plan" ...."It is

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requested that with each shift change, a staff person be appointed, who would spend 10 mins. for a one on one with Resident for positive attention and support. Incident of 4/11 appears to be a suicide gesture w/o intent or plan to carry out".

Resident #121 was seen by the licensed psychologist on 4/28/21 via telehealth and progress note states in part, "Staff consult prior to session indicated that Resident keeps saying 'I don't want to live'" ... "at end of session (he/she) started to cry saying (he/she) could not do it and (he/she) did not want to live. Resident has expressed in prior session (he/she) has no plan and no way or strength to do it. What Resident is expressing is not suicidal ideation but no will to live". Current risk factor for suicidal/self injury was documented as none.

On 5/06/21 at 6:58 am, surveyor spoke with LPN (licensed practical nurse) #1 who was caring for Resident #121 on 2/04/21 and 4/11/21 during the aforementioned incidents with the call bell cord. LPN #1 stated that in February, the CNA found the resident with the call light cord looped around their neck and originally the resident said (he/she) wanted to hurt (himself/herself) but then said (he/she) did not say that. LPN #1 stated that the second time (he/she) put the call light cord around (his/her) neck the roommate told the CNA and the CNA came and got them. LPN #1 stated the resident had already taken the cord off and said it started to hurt and (he/she) took it off. Surveyor asked LPN #1 what was done each time to prevent it from happening again and LPN #1 responded CNAs came in both times and did one on one care "I think for a couple days".

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A nursing progress note dated 5/01/21 12:33 am states in part "Late note for 2158 (9:58 pm): Resident was found in room laying in bed with eyes closed with call light tied tightly around neck. Resident was turning blue and when released and untied call light cord, resident stated (he/she) wished to die and that I had not found (him/her) so soon. Vitals were taken B/P 118/76, Pulse 84, O2 96, Resp 18, Temp 98.4. Placed aide 1 on 1 while calling transport and notifying doctor and family". Subsequent progress note dated 5/01/21 12:39 am states in part "late note for 2232 (10:32 pm) transport arrived ...As resident was leaving (he/she) stated (he/she) didn't remember tying call light cord around (his/her) neck and (he/she) didn't know why (he/she) would do something like that".

The After Visit Summary from (facility name omitted) Emergency Department dated 4/30/21 states in part, "Patient is not truly 'suicidal' due to the severity of (his/her) dementia. ((He/she) can't really decide to commit suicide). And (he/she) is so disabled (bed bound) that (he/she) is not able to act on a suicidal impulse even if (he/she) did have one. There is no known treatment for (his/her) acting out and having another psych evaluation and treatment would not do (him/her) any good. (He/she) does not need protective custody at a psych facility to prevent suicide. There is just no value in this. Please remove the call cord from (his/her) reach. (Facility name omitted) is a safe and good place for (him/her) to stay". Surveyor requested the resident's clinical records from (facility name omitted) emergency department on 5/05/21, however, as of 5/18/21 the records had not been received.

Nursing progress note dated 5/01/21 9:11 am

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states in part "Resident back from ER for EVAL with no new orders noted. Resident denies suicidal ideations at this time. Placed on 1:1 observation and given hand bell to ring when needing assistance. Educated on use of hand bell and Resident states 'I'm not too far gone to understand how to use a bell'".

On 5/10/21 at 1:54 pm, surveyor spoke with RN #3 who was Resident #121's nurse on 4/30/21. RN #3 stated Resident #121's call light was on and they went to answer it and found resident with the call light cord wrapped around (his/her) neck 2 to 3 times and had to get help to remove it. RN #3 stated the resident's neck had a "reddish bruise place" where the call light clip was in their neck and neck appeared "like if you wear a rubber band on your wrist". RN #3 stated the call light cord became unplugged from the wall and caused the light to come on. RN #3 stated that "after the fact I was told (he/she) had done it before".

Resident #121's current care plan includes the problem area stating in part "has hx (history) of suicidal ideations", care plan approaches include in part, "monitor safety needs, 1 on 1 monitoring/sitter with res during times of crisis", "hand call bell", "In room visits 2x day by staff".

On 5/05/21 at approximately 3:30 pm, surveyor spoke with the MDS nurse who stated they were the manager on Saturday, 5/01/21, and they gave the resident the hand bells that day and added it to the care plan.

On 5/04/21 at approximately 6:40 pm, this surveyor and Surveyor #2 observed Resident #121's room, the resident's bed was positioned

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with the left side against the wall with the bed's electrical cord plugged into an outlet on the left side of the bed approximately two feet above the mattress. If the resident were in the bed, the electrical cord and outlet would be within arm's reach. Surveyor did not observe the resident in the bed on 5/04/21 during the first day of the survey. Both call light cords were plugged into the call light port on the wall and cords were lying on the other empty bed in the resident's room. The resident's over bed light had a string attached to turn the light on and off. At 6:55 pm Surveyor #2 discussed the room observations with the administrator, assistant administrator, DON (director of nursing), and nurse consultant #1.

The following morning, on 5/05/21 at approximately 8:00 am, surveyor entered the resident's room and observed a maintenance staff member in the room. Maintenance worker stated they were moving the bed outlet and removing the call light from the room because the resident was suicidal and they needed to get all the cords out. Resident #121 was not in the room during this time. At 1:06 pm, surveyor observed the resident's room and noted the outlet on the left side of the bed had been replaced with a solid plate covering it and the bed was now plugged into an outlet to the right side of the bed's headboard with a cord cover covering over the cord going down the wall. The call light cords were removed and the call light plug in ports were covered with a solid plate. The string attached to the over bed light had been removed.

On 5/06/21 at 1:50 pm, surveyor spoke with the administrator, DON, and the social worker and discussed precautions that were taken following

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each incident with the call bell cord. The DON stated that there were no recommendations from (facility name omitted) for suicide precautions when Resident #121 was readmitted to the facility. The administrator stated after the second incident, the resident was sent to the ER and the ER decided that (he/she) did not need evaluation and the facility put (him/her) on one to one checks until (he/she) was seen by (name omitted) psych nurse practitioner and (name omitted) psych services. The administrator stated the one to one checks were continued until the nurse practitioner and psych services decided to discontinue. The administrator further stated that after the third time (he/she) was sent to the ER and sent back, the call bell cord was taken away. The administrator stated that yesterday they took the outlet, put on a blank cover and wire molded the bed's electrical cord to the wall and removed the cord from the resident's radio and replaced it with batteries.

On 5/10/21 at 1:45 pm, surveyor spoke with the administrator and DON and asked why Resident #121's call light cord was not removed prior to the third incident. The DON stated that following the second incident it was "something that was missed" and "I didn't see it based on what the ER was saying".

Surveyor requested and received the facility policy and procedure entitled, "Suicidal Precautions" which states in part:
Policy
The resident who requires closer observation because of possible suicide are:
b. Depressed residents
e. Confused residents
f. Those with a history of previous suicide

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attempts
g. Those who have expressed a wish to die
From a nursing standpoint, suicide must always be kept in mind when caring for the resident with organic brain syndrome. Any attempt at suicide, any talk of death, uselessness of life or attempts (regardless of how minor), are considered serious and must be reported and written on the resident's chart.
Procedures
2. Maintain safe environment by removing sharp objects, cleaning solutions etc.
3. Careful documentation of subjective/objective assessment in Clinical Record.

On 5/12/21 at 12:30 pm during a meeting with the administrator, DON, nurse consultant #1, and nurse consultant #2 surveyor discussed the concern of Resident #121's call bell cord not being removed following two separate incidents of the resident wrapping the call light cord around their neck.

No further information regarding this issue was presented to the survey team prior to the exit conference on 5/12/21.

This is a complaint deficiency.
2. The facility's response to Resident #64's elopement failed to include documentation of an investigation into how the resident was able to exit the building without facility staff being aware.

Resident #64's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 3/1/21, had the resident assessed as being able to make self understood and as being able to understand others. Resident #64's brief interview for mental status (BIMS) summary

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score was documented as six (6) out of 15. Resident #64 was documented as requiring limited assistance with bed mobility, transfers, toilet use, and personal hygiene. Resident #64 was diagnosed with traumatic brain injury (TBI).

Resident #64's clinical documentation included a nursing note dated 4/24/21 at 12:55 a.m. that appeared to be a late entry for 4/23/21 at 10:45 p.m. This note included the following information: "A nurse from North Side Hall called this nurse asked if I had all my patients on the floor, I checked on all my patients everyone was present and accounted for with the exception of this (patient). The nurse stated (local ambulance service name omitted) seen a male wearing a hat and jacket walking down the hill past the (hospital) thought (the patient) might be a patient here (at) this facility. Two nurses drove down the road together picked (patient) up (at) (local church name omitted) (patient) transported back to this facility no acute distress noted." Documentation indicated Resident #64 was immediately placed on a secure unit in the facility and was also placed on 'every 15 minute' checks.

On 5/11/21 at 10:22 a.m., the facility's Administrator, Director of Nursing (DON), and Nurse Consultant #2 was asked about the availability of recordings from facility security cameras. It was reported the facility does not have security cameras.

On 5/11/21 at 4:25 p.m., the facility's Acting Maintenance Director (AMD) was interviewed about the facility's door alarms. The AMD reported that all doors exiting the building, with the exception of the front doors, had an alarm that when triggered would sound until someone

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turned the alarm off. The AMD explained that there was a door, prior to residents accessing the front doors, that when triggered would sound until someone turned the alarm off.

On 5/12/21 at 11:13, the Assistant Administrator provided the survey team with staff members' written statements obtained in response to Resident #64's aforementioned elopement. No information was provided to indicate the facility's doors were checked after the elopement to evaluate the functioning of the door alarms. The survey team was provided documentation that showed the routine door checks were completed on 4/23/21 and 4/26/21; this documentation did not include the times of when the facility's doors were checked. No evaluation of the door alarm system was documented as part of the investigation into this event.

The written statements provided by facility staff working at the time Resident #64 eloped on 4/23/21 addressed the discovery of the resident missing and the return of the resident. The written statements did not address an investigation into how Resident #64 was able to exit the building without staff being aware.

The facility policy titled "Wandering and Elopement" (with a revision date of March 2019) included the following information: "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents." This policy focused on the resident specific prevention of and response to an elopement; this policy did not address the investigation of facility factors that could have contributed to an elopement.

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| F 689 | Continued From page 50<br><br>The facility policy titled "INCIDENT AND ACCIDENT REPORT" (no date was found on this document) included the following information:<br>- "The Incident and Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury, allegations of theft and abuse registered by residents, visitors or family members and resident altercations and associates."<br>- "Incident is defined as any happening, not consistent with the routine operation of the facility that does not result in bodily injury or property damage."<br>- "An investigation must be initiated immediately and the incident must be reported within 24 hours of the discovery to the OLC and APS within 5 days."<br><br>The survey team had a meeting with the facility's Administrator, Director of Nursing, Nurse Consultant #1, and Nurse Consultant #2, on 5/12/21 at 12:27 p.m. During this meeting, the failure of facility staff's investigation, of this event, to attempt to address how the resident was able to exit the building without facility staff knowledge was discussed. No additional information related to this issue was provided to the survey team. | F 689 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- | F 692 | | |

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§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on interviews and the review of documents, it was determined the facility staff failed to provide services to address maintaining desirable body weight range for one (1) of 27 sampled current residents (Resident #44).

The findings include:

The facility staff failed to act upon dietary recommendations to address Resident #44's weight loss.

Resident #44's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 2/11/21, was signed as completed on 2/12/21. Resident #44 was assessed as being able to make self understood and as being able to understand others. Resident #44's brief interview for mental status (BIMS) summary score was documented as zero (0) out of 15. Resident #44 was documented as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #4 was

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documented as having total dependence for eating, transfers, and bathing. Resident #44's diagnoses included, but were not limited to: high blood pressure, Alzheimer's disease, depression, and lower back pain.

Review of Resident #44's clinical documentation revealed the following weights:
- 116 pounds on 6/2/20;
- 120 pounds on 7/1/20;
- 121 pounds on 8/3/20;
- 120 pounds on 9/2/20;
- 101 pounds on 10/1/20;
- 98 pounds on 12/3/20;
- 91 pounds on 1/4/21;
- 92 pounds on 2/3/21;
- 90 pounds on 3/3/21;
- 91 pounds on 4/1/21; and
- 92 pounds on 5/3/21.

The following information was found in dietary notes:
- On 10/7/20 at 12:57 p.m. - " ... 101 (pounds) revealing a significant weight loss of 15.9% in 30 and 90 (days) and 13.7% in 180 (days). (The resident) is (status post) (fractured) hip. (The resident) receives pureed diet and intake is (approximately) 50% of meals. Recommend the addition of MedPass 90cc (three times a day). May want to consider the addition of 7.5mg remeron [sic] in attempt to increase intake. Will follow."
- On 12/31/20 at 2:15 p.m. - " ... 98 (pounds) (on) 12/3; 30 day (weight) not available; 90 day (weight): 120 (pounds) (on) 9/2; 180 day (weight): 116 (pounds) (on) 6/2. Weight loss is significant (times) 90 and 180 days. BMI (body mass index): 16.8 indicating underweight status. (The resident) receives a regular puree diet and is on

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Mirtazapine. Will recommend Medpass 60 ml (three times a day) for additional calories to support weight gain. Will continue to monitor.
- On 1/28/21 at 9:39 a.m. - " ... 91 (pounds) (on) 1/4; 30 day (weight): 98 (pounds) (on) 12/3; 90 day (weight): 101 (pounds) (on) 10/1; 180 day (weight): 120 (pounds) (on) 7/1. Weight loss is significant (times) 30, 90 and 180 days. (The resident) is on a regular puree diet. (Oral) intake 7 day (average): (breakfast) - 67% (lunch) - 57% (dinner) - 67% ... Will recommend start Medpass 120 ml (three times a day) and Prostat 30 ml (twice a day). Will monitor for additional needs."
- On 2/25/21 at 6:53 a.m. - " ...92 (pounds) (on) 2/3; 30 day (weight): 91 (pounds) (on) 1/4; 90 day (weight): not (available); 180 day (weight): 121 (pounds) (on) 8/3. Weight loss is significant (times) 180 days. BMI (body mass index): 15.8 indicating underweight status. (The resident) is on a regular puree diet with no supplements. (Oral) intake 7 day (average): (breakfast) - 64% (lunch) - 68% (dinner) - 67%. Will recommend start Medpass 120 ml (three times a day) to support weight gain. Will continue to monitor.
- On 3/31/21 at 4:10 P.M. - " ...90 (pounds) (on) 3/3 indicating a significant weight loss (times) 90 and 180 days. (The resident) is on a regular puree diet. Will recommend Medpass 120 ml (three times a day). Will monitor.

The following information was found as part of a medical provider note dated 10/14/2020: "Today we will start giving (the resident) 90cc of MedPass three times a day ... I will continue to monitor (the resident) for weight loss and make further adjustments if needed."

Resident #44's clinical documentation failed to show evidence of addressing the aforementioned

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| F 692 | Continued From page 54<br>Med Pass recommendations until 4/6/21 when Med Pass 120 ml (three times a day) was ordered by a medical provider. (Med Pass is a nutritional supplement.) Resident #44's care plan included the following approach: "IF NOT ALREADY PRESCIBED, ASSESS NEED FOR SUPPLEMENT/ASSESS & MEET (the resident's) ORAL CARE NEEDS."<br><br>The survey team had a meeting with the facility's Administrator, Director of Nursing, Nurse Consultant #1, and Nurse Consultant #2, on 5/12/21 at 12:27 p.m. During this meeting, the failure of facility staff to timely act on dietary recommendations to address Resident #44's weight loss was discussed. No additional information related to this issue was provided to the survey team. | F 692 | | |
| F 728 SS=D | Facility Hiring and Use of Nurse Aide<br>CFR(s): 483.35(d)(1)-(3)<br><br>§483.35(d) Requirement for facility hiring and use of nurse aides-<br>§483.35(d)(1) General rule.<br>A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless-<br>(i) That individual is competent to provide nursing and nursing related services; and<br>(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or<br>(B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). | F 728 | | |

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§483.35(d)(2) Non-permanent employees.
A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.

§483.35(d)(3) Minimum Competency
A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual-
(i) Is a full-time employee in a State-approved training and competency evaluation program;
(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or
(iii) Has been deemed or determined competent as provided in §483.150(a) and (b).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, employee record review, and facility documentation review, the facility staff failed to ensure that one (Employee # 27) of four unlicensed nurse aides was able to demonstrate competency in skills and techniques necessary to care for residents' needs.

The findings included:

For Employee # 27, the facility staff failed to ensure a competency skills proficiency checklist was documented.

Review of Employee Records was conducted on 05/11/2021. Review of the personnel file for Employee # 27 revealed the following:

Employee # 27 was hired on 7/17/2020 as an

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| F 728 | Continued From page 56<br>"unlicensed nurses aide." Employee #27 finished the "AHCA (American Health Care Association) -NCAL (National Center for Assisted Living) Temporary Nurse Aides online course" on 7/15/2020. The facility staff was unable to provide a copy of the competency skills checklist for Employee # 27.<br><br>On 5/12/2021 at 9:48 a.m., an interview was conducted with the Human Resources Director who stated the staff development coordinator could not find the competency skills check list for Employee 27. The Human Resources Director stated the expectation was that a skills checklist would be completed and in the file for each unlicensed nurses aide.<br><br>The Administrator was advised of the issue on 05/12/2021 during the end of day debriefing.<br><br>No further information was provided. | F 728 | | |
| F 740 SS=G | Behavioral Health Services<br>CFR(s): 483.40<br><br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, and | F 740 | | |

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clinical record review, the facility staff failed to coordinate necessary behavioral health care services to attain the highest practicable physical, mental, and psychological well-being for 1 of 27 residents, Resident #121.

The finding included:

For Resident #121, facility staff failed coordinate behavioral health care services between the resident's guardian, facility staff, physician, and behavioral health care services following suicidal ideations resulting in three separate suicide attempts. In one of the attempts, The resident was found in room laying in bed with eyes closed with call light tied tightly around neck. The resident was turning blue and when released and untied call light cord, resident stated (he/she) wished to die. This is harm.

Resident #121's diagnosis list indicated diagnoses, which included, but not limited to Mood Disorder due to Known Physiological Condition, Schizoaffective Disorder Unspecified, Major Depressive Disorder Recurrent Unspecified, Unspecified Dementia with Behavioral Disturbance, Dysphagia following Unspecified Cerebrovascular Disease, Vitamin B12 Deficiency Anemia Unspecified, and Type 2 Diabetes Mellitus with Diabetic Neuropathy Unspecified.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/02/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. Resident #121 was coded as requiring supervision only for eating, extensive assistance with bed mobility,

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dressing, personal hygiene, and being totally dependent in transfers. In section I, Active Diagnoses, Resident #121 was coded for the diagnoses of anxiety disorder, depression, schizophrenia, and schizoaffective disorder unspecified.

On 5/04/21 at approximately 2:45 pm surveyor observed Resident #121 sitting up in a reclining chair in the common area with other residents watching television. Surveyor introduced self and asked the resident how they were doing, Resident #121 immediately responded "depressed". The resident further stated "I'd rather be dead" and "I pray every day that I will die". The resident had a hand-held looped strap with jingle bells attached within reach, surveyor asked what the bells were for and resident stated "to get the nurses when I need them". On 5/04/21 at 6:34 pm, surveyor again spoke with the resident in the presence of Surveyor #2 and asked the resident if this surveyor could look at their neck. Resident #121 stated "what's wrong with my neck, oh I tried to choke myself" and resident further stated (he/she) "turned it loose when it started to hurt". Resident then became tearful and stated they were tired of living.

A nursing progress note dated 2/04/21 8:48 pm states "this nurse was notified by cna (certified nursing assistant) when (he/she) went in to answer call bell call bell was pulled out of the wall and was laying behind and across res (resident) neck when asked about this res stated (he/she) didn't know it was that way."

A subsequent nursing progress note dated 2/04/21 9:06 pm states "this nurse went in to talk to res about (him/her) going to er where (he/she)

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had call bell around neck res stated (he/she) didn't want to hurt (himself/herself) that (he/she) didn't know it was that way I explained to res were [sp] (he/she) had previously said (he/she) wanted to hurt (himself/herself) that (he/she) needs to go to er res stated (he/she) didn't even remember saying that that I'm libel to say anything just because I say it doesn't mean I need it".

Resident #121 was transported to the local ER and admitted on 2/04/21. The (hospital name omitted) Discharge Summary dated 2/09/21 states in part, "75-year-old (male/female) brought in for suspected suicidal intent. The nursing home reports that they found (him/her) with (his/her) nurse call light cord wrapped around (his/her) neck. The patient states that (he/she) does not remember this nor does (he/she) remember any intent to hurt (himself/herself). (He/she) admits to being depressed but states (he/she) has no intention of harming (himself/herself). In the ER (he/she) was found to have acute blood loss anemia with AKI (acute kidney injury) with UTI (urinary tract infection). (He/she) was admitted to the ICU with one-to-one"; "Crisis was consulted and initially recommended (he/she) go back to (facility name omitted) that can consult psychiatry NP (nurse practitioner), but (facility name omitted) declined. Today (he/she) was coordinate [sp] a bed with (facility name omitted) for inpatient psych, but require [sp] COVID 19 was positive today, after being negative (antigen and 4plex 2/05/21). Nursing home was notified and stated that patient had previously been COVID positive November 6th. Because of new COVID positive status patient was transferred to (facility name omitted). Patient is not able to make (his/her) own medical decisions with (his/her) confused status,

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continued suicidal ideations/depression/dementia".

Resident #121's Physician Discharge Summary from (facility name omitted) dated 2/11/21 states in part, "Patient was also seen by psychiatry. (He/she) is still actively suicidal/homicidal. (He/she) should continue full psych precautions"; "Patient is now medically stable for discharge. I have discussed with hospitalist at (facility name omitted) who agrees to accept patient in transfer and will assist in getting patient to (facility name omitted) inpatient psych as previously planned".

Resident #121 was admitted to (facility name omitted) for inpatient psych care on 2/13/21 and discharged on 2/27/21. Surveyor requested the resident's clinical records on 5/10/21, however, as of 5/18/21 the records had not been received.

Resident #121 was readmitted to the facility on 2/27/21 following inpatient psychiatric care at (facility name omitted).

A nursing progress note dated 4/11/21 7:46 pm states "this nurse was setting at desk was told by cna that res roommate had told (him/her) that res had put call bell around (his/her) neck when this nurse spoke with res (he/she) stated (he/she) was trying to kill herself but (he/she) stopped when it started to hurt". Addendum dated 4/11/21 9:44 pm states "Upon assessment of res o [sp] injuries noted by this nurse". Resident #121 was transported to the local ER at 7:58 pm.

The After Visit Summary from (facility name omitted) Emergency Department dated 4/11/21 states in part, "Follow-up with behavioral medicine on an outpatient basis. Maintain

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suicidal precautions". Surveyor requested the resident's clinical records from (facility name omitted) emergency department on 5/05/21, however, as of 5/18/21 the records had not been received.

A nursing progress note dated 4/11/21 11:58 pm states "res back from (facility name omitted) er only order is verbal order from hospital to follow up with (name omitted) on 4/12/21 res in bed with eyes closed".

Resident #121 was seen by the psychiatric NP the following day on 4/12/21, the progress note states in part, "Per nursing patient had made a suicide attempt by wrapping call bell around (his/her) neck and was sent out to E.R. r/t suicide attempt and was returned back to the facility from (facility name omitted) with a diagnosis of memory problem. Subjective: Lying in bed (patient currently constant observation by CNA). Discussed with patient (his/her) attempt at suicide yesterday. Pt verbalized, 'I don't remember that, I'm glad I don't.' Denies thoughts of self harm/suicidal ideations. Endorses depressed; denies anxiety". Recommendations include "continue constant observation". On 5/06/21 at 1:50 pm, surveyor spoke with the administrator, DON (director of nursing), and the social worker and asked how long did the psychiatric NP want Resident #121 to remain under constant observation, the DON stated "(he/she) didn't specify".

Surveyor attempted to contact the psychiatric NP on 5/05/21, 5/06/21, and 5/10/21; however, the voice mailbox was full each time and surveyor was unable to leave a message.

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Resident #121 was seen by the licensed psychologist via telehealth on 4/14/21, progress note from the visit states in part, "Approached Resident with progress note report of 4/11/21, 7:46 pm, finding Resident with call bell cord around (his/her) neck. However, no evidence of intent or plan or strength to tighten cord. When confronted, Resident said (he/she) had no recall of doing that" ...."(He/she) said (he/she) still wanted to die but denied intent or plan" ...."It is requested that with each shift change, a staff person be appointed, who would spend 10 mins. for a one on one with Resident for positive attention and support. Incident of 4/11 appears to be a suicide gesture w/o intent or plan to carry out".

Resident #121 was seen by the licensed psychologist on 4/28/21 via telehealth and progress note states in part, "Staff consult prior to session indicated that Resident keeps saying 'I don't want to live'" ... "at end of session (he/she) started to cry saying (he/she) could not do it and (he/she) did not want to live. Resident has expressed in prior session (he/she) has no plan and no way or strength to do it. What Resident is expressing is not suicidal ideation but no will to live". Current risk factor for suicidal/self injury was documented as none.

On 5/06/21 at 6:58 am, surveyor spoke with LPN (licensed practical nurse) #1 who was caring for Resident #121 on 2/04/21 and 4/11/21 during the aforementioned incidents with the call bell cord. LPN #1 stated that in February, the CNA found the resident with the call light cord looped around their neck and originally the resident said (he/she) wanted to hurt (himself/herself) but then said (he/she) did not say that. LPN #1 stated that the

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second time (he/she) put the call light cord around (his/her) neck the roommate told the CNA and the CNA came and got them. LPN #1 stated the resident had already taken the cord off and said it started to hurt and (he/she) took it off. Surveyor asked LPN #1 what was done each time to prevent it from happening again and LPN #1 responded CNAs came in both times and did one on one care "I think for a couple days".

A nursing progress note dated 5/01/21 12:33 am states in part "Late note for 2158 (9:58 pm): Resident was found in room laying in bed with eyes closed with call light tied tightly around neck. Resident was turning blue and when released and untied call light cord, resident stated (he/she) wished to die and that I had not found (him/her) so soon. Vitals were taken B/P 118/76, Pulse 84, O2 96, Resp 18, Temp 98.4. Placed aide 1 on 1 while calling transport and notifying doctor and family". Subsequent progress note dated 5/01/21 12:39 am states in part "late note for 2232 (10:32 pm) transport arrived ...As resident was leaving (he/she) stated (he/she) didn't remember tying call light cord around (his/her) neck and (he/she) didn't know why (he/she) would do something like that".

The After Visit Summary from (facility name omitted) Emergency Department dated 4/30/21 states in part, "Patient is not truly 'suicidal' due to the severity of (his/her) dementia. ((He/she) can't really decide to commit suicide). And (he/she) is so disabled (bed bound) that (he/she) is not able to act on a suicidal impulse even if (he/she) did have one. There is no known treatment for (his/her) acting out and having another psych evaluation and treatment would not do (him/her) any good. (He/she) does not need protective

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custody at a psych facility to prevent suicide. There is just no value in this. Please remove the call cord from (his/her) reach. (Facility name omitted) is a safe and good place for (him/her) to stay". Surveyor requested the resident's clinical records from (facility name omitted) emergency department on 5/05/21, however, as of 5/18/21 the records had not been received.

Nursing progress note dated 5/01/21 9:11 am states in part "Resident back from ER for EVAL with no new orders noted. Resident denies suicidal ideations at this time. Placed on 1:1 observation and given hand bell to ring when needing assistance. Educated on use of hand bell and Resident states 'I'm not too far gone to understand how to use a bell'".

On 5/10/21 at 1:54 pm, surveyor spoke with RN #3 who was Resident #121's nurse on 4/30/21. RN #3 stated Resident #121's call light was on and they went to answer it and found resident with the call light cord wrapped around (his/her) neck 2 to 3 times and had to get help to remove it. RN #3 stated the resident's neck had a "reddish bruise place" where the call light clip was in their neck and neck appeared "like if you wear a rubber band on your wrist". RN #3 stated the call light cord became unplugged from the wall and caused the light to come on. RN #3 stated that "after the fact I was told (he/she) had done it before".

Resident #121's current care plan includes the problem area stating in part "has hx of suicidal ideations", care plan approaches include in part, "monitor safety needs, 1 on 1 monitoring/sitter with res during times of crisis", "hand call bell", "In room visits 2x day by staff".

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On 5/05/21 at approximately 3:30 pm, surveyor spoke with the MDS nurse who stated they were the manager on Saturday, 5/01/21, and they gave the resident the hand bells that day and added it to the care plan.

Resident #121 was seen for their weekly telehealth visit with the licensed psychologist on 5/05/21, the progress note states in part, "(He/she) added 'I'm depressed out of my mind. I don't want to live'.. ...(He/she) continues to express low will to live in terms of praying for god to take (him/her), which is differentiated from active suicidal ideation, intent, or plan at this time." The progress note does not include any documentation of the incident on 4/30/21 when the resident wrapped the call bell cord around their neck. Surveyor could not locate documentation that the psychologist was notified of the 4/30/21 incident.

Surveyor attempted to contact the licensed psychologist by leaving voice messages on 5/06/21 and 5/10/21, however, as of survey exit on 5/12/21 the calls had not been returned.

Surveyor was unable to locate documentation in the resident's clinical record of the psychiatric NP being notified following the 4/30/21 incident. The last documented progress note from the psychiatric NP was dated 4/28/21.

On 5/04/21 at approximately 6:40 pm, this surveyor and Surveyor #2 observed Resident #121's room, the resident's bed was positioned with the left side against the wall with the bed's electrical cord plugged into an outlet on the left side of the bed approximately two feet above the

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mattress. If the resident were in the bed, the electrical cord and outlet would be within arm's reach. Surveyor did not observe the resident in the bed on 5/04/21 during the first day of the survey. Both call light cords were plugged into the call light port on the wall and cords were lying on the other empty bed in the resident's room. The resident's over bed light had a string attached to turn the light on and off. At 6:55 pm Surveyor #2 discussed the room observations with the administrator, assistant administrator, DON, and nurse consultant #1.

The following morning, on 5/05/21 at approximately 8:00 am, surveyor entered the resident's room and observed a maintenance staff member in the room. Maintenance worker stated they were moving the bed outlet and removing the call light from the room because the resident was suicidal and they needed to get all the cords out. Resident #121 was not in the room during this time. At 1:06 pm, surveyor observed the resident's room and noted the outlet on the left side of the bed had been replaced with a solid plate covering it and the bed was now plugged into an outlet to the right side of the bed's headboard with a cord cover covering over the cord going down the wall. The call light cords were removed and the call light plug in ports were covered with a solid plate. The string attached to the over bed light had been removed.

On 5/06/21 at 1:50 pm, surveyor spoke with the administrator, DON (director of nursing), and the social worker and discussed precautions that were taken following each incident with the call bell cord. The DON stated that there were no recommendations from (facility name omitted) for suicide precautions when Resident #121 was

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readmitted to the facility. The administrator stated after the second incident, the resident was sent to the ER and the ER decided that (he/she) did not need evaluation and the facility put (him/her) on one to one checks until (he/she) was seen by (name omitted) psych nurse practitioner and (name omitted) psych services. The administrator stated the one to one checks were continued until the nurse practitioner and psych services decided to discontinue. The administrator further stated that after the third time (he/she) was sent to the ER and sent back, the call bell cord was taken away. The administrator stated that yesterday they took the outlet, put on a blank cover and wire molded the bed's electrical cord to the wall and removed the cord from the resident's radio and replaced it with batteries.

On 5/10/21 at 1:45 pm, surveyor spoke with the administrator and DON and asked why Resident #121's call light cord was not removed prior to the third incident. The DON stated that following the second incident it was "something that was missed" and "I didn't see it based on what the ER was saying".

Surveyor requested and received the facility policy and procedure entitled Suicidal Precautions which states in part:
Policy
The resident who requires closer observation because of possible suicide are:
b. Depressed residents
e. Confused residents
f. Those with a history of previous suicide attempts
g. Those who have expressed a wish to die
From a nursing standpoint, suicide must always

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be kept in mind when caring for the resident with organic brain syndrome. Any attempt at suicide, any talk of death, uselessness of life or attempts (regardless of how minor), are considered serious and must be reported and written on the resident's chart.
Procedures
2. Maintain safe environment by removing sharp objects, cleaning solutions etc.
3. Careful documentation of subjective/objective assessment in Clinical Record.

On 5/06/21 at 2:59 pm, surveyor spoke with the administrator and asked if the facility had discussed the resident's current situation with the resident's physician or the medical director for assistance, administrator stated "maybe the DON has but I haven't". At 3:15 pm, the DON stated they had just spoken with the medical director and they are okay with the resident being here now but if it happens again and the ER will not provide services then discharge (him/her). A progress note written by the DON dated 5/06/21 3:16 pm states "This nurse spoke with (name omitted), Medical Director of this facility in regards to resident's multiple discharges to ER d/t resident being found with cord wrapped around resident's neck. (Name omitted) advised that at this time (he/she) is comfortable with resident being in facility, however, if resident is discharged to ER from this facility for this or any other attempt to harm self and ER does not provide crisis services for resident that (name omitted) will request discharge from this facility d/t facility not being able to provide the extra services resident seems to need".

Surveyor could not locate documentation of physician notification following the resident's

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return from the ER on 5/01/21 without a mental health evaluation. Surveyor could not locate documentation that the resident's physician had assessed (him/her) following the incident on 4/30/21. On 5/10/21 at approximately 3:30 pm, surveyor spoke with Resident #121's physician via telephone. The physician stated they had been in the facility in the last 2 weeks, they stated they were aware of the three suicide attempts by Resident #121. Physician stated they have a problem with the ER and have no control over them. The physician further stated it is almost impossible to get an appointment with a psychiatrist. Surveyor asked the physician if they feel that Resident #121 is safe in the facility and they stated "that's a tough one" but it is a "guarded yes" and "overall I think it is".

On 5/10/21 at 1:20 pm surveyor spoke with the facility medical director concerning Resident #121's history of suicide attempts. The medical director stated that he was not very familiar with Resident #121 as (he/she) is (name omitted) patient but the facility did notify them when the resident was sent out on 5/01/21. The medical director stated that they do not think the ER called in the crisis team for the resident on 5/01/21. The medical director also stated that it is "very unlikely that an outpatient psychiatrist would see (him/her)". They also stated that the facility could watch (him/her) carefully, remove things out of reach, continue to see the psychiatric nurse practitioner, and set something up with nursing to check on (him/her).

On 5/06/21 at 2:32 pm, surveyor spoke with (name omitted) County Social Services APS (adult protective services) worker who stated they were present at the facility on 5/03/21 concerning

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the resident's suicide attempts, APS further stated that this is still an open investigation. APS worker stated they spoke to the resident's guardian via phone while onsite at the facility and asked about sending the resident out for further evaluation and the guardian stated the facility was not doing what (name omitted) the psychologist ordered and (he/she) did not want the resident sent out. The guardian also wanted the resident moved out to another facility. APS worker stated the area ombudsman was present during the call with the guardian.

On 5/05/21 at 4:41 pm surveyor spoke with the facility social worker who stated the guardian does not want the resident sent out to a psych hospital but did not say why.

On 5/06/21 at 9:45 am, surveyor spoke with the guardian listed on the resident's face sheet. Guardian #1 stated (name omitted) County DSS (Department of Social Services) has guardianship of Resident #121 and it includes three DSS employees. Guardian #1 stated the resident has had three suicide attempts and the first time they received conflicting stories and the resident said (he/she) did not do it. Guardian #1 stated they have been in contact with (name omitted), the licensed psychologist who recommended 20 minutes of one to one time each day, Resident #121 does not need to be sent out, they need to know someone cares. Guardian #1 states the psychologist believes the resident is doing this for attention. Guardian #1 stated the resident's guardianship is being changed to (name omitted) and it is currently in the court system. On 5/06/21 at 12:10 pm, surveyor meet with Guardian #1 and Guardian #2 onsite at the facility following their visit with Resident #121.

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On 5/11/21 at 11:30 am, surveyor spoke with Guardian #3 who stated they were present during the phone conversation between Guardian #1 and (name omitted) County APS when further evaluation of Resident #121 was declined. Guardian #3 stated they are in agreement with Guardian #1's decisions and does not see the reason to send the resident out as (he/she) is not suicidal unless (he/she) truly hurts themselves. Guardian #3 stated the resident is seeking attention and they are trying to follow the advice of the psychologist.

On 5/06/21 at 1:50 pm, surveyor spoke with the administrator who stated after the third incident, (name omitted) County APS was onsite at the facility and had behavioral health on the phone willing to evaluate the resident and the guardian refused for (name omitted) behavioral health to evaluate (him/her). Surveyor asked if the facility feels the resident is appropriate to stay in the facility at this time and the administrator stated they are potentially looking at a discharge unless the guardian comes around or the new guardian allows evaluation and "right now I think (he/she)'s okay".

On 5/12/21 at 10:45 am, surveyor spoke with the administrator and asked why the facility did not contact the guardian to further discuss the need for a mental evaluation with the guardian after his/her refusal was voiced to the (name omitted) County APS worker. The administrator stated APS was the direct liaison and (he/she) said (he/she) did not want the resident sent out and did not want (him/her) in this facility. Surveyor also asked if the facility had spoken with either of the two additional guardians and the DON stated

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| F 740 | Continued From page 72<br>the resident's guardianship is with (name omitted) and if guardianship is shared "that's news to us". The resident's face sheet lists Guardian #3 as the second contact with the relationship listed as "guardian".<br><br>Surveyor was unable to locate documentation of physician or medical director notification of the guardian's decision to decline the mental evaluation being offered by (name omitted) County DSS APS.<br><br>On 5/12/21 at 12:30 pm during a meeting with the administrator, DON, nurse consultant #1, and nurse consultant #2 surveyor discussed the concern of facility failing to follow up and coordinate care decisions related to the resident's suicidal ideations with the guardian, physician, psychiatric NP, behavioral psychologist, or the medical director.<br><br>No further information was presented to the survey team prior to the exit conference on 5/12/21. | F 740 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures | F 755 | | |

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that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview. and clinical record review, facility staff administered expired medications for 1 of 27 ( Resident #13).

Resident # 13 was admitted to the facility [9/17/17] with diagnoses including lymphedema, COPD, morbid obesity, type 2 diabetes mellitus, venous insufficiency, cellulitis of lower limb, major depressive disorder, and psychosis. On the quarterly minimum data set assessment (MDS) with assessment reference date 4/26/21, the resident scored 10/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

On 5/06/21 at 2:38 PM, the surveyor examined

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| F 755 | Continued From page 74<br>the south front hall medication cart. The surveyor discovered a Lispro humalog insulin pen labeled for Resident #13 which was marked opened 3-22-21 expired 4-19-21. The resident's nurse was with the surveyor when the expired pen was discovered.<br><br>Per the April medication administration record (MAR), the resident received 3 units per sliding scale for a blood sugar of 205 on 4/29/2021 at 4:30 PM; 3 units for blood sugar 211 per sliding scale on 5/1/2021 at 11:30 AM; 9 units per sliding scale for blood sugar 305 on 5/2/2021 at 7:30 AM; 3 units per sliding scale on 5/3/2021 at 4:30 PM; and 3 units per sliding scale for blood sugar 206 on 5/6/2021 at 11:30 AM. The resident did not have another Lispro pen in the medication cart.<br><br>The facility's Storage of Medications policy stated, under Unusable Drugs or Biologicals, "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.<br><br>The director of nursing and administrator were notified of the concern during a summary meeting on 5/6/2021. | F 755 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary | F 761 | | |

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instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, facility failed to remove from storage expired medications from the resident's medical supplies for 2 of 27 residents in the survey sample ( Residents #13 and 78).

The facility's Storage of Medications policy stated, under Unusable Drugs or Biologicals, "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

1. For Resident #13, facility staff failed to discard expired insulin.

On 5/06/21 at 2:38 PM, the surveyor examined

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| F 761 | Continued From page 76<br>the south front hall medication cart. The surveyor discovered a Lispro humalog insulin pen labeled for Resident #13 which was marked opened 3-22-21 expired 4-19-21. The resident's nurse was with the surveyor when the expired pen was discovered.<br><br>The resident did not have another Lispro pen in the medication cart.<br><br>2. For Resident #78, facility staff failed to discard expired Paroxetine.<br><br>Resident #78 was admitted to the facility [8/16/16] with diagnoses including cerebral infarction, schizoaffective disorder, bipolar disorder, violent behavior and hemiplegia. On the quarterly minimum data set assessment (MDS) with assessment reference date 3/9/2021, the resident the resident scored 11/15 on the brief interview for mental status and was assessed as without signs of delirium. The resident did exhibit hallucinations and behavioral symptoms not directed toward others in the week prior to the assessment.<br><br>On 5/06/21 at 10:06 AM, the surveyor examined the North front hall medication cart and discovered a card with one paroxetine 10 mg and expiration date 4/30/2021 labeled for Resident # 78. There was another, unexpired, card with paroxetine 10 mg in the medication cart.<br><br>The director of nursing and administrator were notified of the concern during a summary meeting on 5/6/2021. | F 761 | | |
| F 842 SS=E | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) | F 842 | | |

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§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

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by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interviews and the review of documents, it was determined the facility staff failed to ensure complete and/or accurate clinical documentation for six (6) out of 27 sampled current residents (Resident #13, Resident #90, Resident #101, Resident #121, Resident #124, and Resident #138).

The findings include:

1. The facility staff failed to insure Resident #13's

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clinical record included information about an episode of vomiting the resident experienced.

Resident #13's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/26/21, was signed as completed on 4/27/21. Resident #13 was assessed as being able to make self understood and as being able to understand others. Resident #13's brief interview for mental status (BIMS) summary score was documented as 10 out of 15. Resident #13 was documented as requiring supervision with eating but not as requiring physical assistance with eating. Resident #13 was documented as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #13 was assessed as having total dependence for bathing. Resident #13's diagnoses included, but were not limited to: high blood pressure, diabetes, depression, and lung disease.

During an interview on 5/6/21 at 8:05 a.m., the facility's Administrator reported they were present at the facility when Resident #13 was discovered to need to be cleaned due to having vomit on the clothes they were wearing.

During an interview on 5/12/21 at 8:55 a.m., the facility's Administrator and Assistant Administrator confirmed the resident's clinical documentation did not include information related to Resident #13 being found with vomit on the clothes they were wearing.

During an interview on 5/12/21 at 10:39 a.m., CNA (certified nursing assistant) #15 confirmed that Resident #13 had vomited on self as referenced above.

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The following information was found in a facility policy titled "Charting and Documentation" (with a revised date of July 2017): "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care ... Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate."

The survey team had a meeting with the facility's Administrator, Director of Nursing, Nurse Consultant #1, and Nurse Consultant #2, on 5/12/21 at 12:27 p.m. During this meeting, the failure of facility staff to document an assessment and/or treatment for Resident #13 related to the resident being found with vomit on their clothes was discussed. No additional information related to this issue was provided to the survey team.
2. For Resident #90, facility clinical documentation did not match the facility reported incident.

Resident #90 was admitted with diagnoses including fracture, arthritis, effusion of the left knee, hypertension, and hepatitis. On the minimum data set assessment with assessment reference date 3/19/21, the resident scored 0/15 on the brief interview for mental status and was assessed as having signs of delirium consisting of constant inattention and disorganized thinking. The resident was assessed as without signs of psychosis or behaviors affecting care.

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A facility reported incident dated 4/19/21 under Describe incident, including location, and action taken: "Resident [#90] was found outside the facility and resident was was assisted by facility by staff. The resident was assessed by nursing staff and no injuries were found. MD, RP, and APS notified. The resident was placed on 15 minute checks. Investigation initiated and final report to follow on five business days. Under Final Investigation: The incident involving Resident [#90] has been investigated by the facility. It was determined that Resident [#90] was found outside the facility and resident assisted back in the facility by staff. The resident was assessed by nursing staff and no injuries were found. MD, RP, and APS notified. There resident was placed on Q15 minute checks 72 hours. No other exit seeking occurrences similar to this has happened with Resident #90].

The only documentation in the clinical record on that date was a nursing note which read: "4/19/2021 2:00 AM Pt OOB in WC self propelling in hallway & in & out of other patients rooms rummaging redirected behavior numerous times pt's pants pockets full of straws, tissue papers, gloves, random stuff, pt tore through bottom of plastic in hallway crawled underneath ad opened the door leading outside pt redirected plastic restored per Maintenance, pt agitated @ times cussing @ staff, when this nurse was opening med cart drawer pt wheeled up beside the med cart slammed it shut twice stating ' you don't need anything in there get out' pt had a lighter acting like he was going to light the plastic barrier on fire in the hallway lighter confiscated when asked where he obtained the lighter he said shut the fuck up pt knocked down stack of folders on a rack, came behind the nurses desk

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numerous times rummaging through drawers trying to get in crash cart redirected pt numerous times pt would become angry using vulgar language @ staff, gave pt several snacks throughout the night, pt's (L) knee remains swollen. Called [redacted]NP regarding pt's behavior new order noted Give Vistaril 25 mg po X1 dose now DX-Anxiety".

The surveyor was unable to determine from the record whether the resident actually left the building.

The director of nursing indicated that crawling under the plastic and opening the door constituted an elopement.

3. For Resident #101, facility staff did not document the appearance or extent of wounds on the resident's sacrum and hip.

Resident #1 was admitted to the facility with diagnoses including dementia, diabetes mellitus, essential hypertension, major depression, anxiety, and mood disorder. On the annual minimum data set assessment with assessment reference date 3/10/2021, the resident scored 4/15 on the brief interview for mental status and was assessed as having continuous signs of delirium (inattention and disorganized thinking). The resident was not assessed as exhibiting signs of psychosis or behaviors affecting care.

Clinical Record review on 5/10/2021 revealed a physician order dated 4/26/21 to apply foam dressing to left hip Q3 days and PRN. Per the nurse practitioner (NP) note on that date, the NP had been notified there was an abscess or boil that needed assessment. The issue was not

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mentioned in nursing notes or skin assessments. A NP note dated 3/17/21 indicated staff asked the NP to assess a coccyx wound. The NP ordered a calcium alginate dressing to be changed every 3 days.

No treatments of the sacral wound were documented on the May 2021 treatment administration record (TAR). The record did not include an order to discontinue the sacral dressing.

The resident's care plan included "at risk of skin breakdown related to decreased mobility, incontinence, and history of refusing care". The care plan did not address actual wounds.

On 05/10/21, LPN #1 from the skilled unit had not seen the resident's wound. The TAR has no documented treatment of the sacral wound in May. The order was to clean with NS, apply Calcium alginate and apply border foam. LPN #1 went with the surveyor to assess the wound on 05/10/21 at 4:10 PM. There was no dressing on the sacral wound. The wound was several open areas with no depth. The most recent documented description of the wound was the one in the 3/17/21 NP note. LPN #1 stated she would get an order for a smaller dressing than the one ordered to better fit the affected area. At 05/10/21 at 4:21 PM, the nurse washed buttocks with normal saline and 4x4s ; patted dry with clean 4x4s; covered with a cut down calcium alginate dressing, and covered with a 3x3 bordered dressing.

4. For Resident #124, facility staff documented

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administering pain medication which was not administered.

Resident #124 was admitted to the facility with diagnoses including hypertensive heart disease, paraplegia, cauda equina syndrome, spina bifida, back and wrist pain, and major depression. On the quarterly minimum data set assessment with assessment reference date 4/6/21, the resident scored 12/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

Per adult protective service report and facility investigation documents, the resident's Percocet was missing and not available for administration on 2/14/2020 for the midnight and 6 AM doses.

The nurse caring for the resident that night documented administering the resident's pain medication with a pain level of 9/10 at both midnight and 6 AM (February 2020 medication administration record).

The administrator and director of nursing were notified of the concern during summary meetings on 5/6/2021.

5. For Resident #138 the facility staff failed to ensure that treatments were documented as completed.

Resident #138's face sheet listed diagnoses which included but not limited to pressure ulcer to right ankle, unstageable, peripheral vascular disease, anemia, pressure ulcer of left heel, unstageable, pressure ulcer of sacral region, unstageable, type 2 diabetes, chronic obstructive pulmonary disease, and depression.

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The most admission MDS (minimum data set) with an ARD (assessment reference date) of 04/14/2021 assigned the resident a BIMS (brief interview for mental status) score of 00 in section C, cognitive patterns. A score of 00 indicates the resident is severely cognitively impaired.

Resident #138's interim care plan was reviewed and contain a plan for "has impaired skin integrity r/t (related to) stage 2 R (right) hip, bilateral heels, R ankle, sacrum". Interventions for plan included "tx (treatment) as ordered".

Resident #138's clinical record was reviewed and contained a signed physician's order summary for the months of April and May 2021, which read in part "Cleanse Right heel wound with NS (normal saline), pat dry, apply Santyl ointment, adaptive, cover site daily and PRN (as needed)", "Cleanse left heel wound with normal saline, pat dry, apply Santyl ointment, adaptive, and cover site daily and PRN", "Stage 3 to right lateral malleolus (ankle) cleanse with NS pat dry apply polymem pink oval and change Q (every) day", and "Cleanse sacral wound with NS, pat dry, apply Santyl ointment, adaptive, 4 x 4, and cover site daily and PRN".

Resident #138's TAR's (treatment administration record) for the month of April and May were reviewed and contained entries as above. The entries for "Cleanse right heel wound with NS, pat dry, apply Santyl ointment, adaptive, and cover site daily and PRN", "Cleanse left heel wound with normal saline, pat dry, apply Santyl ointment, adaptive and cover site daily and PRN" and "Cleanse sacral wound with NS, pat dry, apply Mesalt, adaptive 4x4 and cover daily" were not

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initialed as completed on 04/20/21 and 04/26/21. The entries for "Cleanse right heel wound with NS, pat dry, apply Santyl ointment, adaptive, and cover site daily and PRN", "Cleanse left heel wound with normal saline, pat dry, apply Santyl ointment, adaptive and cover site daily and PRN", "Stage 3 to right lateral malleolus cleanse with NS pat dry apply polymem pink oval and change Q (every) day", "Cleanse sacral wound with NS, pat dry, apply Santyl ointment, adaptive, 4 x 4 , and cover site daily & PRN" were not initialed as completed on 05/07//21.

Surveyor spoke with the DON (director of nursing) and RNC (regional nurse consultant) #1 on 05/11/21 at approximately 2:45 pm regarding the blank areas on the TAR's. RNC #1 stated they felt it was a documentation issue. RNC #1 stated they would have the nurses that worked these days to speak with the surveyor.

Surveyor spoke with RN (registered nurse) #1, who is the facility's staff development coordinator, on 05/11/21 at approximately 3:05 pm. RN #1 stated they were working the floor on 04/20/21. RN #1 stated that APS (adult protective services) came into the facility and called staff to the lobby of the building, and after this, they (RN#1) just forgot to initial the treatment sheet. RN #1 stated they do not normally work the floor.
Surveyor spoke with UM (unit manager) on 05/11/21. Unit manager stated they completed Resident #138's treatment on 05/07/21, but just failed to initial the treatment sheet.

RNC #1 stated that they had spoken with the nurse that was working on 04/26/21 and that nurse stated they had completed the treatment, but just failed to initial the treatment sheet. RNC

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#1 stated they would have said nurse to call surveyor to confirm, since they were not working at this time.

The concern of failing to ensure treatments were documented as completed was discussed with the administrative team (administrator, assistant administrator, DON, RNC #1, RNC #2, regional vice-president of operations) on 05/12/21 at approximately 12:30 pm

No further information was provided prior to exit.
6. For Resident #121, facility staff failed to document treatment to an unstageable pressure area to the resident's left heel.

Resident #121's diagnosis list indicated diagnoses, which included, but not limited to Mood Disorder due to Known Physiological Condition, Schizoaffective Disorder Unspecified, Major Depressive Disorder Recurrent Unspecified, Unspecified Dementia with Behavioral Disturbance, Dysphagia following Unspecified Cerebrovascular Disease, Vitamin B12 Deficiency Anemia Unspecified, and Type 2 Diabetes Mellitus with Diabetic Neuropathy Unspecified.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/02/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. In section M, Skin Conditions, Resident #121 was coded as having one unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar.

Resident #121's clinical record included an active physician's order dated 2/27/21 stating "US

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(unstageable) to left heel cleanse with NS (normal saline) initially pat dry apply polymem pink cut to fit wound cover with bordered foam and change QD (everyday)". A review of Resident #121's April 2021 TAR (treatment administration record) and May 2021 TAR revealed the treatment to the left heel was not signed off as being completed on 4/20/21, 4/21/21, 4/22/21, 4/23/21, 4/24/21, 4/25/21, 4/26/21, 4/27/21, 4/28/21, 4/30/21, 5/01/21, 5/02/21, 5/03/21, 5/04/21, and 5/05/21.

On 5/06/21 at 3:31 pm, surveyor observed RN (registered nurse) #1 perform the physician ordered treatment to the resident's left heel. RN #1 stated the area was looking much better. Surveyor observed the area to the resident's left heel, no redness or drainage were noted and no concerns were identified with the wound care observation.

On 5/06/21 at 4:09 pm, surveyor notified the DON (director of nursing) of the treatment omissions on the April 2021 and May 2021 TARs for the treatment to the resident's left heel. The DON stated they would check into this.

On 5/06/21 at 4:43 pm, surveyor spoke with RN #2 who stated "I do (his/her) treatment every day" and "it's completely my fault for not signing off". RN #2 stated they worked and did the treatment on 4/20/21, 4/21/21, 4/25/21, 4/26/21, 5/03/21, and 5/04/21.

Surveyor requested and received the facility policy entitled, "Charting and Documentation" which states in part:
Policy Statement: All services provided to the resident, progress toward the care plan goals, or

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| F 842 | Continued From page 89<br>any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.<br>2. The following information is to be documented in the resident medical record:<br>c. Treatments or services performed;<br><br>The concern of Resident #121's pressure ulcer treatment omissions were discussed with the administrator, DON, nurse consultant #1, and nurse consultant #2 during a meeting on 5/12/21 at 12:30 pm.<br><br>No further information was provided to the survey team prior to the exit conference on 5/12/21. | F 842 | | |
| F 886 SS=E | COVID-19 Testing-Residents & Staff<br>CFR(s): 483.80 (h)(1)-(6)<br><br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not<br>limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with<br>COVID-19 in the facility; | F 886 | | |

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(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in

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emergencies due to testing supply shortages, contact state
and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, the facility staff failed to conduct COVID-19 outbreak testing for asymptomatic staff and residents during an identified facility COVID-19 outbreak for 1 of 3 staff members (LPN #2) and 3 of 3 residents (Resident #92, #109, and #116).

The findings included:

The facility staff failed to conduct COVID-19 outbreak testing for one asymptomatic staff member and three residents.

At the time of the survey, there were currently two COVID-19 positive residents and one positive staff member.

On 5/04/21 at approximately 1:45 pm during the Entrance Conference with the survey team, the administrator stated the facility currently has two COVID-19 positive residents and one positive staff member. The first COVID-19 positive result during this current outbreak was identified on 4/12/21. The administrator stated the facility is testing residents with signs and symptoms or potential exposures only and testing unvaccinated staff twice weekly. Administrator further stated that the county positivity rate went to red status yesterday.

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4/27/21 documents in part, "Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents, regardless of vaccination status, should be tested immediately, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identified no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result".

A review of LPN (licensed practical nurse) #2's COVID-19 testing since the onset of the current COVID-19 outbreak on 4/12/21 revealed documentation of testing performed on 4/20/21 only. COVID-19 Test form dated 4/20/21 for LPN #2 documented a negative result.

On 5/11/21 at 11:10 am surveyor spoke with the IP (infection preventionist) who stated staff that were present in the facility on 4/12/21 were tested at that time and the rest of the staff were tested on 4/13/21. The IP stated that staff COVID-19 testing is not mandatory.

A review of Resident #92's COVID-19 current outbreak testing documentation revealed the resident was tested on 4/12/21 with negative results and 5/06/21 with negative results. Surveyor was unable to locate documentation of COVID-19 testing results obtained between 4/12/21 and 5/06/21.

A review of Resident #109's medical record revealed the last documented COVID-19 test was obtained on 3/24/21 with negative results. Surveyor was unable to locate documentation of COVID-19 testing results since the facility COVID-19 outbreak was identified on 4/12/21.

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A review of Resident #116's medical record revealed the resident was tested on 4/12/21 with negative results and the next documented COVID-19 test was performed on 4/26/21 with positive results.

On 5/11/21 at 2:30 pm the DON (director of nursing) stated they "don't have any of these" as they returned the surveyor's list of missing COVID-19 testing results for Resident #92, 109, and 116.

On 5/11/21 at 4:10 pm surveyor spoke with the IP and discussed the missing resident COVID-19 testing results. The IP stated they do not have any results for Resident #92 or Resident #109 for 4/19/21 or 4/26/21, stating both residents were tested but the results were not documented. The IP stated for Resident #116, COVID-19 results were "probably not documented for 4/19/21".

Surveyor requested and received the facility policy entitled "COVID-19 Testing Plan" which states in part:
Testing in Response to an Outbreak
2. Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff, vaccinated and unvaccinated, staff and residents should be tested, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.
Filing of Confidential Lab Results
1. Employees:
a. All hard copies are filed in the COVID-19 binder in the Infection Preventionist office.

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| F 886 | Continued From page 94<br>2. Residents:<br>a. Lab results are provided to the attending physician for signature, then place in the medical record.<br><br>On 5/11/21 at 4:54 pm during a meeting with the administrator, assistant administrator, director of nursing, vice president of operations, nurse consultant #1, and nurse consultant #2, surveyor discussed the concern of LPN #2, Resident #92, Resident #109, and Resident #116's missing COVID-19 testing results.<br><br>No further information regarding this issue was presented to the survey team prior to the exit conference on 5/12/21. | F 886 | | |