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	495105	A. BUILDING _____ B. WING _____	C 07/01/2021

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LYNCHBURG HEALTH & REHABILITATION CENTER	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 6/29/2021 through 7/1/2021. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/29/21 through 7/1/21. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of quality of care at a scope and severity Level 4, pattern that resulted in the identification of substandard quality of care. Complaint (VA00052081) was investigated during the survey and was substantiated with a deficiency cited. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 150 at the time of the survey. The survey sample consisted of thirty current resident reviews and three closed record reviews. The expanded survey sample consisted of five current resident reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 641	The statements made in the following	8/6/21

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

Electronically Signed | 07/23/2021

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F 641	Continued From page 1 interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) for one of 38 residents in the survey sample. An admission MDS for Resident #56 had an inaccurate assessment of the resident's dental issues. The findings include: Resident #56 was admitted to the facility on 5/5/21 with diagnoses that included atrial fibrillation, atherosclerotic heart disease, hypertension, heart failure, benign prostatic hyperplasia, inguinal hernia, gastroesophageal reflux disease and localized edema. The MDS dated 5/11/21 assessed the resident with moderately impaired cognitive skills. On 6/29/21 at 2:52 p.m., Resident #56 was interviewed about quality of care in the facility. The resident was observed when talking with missing front teeth. Other visible teeth were broken, dark in color with several teeth black and decayed next to the gum tissue. The resident was interviewed about the condition of his teeth at this time. Resident #56 stated his teeth were in bad shape and he had not been to a dentist in over two years. The resident stated he only had six teeth with a fragment of a tooth near the front. Resident #56 stated, "Sometimes it's hard to chew." Section L of Resident #56's admission MDS assessment dated 5/11/21 documented the resident had no dental issues. Form sections to indicate tooth fragments, obvious/likely cavities, broken teeth and difficulty with chewing were blank. The form was marked, "None of the above [tooth fragments, obvious/likely cavities, broken	F 641	plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 1. A dental appointment was made for resident #56 immediately, while surveyors were onsite. 2. An audit will be conducted by the DON or designee on current residents to assess for dental care needs. 3. DON or designee will educate nursing staff on the appropriate steps to take for addressing dental care needs when identified. 4. MDS or designee will conduct an audit of MDS assessments to address dental care needs 3 times a week for 2 weeks, and weekly for 2 weeks. Concerns will be addressed immediately, and findings will be evaluated in the quarterly QAPI meeting. 5. Date of Compliance: August 6, 2021.	

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F 641	Continued From page 2 teeth, difficulty chewing] were present." On 6/30/21 at 5:30 p.m., the registered nurse (RN #2) responsible for MDS assessments was interviewed about Resident #56's dental assessment. RN #2 stated her assessment included interviews with the resident and a review of the clinical record. RN #2 stated she did not have an explanation for the inaccurate assessment of the resident's dental condition. This finding was reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p.m.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		8/6/21

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F 657	Continued From page 3 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to review and revise the comprehensive care plan for 5 of 38 Residents, (Resident #10, #23, #133, and #71). Resident #10's care plan was not reviewed and revised regarding hospice services, enhanced droplet precautions, and diabetes mellitus. Resident #23's care plan was not reviewed and revised regarding the resolution of pressure ulcers. Resident #133's care plan did not include hospice services. Resident #86's care plan was not reviewed and revised to include hospice admission and the use of geri-sleeves. Resident #71's care plan was not revised with problems, goals and interventions regarding pressure ulcers. Findings were: 1. Resident #10 was admitted to the facility on 02/01/2020 with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), malignant neoplasm of the endometrium, vascular dementia and hypertension. The most recent MDS (minimum data set) was a quarterly review with an ARD (assessment reference date) of 06/23/2021. Resident #10 was assessed as moderately impaired with a cognitive summary score of "10".	F 657	F657 1. Care plans for residents #10, #23, #133, and #71 were updated immediately, while surveyors were onsite. 2. An audit will be conducted by the DON or designee on current orders for hospice services, enhanced droplet-contact precautions, and diabetes, geri-sleeves, and pressure ulcers to ensure appropriate care plans are in place. 3. DON or designee will educate licensed staff on the appropriate process for updating care plans with current orders for hospice services, enhanced droplet-contact precautions, diabetes, geri-sleeves, and pressure ulcers. 4. DON or designee will conduct an audit of new orders for hospice services, enhanced droplet-contact precautions, diabetes, geri-sleeves, and pressure ulcers 3 times a week for 2 weeks and weekly for 2 weeks to ensure care plans are updated appropriately. Findings will be evaluated in the quarterly QAPI meeting 5. Date of Compliance: August 6, 2021.	

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F 657	Continued From page 4 On 06/29/2021 at approximately 11:00 a.m., during initial tour of the facility, Resident #10 was interviewed regarding life at the facility. During the interview, Resident #10 stated, "I just had a birthday last week...I was 90...my sister and I ate a whole chocolate cake to celebrate." Resident #10 was asked if she was a diabetic. She stated, "Heck no!" The clinical record was reviewed at approximately 2:00 p.m. An order was observed for Hospice Services. The care plan was reviewed. There were no interventions on the care plan for hospice services or any mention that hospice services were in place. Also observed on the care plan was a problem area, "Enhanced Droplet Precautions" with interventions in place. Resident #10 was not on enhanced droplet precautions. A problem area "Diabetes Mellitus" with interventions was also on the care plan. Resident #10 did not have a diagnosis of diabetes on her clinical record. On 06/30/2021 at approximately 3:30 p.m. the DON (director of nursing) was interviewed regarding the review and revision of care plans. She stated, "It's a combination between nursing and MDS." The problems identified with Resident #10's care plan were discussed. The corporate nurse consultant stated, "The nurses should be reviewing the care plans and updating them." He and the DON were asked how often care plans should be reviewed. The DON stated, "MDS makes changes at the quarterly and annual meetings...anything else should be updated and changed as it happens, usually within 24 hours." They were asked who should have made the changes to Resident #10's care plan. The DON	F 657		

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stated, "The charge nurse..but (name of LPN-licensed practical nurse #6) just took that position back over, (Name of LPN #5) was doing it before...I will look at it though and update it."

On 07/01/2021 at approximately 9:00 a.m., LPN #6 was interviewed regarding care plan revision. She stated, "I try to review them, but I just came back...(Name of LPN #5) would have done that." LPN #5 was then interviewed. She stated, "(Name of LPN #6) should do that."

The facility policy "Care Planning" was obtained and reviewed. The following was observed: "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly."

The above information was discussed with the administrator, the DON, the unit manager, and the corporate nurse consultant, during an end of the day meeting on 07/01/2021 at approximately 1:30 p.m. The DON was asked if there was an additional policy regarding reviewing and revising care plans that discussed the frequency of care plan revision. The corporate nurse consultant stated, "It is nursing...it's taught in school and it carries over to their job...they should have done it." The DON stated, "What you have is the only policy we have...there isn't one about revising."

No further information was obtained prior to the exit conference on 07/01/2021.

2. Resident #23 was admitted to the facility on 03/15/2021. Her admitting diagnoses included but were not limited to: Ulcerative colitis, hypertension, adult failure to thrive and major depressive disorder. An admission MDS

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(minimum data set) with an ARD (assessment reference date) of 04/13/2021, assessed Resident #23 as moderately impaired with a cognitive summary score of "08".

During the initial tour of the facility on 06/29/2021, at approximately 11:15 a.m., Resident #23 was interviewed. She was asked if she had any wounds, or sores on her body that the facility was treating. She stated, "No, I had some, but they done healed them all up. I'm good now."

On 06/29/2021 at approximately 1:30 p.m., the unit manager, LPN (Licensed Practical Nurse) #6 was asked if Resident #23 had any current skin issues. She stated, "No, she had some pressure areas at one time, but they are healed now."

The clinical record was reviewed on 06/30/2021 at approximately 8:30 a.m. The care plan was reviewed. Observed were problem areas listed for: "...has DTI [deep tissue injury] to left heel...Unstageable pressure ulcer to right heel...has stage 3 pressure ulcer sacrum..." with interventions to "Administer treatments as ordered and monitor for effectiveness" for all three areas.

On 06/30/2021 at approximately 10:00 a.m., Resident #23's care plan was discussed with the DON. She stated that the nurses should have updated the care plan when the pressure areas resolved.

On 07/01/2021 at approximately 9:00 a.m., LPN #5, who was the former unit manager was interviewed regarding Resident #23's care plan for pressure areas and deep tissue injury. She stated, "I thought I had resolved that off the care

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plan...I am sure I did." LPN #5 was told the problem areas were still showing as current. She stated, "I don't know what happened."

The above information was discussed with the administrator, the DON, the unit manager, and the corporate nurse consultant, during an end of the day meeting on 07/01/2021 at approximately 1:30 p.m.

No further information was obtained prior to the exit conference on 07/01/2021.

3. Resident # 133 was admitted to the facility on 05/30/2021 with the following diagnoses, including but not limited to: Dysphagia, vascular dementia, and adult failure to thrive. The admission MDS (minimum data set) with an ARD (assessment reference date) of 05/30/2021, assessed her as severely cognitively impaired with a summary score of "06".

The clinical record was reviewed on 06/30/2021 at approximately 1:00 p.m. A physician order for Hospice services was observed. The hospice records were reviewed indicating Resident #133 was admitted to hospice services on 06/18/2021. The facility care plan was reviewed. There were no interventions or indications on the care plan that Resident #133 was receiving hospice services.

On 06/30/2021 at approximately 1:30 p.m., Resident #133's care plan for hospice was discussed with the DON. She stated, "That resident is a recent admission to hospice, but the care plan should have been updated within 24 hours by the nursing staff to include that."

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The above information was discussed with the administrator, the DON, the unit manager, and the corporate nurse consultant, during an end of the day meeting on 07/01/2021 at approximately 1:30 p.m.

No further information was obtained prior to the exit conference on 07/01/2021.
4a. Resident #86 was originally admitted to the facility on 06/28/2019 and readmitted on 01/12/2021 with diagnoses including hospice, acute kidney failure, hypertension, mood disorder, dementia, anxiety, anemia, depression, and hyperlipidemia. The most recent minimum data set (MDS) dated 05/18/2021 was a significant change and assessed Resident #86 as severely cognitively impaired for daily decision making with a score of 7 out of 15.

On 06/29/2021 at 10:51 a.m. during the initial tour, Resident #86 was observed sitting near the nurse's station on the West Unit wearing geri-sleeves on both of his arms.

On 06/30/2021 at 8:23 a.m. Resident #86 was observed sitting near the nurse's station on the West Unit, he was not wearing geri-sleeves at this time.

On 06/30/2021 at 10:50 a.m., Resident #86 was observed sitting near the West Unit nurse's station wearing geri-sleeves on both of his arms.

On 06/30/21 8:23 a.m., Resident #86 was observed sitting near the West Unit nurse's station, he was not wearing geri-sleeves at this time.

On 06/30/21 at 10:50 a.m., Resident #86 was

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observed being transported in his wheelchair on the West Unit by the certified nursing assistant (CNA #3) who routinely provides care for him. Resident #86 was observed attempting to removing his geri-sleeves. CNA #3 was interviewed regarding the use and application of the geri-sleeves for Resident #86 at the time of the transport. CNA #3 stated at times Resident #86 becomes upset and will remove his geri-sleeves at other times he will not allow staff to place them on him at all. CNA #3 was asked if they documented Resident #86's refusal to wear the geri-sleeves. CNA #3 stated yes she notifies the charge nurse each time Resident #86 refuses care.

On 6/30/2021 Resident #86's clinical record was reviewed. Observed on the physician's order summary was the following order:...."Geri Sleeves bilateral Arms every shift for prevention.... Order Status: Active. Order Date: 04/13/2021. Start Date 04/13/2021...."

Resident #86's care plan did not document the use of the geri-sleeves as a preventive measure.

On 06/30/2021 at 12:30 p.m. and 6:30 p.m., Resident #86 was observed on the West Unit wearing geri-sleeves on both of his arms. On 06/30/2021 at 6:30 p.m., the unit manager (LPN #4) was interviewed regarding the use and application of the geri-sleeves for Resident #86. LPN #4 stated Resident #86 would often remove his geri-sleeves and slipper socks and she had educated staff on the importance of documenting his refusals and removals. LPN #4 was asked if the geri-sleeves should be included on the treatment orders and the care plans. LPN #4 stated yes this would be a way to document

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Resident #86's refusal to wear and/or removal of the geri-sleeves. LPN #4 was asked who was responsible for updating the care plans and treatment orders. LPN #4 stated both nursing and the MDS coordinators updated care plans and treatment orders.

On 07/01/2021 at 9:10 a.m., the MDS Coordinator (RN #1) was interviewed regarding the geri-sleeves and updating the care plan. RN #1 stated the geri-sleeves should have been added to the care plan. The corporate consultant was present at the time of the interview and stated he spoke with the nursing staff on the West Unit and there was some confusion whether or not to include the geri-sleeves on the treatment record and the care plans because Resident #86 would remove the geri-sleeves. The corporate consultant was asked what was the expectation and he stated the geri-sleeves should have been placed on both the treatment record and the care plans as an intervention.

4b. Resident #86's clinical record was reviewed on 06/30/21. Observed on the physician's order summary was the following order: ".....ADMIT to Hospice [agency name and number]. Order Status: Active. Order Date: 05/13/2021...." Observed within the clinical record was a progress note dated 05/13/2021 which documented, "....He (Resident #86) was admitted to Hospice [agency name] effective today 5/13/2021.... Son [Name] has been updated, staff will continue to monitor for changes...." Resident #86's hospice binder was reviewed. Observed within the binder was weekly hospice documentation regarding Resident #86's care. Resident #86's care plan did not include the hospice admission.

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On 06/30/21 at 6:15 p.m. the unit manager, LPN #4 was interviewed regarding if the hospice admission should have been included on Resident #86's care plan. LPN #4 stated yes that the MDS nurses should have included it when the significant change was completed.

On 07/01/21 at 9:10 a.m., the MDS coordinator (RN #1) was interviewed regarding if the hospice admission should be included on the care plan. RN #1 stated she normally reviewed and revised the care plans during the comprehensive assessments for any triggered CAAs (care area assessments) and the hospice admission should have been added to the care plan during the recent significant change assessment on 05/18/2021.

The above findings was shared with the administrator, director of nursing and corporate consultant during a meeting on 07/01/2021 at 1:10 p.m.

5. Resident #71 was admitted to the facility on 5/14/21 with a re-admission on 6/17/21. Diagnoses for Resident #71 included enterocolitis due to clostridium difficile (C-diff), neuropathic bladder, history of urinary tract infections, hypertension, chronic kidney disease, autistic disorder and anemia. The minimum data set (MDS) dated 5/11/21 assessed Resident #71 with moderately impaired cognitive skills.

Resident #71's clinical record documented the resident was re-admitted from the hospital on 6/17/21 with multiple pressure ulcers on his buttocks. A weekly skin evaluation sheet dated 6/17/21 documented the following pressure ulcer assessment for Resident #71:

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F 657	Continued From page 12 Left buttock - stage 2 pressure ulcer measuring 0.5 x 0.5 x 0 (length by width by depth in centimeters) Right buttock - two stage 2 pressure ulcers measuring 4.0 x 1.0 x 0 cm and 2.0 x 1.0 x 0 cm The clinical record documented a physician's order dated 6/18/21 to cleanse and apply zinc ointment with a dry dressing to the right and left buttock ulcers until healed. Nursing notes documented dressing changes and treatments were implemented as ordered. Resident #71's current plan of care (print date 6/30/21) was not revised with problems, goals and/or interventions regarding the pressure ulcers. The plan of care created on 5/17/21 listed the resident had potential for skin impairment but made no mention the resident currently had pressure ulcers with ongoing treatments. On 7/1/21 at 9:00 a.m., the registered nurse (RN #1) responsible for MDS and care plans was interviewed about Resident #71. RN #1 stated she and the nurses were responsible for updating care plans as needed. Concerning Resident #71's care plan, RN #1 stated if the pressure ulcers were not on the plan then it had not been updated. This finding was reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p.m.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		8/6/21

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F 677	Continued From page 13 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, complaint investigation, clinical record review, and staff interview, the facility staff failed for three of 38 residents in the survey sample (Residents # 80, 88 and 127), to provide routine foot care. Residents # 80, 88 and 127 had elongated toenails with clearly visible debris under the great toes on their left and right feet. The findings include: 1. Resident # 88 was admitted to the facility on 3/3/2020, and most recently readmitted on 1/28/2021 with diagnoses that included malignant neoplasm of endometrium, anemia, hypertension, renal insufficiency, diabetes mellitus, depression, generalized muscle weakness, difficulty walking, dysphagia, pulmonary hypertension, cerebral atherosclerosis, and gastroesophageal reflux disease. According to a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/21/2021, Resident # 88 was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 09 out of 15. Under Section G (Functional Status), the resident was assessed as needing limited assistance with one person physical assist for personal hygiene. At approximately 9:00 a.m. on 6/30/2021, an observation of Resident # 88's fingernails and toenails was conducted. Resident # 88's toenails	F 677	F677 1. Residents #80, #88, and #127 were placed on the podiatry list for a visit immediately, while surveyors were onsite. 2. An audit will be conducted by the DON or designee on current residents to assess for podiatry care needs. 3. DON or designee will educate nursing staff on the appropriate steps to take for addressing podiatry care needs when identified. 4. DON or designee will conduct an audit to ensure podiatry care needs are being addressed appropriately in the clinical meeting 3 times a week for 2 weeks and weekly for 2 weeks. Concerns will be addressed immediately, and findings will be evaluated in the quarterly QAPI meeting. 5. Date of Compliance: August 6, 2021.	

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F 677	Continued From page 14	F 677		

were elongated and in need of trimming. There was debris clearly visible under the nails on the great toes of her right and left feet. LPN # 7 (Licensed Practical Nurse) was present for the observation.

2. Resident # 127 was admitted to the facility on 5/21/2021 with diagnoses that included malignant neoplasm of the left breast, hypertension, diabetes mellitus, arthritis, history of falling, right hip pain, difficulty walking, generalized muscle weakness, and hypercalcemia.

According to an Admission MDS with an ARD of 5/27/2021, Resident # 127 was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 11 out of 15. Under Section G (Functional Status), the resident was assessed as needing extensive assistance with one person physical assist for personal hygiene.

At approximately 9:20 a.m. on 6/30/2021, an observation of Resident # 127's fingernails and toenails was conducted. Resident # 127's toenails were elongated and in need of trimming. There was debris clearly visible under the nails on the great toes of her right and left feet. LPN # 7 was present for the observation.

During the observation, Resident # 127 was asked who trims her toenails and when was the last time they were trimmed. The resident said she did not know (who trimmed them), but thought it was several months since they were trimmed.

At approximately 9:50 a.m. on 6/30/2021, SW # 2 (Social Worker), who was identified as the person

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who schedules podiatry visits, was interviewed. Asked how he decides who sees the Podiatrist, SW # 2 said, "I start with the farthest out (meaning the resident with the longest time since a podiatry visit) and put them on the list." SW # 2 went on to say, "The Podiatrist comes once a month and sees 20 residents. In six months he will have seen everyone." When asked what happens if nursing identifies a resident that needs to be seen by the Podiatrist, SW # 2 said, "If nursing tells me about someone, I will put their name on the list."

SW # 2 was asked for, and provided, a list of facility residents that included the date each was last seen by the Podiatrist, as well as a list of residents scheduled for the next podiatry visit. According to the facility list, Resident # 88 was last seen by the Podiatrist on 3/31/2021. Resident # 127 was on the facility list, but there was no last seen date. Resident # 127 was on the podiatry schedule for 7/7/2021.

3. Resident # 80 was admitted to the facility on 1/21/2021, and most recently readmitted on 5/13/2021, with diagnoses that included pneumonia, anemia, atrial fibrillation, depression, gastroesophageal reflux disease, acute respiratory failure with hypoxia, ventral hernia with obstruction, generalized muscle weakness, difficulty walking, overactive bladder, morbid obesity, and polyneuropathy.

According to an Admission MDS with an ARD of 5/19/2021, Resident # 80 was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. Under Section G (Functional Status), the resident was assessed as needing extensive

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F 677	Continued From page 16 assistance with one person physical assist for personal hygiene. At approximately 10:20 a.m. on 6/30/2021, an observation of Resident # 80's fingernails and toenails was conducted. Resident # 127's toenails were elongated and in need of trimming. There was debris clearly visible under the nails on the great toes of her right and left feet. CNA # 3 (Certified Nursing Assistant) was present for the observation. Resident # 80's name appeared on the facility podiatry list provided by SW # 2, but there was no date indicating when she was last seen. Resident # 80's name was listed on the on the podiatry schedule for 7/7/2021. A review of the Progress Notes (Nurses Notes) in Resident # 80's electronic health record revealed the following entry, dated 2/9/2021, made by Discharge Planning (SW # 2), "Resident was seen by the podiatrist, Dr. (name) on this date...." At approximately 1:15 p.m. on 7/1/2021, during a meeting that included the Administrator, Director of Nursing, and the survey team, the findings regarding Residents # 88, 127 and 80 were discussed.	F 677		
F 684 SS=K	COMPLAINT DEFICIENCY Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		8/6/21

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F 684	Continued From page 17 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure glucose-monitoring devices were calibrated and accurate on three of three units. A total of twelve glucose monitoring devices were located on nine medication carts and available for use on all three units. Review of the calibration logs for the devices revealed calibration had not been completed on a nightly basis per facility policy. All twelve devices were calibrated for accuracy by facility staff, and nine devices were out of range. Staff observed conducting the calibration of the devices did not follow manufacturer instructions for correctly performing the calibrations, and control solutions for the testing of high and low values were expired. Thirty-two (32) residents were identified as requiring insulin and blood sugar monitoring. Thirteen (13) of those residents (Residents # 27, 95, 113, 108, 249, 384, 42, 97, 69, 84, 88, 236, and 247) were included in the survey sample and the extended survey sample. Four of the thirteen residents (#27, 108, 249, and 69) were identified as having concerns related to glucose monitoring. Staff were performing blood sugar tests and administering insulin based on blood sugar readings obtained on equipment that had not been calibrated. This was identified as Immediate Jeopardy (IJ) in the area of Quality of Care 06/30/2021 at 4:55 p.m., with resulting SQC (substandard quality of	F 684	1. New blood glucose meters were purchased immediately, calibrated per manufacturer□s guidelines and documented on the Blood Glucose Meter Control Log while surveyors were onsite. Resident #56 was provided support hose. A med error was completed for failure to start antibiotic as ordered for resident #71, and weights were obtained for residents #32 and #42, while surveyors were onsite. 2. An audit was conducted to identify all residents with current blood glucose monitoring orders. All identified residents had their blood glucose level checked immediately with a one-time order while surveyors were onsite. An audit will be conducted by the DON or designee for current residents to ensure physician orders for support hose, antibiotics, and weights and being followed. 3. All licensed staff were educated by the Director of Nursing or designee on the manufacturer□s guidelines for calibrating blood glucose monitors and appropriate documentation while surveyors were onsite. DON or designee will educate licensed staff of the importance of following physician orders for support hose, antibiotics, and weights. 4. Blood Glucose Meter Control Log will be audited daily for 4 weeks and weekly thereafter by DON or designee. DON or	

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F 684	Continued From page 18 care). The Immediate Jeopardy was abated on 07/01/2021 at 1:10 p.m., and the Scope and Severity was lowered to Level II, pattern. The facility staff also failed to follow physician orders for four of 38 residents in the survey sample: Residents #56, #71, #42 and #32. Resident #56 was not provided support hose as ordered by the physician. Resident #71 was not started on antibiotics as ordered by the physician until four days after admission. Residents #32 and #42 did not have physician ordered weights obtained by staff. Findings include: 1. On 6/30/21 at 9:45 a.m., accompanied by the licensed practical nurse (LPN #6), the medication carts were inspected on the East unit. The January, February, and March 2021 blood glucose monitoring calibration sheets for the East unit glucometers were blank with no entries or control checks completed on the unit's three medication carts. There were no blood glucose monitoring calibration sheets for the glucometers for April, May, or June 2021. On 6/30/21 at 10:15 a.m., accompanied by the East unit manager (LPN #6), three blood glucose monitors were checked with the manufacturer's control solution. The acceptable high range was labeled as 204-255 and the acceptable low range was 82-101. Cart #1 included two glucometers. The first glucometer had a high reading of 233 and a low reading of 96 with both readings within range. The second glucometer had a high reading of 243 and a low of 94 with both readings within	F 684	designee will audit physician orders for support hose, antibiotics, and weights to ensure they are followed appropriately 3 times a week for 2 weeks and weekly for 2 weeks. Concerns will be addressed immediately, and findings will be evaluated in the quarterly QAPI meeting. 5. Date of Compliance: August 6, 2021.	

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range.

Cart #2 included two glucometers. There was no test solution for Cart #2. LPN #6 stated she would use the solution from cart #3. One of the glucometers from Cart #2 had a high reading of 258 and a low reading of 88, with the high reading out of range. The second glucometer on Cart #2, had a high reading of 237 and a low reading of 94, both readings were within range.

Cart #3 included two glucometers. One of the glucometers from Cart #3 had a high reading of 359 and a low reading of 79, both readings were out of range. The second glucometer on Cart #3 had a high reading of 223 and a low reading of 91, both readings were within range. LPN #6 stated at the time of the cart inspections that there was no documentation of which glucometer was used with which resident.

2. On 06/30/21 at 10:18 AM, medication storage and labeling was observed on the South wing. Medication cart B was observed. This cart had one glucometer; the glucometer was labeled with a permanent marker, "Cart B #1.'" LPN (Licensed Practical Nurse) # 3 stated that the device is cleaned before and after each use, and provided the cleaning protocol with demonstration. LPN #3 was asked if the glucometer had been calibrated. LPN #3 stated, "I'll have to get an answer for that and stated, I don't do it." LPN #3 had a new bottle of test strips dated 06/30/21. There was no control solution on this medication cart to do a calibration test.

At 10:28 AM, LPN #3 asked LPN #2 about the glucometers being calibrated. LPN #2 stated that they should be calibrated every night on 3rd shift.

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LPN #2 stated that the 3rd shift nurse has a checklist with things to do and that is one of them. LPN #2 was asked how many glucometers were on the South unit. LPN #2 stated that Cart A has two glucometers, Cart B has one glucometer and Cart C has one glucometer, for a total of four glucometers on the South unit.

The glucometers were labeled as Cart A #1 and #2, Cart B #1, and Cart C #1.

At approximately 10:30 AM, LPN #3 asked LPN #1 where the calibration/control solution to test the glucometers was located. LPN #1 stated that they do the calibration test to see if the glucometers are operating correctly and then document in the "book." LPN #1 stated that this is done every night on the glucometers. LPN #1 was asked to perform a control test. LPN #1 and LPN #3 both stated that they did not have any control solution on their carts [Cart B and Cart C]. LPN #1 was then asked to review the book with quality control tests.

LPN #1 went to the nurse's station and pulled a binder book with glucometer control testing results. Inside the book were sheets titled, "blood glucose monitoring meter checks quality control record." LPN #1 stated that there is a sheet for each glucometer on the unit. Each sheet had 13 columns, each column labeled as follows: the date, station/shift, operator initials, meter cleaned, check strip result, test strip lot #, expiration date, code #, Level 1 control range , Level 1 control result, Level 2 control range, Level 2 control result, and Corrective Action column [last]. The glucometers were counted on the South wing unit by staff and verified that four glucometers were on the South wing [2 glucometers on Cart A, 1 on

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Cart B, and 1 Cart C].

The quality control logs located in the book were reviewed for the last three months, April 2021 through present [June 2021], the following was revealed:

Cart A glucometer #1 only had one log sheet for June. The dates tested were June 24th, 25th, 28th, and 29th. It was documented that this glucometer was in range on those dates. There was no log for Cart A glucometer #2, although there were two glucometers on Cart A. There was no documentation for Cart A #1 or #2 glucometers for the months of April and May to evidence any testing.

Cart B glucometer #1 log sheet for June documented testing dates were June 24th, 25th, 28th, and 29th. There was no documentation for April or May 2021 to evidence any testing.

Cart C glucometer #1 log sheet for June documented testing dates were June 24th, 25th, 28th, and 29th. There was no documentation for April or May to evidence any testing.

At approximately 10:40 AM, LPN #2 stated that she had control solution on her cart, Cart A.

At 10:42 AM, LPN #2 and LPN #3 gathered their assigned glucometers and supplies to perform the control tests, which included Cart A glucometers #1 and #2, and Cart B glucometer #1. All the supplies gathered [test strips, control solution] were verified by lot number, not expired, and not past an open date.

Cart A glucometer #1 was tested and did not pass

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the control test for the level 2 test. The level 2 test range was listed on the bottle as 204-254. The actual result for glucometer #1 was 345.

Cart A glucometer #2 was tested and did not pass the control test for the level 2 test. The level 2 test range was listed on the bottle as 204-254. The actual result for glucometer #2 was 349.

Cart B glucometer #1 was tested and did not pass the control test for level 2 test. The level 2 test range was listed on the bottle as 204-254. The actual result for glucometer #1 was 362.

According to the control logs, all four glucometers were last tested on 06/29/21 and all four passed the control test [level 1 and level 2].

At 11:05 AM, LPN#1 was asked to test Cart C glucometer #1. LPN #1 stated, "I don't have any controls [solution] on my cart because it expired and the facility doesn't have anymore." LPN #1 stated that she had thrown them away this morning. LPN #1 stated that she only had one glucometer on her cart. The control solution was borrowed from Cart A to perform the control test.

Cart C glucometer #1 was tested and did not pass the control for the level 2 test. The level 2 test range was listed on the bottle as 204-254. The actual result for glucometer #1 was 348.

All four glucometers on the South wing were found out of calibration and none of the glucometers were removed from service.

At approximately 11:45 AM, LPN #2 performed a blood glucose check on Resident #108 with glucometer #2 from Cart A. This glucometer was

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checked at approximately 10:45 AM and was found out of calibration [failed the level 2 test]. The resident's blood glucose result on this glucometer was 259.

Resident #108 was admitted to the facility on 06/05/21. Diagnoses for Resident #108 included, but were not limited to: type 2 diabetes with hyperglycemia [insulin dependent], muscle weakness, chronic kidney disease stage 3, and vascular dementia without behaviors.

The most current MDS (minimum data set) for Resident #108 was a five day admission assessment dated 06/08/21. This MDS assessed the resident with a cognitive score of 13. Resident #108 was assessed in Section N. [Medications] as receiving 3 injections of insulin in the last three days [with one order for insulin].

Resident #108's physician's orders were reviewed and documented orders for, but not limited to: "....Accuchecks AC [before meals] and HS [bedtime] as needed for DM [diabetes mellitus] Notify MD [medical doctor] for BS [blood sugar] less than 60 or greater than 400...Accuchecks AC and HS before meals and at bedtime for for DM Notify MD for BS less than 60 or greater than 400...Hold meal insulin for blood sugars less than 100...Insulin Glargine...inject 50 units subcutaneously in the morning...Insulin Lispro...inject 15 units subcutaneously with meals for Diabetes Hold meal time insulin for blood sugars less than 100..."

Resident #108's care plan was reviewed and documented, "...has Diabetes Mellitus...medication as ordered by doctor. Monitor/document for side effects...dietary

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consult...educate regarding medications...compliance...podiatry consult as needed..."

Resident #108's MARS [medication administration records] were then reviewed. According to the resident's MARS the resident was given 15 units of Lispro by LPN#2 on 06/30/21 at noon. The resident was also given Lispro 15 units at 5:00 PM, the blood glucose reading was 173.

3. On 6/30/21 at 4:13 PM, glucometer calibration tests were performed on the west wing by registered nurse, (RN) #4. Test solution and test strips were not expired. The results were as follows:

Glucometer labeled west "C" cart was tested. The bottle of test strips indicated the range for low side (Level 1) should be 83-103. The bottle also indicated the range for high side (level 2) should be 206-257. The test was run for low side with the results being 79 (indicating out of parameter). The test was completed for the high side with the results being 355 (indicating out of parameter).

"B" cart glucometer was tested. The bottle of test strips indicated the range for low side should be 83-104. The bottle also indicated the range for high side should be 209-261. The test was run for low side with the results being 90 (indicating within parameter). The test was completed for the high side with the results being 357 (indicating out of parameter).

"A" cart glucometer was tested. The bottle of test strips indicated the range for low side should be 82-102. The bottle also indicated the range for

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high side should be 204-254. The test was run for low side with the results being 83 (indicating within parameter). The test was completed for the high side with the results being 350 (indicating out of parameter).

RN #4 stated that she would take the glucometers out of service and get a new one.

Glucometer calibration logs were then reviewed with the unit manager (license practical nurse, LPN #4). Documentation showed each cart glucometers (A, B, and C) were last tested on 2/7/21 with only one test done prior on 2/5/21. LPN #4 stated that tests on the glucometers are supposed to be run on every night shift.

Resident #27 was admitted to the facility on 1/15/19. Diagnoses for Resident #27 included: Type 2 diabetes, cognitive deficit, coagulation defect, and muscle weakness. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/20/21. Resident #27 was assessed with a cognitive score of 9 indicating moderately cognitively impaired.

On 6/30/21 Resident #27's medical record was reviewed. A progress noted dated 6/29/21 documented a call from the facility contracted lab indicating Resident #27 had a critical glucose result of 24 from a lab that was taken earlier in the morning. The lab report dated 6/29/21 documented that the lab test was taken at 5:38 AM on 6/29/21 and also documented the glucose lab was confirmed by a repeat analysis.

Resident #27's blood sugar test flow sheet was then reviewed and documented a blood sugar

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test had been obtained on 6/29/21 at 5:51 AM with results being 83 (13 minutes after the lab had drawn blood).

4. Resident #69 was admitted to the facility on 11/25/2015 with the following diagnoses, including but not limited to: end stage renal disease, dementia, hypertension, schizoeffective disorder, and diabetes mellitus.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/12/2021. Resident #69 was assessed as cognitively intact with a summary score of "12".

The clinical record was reviewed on 06/30/2021 at approximately 4:00 p.m. The following progress notes were observed:

"06/26/2021 23:37 [11:37 p.m.] Resident blood sugar at 2154 [9:54 p.m.] was 67. Resident was alert and stated he did not feel like his blood sugar was low. Went and got a coke and snacks from vending machine for resident. Resident was eating snacks and drinking his coke when leaving room. Went to recheck bs [blood sugar] at 2230 [10:30 p.m.] and resident was in the floor between the two beds, Resident was laying on his left side. Resident had spilled his coke and was laying in the coke on the floor. Resident would open his eyes but was unresponsive. Resident was breathing and had a pulse. Call for nursing assistants and called 911 from the room. Attempted several times to get a BS and got reading all over the place. One read HI, one read 85, one read 247, last one read 54. Gave resident glucose since he was being [beginning] to be a little more alert. However, resident would just

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cough and not swallow glucose. 3 emts [emergency medical technicians] arrived and assisted resident to stretcher..."

"6/27/2021 01:55 [a.m.] Received report from [Name] in ER [emergency room] who states when resident got to hospital he was alert and answering correctly. She noted he had urinated on himself and she walked him to the bathroom and cleaned him. His BS was 226. His white blood cells are up @ 21.8 she states. He was DX [diagnosed] with UTI [urinary tract infection ...States he is returning back to the facility via car and wife."

The following note was a late entry created 06/27/2021 at 2:36 a.m.: "6/26/2021 02:09 During report, evening shift nurse stated resident had had a low BS at bedtime. She asked to stop report and recheck up on him. This nurse was the third nurse in to see resident. He was laying in the floor. He was on his left side with a small amount of white froth noted at the corners of his mouth. He barely had his eyes open but they weren't focused. He could not answer or response to stimuli by nurses. His skin was very cold and clammy. He had his coke spilled all over him. He was making the snoring noises diabetics make when they are trying to slip into a coma. All nurses were called to the room and crash cart brought in. No code performed r/t [related to] he has a heart beat and he is breathing at this time. 911 was called. Evening nurse unable to obtain an accurate blood sugar r/t [related to] spilled coke on his hands. Staff stayed at bedside until EMTs arrived and took him to the ambulance around 2348 [11:48] pm. Ambulance remained in the lot for 20 minutes before leaving for the hospital."

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"6/28/2021 15:20 [3:20 p.m.] MEDICAL NOTE: ProMedical Progress Note
CC: Okay ...S: Patient is being evaluated today for hospital follow-up. On 6/26/2021, patient had an episode of hypoglycemia. Nursing staff found the patient laying on the floor on his left side with a small amount of white frothy at the corners of his mouth. Patient barely can keep his eyes open and focus. He cannot answer or respond to stimuli by nurses. Patient was very cold and clammy. Patient was sent to the emergency department for further evaluation. CT scan of the head and neck were unremarkable. There was concern for UTI and patient was started on Keflex. On 6/11/2021, patient was evaluated for hypoglycemia. Patient's blood sugars were 64 and 87 and insulin was held. At the time he was thought this could have been an isolated incident. An A1c was checked. On 6/22/2021, patient was evaluated to follow-up on diabetes to follow-up on the results of the A1c. A1c was 9.9 on 6/15/2021. Patient was currently taking Humalog 8 units with meals, glargine insulin 50 units daily and a sliding scale as needed for blood sugars greater than 200. Glargine was increased from 50 units to 55 units daily. Lispro was increased to 10 units with meals. Since 6/15/2021, blood sugar ranges have been between 95 and 472. Patient states that he is eating all of his meals. He denies any changes in his diet. He is on a diabetic diet ...A: This is a 58-year-old male with a history of diabetes being evaluated for a fall that occurred on 6/26/2021 and an episode of hypoglycemia resulting in a hospital follow-up. P: Consulted for mechanical ground-level fall with no significant injuries. There was questionable loss of consciousness due to hypoglycemia. Medications were evaluated and no changes are indicated at this time. We will

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follow-up with patient in 2 weeks."

The hospital records from the emergency room documented the following:
"Basic information Chief complaint: Pt (patient) sent for suspected syncopal episode from [name of facility] d/t [due to] hypoglycemia. Pt stated, "I don't know what I was doing but I was lightheaded and then it all went blank." Pt was hypoglycemic upon EMS arrival, blood sugar rose w/ [with] D10... History of Present Illness: 58-year-old male with history of end stage renal disease now status post kidney transplant...type 2 diabetes with brittle blood sugars presents with concern for hypoglycemia and subsequent syncopal episode. Patient reports he ate a full dinner of a cheeseburger, fries, tea, and coffee. He then went back to his room and his blood sugar was checked and found to be in the 50s. Staff immediately brought him things to eat. He does remember drinking a coke but then had a syncopal episode and fell from the bed...daughter reports that he has very labile blood sugars and has had syncopal episodes from hypoglycemia in the past...states this event appears very similar to past events."

Laboratory data from the emergency room showed a Glucometer POCT [point of contact testing] reading on 06/26/2021 at 23:58 [11:58 p.m.] of 226. A routine Chemistry lab test dated 06/27/2021 and resulted at 00:57 [12:57 a.m.] showed a blood glucose level of 254.

Concerns were voiced to the DON, administrator, the corporate nurse consultant on 06/30/2021 at approximately 4:50 p.m., that the blood glucose monitors in the facility were not calibrated per facility policy and when tested with the control

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solution were testing out of range. Documentation in Resident #69's record indicated that blood sugar "readings were all over the place."

5. Resident #249 had scheduled insulin and insulin administered before meals and at bedtime each day with dosages determined by blood sugar readings (sliding scale). These readings were obtained with glucometers that either had not been calibrated, were calibrated with out of date solution or were found out of calibration (not meeting manufacturer's specifications for calibration).

Resident #249 was admitted to the facility on 6/25/21 with diagnoses that included status post orthopedic surgical amputation, diabetes, hypothyroidism, hypertension, gout, history of breast cancer, asthma and gastroesophageal reflux disease. The admission nursing assessment dated 6/25/21 assessed Resident #249 as cognitively intact.

Resident #249's clinical record documented the following physician orders dated 6/26/21 for insulin to manage diabetes.

Insulin Lispro100 units/milliliter (ml), inject per sliding scale subcutaneously before meals and at bedtime. Sliding scale listed: blood sugar 200 to 299 give 5 units, 300 to 399 give 10 units, 400 to 401 give 15 units, above 400 call physician.

NPH Isophane & regular suspension insulin pen (70-30) 100 units/ml, inject 20 units subcutaneously each evening and 30 units each morning.

Accuchecks (blood sugar) before meals and at

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bedtime each day.

The record documented a physician's order dated 6/28/21 for Glucagen Hypokit solution (Glucagon HCL (rDNA)) 1 milligram with instructions to inject one application intramuscularly as needed for low blood sugar

Resident #249's clinical record documented the insulin was administered as ordered. Blood sugar checks were documented before meals and at bedtime each day, with insulin administered per sliding scale.

A nursing note dated 6/28/21 at 1:17 p.m. documented, "...rsd [resident's] BS [blood sugar] was 61 @ [at] 1230 pm gave rsd. teddy grams and graham crackers. rsd. alert and verbal at this this time stated she felt okay and didn't feel like her BS was low. recheck BS at 1245 pm it was 59 gave rsd 1 IM [intramuscular] glucagon rechecked BS at 105 pm bs 149..." (Sic)

On 6/30/21 at 2:15 p.m., the director of nursing (DON) was interviewed about calibration of the facility's glucometers. The DON stated the night shift (11:00 p.m. to 7:00 a.m.) nurses were responsible for calibrating the glucometers each night. The DON stated any glucometers found out of calibration were supposed to be taken out of service and replaced with a meters meeting control checks. The DON stated any problems with glucometer calibrations were supposed to be reported to her or the unit managers. The DON stated she had not been made aware of any issues with glucometers out of calibration in the facility.

The facility was determined to be in immediate

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jeopardy on 6/30/21 at 4:55 p.m. regarding a system failure with glucometers on all nursing units found without recent calibrations, found out of calibration or had been calibrated with out of date solution. There was no system to track which glucometers were used with which residents and glucometers were found without accurate date setup for historical reference of blood sugar readings.

The facility staff presented the following plan of correction that was accepted by the survey team on 06/30/2021 at 6:37 p.m.:

1) New blood glucose meters will be purchased immediately, calibrated per manufacturer's guidelines and documented on the Blood Glucose Monitoring Control Log.

2) An audit will be conducted to identify all residents with current blood glucose monitoring orders. All identified residents will have their blood glucose level checked immediately with a one-time order. We will use the new glucometers post calibration to obtain blood glucose levels.

3) All licensed staff will be educated by the Director of Nursing or designee on the manufacturer's guidelines for calibrating blood glucose monitors and appropriate documentation. Calibration and documentation will be completed once a shift. By tomorrow 7/1 at 1200 will educate remaining nursing staff before their shift is scheduled.

4) Blood Glucose Monitoring Control Log will be audited daily for 4 weeks and weekly thereafter.

5) Step 1 will be completed by 6/30/2021 at 1900.

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Step 2 will be completed by 6/30/2021 at 2100.
Step 3 will be completed by 7/1/2021 at 1200.

On 06/30/21 at 6:40 PM, LPN #2 was interviewed and was asked if glucometer #1 and glucometer #2 for Cart A had been taken out of service and if the information regarding the failed control tests for both of these glucometers had been reported. LPN #1 stated that they had not been taken out of service and the information had not been reported to anyone. LPN #2 was then asked if Resident #108 received any insulin after the glucose reading. LPN #1 stated that she did administer the resident 15 units of Lispro [with lunch per order] based on the blood glucose reading from the glucometer that failed the control test.

On 06/30/21 at 6:50 PM, LPN #3 was interviewed and was asked if glucometer #1 for Cart B had been taken out of service and if the information regarding the failed control test the glucometer had been reported. LPN #3, "No, you took the book." LPN #3 was asked again, if the failed test had been reported to anyone. LPN #3 stated, "No."

On 7/1/21 at 8:22 a.m., the licensed practical nurse (LPN #2) that administered the Glucagon to Resident #249 on 6/28/21 was interviewed. LPN #2 stated the unit glucometers were used for blood sugar checks and administration of scheduled and sliding scale insulin. LPN #2 stated she did not think Resident #249 was checked with an out of range glucometer but there was no record of which glucometers were used with the resident.

On 07/01/21 at 8:57 AM, Resident #27 was

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interviewed regarding the hypoglycemic event on 6/29/21. Resident #27 said he has been a diabetic most of his adult life and knows when his blood sugar is getting low. Resident #27 stated he could not remember what day the lab technician drew labs but had not been feeling that his blood sugars had been low lately. Resident #27 said he did not remember eating anything after the labs test were taken but did eat breakfast.

On 07/01/21 at approximately 9:00 AM, the glucometer control solution test information was reviewed for the [name of glucometer] that were being used by the facility.

The glucometer manual, "[Name of glucometer] blood glucose monitoring system...Compare the result to the range printed on the test strip bottle. Make sure the result is within the acceptable range. If the result falls within the range, the meter and test strip are working correctly. Do not use system if control solution is out of range. Healthcare professionals: Record result in quality logbook..."

On 07/01/21 at 10:00 AM, the DON (director of nursing), the administrator and nurse consultant were again made aware of the serious concerns regarding staff not performing glucometer control checks and using glucometers after failing the control tests and administering insulin based on a test result from a glucometer that had failed control tests. The DON stated that they did not have a policy, but stated that the glucometer control tests are done every night by night shift and that the glucometer manual is the policy and stated "that is what we go by."

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On 7/1/21 at 11:30 a.m., in-service education records were presented by the facility documenting staff education regarding: blood glucose meter control logs; completion of the calibration logs; blood glucose meter calibration protocol per manufacturer's guidelines; visual, verbal and return demonstrations of performing calibration; use of control solutions; and logging results in calibration test book. All current nursing staff were educated and a system was in place to educate any unavailable staff prior to their next scheduled shift. Glucometer checks were documented on all residents with current orders for blood sugar checks (30 residents) using newly purchased and successfully calibrated glucometers.

On 7/1/21 at 12:08 p.m., the survey team inspected all glucometers in use on the three nursing units. All glucometers in use had been calibrated and were documented as meeting manufacturer's calibration requirements. Nurses on each unit demonstrated to surveyors the calibration protocol using testing solutions and demonstrated competency in calibration performance and documentation in logbooks. Staff were interviewed at the time of the demonstrations and all verified participation in staff education concerning glucometers, calibration protocols, documentation of calibrations and steps to take glucometers out of service if found out of calibration.

On 7/1/21 at 1:09 p.m., the survey team informed the administrator, director of nursing and corporate consultant that the survey team had verified implementation of their plan of removal of immediate jeopardy.

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The Immediate Jeopardy was abated on 07/01/2021 at 1:10 p.m., and the Scope and Severity was lowered to Level II, pattern.

No further information was provided prior to exit.

6. Resident # 42 was admitted to the facility 8/5/17 with diagnoses to include, but were not limited to: congestive heart failure, osteoarthritis, diabetes, COPD, and GERD.

The most recent MDS (minimum data set) was quarterly review dated 4/27/21 had Resident # 42 coded 15 out of 15 for cognition, indicating cognitively intact.

The clinical record was reviewed 6/29/21 at 2:45 p.m. There was an order written and carried forward from 4/12/21 for "daily wts [weights] at night shift...call cardiovascular if wts greater than 3-5 pounds..." The MAR (medication administration record) and TAR (treatment administration record) were reviewed but no daily weights were located on the records. The "Weights and Vitals" tab of the record was then reviewed, but no daily weghts were recorded.

On 6/30/21 3:30 p.m. the DON (director of nursing) was asked for assistance in locating the daily weights. On 7/1/21 at 8:24 a.m. the DON was asked if any documentation for the daily weights had been found. She stated "I didn't see any daily weights." The DON was asked if that meant the weights were not done, and she replied "Yes."

The administrator, DON, and nurse consultant were made aware of the findings 7/1/21 at 1:15 p.m. during a meeting with facility staff.

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No further information was provided prior to the exit conference.
7. Resident #56 was admitted to the facility on 5/5/21 with diagnoses that included atrial fibrillation, atherosclerotic heart disease, hypertension, heart failure, benign prostatic hyperplasia, inguinal hernia, gastroesophageal reflux disease and localized edema. The MDS dated 5/11/21 assessed the resident with moderately impaired cognitive skills.

On 6/29/21 at 2:52 p.m., Resident #56 was interviewed about quality of care in the facility. Resident #56 stated that he had ongoing swelling in his feet and legs. The resident stated he wore support hose prior to coming to the facility and was told several times hose would be provided by the facility. Resident #56 stated he did not currently have support hose and had not had a pair since his admission. The resident was observed at this time with no hose or socks in use.

Resident #56's clinical record documented assessment of lower extremity edema by the nurse practitioner (NP). A NP progress note dated 5/10/21 documented, "...Patient states he noticed last couple days he has had increased swelling to bilateral lower extremities. He states when he was at home he had TED hose but he forgot to bring them with him...1+ edema noted bilateral lower extremities...We will order TED hose in a.m. and off in p.m. as needed for edema..."

Resident #56's clinical record documented a physician's order dated 5/10/21 for TED (support) hose to bilateral lower extremities as needed for

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edema with instructions to put on in the morning and off in the evenings "every 24 hours."

The nurse practitioner (NP) documented the resident had not been provided TED hose as of 6/22/21. The NP's progress note dated 6/22/21 documented, "...He [Resident #56] is also states he is [has] not had his TED hose placed...I will reorder TED hose..." (sic)

An additional physician's order dated 6/22/21 documented, "patient still needs his ted hose as ordered..."

The resident's treatment administration record and nursing notes made no mention of the TED hose. Resident #56's plan of care (revised 5/13/21) documented the resident had congestive heart failure. Interventions to minimize complications of heart failure included monitoring for edema.

On 6/30/21 at 5:51 p.m., the licensed practical nurse (LPN #1) caring for Resident #56 was interviewed. LPN #1 stated there was nothing in the computerized record indicating the resident required TED hose. LPN #1 stated the night shift nurses were supposed to review orders and catch errors. LPN #1 reviewed the resident's treatment record, stated TED hose were not listed and she was not aware the resident had an order for hose.

On 6/30/21 at 5:56 p.m., the registered nurse (RN #3) working on Resident #56's unit was interviewed about the TED hose. RN #3 reviewed the record and stated she did not know why the resident did not have hose or why the hose order was not listed on the treatment record.

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On 7/1/21 at 8:21 a.m., the certified nurses' aide (CNA #1) caring for Resident #56 was interviewed about TED hose. CNA #1 stated she had not been informed that the resident required support hose.

This finding was reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p.m.

8. Resident #71 was admitted to the facility on 5/14/21 with a re-admission on 6/17/21. Diagnoses for Resident #71 included enterocolitis due to clostridium difficile (C-diff), neuropathic bladder, history of urinary tract infections, hypertension, chronic kidney disease, autistic disorder and anemia. The minimum data set (MDS) dated 5/11/21 assessed Resident #71 with moderately impaired cognitive skills.

Resident #71's clinical record documented the resident was re-admitted to the facility on 6/17/21 with a diagnosis of C-diff. The record documented a physician's order dated 6/17/21 for the antibiotic Fidaxomicin tablet 200 milligrams (mg) with instructions to give the medication two times per day for 10 days for treatment of C-diff.

Resident #71's medication administration record (MAR) documented the Fidaxomicin 200 mg was not administered on 6/18/21, 6/19/21, 6/20/21 and 6/21/21 (8:00 a.m. dose). Resident #71's Fidaxomicin was not given until 6/21/21 at 8:00 p.m., four days after the resident's admission.

Nursing notes from 6/17/21 through 6/21/21 documented no explanation of why the Fidaxomicin was not administered. A new order for the Fidaxomicin 200 mg twice per day for 10

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days was entered on 6/21/21.

A physician's progress note dated 6/21/21 documented, "...returns back to skilled care after being readmitted for recurrent C. difficile and sepsis. Originally was treated for urosepsis and then developed C. difficile. Had noted recurrent in the facility and was placed on oral vancomycin. Continued to worsen so went to the hospital is found to be septic with recurrent C. difficile. He is placed now on new antibiotic...Apparently was an issue with the antibiotic he had not received over the weekend but thankfully is [has] not had any recurrent diarrhea and states his belly feels okay...Plan: Continue his antibiotic till completion..." (Sic)

On 7/1/21 at 8:25 a.m., the licensed practical nurse (LPN #2) routinely caring for Resident #71 was interviewed about the delayed antibiotic administration. LPN #2 stated the resident's antibiotic was delayed for four days. LPN #2 stated the order for the Fidaxomicin was sent to the pharmacy when the resident was readmitted on 6/17/21. LPN #2 stated she called the pharmacy on 6/19/21 because the medication was not in the facility and pharmacy confirmed they had the order. LPN #2 stated the pharmacy faxed an authorization request for the drug due to the cost on Saturday (6/19/21). LPN #2 stated the fax was sent to the nursing unit and was overlooked during the weekend. LPN #2 stated the pharmacy never called about the drug but just sent the fax. LPN #2 stated she did not call the physician or anyone about not having the medication. LPN #2 stated when the physician assessed the resident on 6/21/21 the medication was reordered and started at 8:00 p.m. that evening. LPN #2 stated she should have notified

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the physician when the antibiotic was delayed or asked about an alternate medication. LPN #2 stated she did not realize the pharmacy was waiting on an authorization.

On 7/1/21 at 9:00 a.m., the director of nursing (DON) was interviewed about Resident #71's delay in antibiotic administration. The DON stated that due Fidaxomicin's cost, facility approval was required for the pharmacy to provide the medication. The DON stated the pharmacy faxed a request to the nursing unit on the weekend (6/19/21) and nurses were not aware of the fax. The DON stated the drug only required approval from the facility administration (DON or administrator), not the physician. The DON stated the pharmacy should have called her or the administrator for the drug cost approval instead of faxing the requests to the nursing unit. The DON stated she was not aware of an issue with obtaining the Fidaxomicin for Resident #71 until Monday 6/21/21.

This finding was reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p.m.

9. Resident #32 was originally admitted to the facility on 09/18/2019 and readmitted on 04/12/2021 with diagnoses that included schizoaffective disorder, hypertension, colon cancer, muscle weakness, unspecified psychosis, major depression disorder, anemia, dysphasia, unspecified severe protein-calorie malnutrition, and Parkinson's disease. The most recent minimum data set (MDS) dated 04/16/2021 was the admission assessment and assessed Resident #32 as moderately impaired for daily decision making with a score of 9 out of 15.

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On 06/30/2021, Resident #32's clinical record was reviewed. Observed on the physician's order summary was the following order: ".... obtain weekly weight. Order Status: Active. Order Date: 04/28/2021...."

Observed on the care plans was the following: ".... Nutrition risk r/t (related to) colon cancer/tx (treatment), hx (history) overweight. Does not wear bottom dentures during meals by how choice, limited chewing. Hx (history) mech (mechanical) altered diet d/t (due to dysphasia. Hx (history) weight fluctuations - currently loss. Created on: 12/05/2014. Revision on: 04/19/2021. Goal: Resident will avoid significant weight change through next review.. Revision on 05/11/2021. Target date 07/28/2021. Interventions:... Weights per protocol.... Created on: 03/25/2020..."

Observed within the clinical record were the following weights:
"04/12/2021.... 164.9 (Standing)" - readmission
"04/29/2021.... 166.8"
"05/01/2021.... 166.5 (Standing)"
"05/20/2021.... 168 lbs"
"06/01/2021.... 178.3 lbs (Standing)"
"06/16/2021.... 179.9 lbs."

On 06/30/2021 at 6:01 p.m., the unit manager (LPN #4) was interviewed regarding how weight orders were communicated to staff. LPN #4 stated the weight orders are communicated in daily meetings and is also posted on the unit bulletin board by the Dietitian. LPN #4 was asked if she had a copy of she sheet that was provided by the dietitian. LPN #4 stated she did not have a hard copy of the notice from the dietitian and was not sure how the order for the weekly weights

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F 684	Continued From page 43 was missed for Resident #32. LPN #4 was asked who was responsible for weighing the residents. LPN #4 stated mostly the certified nursing assistants (CNAs) completed the weights. LPN #4 was asked how were the weight orders communicated to the CNAs. LPN #4 stated the CNAs could view the information on the unit bulletin board and were given a weight sheet. LPN #4 was asked Resident #32 refused weights. LPN #4 stated, "no, not that I am aware of." On 06/30/2021 at 6:15 p.m., the registered dietitian (OS #1) was interviewed regarding how weight orders were communicated to staff. OS #1 stated the information was shared in the facility weight meetings and nursing was able to print the orders and communicate it to the CNAs to obtain the weights. OS #1 stated Resident #32 had lost weight while he was in the hospital and when he was readmitted to the facility the order for weekly weights was placed. OS #1 stated since Resident #32 readmitted, he had noted some increased intake and was eating better. The above findings were reviewed with the administrator, director of nursing and corporate consultant during a meeting on 07/01/2021 at 1:10 p.m.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		8/6/21

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F 761	Continued From page 44 §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, document review, and staff interview, the facility staff failed to ensure expired vaccine was not available for administration on one of 3 units: East unit. A bag containing seven expired vials of Afluria, an influenza vaccine, was in a thermal container in the medication room refrigerator. Findings include: On 6/30/21 at approximately 10:15 a.m. an inspection of the medication room on the East unit was conducted with LPN (licensed practical nurse) # 6. A silver thermal bag was located in the bottom of the refrigerator and contained seven multi-dose boxes of Afluria. The boxes were marked with an expiration date of 6/10/21. LPN # 6 stated "I had no idea those were even in there."	F 761	F761 1. Expired Afluria vaccine in the East Unit medication room was discarded immediately, while surveyors were onsite. 2. An audit was conducted of all medication rooms by the DON that identified no other expired medication. 3. DON or designee will educate licensed staff on the importance of discarding expired medication. 4. DON or designee will audit medication rooms daily for 4 weeks to ensure there is no expired medication present. Concerns will be addressed immediately, and findings will be evaluated in the quarterly QAPI meeting. 5. Date of Compliance: August 6, 2021.	

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F 761	Continued From page 45 The package insert for the Afluria vaccine under "16.2 Storage and Handling" directs "Do not use AFLURIA QUADRIVALENT (sic) beyond the expiration date....." The administrator, DON, and nurse consultant were made aware of the findings 7/1/21 at 1:15 p.m. during a meeting with facility staff. No further information was provided prior to the exit conference.	F 761		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview the facility staff failed to honor food preferences for one of 38 residents in the survey sample: Resident # 18. Findings include: Resident # 18 was admitted to the facility 1/26/21 with diagnoses to include, but were not limited to: osteoporosis, muscle weakness, COPD, and Vitamin D deficiency. The most MDS (minimum data set) was a quarterly review dated 4/6/21 and had Resident # 18 assessed 13 out of 15 for cognition, indicating	F 800	F800 1. Resident #18□s meal tray card was updated immediately to provide clarification on preferences and condiments. Resident #18 was provided with a new meal tray with her food preferences and requested condiments immediately, while surveyors were onsite. 2. An audit will be conducted of current meal tray cards to ensure clear communication with preferences and condiments. 3. Dining Services Manager or designee will educate kitchen staff on how meal tray card preferences and condiments are	8/6/21

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F 800	Continued From page 46 cognitively intact. On 6/30/21 at approximately 8:25 a.m. Residenty # 18 was observed with her breakfast tray on the overbed table. Resident # 18 was asked about her breakfast. She stated "Not too good. I have scrambled eggs and oatmeal I am not going to eat, and look here: I have a biscuit but no butter or jelly or anything to put on it! Some of that sausage gravy would be nice to have to put on it..." (Resident # 18's roommate had sausage gravy on her biscuit). The meal ticket for Resident # 18 was reviewed and revealed the resident should have also received a banana and bacon on her meal tray. Also included on the ticket was a note written in bold print "Note: No Meat. (Can have eggs, Sausage, Bacon, and Sausage Gravy)." On 6/30/21 at 8:45 a.m. the regional certified dietary manager, identified as Other Staff (OS) # 7, and the RD (registered dietitian) were interviewed about the meal ticket. OS # 1 and the RD were asked why the resident wasn't given sausage gravy for her biscuit as indicated she could have on the meal ticket. They were also asked about the lack of condiments on the meal tray. OS # 1 stated "Well, that's my fault; I was afraid I'd get a tag if I served her meat...I didn't read past the 'No Meat' to see she could have had sausage gravy. I will send a new tray down right now." The RD then stated "As far as butter, jelly, etc., there are condiment carts on the units so all the resident has to do is ask for that." The administrator, DON, and nurse consultant were made aware of the findings 7/1/21 at 1:15 p.m. during a meeting with facility staff.	F 800	clarified. 4. Dining Services Manager or designee will audit meal trays 3 times a week for 2 weeks and weekly for 2 weeks to ensure meal trays match meal tray cards for preferences and condiments. Concerns will be addressed immediately, and findings will be evaluated in the quarterly QAPI meeting. 5. Date of Compliance: August 6, 2021.	

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F 800	Continued From page 47 No further information was provided prior to the exit conference.	F 800		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to store and prepare food in a sanitary manner in the main kitchen. The findings include: On 6/29/21 at 10:48 a.m., accompanied by the dietary manager (other staff #2), the kitchen and food storage areas were inspected. Stored in the walk-in refrigerator was a plastic container of potato salad. The potato salad was labeled with	F 812	1. Potato salad and applesauce were discarded immediately and scoop was removed from sugar immediately, while surveyors were onsite. 2. An audit was conducted at that time that identified no other leftovers with a past discard by date and no other scoop handles touching food product. 3. Dining Services Manager or designee will educate kitchen staff on the process for discarding leftovers timely and for appropriate placement of scoops.	8/6/21

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F 812	Continued From page 48 a prep date of 6/12/21 and use by date of 6/19/21. A plastic container of applesauce was also stored and labeled with prep date of 6/17/21 and use by date of 6/28/21. The dietary manager was interviewed at the time of the observation. The dietary manager stated the potato salad and applesauce should have been discarded prior to today. On 6/29/21 at 11:04 a.m., accompanied by the dietary manager, meal preparation was observed in the kitchen. A scoop was observed stored in bulk container of raw sugar, with the handle touching the sugar. The dietary manager stated at the time of the observation that the scoop was supposed to be stored separately and not positioned in the food product. The facility's policy titled Leftovers (effective 9/14/18) documented, "Leftovers shall be stored in a manner which maintains the food so that it is safe to eat, and retains optimal nutrient content and aesthetic quality...All leftovers shall be stored in sealed or air-tight containers...All leftovers containers shall be labeled, indicating the name of the product and the use-by-date...Storage of leftovers is a maximum of (7) seven days from date prepared..." These findings were reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p.m.	F 812	4. Dining Services Manager or designee will audit to ensure leftovers are discarded appropriately by their discard by date and that scoops are placed appropriately twice daily for 4 weeks. Concerns will be addressed immediately, and findings will be evaluated in the quarterly QAPI meeting. 5. Date of Compliance: August 6, 2021.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		8/6/21

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(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 by and in compliance with 45 CFR 164.512.

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

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F 842	Continued From page 50 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 clinical record review and staff interview, the facility staff failed to ensure a complete and accurate clinical record for two of 38 residents (Resident #285 and Resident #71). Resident #285's clinical record contained another resident's Covid-19 vaccination record, and Resident #71 had an incomplete treatment record for pressure ulcer dressing changes. Findings include: 1. Resident #285 was admitted to the facility on 06/18/21. Diagnoses for this resident included, but were not limited to: cerebral infarct (stroke/sub-dural hematoma), dysphagia,	F 842	F842 1. Resident #285□s medical record was corrected immediately, while surveyors were onsite. Medication errors were completed for resident #71- failure to record completion of pressure ulcer treatment on the treatment administration record. 2. An audit will be conducted by the DON or designee on current resident□s COVID-19 vaccination records to ensure the appropriate record is in the correlating patient□s medical record. An audit will be conducted by the DON or designee to ensure completed pressure ulcer	

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pneumonitis, muscle weakness, high blood pressure, peg tube placement, acute hypoxia and respiratory failure.

The most current MDS (minimum data set) was an admission assessment (still in progress). This MDS was not complete. Resident #285 was assessed as alert and oriented to person and place on the nursing admission assessment dated 06/18/21.

On 06/29/21 at 2:59 PM, Resident #285's clinical records were reviewed. Another resident's [identified as Resident #286] Covid-19 vaccination record was located in Resident #285's chart. Resident #285's own Covid-19 vaccination record was also observed in the record.

On 07/01/21 at 8:50 AM, the SW (social worker) was interviewed regarding the above information. The SW stated that when a new admission comes in she will see the residents and gather the information/documentation and then scan it all in. The SW stated that she didn't think anyone goes behind her to check that what she has scanned is accurate for each resident, but stated while scanning she will check and double check to ensure the records are accurate. The SW stated that she wasn't aware that the records were commingled, and stated that if other staff happen to see that scanned items are incorrect they will tell her that it has been scanned in error. The SW stated that she wasn't aware of the error and that it had not been reported to her.

The DON and administrator were made aware on 07/01/21 at 1:30 PM. No further information and/or documentation was presented prior to the

treatments are documented on the treatment administration record.
3. DON or designee will educate medical records on the importance of ensuring COVID-19 vaccination records are scanned into the accurate, correlating medical record. DON or designee will educate licensed staff on the appropriate process for documenting completion of pressure ulcer treatments on the treatment administration record.
4. DON or designee will audit COVID-19 vaccination records to ensure they are scanned into the accurate, correlating patient□s medical record 3 times a week for 2 weeks, and weekly for 2 weeks. DON or designee will audit treatment administration records 3 times a week for 2 weeks and weekly for 2 weeks, to ensure completed treatments are documented appropriately on the treatment administration record. Concerns will be addressed immediately, and findings will be evaluated in the quarterly QAPI meeting.
5. Date of Compliance: August 6, 2021.

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exit conference.
2. Resident #71 was admitted to the facility on 5/14/21 with a re-admission on 6/17/21. Diagnoses for Resident #71 included enterocolitis due to clostridium difficile (C-diff), neuropathic bladder, history of urinary tract infections, hypertension, chronic kidney disease, autistic disorder and anemia. The minimum data set (MDS) dated 5/11/21 assessed Resident #71 with moderately impaired cognitive skills.

Resident #71's clinical record documented the resident was re-admitted from the hospital on 6/17/21 with multiple pressure ulcers on his buttocks. A weekly skin evaluation sheet dated 6/17/21 documented the following pressure ulcer assessment for Resident #71:

Left buttock - stage 2 pressure ulcer measuring 0.5 x 0.5 x 0 (length by width by depth in centimeters)
Right buttock - two stage 2 pressure ulcers measuring 4.0 x 1.0 x 0 cm and 2.0 x 1.0 x 0 cm

The clinical record documented a physician's order dated 6/18/21 to cleanse and apply zinc ointment with a dry dressing to the right and left buttock ulcers until healed.

Resident #71's treatment administration record (TAR) documented no daily dressing changes/treatments for the pressure ulcers from 6/18/21 through 6/24/21 and on 6/26/21. Spaces for nurses' initials signing off completion of the treatments were blank. There were no attached notes or explanation of why the TAR was incomplete.

Nursing notes from 6/18/21 through 6/26/21

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F 842	Continued From page 53 documented treatments and dressing changes to the resident's pressure ulcers. On 7/1/21 at 8:25 a.m., the licensed practical nurse (LPN #2) routinely caring for Resident #71 was interviewed about the incomplete TAR. LPN #2 stated the treatments and dressing changes were done on the day shift as ordered. LPN #2 stated she did not know why the TAR was not signed off or completed. On 7/1/21 at 9:00 a.m., the director of nursing (DON) was interviewed about Resident #71's incomplete TAR. The DON stated skilled nursing notes made mention of the intact dressings on the resident. The DON stated the treatments should have been signed off on the TAR to document implementation of the physician's order. This finding was reviewed with the administrator and DON during a meeting on 7/1/21 at 1:10 p.m.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/6/21

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F 880	Continued From page 54 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 55 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and clinical record review, the facility staff failed to follow infection control practices during meal tray distribution on one of three nursing units. Staff members on the South wing failed to don gowns and gloves when serving meal trays to residents on droplet precautions. The findings include: On 6/29/21 at 12:20 p.m., meal tray service on the South unit was observed. On 6/29/21 at 12:36 p.m., certified nurses' aide (CNA) #2 with a mask on and no other personal protective equipment (PPE), entered room (number), positioned the over-bed table and placed the meal tray for A-bed resident. CNA #1, without gown or gloves, also entered this room and set up the meal tray for B-bed resident. CNA #1 and #2 exited the room and applied hand sanitizer to their hands. On 6/29/21 at 12:38 p.m., CNA #2 entered room (number), moved the over-bed table and setup the meal tray for the B-bed resident. CNA #2 had no gown or gloves on	F 880	F880 1. Staff on the South unit were educated on PPE donning requirements for passing meal trays immediately, while surveyors were onsite. 2. An audit of tray passes on all other units at the time of survey identified no other deficient practice for donning PPE while passing meal trays. 3. DON or designee will educate nursing staff on appropriate practice for donning PPE for passing meal trays. 4. DON or designee will observe PPE donning practices during meal tray passes daily for 2 weeks. Concerns will be addressed immediately, and findings will be evaluated in the quarterly QAPI meeting. 5. Date of Compliance: August 6, 2021.	

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when entering the room and providing meal setup.

All residents in this section of the South wing including rooms the CNAs entered, were identified and posted with signs for droplet precautions. Signs posted documented masks, gowns and gloves were required prior to entering rooms. Clinical record review for the residents in rooms above, documented they were new admissions and were on droplet precautions as part of the facility's COVID-19 prevention protocols.

On 6/29/21 at 12:43 p.m., CNA #2 was interviewed about entering rooms without a gown or gloves. CNA #2 stated staff were supposed to wear masks, gowns and gloves when entering rooms on droplet precautions. CNA #2 stated the residents in the rooms observed were on droplet precautions like all the residents on the unit.

On 6/29/21 at 2:37 p.m., CNA #1 was interviewed about not donning gowns and gloves during the meal observation. CNA #1 stated she thought the gowns and gloves were only required when performing direct care. CNA #1 stated she was not aware the gowns and gloves were required for meal tray delivery. CNA #1 stated the rooms observed were part of the quarantine unit due to COVID-19 and all rooms behind the designated "red line" required full PPE (gowns, gloves, masks).

On 7/1/21 at 11:20 a.m., the director of nursing (DON) was interviewed about the PPE requirement when entering rooms with droplet precautions for meal service. The DON stated anytime staff entered rooms on droplet

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precautions, a gown, gloves and masks were to be worn.

On 7/1/21 at 11:48 a.m., the infection preventionist (other staff #5) was interviewed about the meal observation on 6/29/21. The infection preventionist stated staff were required to wear gowns, gloves and masks anytime they entered rooms on droplet precautions.

The facility's policy titled Transmission Based Precautions - General Practice (effective 2/6/20) documented, "The Center initiates transmission-based precautions (TBPs) to protect other patients, employees and visitors from the spread of a confirmed or suspected infection or contagious disease...Transmission based precautions are used in addition to standard precautions...Meal tray delivery to the room...Use gown, gloves, and/or mask if indicated by the type of isolation precautions being used for the patient...If gown, gloves, and/or mask were used, remove and dispose of properly...Perform hand hygiene..."

This finding was reviewed with the administrator and director of nursing during a meeting on 7/1/21 at 1:10 p.m.