STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495102	A. BUILDING _____ B. WING _____	C 09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-ARLINGTON	550 SOUTH CARLIN SPRINGS ROAD ARLINGTON, VA 22204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated survey was conducted 09/07/2021 through 09/15/2021. Eleven complaints were investigated during the survey. Significant corrections are required for the facility to be in compliance with 42 CFR Part 483 Federal Long Term Care requirements.

Complaints were as follows:
VA00047770: Unsubstantiated
VA00051732: Unsubstantiated
VA00049581: Unsubstantiated with related deficiency
VA00051063: Substantiated without deficient practice
VA00048600: Substantiated without deficient practice
VA00051833: Unsubstantiated
VA00049796: Substantiated with deficient practice
VA00052933: Substantiated with deficient practice
VA00051445: Unsubstantiated
VA00051632: Unsubstantiated
VA00050425: Substantiated with deficient practice

The census in this 240 certified bed facility was 137 at the time of the survey. The survey sample consisted of ten (10) closed records (Resident #1 through Resident #6, and Resident #8 through Resident #11) and ten (10) current Resident reviews (Residents #7 and Resident #12 through Resident #20 and Resident #40). Nineteen additional residents, (Resident #21 through Resident #39) were added to review medication pass times/physician notification only.

ManorCare Arlington is filing this plan of correction for purposes of regulatory compliance. The facility is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 10/14/2021

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 09/07/2021 through 09/15/2021. Eleven complaints were investigated during the survey. Significant corrections are required for the facility to be in compliance with 42 CFR Part 483 Federal Long Term Care requirements. Complaints were as follows: VA00047770: Unsubstantiated VA00051732: Unsubstantiated VA00049581: Unsubstantiated with related deficiency VA00051063: Substantiated without deficient practice VA00048600: Substantiated without deficient practice VA00051833: Unsubstantiated VA00049796: Substantiated with deficient practice VA00052933: Substantiated with deficient practice VA00051445: Unsubstantiated VA00051632: Unsubstantiated VA00050425: Substantiated with deficient practice The census in this 240 certified bed facility was 137 at the time of the survey. The survey sample consisted of ten (10) closed records (Resident #1 through Resident #6, and Resident #8 through Resident #11) and ten (10) current Resident reviews (Residents #7 and Resident #12 through Resident #20 and Resident #40). Nineteen additional residents, (Resident #21 through Resident #39) were added to review medication pass times/physician notification only.	F 000	ManorCare Arlington is filing this plan of correction for purposes of regulatory compliance. The facility is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated	

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

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F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, and staff interview, the facility failed to accommodate mobility needs for one of 21 residents in the survey sample, Resident # 19. The facility failed to facilitate the repair of Resident # 19's electric wheelchair, and furnished him with a manual wheelchair he was unable to use. The findings were: Resident # 19 was admitted to the facility on 3/19/2009, and most recently readmitted on 5/27/2021 with diagnoses that included arteriosclerotic heart disease, cerebrovascular accident, hemiplegia and hemiparesis, acquired absence of kidney, seizures, history of venous thrombosis and embolism, gout, polyneuropathy, benign prostatic hyperplasia, obesity, hyperlipidemia, obstructive sleep apnea, gastroesophageal reflux disease, hypertension, coronary artery disease, and insomnia. According to the most recent complete Minimum Data Set (MDS), a Quarterly Review with an Assessment Reference Date (ARD) of 4/22/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact with a Summary Score of 14 out of 15.	F 558	F558 Reasonable Accommodations Needs/Preferences **I** **Corrective Action** Administrator is working to assist resident #19/responsible party with the repair of the electric wheelchair. PT will evaluate resident for use of alternative equipment. **II** **Identification** PT evaluated like-residents with electric wheelchair to make sure electric wheelchairs are functional. Resident(s) will be provided with an alternative equipment that meets their needs **III** **System change** Education was given to staff for accommodation of individual needs and report inoperable electric wheelchairs to the Maintenance Director (TELS), Administrator and the DON. **IV** **Monitoring** Administrator/designee will monitor residents with electric wheelchair for proper functionality weekly x 4, monthly x 2 and randomly thereafter to ensure compliance. Findings will be	

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F 558	Continued From page 2 Under Section G (Functional Status), at Item G0110 - C (Walk in room), D (Walk in Corridor), E (Locomotion on Unit), and F (Locomotion off Unit), the resident was assessed as the activity not occurring. At Item G0400 (Functional Limitations in Range of Motion), the resident was assessed as having impairment on one side involving upper and lower extremities. At Item G0600 (Mobility Devices), the resident was assessed as using none of the listed mobility devices. According to the review of an incomplete Quarterly Review MDS with an ARD of 7/23/2021, the resident was assessed under Section G (Functional Status), at Item G0110 - C (Walk in room), D (Walk in Corridor), E (Locomotion on Unit), and F (Locomotion off Unit), the resident was assessed as the activity not occurring. At Item G0400 (Functional Limitations in Range of Motion), the resident was assessed as having impairment on one side involving upper and lower extremities. At Item G0600 (Mobility Devices), the resident was assessed as using a wheelchair. Resident # 19 was interviewed on 9/9/2021 at 3:00 p.m. Resident # 19 said he was unable to use his left side, both leg and arm, to do anything. He pointed to an electric wheelchair near his bed and said, "It is broken and needs to be repaired. That is how I get around. I stay in my room all the time. They use a hoyer (lift) to get me out of bed." There was a manual wheelchair in the resident's room which he said staff place him in using the hoyer. Asked if he could use the manual wheelchair, the resident said, "I cannot." At 11:55 a.m. on 9/14/2021, the Director of Nursing (DON) was interviewed by telephone	F 558	forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. V 10/27/2021	

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F 558	Continued From page 3 regarding Resident # 19's electric wheelchair. "He has not used it since the COVID pandemic," the DON said. "He is alert and oriented and can make his need known. He stays in his room all the time." At 12:10 p.m. on 9/14/2021, the DON stated, "The electric wheelchair is his personal property and his wife is aware it does not work. She is trying to get it fixed." The DON went on to say the facility gave the resident a manual wheelchair to use. "He sits in it in his room. We use the Hoyer Lift to get him in the chair and he watches TV," the DON said. Asked if the resident could ambulate in the manual wheelchair, the DON said, "I have never seen him ambulate in the chair. He can use the (manual) wheelchair." At 12:20 p.m. on 9/14/2021, the DON stated, "The insurance company is willing to fix the chair, but they are reluctant to come in the facility due to COVID." There was no documentation in the resident's Electronic Health Record to indicate his electric wheelchair was not in working order, and the DON did not indicate the facility had done anything other then rely on the resident's wife to arrange repairs to the electric wheelchair.	F 558		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of	F 569	F569 Notice and Conveyance of Personal Funds I **Corrective Action** Resident #11 no longer resides at the	

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F 569	Continued From page 4 the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, clinical record review, staff interview, and resident interview, the facility staff failed to convey personal funds to the resident upon discharge from the facility, for one of 21 residents in the survey sample, Resident # 11. The findings were: Resident # 11 was admitted to the facility on 7/28/2020 with diagnoses that included displaced fracture of the third cervical vertebra, disorders of muscle, acute kidney failure, orthostatic hypotension, benign prostatic hyperplasia, obstructive and reflux uropathy, gastroesophageal reflux disease, neuro-muscular dysfunction of the bladder, and enterocolitis due to c-diff. According to the Admission Minimum Data Set (MDS) with an Assessment Reference Date of 8/4/2020, the resident was assessed under Section C (Cognitive Patterns) as being	F 569	facility. Facility has returned funds to resident **II** **Identification** Residents have the potential to be affected. Facility will audit Personal Needs Accounts to validate that funds for discharged residents have been returned to them. **III** **System Change** Administrator will educate the Business Office staff to validate any money is return to a resident at the time of discharge. **IV** **Monitoring** Administrator will audit the personal Need Account weekly x 4, monthly x 2, and randomly to ensure compliance. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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F 569	Continued From page 5 cognitively intact, with a Summary Score of 15 out of 15. At 3:00 p.m. on 9/7/2021, Resident # 11 was interviewed. The resident said the facility still had $278 belonging to him in the Business Office safe. "I called them four days ago and got no satisfaction. I've called them about five times." Resident # 11 was discharged from the facility on 9/23/2020. Review of Resident # 11's clinical record revealed the following Progress Note, dated 7/28/2020 at admission: 7/28/2020 - "...resident came with 285 dollars but resident gave the money to staff to keep for him safely and 285 dollars is in med cart..." On 9/8/2021 at 8:30 a.m., the Administrator was asked about the money belonging to Resident # 11 the facility was holding. "I have no knowledge of that," the Administrator said. At 9:10 a.m. on 9/8/2021, the Regional Business Office Support Manager was interviewed regarding Resident # 11's money being held by the facility. Told that Resident # 11 gave the staff $285 to hold for him, and that the money was placed in a medication cart, the Manager said, ""We do not encourage that kind of thing. The money left like that is usually placed in an envelope and locked in a safe in the Business Office. I don't know where that (the safe) is, but I will find out and get back to you." The Manager was later able to determine that Resident # 11 did not open a trust account. "We encourage residents to open a trust account. At least they get a little interest on their money and it	F 569		

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F 569	Continued From page 6 (the money) is safer." At 1:05 p.m. on 9/8/2021, the Manager reported that an envelope (one gallon plastic bag) was found in the Business Office safe bearing the name of Resident # 11. The envelope contained $85. The Manager provided a copy of a paper found in the bag noting that on 7/28/2020, $285 was placed in the bag. The paper also noted that Resident # 11 authorized a withdrawal of $200 to pay a plumber for repairs to his home, leaving a balance of $85. Asked how the remaining $85 could be returned to Resident # 11, the Manager said the easiest way would be to have the facility Administrator obtain a money order and send it to the resident. The Manager also noted that the Administrator is the only person authorized to obtain a money order. COMPLAINT DEFICIENCY	F 569		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580	F580 Physician Notification of Changes I **Corrective Action** Resident #13 no longer resides at the facility. MD was made aware of late med pass on 9/8/2021 for Resident #21 through Resident #33, and Resident #35 through Resident #39. No adverse effects noted.	

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F 580	Continued From page 7 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, clinical record review and facility document review, the facility staff failed to notify	F 580	LPN #2 has received a skills review on medication administration. **II** **Identification** All residents have the potential to be affected. DON/designee will audit medication administration times from 9/1/2021 to ensure the timely administration of medication. **III** **System Change** Nurses will receive skills review on medication administration. ADON will educate nurses on physician notification for late med pass. **IV** **Monitoring** DON/designee will monitor timely administration of med pass weekly x 4 and monthly x 2 and randomly thereafter. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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F 580	Continued From page 8	F 580		

the physician of late medication administration for 18 of 40 residents, Resident #21 through Resident #33, and Resident #35 through Resident #39.

Findings were:

On 09/08/2021 a medication pass and pour observation was conducted on the third floor of the facility on with LPN (licensed practical nurse) #2. The observation of 9:00 a.m., medications for Resident #13 was not completed until 11:35 a.m. At the time the observation was completed, LPN #2 was asked if the rest of her medication pass would be late. She stated, "Yes."

A listing of all medications given by LPN #2 during the morning medication pass on 09/08/2021 with actual administration times was requested and received on 09/09/2021. Physician ordered medications with a scheduled administration time of 9:00 a.m., and given as late as 2:44 p.m., included but were not limited to: blood pressure medications, oral diabetic medications, diuretics, anticonvulsant's, pain patches, scheduled pain medication (including morphine), inhalers, and extended release medications.

Review of the clinical record for Residents #21 through Resident #39 was completed on 09/13/2021 at approximately 12:30 p.m. There was no documentation of physician notification that medications were not given at prescribed times for any of the residents except Resident #34, who refused to take his medication.

The DON (director of nursing) was interviewed on 09/13/2021 at approximately 1:45 p.m. She was asked if the physician should have been notified

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F 580	Continued From page 9 that the medications were given outside of the prescribed times on 09/08/2021. She stated, "Yes, the physician should have been notified." A copy of the facility policy regarding notification was requested and received. The facility policy "Change in Condition", contained the following: "A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: ...A need to alter treatment significantly..." The facility policy on medication administration contained the following: "...Administer medications in accordance with frequency prescribed by the physician-within 60 minutes before or after prescribed dosing time." No further information was obtained prior to the exit conference on 09/15/2021.	F 580		
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 complaint investigation, clinical record review, and staff interview, the facility staff failed for two of 21 residents in the survey sample, Residents # 11 and 19, to ensure a complete and accurate Minimum Data Set. Facility staff failed to accurately identify Resident # 11's pressure sore status under Section M (Skin Conditions) on an Admission Minimum Data Set; and failed to	F 641	F641 Accuracy of Assessments **I** **Corrective Action** Resident #11 no longer resides at the facility. Modification completed to capture the pressure ulcer present on admission. Section C (Cognitive Patterns), Section D (Mood), Section E (Behavior) was completed for Resident #19.	

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F 641	Continued From page 10 complete Sections C, D, and E on the most recent Quarterly Minimum Data Set for Resident # 19. The findings include: Resident # 11 was admitted to the facility on 7/28/2020 with diagnoses that included displaced fracture of the third cervical vertebra, disorders of muscle, acute kidney failure, orthostatic hypotension, benign prostatic hyperplasia, obstructive and reflux uropathy, gastroesophageal reflux disease, neuro-muscular dysfunction of the bladder, and enterocolitis due to c-diff. According to the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/2020, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Section M (Skin Conditions), M0210 - Unhealed Pressure Ulcers/Injuries asks the question "Does the resident have one or more unhealed pressure ulcers/injuries" was answered "No". Review of the Admission/Re-Admission Evaluation, dated 7/28/2020, under the Clinical Evaluation Integumentary (Skin) category revealed the following: Sacrum open wound measuring 3.0 cm (centimeters) x (by) 1.3 cm, and left lower buttock noted with open area measuring 3.0 cm x 1.0 cm. Review of the Progress Notes in the resident's electronic clinical record revealed the following: "7/29/2020 - 3:33 p.m. - General Progress Notes - " ...Sacrum wound care done as per the orders ...." Progress notes from 8/4/2020 through 9/18/2020 documented continued treatment of	F 641	**II** **Identification** Residents have the potential to be affected. Facility will complete a skin sweep for residents in house. Facility will audit residents to validate completion of sections C, D, and E of the MDS. **III** **System Change** License nurses will be educated on performing 2nd day skin assessments on new/re-admits; Wound nurse will be educated on documenting weekly wound notes for any in house resident with wound. Social Work will be educated on completing section C, D, and E of the MDS timely to ensure compliance. **IV** **Monitoring** MDS will review skin assessment and wound notes for new admissions weekly x 4 and monthly x 2 and randomly thereafter. MDS will review sections C, D, and E weekly x 4 and monthly x 2, and randomly thereafter. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the	

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F 641	Continued From page 11 the wound until it was healed. At 9:10 a.m. on 9/8/2021, RN # 3 (Registered Nurse), the Contract MDS Coordinator, was interviewed about the MDS entry at Section M. "If the wound was present on the ARD, or if there was a treatment on the ARD, it should have been caught and put entered on the MDS as an unhealed pressure area," RN # 3 said. After comparing the Progress Notes entries with the Admission/Re-Admission Evaluation and the MDS, RN # 3 said, "They (the MDS personnel) missed it." 2. Resident # 19 was admitted to the facility on 3/19/2009, and most recently readmitted on 5/27/2021 with diagnoses that included arteriosclerotic heart disease, cerebrovascular accident, hemiplegia and hemiparesis, acquired absence of kidney, seizures, history of venous thrombosis and embolism, gout, polyneuropathy, benign prostatic hyperplasia, obesity, hyperlipidemia, obstructive sleep apnea, gastroesophageal reflux disease, hypertension, coronary artery disease, and insomnia. According to the most recent complete MDS), a Quarterly Review with an ARD of 4/22/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact with a Summary Score of 14 out of 15. Review of the most recent Quarterly Review MDS, with an ARD of 7/23/2021, revealed the following: Section C (Cognitive Patterns) - Items C0100 through C1310 were blank. Section D (Mood) - Items D0100 through D0600 were blank. Section E (Behavior) - Items E0100 through	F 641	need for further audits and/or action plan V 10/27/2021	

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F 641	Continued From page 12 E0900 were blank. At 9:05 a.m. on 9/9/2021, RN # 3 was interviewed about the missing information at Sections C, D, and E on the Quarterly Review MDS dated 7/23/2021. Asked who was responsible for those sections, RN # 3 said, "They are the responsibility of the Social Worker." RN # 3 went on to say, "I don't know if the Social Worker was out sick, or if they didn't have one."	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655	F655 Baseline Care Plan **I** **Corrective Action** Resident #9 and Resident #18 no longer resides at the facility. **II** **Identification** Social Work will conduct an audit of new admissions from 9/1/2021 to validate there is an appropriate baseline care plan in place within 24 hours. In addition to baseline care plan in place need to validate a written summary given and evidence documented in the medical record **III** **System Change** DON/designee will provide education to the IDT and nurses to ensure	

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F 655	Continued From page 13 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to develop a baseline care plan for immediate care within 48 hours of admission for two of 21 residents in the survey sample, Resident #9 and Resident #18. Findings include: 1. Resident #9 was admitted to the facility on 03/25/21 and discharged without returning on 04/04/21. Diagnoses for Resident #9 included, but were not limited to: CHF (congestive heart failure), morbid obesity, diabetes mellitus, hypothyroidism, anxiety, depression, OSA (obstructive sleep apnea), respiratory failure-acute on chronic, venous insufficiency, chronic kidney disease and high blood pressure. The most current MDS (minimum data set) was an admission assessment dated 03/30/21. This	F 655	compliance with baseline care plan. QAA committee will review PCC weekly during morning meeting x 4, monthly x 2 and randomly to validate compliance with baseline care plan. **IV** **Monitoring** Social Worker/designee will audit for compliance with baseline care plan weekly x 4, and randomly there after x 2 months. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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MDS assessed Resident #9 as having a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring extensive assistance of at least two staff members for ADL's (activities of daily living) including bed mobility, dressing, toileting and hygiene. In Section O. of this MDS, Special Treatments, Procedures, and Programs C. Oxygen therapy, the resident was assessed as receiving oxygen prior to admission to the facility and while a resident of the facility during the look back period.

On 09/07/21 through 09/15/21, Resident #9's clinical records were reviewed. A baseline care plan for immediate care of Resident #9 could not be located in the resident's chart.

The resident's comprehensive care plan was then reviewed. This care plan included two areas that were dated 03/26/21 (one day after admission), which were regarding discharge and nutrition and hydration. The was no information regarding oxygen, diabetes, or other care areas.

On 09/13/21 at 1:30 PM, the DON (director of nursing) was asked for assistance in locating the baseline care plan for Resident #9.

On 09/13/21 at 3:30 PM, the DON presented the comprehensive care plan (as described above). The DON was made aware that the care plan only included two areas for Resident #9 that were developed within 48 hours of admission. The DON was asked for the remainder of the baseline care plan. The DON stated, "That's what I have."

No further information and/or documentation was

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presented prior to the exit conference to evidence a baseline care plan was developed and implemented to include instructions needed to provide effective, person-centered care of this resident within 48 hours of admission.
2. Resident # 18 was discharged from the facility on 6/30/2021 and re-admitted to the facility on 7/8/2021 with diagnoses that included hypothyroidism, encephalopathy, alcohol cirrhosis of the liver, gout, alcohol abuse, alcohol induced chronic pancreatitis, arthritis, and cellulitis of the right lower limb.

According to an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/13/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.

Resident # 18's previous Discharge MDS, with an ARD of 6/30/2021, under Section A (Identification Information), Item A0310 -F, Entry/discharge reporting, was coded as 10, Discharge assessment - return not anticipated.

Resident # 18's Electronic Health Record, reviewed at 8:30 a.m. on 9/9/2021, included a one page care plan, created on 7/20/2021, twelve days after admission, that included the following: "Focus: Nutritional/Hydration status as evidenced by significant weight loss on readmission, underweight, dx (diagnosis) hx (history)/meds (medications), therapeutic higher Calorie/protein diet." The Goal for the Focus was, "Will tolerate diet with meal intakes of at least 75%." Interventions to the stated Focus included, "Administer medications as ordered; Obtain/review labs as ordered and notify

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F 655	Continued From page 16 physician of results; Provide diet as ordered: Regular enhanced; Record/review weight per facility protocol." Resident # 18's one page care plan was created on 7/20/2021, twelve days after his admission on 7/8/2021. At 9:15 a.m. on 9/9/2021, RN # 3 (Registered Nurse), was interviewed regarding the care plan for Resident #18. According to RN # 3, "If the resident was discharged as Return Not Anticipated, then the existing care plan would be discontinued." RN # 3 went on to say that if the resident was admitted again, "...the should create a new care plan." No further information was provided to evidence thay a baseline careplan had been created for Resident #18 upon admission to the facility.	F 655		
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).	F 657	F 657 Care Plan Timing and Revision **I** **Corrective Action** Resident #18 no longer resides at the facility. **II** **Identification** All residents at the facility have the potential to be affected. Facility will conduct an audit of all new admissions from 9/1/2021 to validate the completion of an appropriate	

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F 657	Continued From page 17 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 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 and staff interview, the facility failed for to develop a comprehensive care plan within seven days after the completion of a comprehensive assessment one of 21 residents in the survey sample, Resident # 18. Resident # 18's comprehensive care plan was created on 9/9/2021, forty-two days after the completion of the comprehensive admission assessment. The findings were: Resident # 18 was discharged from the facility on 6/30/2021 and re-admitted to the facility on 7/8/2021 with diagnoses that included hypothyroidism, encephalopathy, alcohol cirrhosis of the liver, gout, alcohol abuse, alcohol induced chronic pancreatitis, arthritis, and cellulitis of the right lower limb. According to an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/13/201, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out	F 657	comprehensive care plan within 7 days after completion of the comprehensive assessment. **III** **System Change** DON/designee will provide education to the IDT to ensure compliance comprehensive care plan. QAA committee will review PCC weekly during morning meeting weekly x 4, month x 2 and randomly thereafter. **IV** **Monitoring** MDS/designee will audit for compliance weekly x 4, and monthly x 2, randomly thereafter. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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F 657	Continued From page 18 of 15. Resident # 18's Discharge MDS, with an ARD of 6/30/2021, under Section A (Identification Information), Item A0310 -F, Entry/discharge reporting, was coded as 10, Discharge assessment - return not anticipated. At 9:15 a.m. on 9/9/2021, RN # 3 (Registered Nurse), was interviewed regarding the care plan for Resident #18. According to RN # 3, "If the resident was discharged as Return Not Anticipated, then the existing care plan would be discontinued." RN # 3 went on to say that if the resident was admitted again, "...they should create a new care plan." Resident # 18's Electronic Health Record, reviewed at 8:30 a.m. on 9/9/2021, included two care plans. One care plan, dated 6/30/2021, consisted of 18 focus areas, 15 of which were identified as canceled and three identified as resolved. The second care plan consisted of one page and was created on 7/20/2021, twelve days after admission, that included the following "Focus: Nutritional/Hydration status as evidenced by significant weight loss on readmission, underweight, dx (diagnosis) hx (history)/meds, therapeutic higher Calorie/protein diet." The Goal for the Focus was, "Will tolerate diet with meal intakes of at least 75%." Interventions to the stated Focus included, "Administer medications as ordered; Obtain/review labs as ordered and notify physician of results; Provide diet as ordered: Regular enhanced; Record/review weight per facility protocol."	F 657		

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F 657	Continued From page 19 At approximately 3:30 p.m. on 9/9/2021, review of Resident # 18's Electronic Health Record revealed a new care plan. The new care plan included focus areas of Urinary Incontinence, Discharge Planning, Falls Risk, Gastrointestinal Distress, Discomfort and Mobility, and Skin Integrity. The creation date for the new care plan focus areas was 9/9/2021, forty-two days after the completion of the Admission MDS dated 7/13/2021. No additional information was provided prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medication pass observation, staff interview, and manufacturer's recommendations, the facility failed to ensure that professional standards for the use of a Humalog-100 insulin pen were followed for one of 21 residents, Resident #13. LPN (licensed practical nurse) #2 used an insulin syringe to withdraw 4 units of insulin from a Humalog 100 KwickPen for administration. Findings were: Resident #13 was admitted to the facility on 06/25/2021 with the following diagnoses, including but not limited to: Diabetes Mellitus,	F 658	F658 Services Provided Meet Professional Standards **I** **Corrective Action** Resident #13 no longer resides at the facility. LPN #2 was provided a skills review on insulin administration. **II** **Identification** All residents with insulin injections have the potential to be affected. ADON/designee will audit insulin administration competencies to validate insulin administration guidelines.	

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F 658	Continued From page 20 acute kidney failure, anemia, heart failure, and hypothyroidism. An admission MDS (minimum data set) with an ARD (assessment reference date) of 07/02/2021, assessed Resident #2 as cognitively intact with a summary score of "15". On 09/08/2021, a morning medication pass was observed with LPN #2. At 10:55 a.m., a Humalog 100 units/ml KwikPen was obtained from the stat box. At 11:30 a.m., LPN #2 opened the KwikPen and used an insulin syringe to withdraw 4 units of insulin for Resident #13. After withdrawing the insulin, she placed the KwikPen in a bag in the medication cart labeled with the date of opening. She stated, "I wrote the resident's name on the label of the pen but when I opened it, I pulled that off. I will fix it." She did not write the resident's name on the pen at that time. The 4 units of insulin were administered to Resident #13 at 11:35 a.m. After the administration of insulin the unit manager, RN (registered nurse) #2 was sitting at the nurse's station. The observation of LPN #2 using an insulin syringe to withdraw insulin from the KwikPen was brought to her attention. She shook her head side to side and put her hand to her forehead with her elbow on the counter. At approximately 12:15 p.m., LPN #2 was interviewed regarding the use of an insulin syringe to withdraw insulin from the KwikPen. She stated, "I don't have any needles here for the pen." She was asked if that meant there were no needles for the pens in the facility. She stated, "I have to ask [name of other staff #13], he has all of that in supply." LPN #2 continued preparing	F 658	**III** **System Changes** ADON/designee will provide education and insulin administration skilled review with licensed nurses to validate compliance with insulin administration. **IV** **Monitoring** DON/designee will randomly audit at least a nurse weekly for insulin administration x 4, monthly x 2, and randomly thereafter. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan **V** **10/27/2021**	

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medications for her next resident. OS (Other staff) #13 was observed walking down the hallway, LPN #2 called him by name but continued medication preparation and OS #13 spoke her name and continued walking. OS #13 was stopped and asked if he was the staff that was responsible for supplies. He stated, "Yes." He was asked if there were needles in stock for use with a Humalog 100 unit KwikPen, he stated, "Yes, I have those downstairs." He was asked what LPN #2 needed to do to get the needles on her cart. He stated, "She just has to ask me...I can't look in their carts. If they don't tell me what they need I can't get it." LPN #2 then stated, "Can I get some needles for my cart?"

At approximately 12:45 p.m., LPN #2 was asked if she had gotten the needles needed for the KwikPen. She stated, "Yes, that was my mistake. I should not have used the syringe to get the insulin, I have gotten them [the needles] from [name of OS #13] when I saw that I needed them."

A copy of the manufacturer's insert for the KwikPen was requested from the DON (director of nursing) at approximately 3:00 p.m.

On 09/08/2021 at 4:45 p.m., LPN #4 was observed giving sliding scale insulin to Resident #13. He removed the Humalog 100 KwikPen from the medication cart. The pen was in the same bag that it had been placed in earlier in the day. The bag was dated 09/08/2021 but there was no name on the KwikPen. LPN #4 took the pen to LPN #2 to verify that the pen was the same one opened earlier in the day. LPN #2 looked at the pen and stated, "Yes, it is hers. I tore the name off with the label." Resident #13's name was then

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written on the KwikPen. LPN #4 took the pen back to the medication cart and administered the ordered dose of insulin to Resident #13.

A printout from the pharmacy was presented at approximately 5:10 p.m., but did not contain any information regarding the use of an insulin syringe to withdraw insulin from the KwikPen. At 5:30 p.m., the pharmacy was contacted and OS #14 was interviewed. She was asked if it was okay to use an insulin syringe to withdraw medications from a KwikPen for insulin administration. She stated, "No, I don't think the manufacturer would approve of that, based on the general guidelines it's just not designed for that."

On 09/09/2021, at 8:00 a.m., LPN #2 was observed giving insulin to Resident #13. A blood sugar reading of 184 was obtained. LPN #2 stated, "She will get 2 units of Humalog for sliding scale and she has 3 units scheduled..." LPN #2 removed the Humalog 100 KwikPen from the medication cart. It was in the same bag as the day before and dated 09/08/2021. Resident #13's name was written on the pen. LPN #2 was asked if that was the same pen that she had used the day before. She stated, "Yes."

On 09/09/2021 at approximately 10:20 a.m., the manufacturing company for the Humalog 100 KwikPen was contacted. The representative, OS #15 was asked if it was okay to use an insulin syringe to pull insulin out of a KwikPen for administration. He stated, "I am pretty sure it shouldn't be pulled up with an insulin syringe...that is not an approved method of administration." He was asked if the unit measure would be the same from the pen to the insulin syringe. He stated, "It will be for the 100 unit but

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not the 200 unit." He was asked if the insulin measurement would be the same what difference did it make which way the insulin was given. He stated, "I don't know if it will damage the pen or not, the recommendation is to use the needle that is designed for the pen. I will send this up to the technical team and get an answer."

On 09/10/2021 at approximately 10:20 a.m., OS #15 called. He stated, "I have a response from the technical team. I will read it to you: "...Lilly does not recommend removing insulin from a pen cartridge with a needle and a syringe. If the insulin has been removed from the cartridge by this means, advise the patient or caregiver not to use the prefilled pen again. Removing insulin from the pen's cartridge can result in causing the pen to not function properly. This in turn could lead to inaccurate dosing..."

The DON was interviewed on 09/13/2021 at approximately 9:00 a.m. and asked if the Humalog KwikPen that was opened on 09/08/2021 by LPN #2 was still in use. She was also asked if they had contacted the manufacturer regarding continued use of the pen after LPN #2 withdrew insulin using a needle and syringe. She stated. "The same pen is being used, I didn't follow up with the pharmacy or the manufacturer, maybe [Name of unit manager, RN#2]...I will find out and get back to you."

The DON was interviewed at approximately 9:35 a.m. and stated, "[Name of unit manager, RN #2] said she thought you [this surveyor] were going to contact the pharmacy and tell her what they said....we also got rid of the pen." She was asked when the pen was last used. She stated, "The pen in use is dated September 8." She was told

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F 658	Continued From page 24 that was the date that the initial pen was opened. She stated, "This one came on the night run on September 8th, I think we started using it then." She was told that LPN #2 was observed using the pen in question during Resident #13's morning insulin administration on 09/09/2021. The information received from the manufacturer was given to the DON. She stated, "We need to inservice all the nurses, there is some accountability here...I talked to [Name of unit manager, RN #2] she said we are using the one from the pharmacy and didn't think they were using it [the pen in question]...I will make sure we get rid of the pen...there are some opportunities here." No further information was obtained prior to the exit conference on 09/15/2021.	F 658		
F 684 SS=E	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 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 medication pass and pour observation, staff interview, clinical record review and facility document review, the facility staff failed to follow physician orders for 23 of 40 residents in the survey sample. Medications were not administered at the physician ordered time for 20	F 684	F 684 Quality of Care **I** **Corrective Action** Resident #13 no longer resides at the facility. Resident #8 no longer resides at the facility. Resident #11 no longer resides at the facility. Any weight for Resident #20 is being done as recommended by the RD LPN #2 was provided a skilled review on timely administration of medication. LPN #9 was provided a skilled review	

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F 684	Continued From page 25 residents in the survey sample, Resident #13 and Resident #21 throught Resident #39; physician orders for administration of insulin were not followed for one of 40 residents, Resident #20; Resident #8, assessed with significant weight loss, had no weekly weights obtained as recommended by the registered dietitian (RD) and treatment orders for Resident #8's assessed MASD (moisture associated skin damage) and skin redness were not implemented as recommended by the provider; Resident #11 was not administered Imodium as ordered by the physician for diarrhea. Findings were: 1. A medication pass and pour observation was conducted on the third floor of the facility on 09/08/2021 with LPN (licensed practical nurse) #2. LPN #2 did not complete giving physician ordered 9:00 a.m., medication to Resident #13 until 11:35 a.m., resulting in late medication administration times for Resident #13 and Residents #21 through Resident #39 (19 additional residents). A listing of all medications given by LPN #2 during the morning medication pass on 09/08/2021 with actual administration times was requested and received on 09/09/2021. Physician ordered medications with a scheduled administration time of 9:00 a.m., and given as late as 2:44 p.m., included but were not limited to: blood pressure medications, oral diabetic medications, diuretics, anticonvulsants, pain patches, scheduled pain medication (including morphine), inhalers, and extended release medications. The above information was discussed during an	F 684	on insulin administration. MD was made aware of insulin administration error on 9/8/2021 for Resident #20. No adverse effects noted. MD was made aware of late med pass on 9/8/2021 for Resident #21 through Resident #39. No adverse effect was noted. **II** **Identification** All residents have the potential of being affected. RD/designee will audit current weights recommendations from 9/1/2021 to validate compliance. Unit Managers/designee will audit residents on Imodium from 9/1/2021 to validate compliance with physician order. DON/designee will review NP progress notes from 9/1/2021 to ensure NP orders written in the progress notes are transcribed appropriately. **III** **System Changes** ADON/designee will provide education to licensed nurses on timely administration of medication, following MD order on insulin administration, following weights recommendation guidelines, and the transcription of NP/MD orders.	

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F 684	Continued From page 26 meeting with the DON (director of nursing) and the administrator on 09/09/2021 at approximately 11:30 a.m. Per the facility policy, "Medication Administration" received on 09/09/2021 at approximately 3:30 p.m.: "Read transcribed physician order on MAR [medication administration record]: patient name, medication name, dosage, route and interval ordered...Administer medications in accordance with frequency prescribed by the physician-within 60 minutes before or after prescribed dosing time." No further information was obtained prior to the exit conference on 09/15/2021. 2. Resident # 20 was admitted to the facility 2/24/21 with diagnoses to include, but were not limited to: pleural effusion, myasthenia gravis, senile degeneration of the brain, heart failure, and diabetes. The most recent MDS (minimum data set) was a quarterly assessment dated 6/2/21 and had Resident # 20 assessed as cognitively intact with a score of 14 out of 15. On 9/8/21 at 4:30 p.m. a medication observation was conducted with LPN (licensed practical nurse) # 9. Resident # 20 had an order dated 4/9/21 and carried forward for "Humalog KwikPen Solution Pen-Injector 100 units per ML (milliliter) (Insulin Lispro 1 Unit Dial) Inject 2 units subcutaneously (under the skin) before meals for dm (diabetes mellitus)." The administration times were listed at 7:00 a.m., 11:30 a.m., and 4:30 p.m. After LPN # 9 completed the sliding scale blood sugar, also due at 4:30 p.m., she stated	F 684	ADON/designee will provide education to NP to put treatment orders in PCC. **IV** **Monitoring** RD/designee will monitor weights recommendations weekly x 4, monthly x 2 and randomly thereafter. DON/designee will monitor the timely administration of medication weekly x 4, monthly x 2 and randomly thereafter. DON/designee will monitor NP progress notes weekly x 4, monthly x 2 and randomly thereafter to validate compliance with treatment orders. ADON/designee will review insulin administration weekly x 4, monthly x 2 and randomly thereafter to validate compliance with insulin administration. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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"His blood sugar is 98, so he doesn't need any sliding scale coverage. For blood sugars 70-149, there is no coverage needed."

LPN # 9 then proceeded to prepare another resident's medications. LPN # 9 was asked if she was going to administer the standing order for the 2 units of Lispro. She stated "No, because his blood sugar was 98." It was then pointed out that while the sliding scale reading did not require any intervention for coverage, the resident still had an order for 2 units of Lispro prior to meals, and scheduled for administration at 4:30 p.m. LPN # 9 stated "Do you understand? I am using my nursing judgement here; I am not going to give the 2 units because his blood sugar was 98. He does not need any insulin. I am going to give him some orange juice, and recheck his blood sugar. I will call the doctor to let him know." LPN # 9 was then questioned why she was giving the resident orange juice for a blood sugar of 98. Again, LPN # 9 stated "I am using my nursing clinical judgement; I am giving the resident 2-4 oz orange juice, and will give the 2 units when I recheck his blood sugar in a bit. I will call the doctor to let him know."

On 9/9/21 at 7:45 a.m. the clinical record was reviewed for follow-up of the insulin administration 9/8/21. A progress note, dated 9/8/21 at 5:01 p.m. written by LPN # 9 documented "Resident BS (blood sugar) 98- 2 units Humalog held for now and NP (nurse practitioner) notified two 4-oz of orange juice given and writer will recheck BS, and the 2 units will be given." At 5:40 p.m. a progress note, written by LPN # 9 documented "Writer recheck BS is 166- 2 units of Humalog given..." The MAR (medication administration record) was then

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reviewed. An entry by LPN # 9 at 9:00 p.m. revealed a blood sugar of 189, with 1 unit of Humalog administered per sliding scale parameters.

On 9/9/21 beginning at 11:30 a.m. the DON (director of nursing) and the administrator were made aware of the above findings. The DON stated "Those 2 orders, sliding scale and standing order for insulin before meals, should not exist at the same time." The administrator stated "Nurses' should not be holding a scheduled insulin. They should go by the doctor order. Those orders should be clarified as time versus before meals."

On 9/9/21 at 2:30 p.m. the NP was interviewed about the above observation and findings. The NP stated "Yes, she (LPN # 9) called and told me she was giving (name of resident) some orange juice, so I figured his blood sugar was below 70...she seemed in a hurry..." The NP was asked if LPN # 9 had told him what the blood sugar was. He stated "No." The NP was asked if he asked for the blood sugar reading. The NP again stated "No." The NP was then asked if he had known the blood sugar was 98, would he have consented to giving orange juice, and also should the 2 units due before meals have been administered. The NP stated "No, I did not know the blood sugar was 98; that's a good number, and the 2 units of insulin due before meals should have been given per the order."

No further information was provided prior to the exit conference.

3. Resident #8 was admitted to the facility on 10/2/20 and was discharged to the hospital on 7/29/21. Diagnoses for Resident #8 included

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COPD (chronic obstructive pulmonary disease), anemia, gastroesophageal reflux disease, diabetes, dementia, bipolar disorder, psychotic disorder, osteoarthritis, hypothyroidism and benign prostatic hypertrophy. The minimum data set (MDS) dated 6/15/21 assessed Resident #8 with severely impaired cognitive skills.

a) Resident #8's closed clinical record documented the resident was assessed with a significant unplanned weight loss of 40 pounds (lbs.) on 6/6/21.

The RD's note dated 6/8/21 documented, "...Validated monthly weight from nursing 6/7/21 124.8 lbs, BMI 20.8 = low end reference range for age 71...significant unintentional weight loss (>20% in past month per recorded weights) -- hx [history] of abnormal thyroid function... RECOMMEND: recheck thyroid function labs...add Ensure Plus oral supplement every a.m.; do weekly weights this month for closer monitoring..."

The RD's note dated 7/8/21 documented, "..118.4 lbs show significant unintentional weight loss (5.1% past month) continuing as prior month...RECOMMEND..Weekly weights recommended for this month for closer monitoring .." (Sic)

The clinical record for June 2021 and July 2021 documented the weekly weights were not obtained for Resident #8 as recommended by the RD. There were no weights obtained in June 2021 after the RD's recommendation on 6/8/21. In July, the resident was weighed on 7/4/21, 7/7/21 and 7/22/21. There were no weights obtained during week ending 7/17/21 or week

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ending 7/31/21. The clinical record documented no physician's order for weekly weights.

On 9/8/21 at 9:00 a.m., the RD (other staff #2) was interviewed about Resident #8's weight loss and weight monitoring. The RD stated she recommended weekly weights on 6/8/21 for increased monitoring of the significant weight loss. The RD reviewed the clinical record and stated she did not see weekly weights during June 2021 after her recommendation. The RD stated she was on vacation from 6/11/21 through 6/28/21 and the covering RD did not realize the weights were not done. The RD stated she reviewed the resident on 7/8/21 and again recommended weekly weights due to continued weight loss despite interventions. The RD stated the weights were not obtained weekly as recommended. The RD stated the need for weekly weights was communicated with the nursing staff during clinical meetings.

On 9/8/21 at 3:50 p.m., the registered nurse unit manager (RN #2) was interviewed about Resident #8's weight monitoring. RN #2 stated the RD was supposed to enter or obtain a physician's order for weekly weights. RN #2 stated she did not know why Resident #8's weights were not checked weekly as recommended.

This finding was reviewed with the administrator and director of nursing during a meeting on 9/9/21 at 11:25 a.m.

b) Resident #8's clinical record documented the resident was assessed by the nurse practitioner (NP) on 7/27/21 regarding skin issues that included right ankle/foot redness.

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The NP's progress note dated 7/27/21 at 7:15 a.m. documented, "...Patient seen for...right ankle foot redness..." The NP assessed the resident with blanchable redness on the right outer ankle, blanchable redness on the right outer/lateral foot and moisture associated skin damage on the buttocks. The NP progress note documented treatments as follows.

Right outer ankle redness - "apply skin prep and cover with foam protection"
Right outer lateral foot redness - "apply skin prep and cover with foam protection"
Buttocks - moisture associated skin damage - "clean with saline wound cleanser, pat dry, apply zinc paste"

There were no physician orders entered for treatment of the right ankle/foot redness or MASD as recommended by the NP. The treatment record for July 2021 documented no entries for treatment of the ankle/foot redness or MASD prior to the resident's discharge on 7/29/21.

On 9/8/21 at 11:50 a.m., the registered nurse (RN #4) responsible for wound care was interviewed about Resident #8's treatment orders. RN #4 stated the right ankle/foot redness and MASD were assessed during the NP visit on 7/27/21. RN #4 stated he usually entered treatment orders given by the NP and at other times, the floor nurses entered the orders. RN #4 stated he did not know why the orders for the ankle/foot and MASD were not entered when ordered.

On 9/8/21 at 3:50 p.m., the unit manager (RN #2) was interviewed about treatment orders not implemented for Resident #8. RN #2 stated the

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wound nurse usually made rounds with the NP during assessment of skin issues. RN #2 stated the wound nurse usually entered any orders from the NP regarding wound care. RN #2 stated she did not know why the orders were not entered and/or implemented.

On 7/9/21 at 8:45 a.m., the director of nursing (DON) was interviewed. The DON stated the orders for treatments were not entered into the clinical record. The DON stated the NP sometimes writes notes with recommendations for treatments but does not enter the orders into the electronic health record.

This finding was reviewed with the administrator and DON during a meeting on 9/9/21 at 11:25 a.m.

4. Resident # 11 was admitted to the facility on 7/28/2020 with diagnoses that included displaced fracture of the third cervical vertebra, disorders of muscle, acute kidney failure, orthostatic hypotension, benign prostatic hyperplasia, obstructive and reflux uropathy, gastroesophageal reflux disease, neuro-muscular dysfunction of the bladder, and enterocolitis due to c-diff. According to the Admission Minimum Data Set with an Assessment Reference Date of 8/4/2020, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Review of the Progress Notes in Resident # 11's Electronic Health Record revealed the following entries:

9/3/2020 - "...His major complaint today is some diarrhea which can get explosive and come

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without warning. I ordered Imodium one or two tablets every four hours as needed for this ..."

9/7/2020 - "Resident complained of having diarrhea at 10:30 p.m. Writer did not see any stool to examine its consistency. Resident was encouraged to report episodes of bowel movements to be monitored by the incoming nurses and then be confirmed. Resident did not report any other bowel movements during this shift. He was reassured and made comfortable."

9/7/2020 - "Patient has occasional diarrhea. Imodium ordered PRN (as needed). Not clear whether he's getting it? ..."

9/8/2020 - "...Finally found patient's chart. The order was flagged for Imodium but no one took it off in four days. I reordered Imodium 102 (1 or 2) PRN loose stools...."

According to the Electronic Medication Administration Record (EMAR) in resident # 11's Electronic Health Record, the Imodium ordered by the physician on 9/3/2020 was entered on the EMAR, and was not available when the resident had an episode of diarrhea on 9/7/2020, four days after the order was written.

At 9:50 a.m. on 9/8/2021, the Director of Nursing (DON) was interviewed regarding physician orders. Asked what her expectation was regarding taking order off (transcribing), the DON said, "If is a STAT (urgent) order, it should be taken off immediately. If it's just a regular order, is should be taken off that same day."

COMPLAINT DEFICIENCY

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F 686 SS=G	Continued From page 34 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to assess and implement interventions to prevent a pressure ulcer for one of twenty-one residents in the survey sample, Resident #8. Resident #8 developed a sacral pressure ulcer initially identified at an unstageable status with slough covering 30% of the wound. There was no prior assessment of impaired skin on the sacrum. A nurse with knowledge of redness on the sacrum, failed to document, report and obtain physician orders for treatment prior to the development of the ulcer. Treatment orders for a change in treatment to the pressure ulcer were not implemented. The findings include:	F 686 F 686	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer **I** **Corrective Action** Resident #8 no longer resides at the facility. LNP #2 provided skilled review/education on skin assessment guidelines and intervention. **II** **Identification** All residents at risk for pressure ulcers have or have the potential to be affected. The facility will complete a skin sweep on all residents. New identified pressure ulcers will be address, including comprehensive pressure ulcers assessments, PUSH tools, and Braden's will be completed accordingly. Care plan will be updated to include prevention strategies and individualized interventions and goals. Physician/family will be notified, and treatment orders obtained. **III** **System Change** New admissions or readmissions will have a skin check documented on	

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F 686	Continued From page 35 Resident #8 was admitted to the facility on 10/2/20 and was discharged to the hospital on 7/29/21. Diagnoses for Resident #8 included COPD (chronic obstructive pulmonary disease), anemia, gastroesophageal reflux disease, diabetes, dementia, bipolar disorder, psychotic disorder, osteoarthritis, hypothyroidism and benign prostatic hypertrophy. The minimum data set (MDS) dated 6/15/21 assessed Resident #8 with severely impaired cognitive skills and as requiring the extensive assistance of one person for bed mobility, toileting and hygiene. Resident #8's closed clinical record documented a nursing note dated 7/23/21 stating, "CNA [certified nurses' aide] call writer to attention asking for dressing to apply on sacrum area. Writer on assessment noted resident sacrum with an open area. Resident in bed sacrum area cleanse with NS [normal saline], measured 4 cm [centimeters] x 3 cm [length x width]. NP [nurse practitioner]...notified, wound nurse notified and treatment orders noted by wound nurse." (Sic) The wound nurse documented a late entry note on 7/23/21 stating, "During routine AM care resident was noted to have a pressure injury on coccyx measuring 2.5 cm x 2 cm x <0.1 cm. 70% Granulation and 30% Slough with moderate serosanguinous [serosanguineous] drainage present, No tunneling or undermining present. PUSH tool initiated and Score = 12. Maceration of surrounding skin noted. Braden Scale complete = 11...RP [responsible party]...notified..." (Sic) Physician orders were entered on 7/23/21 to cleanse sacral wound with normal saline, apply Medi-honey and calcium alginate then cover with	F 686	admission and a second skin check documentation within 24 hours of admission. DON/designee will review shower sheets and skin assessments notes for compliance. ADON/designee will provide nurses skilled review/education on skin assessment guidelines and intervention **IV** **Monitoring** DON/designee will conduct random shower sheets, wound notes, and skin assessment x 4, monthly x 2, and randomly thereafter validate compliance. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan **V** **10/27/2021**	

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F 686	Continued From page 36 Optifoam dressing each day shift and as needed. The NP assessed the resident on 7/26/21 and documented, "...Very high risk of skin related impairment due to his comorbid conditions...sacral skin impairment..." A NP note dated 7/27/21 documented, "...Sacrum unstageable pressure injury...Skin - positive for wound pain..." The NP documented in the 7/27/21 progress note to change treatment of the sacral pressure ulcer to, "Cleanse with saline wound cleanser, pat dry, apply Santyl and calcium alginate primary dressing, foam dressing secondary dressing, change daily and as needed..." The change in treatment to include Santyl debriding agent was not entered or implemented prior to the resident's discharge on 7/29/21. Treatment administration records documented continued treatment with normal saline, Medi-honey, calcium alginate with Optifoam dressing from 7/23/21 through 7/29/21. A follow-up assessment by the wound nurse dated 7/28/21 documented, "...Sacral Pressure Injury: 2 cm x 4 cm, 100% slough, surrounding erythema, heavy serosanguinous [serosanguineous] drainage..." Resident #8's Pressure Ulcer Healing Chart documenting pressure ulcer scale for healing (PUSH) scored the resident's sacral pressure ulcer on 7/23/21 as 12. The PUSH score on 7/28/21 was 13, indicating worsening of the pressure ulcer due to an increased amount of exudate.	F 686		

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Prior to the sacral pressure ulcer found by the CNA on 7/23/21, the clinical record (from 7/1/21 through 7/22/21) made no mention or description of the resident's skin including the sacral area. Nurses had signed off the resident's treatment administration record from 7/1/21 through 7/22/21 indicating that a body audit was performed each evening shift. There were no notes and/or documentation associated with the body audits describing the condition or appearance of the resident's skin when these audits were performed. Audits marked as completed on 7/23/21 through 7/28/21 made no mention of the resident's sacral pressure ulcer or any other skin impairments.

Resident #8's plan of care prior to the pressure ulcer acquired on 7/23/21 (initiated 10/3/20) documented the resident had previous redness to the groin area, left/right buttocks redness and was at risk of alterations in skin integrity due to impaired mobility. Interventions to heal redness and prevent skin breakdown included, "...Administer treatment per physician orders...turn and reposition...Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain...Notify physician prn [as needed]...Barrier creams to peri area/buttocks as needed...Observe skin condition with ADL [activities of daily living] care daily; report abnormalities...Provide preventative skin care routinely and prn..."

On 9/8/21 at 11:50 a.m., the registered nurse responsible for wound care (RN #4) was interviewed about Resident #8's sacral pressure ulcer. RN #4 stated the CNA reported on the morning of 7/23/21 that the resident had an open area on his sacrum. RN #4 stated the pressure

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ulcer when first observed was partially covered with yellow slough and had a PUSH score of 12. RN #4 stated if using the staging system, the pressure ulcer was unstageable due to slough covering part of the wound. RN #4 stated he notified the NP and got orders for treatment on 7/23/21. RN #4 stated nobody had reported to him any skin impairments for Resident #8 prior to 7/23/21. RN #4 stated an investigation was done about the resident's acquired pressure ulcer. RN #4 stated he did not know why the pressure ulcer was not identified prior to development of slough and drainage.

On 9/8/21 at 12:20 p.m., the licensed practical nurse (LPN #2) routinely caring for Resident #8 was interviewed about the pressure ulcer. LPN #2 stated the CNA reported to her on 7/23/21 about an open area on the resident's sacrum. LPN #2 stated she measured the wound and reported the area to the wound nurse (RN #4). LPN #2 stated prior to 7/23/21, the resident's sacral area was red and she had been applying barrier cream to the area. LPN #2 described Resident #8 as "total care" and as staying mostly in bed. LPN #2 stated the CNAs attempted to reposition the resident but he stayed mostly on his back. LPN #2 stated she did not document anything about the redness and the only treatment prior to 7/23/21 was barrier cream applied after incontinence in addition to repositioning. LPN #2 stated concerning the change in treatment orders that the wound nurse usually entered orders for changes in wound care.

On 9/8/21 at 12:45 p.m., the nurse practitioner (other staff #3) that treated Resident #8 was interviewed about the pressure ulcer. The NP

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stated the resident had an overall, general decline and was at high risk of skin impairment. The NP stated when he assessed the pressure ulcer (7/27/21) the ulcer was, "already in bad shape when I saw it." The NP stated the wound was covered with slough and was unstageable. The NP did not know why the change in treatment to Santyl was not implemented.

On 9/8/21 at 12:50 p.m., the aide that found the pressure ulcer on 7/23/21 (CNA #1) was interviewed. CNA #1 stated that after she gave the resident a shower on the morning of 7/23/21, she noticed the resident's sacrum was "a little bit open." CNA #1 stated she immediately reported the open area to LPN #2. CNA #1 stated LPN #2 told her she was not allowed to put a dressing on the wound without an order and would get the wound nurse. CNA #1 stated she provided total care for Resident #8 that included incontinence care. CNA #1 stated she gave the resident a shower usually twice per week and had not noticed the open area until 7/23/21.

On 9/8/21 at 3:40 p.m., LPN #4 that signed off body audits for Resident #8 for the four days prior to 7/23/21 was interviewed. LPN #4 stated each evening he performed a "head to toe" assessment of Resident #8's skin looking for any open areas. LPN #4 stated he did not document anything about the appearance or condition of the skin unless there was a skin impairment. When asked if he saw any skin impairments on Resident #8's sacral area in the days prior to 7/23/21, LPN #4 stated, "I don't remember." LPN #4 stated, "If I saw something like that [pressure ulcer], I would put in the notes."

On 9/8/21 at 3:50 p.m., the unit manager (RN #2)

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was interviewed about how Resident #8's pressure ulcer was not identified until an unstageable status and not identified with daily body audits. RN #2 stated the nurses were supposed to do a "head to toe" inspection and document the assessment in the progress notes. RN #2 stated CNA #1 found the open area during morning care and reported it to LPN #2. RN #2 stated prior to 7/23/21 only barrier cream was applied to the sacrum and the redness mentioned by LPN #2 had not been reported. RN #2 stated the wound nurse usually entered orders for changes in treatment. RN #2 stated she did not know why the change in treatment to Santyl was not entered.

On 9/9/21 at 8:20 a.m., the director of nursing (DON) was interviewed about Resident #8's sacrum pressure ulcer. The DON stated Resident #8's pressure ulcer was discovered "late" and stated, "The ball was dropped there." The DON stated the facility had recognized "gaps in the skin process" and were in the process of educating staff and reviewing the assessment protocols. The DON stated Resident #8's pressure ulcer was investigated. The DON stated their investigation revealed that LPN #2 was aware Resident #8 had sacral redness prior to 7/23/21 and had been applying protective cream. The DON stated LPN #2 did not report the sacral redness or seek treatment orders for the area. The DON stated the wound nurse and unit manager were not aware of the sacrum wound until CNA #1 reported the open area on 7/23/21.

The facility's Pressure Ulcer Prevention Pathway (2013) included the following steps to take following a head-to-toe skin assessment for pressure ulcer prevention: Document skin issues

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including color, temperature, turgor, moisture status, integrity, pressure ulcer, if present or known healed pressure ulcer. This pathway documented, "Report any abnormal findings to physician and notify and educate patient and family on findings." For an identified pressure ulcer, the pathway documented to list the location, length, width, depth and PUSH score for each wound and then, "Obtain order for treatment from physician and obtain consultations as needed."

The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury as "localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." The NPIAP defines an unstageable pressure injury as, "Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible...Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (1)

The NPIAP defines the Pressure Ulcer Scale for Healing (PUSH) tool as, "a quick, reliable tool to monitor the change in pressure ulcer status over time." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 2/9/21 at 11:25 a.m.

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F 686	Continued From page 42 (1) NPIAP Pressure Injury Stages. National Pressure Injury Advisory Panel. 9/14/21. www.npiap.org/ This was a complaint deficiency.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review and during the course of a complaint investigation, the facility staff failed to obtain a physician's order for oxygen administration for one of 21 residents in the survey sample, Resident #9. The resident was administered oxygen for 11 days without a physician's orders to specify the type of equipment and/or settings, the frequency and/or duration, or any instructions for care and maintenance of the oxygen. Findings include: Resident #9 was admitted to the facility on 03/25/21 and discharged without returning on 04/04/21. Diagnoses for Resident #9 included, but were not limited to: CHF (congestive heart failure), morbid obesity, diabetes mellitus,	F 695	F 695 Respiratory/Tracheostomy Care and Suctioning. **I** **Corrective Action** Resident #9 no longer resides at the facility. **II** **Identification** All residents at the facility have the potential to be affected. Facility will conduct an audit of current in-house residents to validate there is an order for residents in need of oxygen. **III** **System Change** ADON/designee will provide education to nurses to obtain a physician order prior to applying oxygen on any resident. New and readmissions charts and discharged summary will be reviewed by the IDT during weekdays meeting, and by the weekend supervisor on	

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F 695	Continued From page 43 hypothyroidism, anxiety, depression, OSA (obstructive sleep apnea) and high blood pressure. The most current MDS (minimum data set) was an admission assessment dated 03/30/21. This MDS assessed Resident #9 as having a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills. In Section O. of this MDS, Special Treatments, Procedures, and Programs C. Oxygen therapy, the resident was assessed as receiving oxygen prior to admission (03/25/21) to the facility and while a resident of the facility (during the look back period). During clinical record review, Resident #9's discharge summary (prior to admission to the facility) dated 03/25/21 documented that the resident had a history of OSA and non compliance with CPAP (continuous positive airway pressure) at home and was put on oxygen at 4 LPM (liters per minute) en route to the hospital. Once at the hospital the resident was put on BiPap (bilevel positive airway pressure). No oxygen orders were found on the resident's discharge summary dated 03/25/21. Resident #9's physician's orders to the facility were then reviewed from admission (03/25/21) through discharge (04/04/21). There were no orders for any type oxygen for Resident #9. During an interview with the NP (nurse practitioner) on 09/08/21 at 12:50 PM, the NP was asked about Resident #9 not having an order for oxygen. The NP stated that the resident was "definitely" on oxygen. The NP looked at the resident's electronic clinical record (during the	F 695	weekends to validate compliance with oxygen administration. **IV** **Monitoring** MDS/designee will audit for compliance with oxygen administration weekly x 4, monthly x 2 and randomly thereafter. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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interview) and pulled up the resident's identification photo and zoomed in. Resident #9 was wearing oxygen via nasal cannula in the identification photo taken by the facility on admission. The NP then looked at the resident's vital sign section in the electronic chart and stated that staff were documenting that Resident #9 was on oxygen via nasal cannula, when checking the resident's oxygen saturation. The NP stated that he felt as though the order just wasn't put into the system.

The vital sign section for Resident #9 documented the following: documented Resident #9 was receiving oxygen via nasal cannula with O2 stad betwee 90 - 97% from 03/25/21 through 04/042021.

Nursing notes and respiratory assessments from admission (03/25/21) through discharge (04/05/21) also documented that Resident #9 was receiving oxygen via nasal cannula. The LPM [liters per minute] was not documented or found in the resident's chart.

Resident #9's CCP (comprehensive care plan) dated 04/01/21 documented, "...at risk for respiratory impairment related to asthma, CHF, sleep apnea...evaluate lung sounds, and vital signs as needed..obtain pulse oximetry and report abnormal findings...administer medications/treatments..." There was no information regarding the resident receiving oxygen therapy care and/or treatment.

The resident's MARs/TARs (medication administration records/treatment administration records) were reviewed from admission (03/25/21) through discharge (04/04/21) and did

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F 695	Continued From page 45 not include documentation of oxygen administration. On 09/08/21 at approximately 4:00 PM, the administrator and DON (director of nursing) were made aware of the above information. The DON was asked for a policy on oxygen use and care. The policy titled, "Oxygen Administration" documented, "...Purpose: To describe the method for delivering oxygen in order to improve tissue oxygenation, reduce risk for hypoxia...reduce shortness of breath... 1. Verify physician's order...assemble equipment...assess respiratory status, breathing patterns and pulse oximeter reading as clinically indicated...documentation: Record in progress note date and time oxygen was initiated, condition necessitating oxygen use, respiratory status related to oxygen use, type of delivery, device used and flow rate of Treatment Administration Record. Record oxygen concentrator maintenance and oxygen device used per center procedure.." No further information and/or documentation was presented prior to the exit conference to evidence that a physician's order was obtained for oxygen administration for Resident #9.	F 695		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this	F 711	F711 Physician Visits - Review Care/Notes/Order	

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F 711	Continued From page 46 section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review and during the course of a complaint investigation, the facility staff failed to ensure the physician signed and dated all orders for one of 21 residents in the survey sample, Resident #9. The physician failed to sign Resident #9's orders in a timely manner. Resident #9 was admitted to the facility on 03/25/21 and discharged, without return on 04/04/21; the physician signed the resident's orders on 05/26/21 (two months after the resident's discharge). Findings include: Resident #9 was admitted to the facility on 03/25/21 and discharged from the facility on 04/04/21. Diagnoses for Resident #9 included, but were not limited to: CHF (congestive heart failure), morbid obesity, diabetes mellitus, hypothyroidism, anxiety, depression, OSA (obstructive sleep apnea), pulmonary edema and high blood pressure. The most current MDS (minimum data set) was an admission assessment dated 03/30/21. This MDS assessed the resident as having a cognitive	F 711	**I** **Corrective Action** Resident #9 no longer resides at the facility. **II** **Identification** All residents at the facility have the potential to be affected. Administrator will audit current physician orders to validate physician orders are sign within a timely manner. **III** **System Change** Administrator will provide education to Medical Record Clerk on timely signing of physician orders. **IV** **Monitoring** Administrator will monitor weekly x 4, monthly x 2, and randomly thereafter, to validate NP/MD are signing orders off timely. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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F 711	Continued From page 47 score of 14, indicating the resident was cognitively intact for daily decision making skills. A review of Resident #9's physician orders was completed from admission to discharge. The resident's physician's orders were not signed off by the physician until 05/26/21, two months after the resident discharged from the facility. On 09/09/21 at 2:50 PM, the NP (nurse practitioner) was interviewed regarding the physician orders not being signed and was asked if this was something the NP would be responsible for when he made visits to the resident. The NP stated that the orders are put into the computer and are entered under the physician's name. The NP stated that he can't sign off an order that is ordered by the physician and is under the physician's name. On 09/09/21 at 3:20 PM, the attending physician was interviewed regarding Resident #9's physician's orders not being signed off in a timely manner. The physician stated that he will try to see the patient every week or so and sign off on the orders, but stated that he just missed this one. The physician stated, "I didn't sign." On 09/08/21 at 3:30 PM, the DON (director of nursing) was asked for policy on physician services. A policy was presented and reviewed titled, "Medical Provider Responsibilities and Guidelines." The policy documented, "...the attending physician or designated medical provider should provide timely medical orders on an appropriate assessment, review of relevant preadmission and post admission	F 711		

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F 711	Continued From page 48 information...attending physicians or designated medical provider should assist in maintaining a complete and accurate medical record...the attending physician should sign and date orders as defined by federal or state requirements..." No further information and/or documentation was presented prior to the exit conference to evidence that the physician signed and dated all orders for Resident #9 in a timely manner.	F 711		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726	F 726 Competent Nursing Staff I **Corrective Action** Resident #13 no longer resides at the facility. Resident #20 through Resident #39 were observed for any adverse effect for lack of clinical competency with medication administration during med pass on 9/8/2021. No adverse effect noted. NP was made aware of lack of clinical competency with diabetic management for Resident #20. No adverse effect noted. LNP #2 was provided education/skilled review on insulin administration and med pass. LPN #9 was provided education/skilled	

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F 726	Continued From page 49 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, resident interview, and facility document review, the facility staff failed demonstrate clinical competency with diabetic management and medication administration for 21 residents, Resident #13, Resident #20, and Resident #21 through Resident #39. LPN (licensed practical nurse) #2 used an insulin syringe to withdraw insulin from a Humalog kwikpen for Resident #13 and failed to administer physician ordered medications at the time ordered for Residents #21 through Resident #39. LPN #9 administered eight (8) ounces of orange juice for a blood sugar of 98 to Resident #20. Findings were: 1. A medication pass and pour observation was conducted on the third floor of the facility on 09/08/2021 with LPN (licensed practical nurse) #2. During the medication pass observation two medications for Resident #13 were not available on the medication cart. LPN #2 stopped the medication pass, placed the medications in the cart and went to the medication dispensing machine on another floor to obtain the medications. LPN #2 was unable to access the machine and was assisted by LPN #3. When asked why she could not access the machine, she stated, "You have to come in here every couple of weeks if you need something or not to keep your access active. I need to get my	F 726	review on insulin administration. **II** **Identification** All residents have the potential to be affected. ADON/designee will audit med pass competencies for licensed nurse to validate compliance. **III** **System Change** ADON/designee will educate licensed nurses on diabetic management and medication administration. **IV** **Monitoring** DON/designee will audit med pass and insulin administrator weekly x 4, monthly x 2 and randomly. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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supervisor to get me back in." She was asked what happened if no one working had an active access. She stated, "There's always somebody here."

During the observation at 11:30 a.m., LPN #2 opened a KwikPen and used an insulin syringe to withdraw 4 units of insulin for Resident #13. After withdrawing the insulin, she placed the KwikPen in a bag in the medication cart labeled with the date of opening. She stated, "I wrote the resident's name on the label of the pen but when I opened it, I pulled that off. I will fix it." She did not write the resident's name on the pen at that time.

LPN #2 did not complete giving physician ordered 9:00 a.m., medications to Resident #13 until 11:35 a.m., resulting in late medication administration times for Resident #13 and an 19 additional residents.

A listing of all medications given by LPN #2 during the morning medication pass on 09/08/2021 with actual administration times was requested and received on 09/09/2021. Physician ordered medications with a scheduled administration time of 9:00 a.m., and given as late as 2:44 p.m., included but were not limited to: blood pressure medications, oral diabetic medications, diuretics, anticonvulsants, pain patches, scheduled pain medication (including morphine), inhalers, and extended release medications.

LPN #2's job description and competency records were reviewed. LPN #2's performance appraisal for 11/26/2020 through 11/26/2021 included an area "Medication Management Skills Evaluation". There were four columns on the evaluation: Skills/technique; Not applicable to center or

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F 726	Continued From page 51 position; Validation/Return demonstration; and Facilitator signature/date. The facilitator signature column had initials of the facilitator and the date of 12/15/2020 at the top of the column and a line straight down through the rows adjacent to the skills listed. There was no documentation on the form indicating if the skills had been demonstrated to the facilitator. The human resources director, OS (other staff) #9 was interviewed on 09/09/2021 at 3:50 p.m. She was asked how often competency were done for staff and what was the process. She stated, "They are done yearly. They can be observed or they can talk through the skill to the person checking them off." The competency check list for LPN #2 was discussed. She stated, "[Name] did hers. He is our hospital liaison now but he was the lead nurse then...it looks like he was just being lazy and drew the line down like that instead of initialing each thing." OS #9 was interviewed at 4:30 p.m. on 09/09/2021. He stated, "It takes a full day to do those. I tell them when I am coming, we work on the med cart in the morning and then we go to a classroom to do the rest. They can either show me the skill or talk through it...if they don't know how to do something and need help we review it and they tell it back to me...if they need to I will tell them to review the procedure manual." He was asked if he could tell what if anything LPN #2 needed help with or a review of by looking at the competency list he had completed. He stated, "No, I don't write that down...it was an oversight on my part to complete that one like that." Per the competency checklist: "Medications are to be administered within one hour of scheduled	F 726		

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dose time/range; Administers injectable medications according to manufacturer's recommendations."

Concerns were voiced to OS #9 and to the administrator regarding LPN #2. On 09/08/2021, medications to 20 residents were given outside of the prescribed time frame, an insulin syringe was used to withdraw insulin from a Humalog KwikPen which was against manufacturer's recommendations, the pen was not labeled properly, and it was left in use.

On 09/08/21 at 8:30 AM, an interview was conducted with Resident #17. The resident was asked about his care and services since admission on 09/04/21. Resident #17 stated that staff are incompetent and don't have proper knowledge or skills. The resident stated that the staff are not efficient or attentive. Resident #17 stated that he barely had any toilet paper left in the bathroom and that they bring him stuff to eat that he doesn't like and that staff do not ask him what he likes or doesn't like. Resident #17 stated, "I can't say I'd consider this excellent care." The resident stated and asked, why can't staff give you more toilet paper, just in case you need it.

No further information was obtained prior to the exit conference on 09/15/2021.
2. Resident # 20 was admitted to the facility 2/24/21 with diagnoses to include, but were not limited to: pleural effusion, myasthenia gravis, senile degeneration of the brain, heart failure, and diabetes.

The most recent MDS (minimum data set) was a quarterly assessment dated 6/2/21 and had

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Resident # 20 assessed as cognitively intact with a score of 14 out of 15.

On 9/8/21 at 4:30 p.m. a medication observation was conducted with LPN (licensed practical nurse) # 9. Resident # 20 had an order dated 4/9/21 and carried forward for "Humalog KwikPen Solution Pen-Injector 100 units/ML (milliliter) inject per sliding scale: 70-149=0 units. 150-199= 1 unit; 200-249=3 units; 250-299=5 units; 300-349= 7 units; 350 or greater: 8 units and call MD." The sliding scale insulin was ordered to be done before meals and at bedtime. The times listed on the MAR (medication administration record) were 7:00 a.m., 11:30 a.m., 4:30 p.m. and 9:00 p.m.

After LPN # 9 completed the sliding scale blood sugar due at 4:30 p.m., she stated "His blood sugar is 98, so he doesn't need any sliding scale coverage. For blood sugars 70-149, there is no coverage needed. I am going to give him some orange juice, and recheck his blood sugar. I will call the doctor to let him know."

LPN # 9 was then questioned why she was giving the resident orange juice for a blood sugar of 98. LPN # 9 stated "I am using my nursing clinical judgement; I am giving the resident 2-4 oz orange juice (8 oz.), and will give 2 units of Humalog when I recheck his blood sugar in a bit. I will call the doctor to let him know." LPN # 9 was asked again about why she was giving the orage juice, and again stated "Do you understand? I am using my nursing clinical judgement here; his blood sugar is 98; I am going to hold the 2 units before meals, give him orange juice, and recheck his blood sugar."

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On 9/9/21 at 7:45 a.m. the clinical record was reviewed for follow-up of the insulin administration 9/8/21. A progress note, dated 9/8/21 at 5:01 p.m. written by LPN # 9 documented "Resident BS (blood sugar) 98- 2 units Humalog held for now and NP (nurse practitioner) notified two 4-oz of orange juice given and writer will recheck BS, and the 2 units will be given." At 5:40 p.m. a progress note, written by LPN # 9 documented "Writer recheck BS is 166- 2 units of Humalog given..." The MAR was then reviewed. An entry by LPN # 9 at 9:00 p.m. revealed a blood sugar of 189, with 1 unit of Humalog administered per sliding scale parameters.

On 9/9/21 beginning at 11:30 a.m. the DON (director of nursing) and the administrator were made aware of the above findings. The DON stated "Those 2 orders, sliding scale and standing order for insulin before meals, should not exist at the same time." The administrator stated "Nurses' should not be holding a scheduled insulin. They should go by the doctor order. Those orders should be clarified as time versus before meals."

The job description/competencies for LPN's was requested from the DON. Under "Essential Job Functions- General Nursing Care Responsibilities" documented "Demonstrates the ability to administer medications timely and according to facility policy."

On 9/9/21 at 2:30 p.m. the NP was interviewed about the above observation and findings. The NP stated "Yes, she (LPN # 9) called and told me she was giving (name of resident) some orange juice, so I figured his blood sugar was below

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F 726	Continued From page 55 70...she seemed in a hurry..." The NP was asked if LPN # 9 had told him what the blood sugar was. He stated "No." The NP was asked if he asked for the blood sugar reading. The NP again stated "No." The NP was then asked if he had known the blood sugar was 98, would he have consented to giving orange juice, and also should the 2 units due before meals have been administered. The NP stated "No, I did not know the blood sugar was 98; that's a good number, and the 2 units of insulin due before meals should have been given per the order." No further information was provided prior to the exit conference.	F 726		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and complaint investigation, the facility staff provided ongoing psychiatric services without a physician's order or clinical justification for one of twenty-one residents in the survey sample, Resident #7. Resident #7, with no behaviors or psychotropic medication use, was seen by a	F 740	F 740 Behavioral Health Services **I** **Corrective Action** Resident #7 is no longer being seen by a psychiatric. **II** **Identification** All residents have the potential of being affected. Unit Managers will audit current in residents to validate a clinical justification or physician's order for psychiatric services.	

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F 740	Continued From page 56 psychiatric provider ten (10) times in a seven-month period. There were no physician orders for the psychiatric consultations and no documented clinical justification for the repeated visits. The findings include: Resident #7 was admitted to the facility on 11/26/19 with diagnoses that included atrial fibrillation, dementia, hypothyroidism, hypertension, history of fractured femur and neuro-cognitive disorder. The minimum data set (MDS) dated 6/24/21 assessed Resident #7 with severely impaired cognitive skills. Resident #7's clinical record documented the resident was assessed by a psychiatric provider (nurse practitioner or physician) ten times in the seven months from 1/1/21 through 7/31/21. Psychiatric visits were documented on 1/11/21, 1/25/21, 2/26/21, 3/8/21, 4/5/21, 4/26/21, 5/24/21, 6/21/21, 7/19/21 and 7/23/21. These psychiatric progress notes documented the following. 1/11/21 - "Patient seen to evaluate mental status and adjust medications for behavioral disturbance...No acute concerns per attending staff. No reported negative behaviors...Pt [patient] is receiving care under...hospice...no psychotropic medications..." 1/25/21 - "...Patient seen to evaluate mental status and adjust medications for behavioral disturbance...No acute concerns per attending staff. No reported negative behaviors...Pt [patient] is receiving care under...hospice...Past psych History Dementia...Psychiatric team will monitor mood and behavior..."	F 740	**III** **System Change** ADON/designee will provide education on obtaining a physician order for psychiatric consultation to the IDT to validate compliance. **IV** **Monitoring** Social Worker/designee will audit psychiatric services weekly x 4, monthly x 2, and randomly to validate compliance with clinical justification or physician's order for psychiatric services. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or action plan. **V** **10/27/2021**	

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2/26/21 - "Patient seen to evaluate mental status and adjust medications for behavioral disturbance...Patient is evaluated for a quarterly review...Current medications Ativan 0.25 mg q 6 hrs PRN [every 6 hours as needed]..."

3/8/21 - "Patient seen to evaluate mental status and adjust medications for behavioral disturbance...Per staff and chart review, no recent changes to mood or behaviors. No reported negative behaviors...Patient under hospice services...Psychiatric team to monitor mood and behavior..."

4/5/21 - "Patient seen to evaluate mental status and adjust medications for behavioral disturbance...No reported negative behaviors. Limited speech and mostly nonverbal...Psychiatric team to monitor mood and behavior..."

4/26/21 - "Patient seen to evaluate mental status and adjust medications for behavioral disturbance...No acute concerns per patient and attending staff..."

6/21/21 - "Patient seen to evaluate mental status and adjust medications for behavioral disturbance...No reported negative behavior...Psychiatric team will monitor mood and behavior..."

7/19/21 - "Patient seen to evaluate mental status and adjust medications for behavioral disturbance...The mood appears to be at baseline. No acute concerns per attending nurse...No reported negative behavior..."

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F 740	Continued From page 58 7/23/21 - "Patient seen to evaluate mental status and adjust medications for behavioral disturbance...Patient seen for quarterly evaluation...no recent changes to mood or behaviors. No reported negative behaviors...pt appears to be in no acute psychiatric distress, the need for psychiatric medications will be reassessed from time to time..." The clinical record documented no physician's order for a psychiatric consultation or ongoing psychiatric services. Physician progress notes from January 2021 through July 2021 made no mention of a referral for psychiatric services or a need for ongoing psychiatric care. The nurse practitioner (NP) notes dated 6/14/21, 7/16/21 and 7/29/21 documented the resident had dementia, received hospice services and documented his psychiatric assessments describing the resident as, "calm, cooperative" with cognitive impairment. The NP documented with each visit a review of medications and lab results with no mention of any psychotropic medications, mood problems or negative behaviors. Resident #7's clinical record documented the resident had been in care of hospice services since 9/15/20 and was currently prescribed no psychotropic medications. A previous physician's order for the anti-anxiety medication Ativan 0.25 milligrams as needed was ordered on 9/15/20 when the resident entered hospice and was discontinued on 7/25/21. Nursing notes from 1/1/21 through 9/6/21 documented no episodes of anxiety, no administration of the as needed Ativan and no physical and/or verbal behaviors. The resident's plan of care (revised 7/23/21)	F 740		

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made no mention of psychotropic medication use or any problems, goals and/or interventions regarding behaviors or anxiety. MDS assessments dated 12/20/20, 3/24/21 and 6/24/21 documented the resident had no behaviors of any type.

On 9/15/21 at 10:50 a.m., the director of nursing (DON) was interviewed about the reason for Resident #7's repeated psychiatric visits. The DON stated that at one time it was facility practice for psychiatry to review any residents on psychoactive medications. The DON stated she thought psychiatry started seeing Resident #7 after she was enrolled in hospice in September 2020. The DON stated she did not know any other reason the resident would have been seen by psychiatry. The DON stated she had previously researched the issue due to a family concern about the visits and stated, "We could not figure it out." The DON stated she had contacted the hospice provider and they had not requested psychiatric services and were not aware of the psychiatric visits. The DON stated there was no order for psychiatric services and she did not know why psychiatry was assessing the resident on an ongoing basis.

On 9/15/21 at 12:30 p.m., the DON stated she reviewed the clinical record again and did not find a physician's order for psychiatric services.

Resident #7's psychiatric providers were not available for interview as the DON stated the facility terminated the contract with this service as of 8/1/21.

This finding was reviewed with the administrator and director of nursing during a team meeting on

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F 740	Continued From page 60 9/15/21 at 1:00 p.m. This was a complaint deficiency.	F 740		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, and clinical record review, the facility staff failed to ensure a medication error rate of less than five percent. A medication pass and pour observation conducted on 09/08/2021 with 34 opportunities and 13 errors, yielded an medication error rate of 38.23 percent. Findings were: A medication pass and pour observation was conducted on 09/08/2021 on the third floor of the facility. At 8:10 a.m., LPN #13 was observed preparing medications for Resident #21. During the preparation she pulled a bottle of MiAcid Gas Relief 80 mg tablets from the drawer. She placed one pill in the medication cup. The bottle was observed to have another resident's name on the pharmacy label. When all of the medications were prepared and she was ready to go into Resident #21's room, LPN #13 was asked to recheck the label on the MiAcid Gas Relief. She stated, "Oh no, that is not his bottle." She removed the medication from the pill cup, discarded it and obtained the medication from	F 759	F 759 Free of Medication Error Rts 5 Prcnt or More **I** **Corrective Action** LPN #2 and LPN #9 were provided med pass competencies. **II** **Identification** ADON/designee provide med pass skilled review with licensed nurses to validate compliance with med pass. **III** **System Change** DON/designee will audit med pass weekly x 4, monthly x 2, and randomly thereafter to validate compliance with med pass. **IV** **Monitoring** Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will	

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F 759	Continued From page 61 Resident #40's medication bottle. She stated, "I should have looked at that more carefully, I am sorry." The medication pass observation continued with LPN #2 at 8:38 a.m. LPN #2 began medication preparation for Resident #13. She stated, "Her blood sugar this morning was 113 so she does not get her Humalog sliding scale. I am not giving her the scheduled Humalog until she gets her food." She then opened the medication cart and began pulling the medications scheduled for 9:00 a.m. She pulled Famotodine (given for gastro-esophageal reflux) 20 mg, Isosorbide ER (extended release-given for hypertension), Metolazone (given for edema) 2.5 mg, Tradgenta (given for diabetes mellitus) 5 mg, Vitron-C (given for anemia) 65-125 mg, Spironolactone (given for congestive heart failure) 25 mg, and Lactulose (given for elevated ammonia level) 30 cc. OS (other staff) #13 was walking down the hallway, LPN #2 asked him to bring her some sodium chloride. He returned with a bottle and she added one NACL (given for hyponatremia) 1 gram to the medications. She looked in the cart and stated, "I do not have the potassium (given for hypokalemia) or the Bumetadine (given for edema) here." She was asked how the medications were restocked on the cart. She stated, "When we get down to two tablets the nurses are supposed to order them. The sodium chloride wasn't here it comes from central supply and these are also not here." She placed the medication cup with the prepared medication in the medication cart and the cup of Lactulose. She shut the cart and locked it. She was asked what she was going to do. She stated, "I am going down to the [name of the medication dispensing device] and get the potassium and the	F 759	determine the need for further audits and/or action plan. V 10/27/2021	

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Bumetadine."

LPN #2 went down to the second floor at approximately 8:50 a.m. and asked LPN #3 to help her get medications out of the machine. Neither the potassium or the Bumetadine dosages were available from the machine. LPN #3 stated, "You will need to call the physician and get the order changed to the dosage that is in the machine." LPN #3 was asked what that meant. He stated, "The patient is ordered 40 meq of potassium, the machine has 10 meq only. It will not give us 40 meq [4 tablets] unless the order is changed in the computer to read four 10 meq tablets."

At approximately 9:30 a.m., the orders were changed in the computer but were not showing in the machine when attempts were made to withdraw the medications. LPN #3 told LPN #2, "You need to call the doctor and tell him the medications are not on time." LPN #2 went to the phone and called the physician, leaving a message for him to call her back. LPN #3 made multiple attempts to obtain the medications from the machine but was unable to obtain them. LPN #3 stated, "It usually takes a few minutes for the new order to show up in here [dispensing machine] before we can get it out."

LPN #2 returned to the third floor. At 9:43 a.m., the physician called. She told him that the potassium was not available and hung up the phone. She stated, "I can give the potassium later." She was asked what the physician said about the Bumetadine . She stated, "I did not ask him, I will call him back." She called the physician back. She hung up the phone and stated, "He said I can give the medication if we get it before

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F 759	Continued From page 63 3:00 [p.m.], he doesn't want me to give it after that." At 9:47 a.m., LPN #2 returned to the medication cart. She removed the medications she had prepared earlier and placed them on top of the cart. She looked in the cart and stated "I do not have any insulin syringes." The syringes were brought to her by OS #13. At 9:54 a.m., LPN #2 removed a box containing a vial of Lantus from the cart. There was no name or pharmacy label on the box. She had the vial in her hand and began to draw up the insulin. She was asked if the Lantus was a stock medication. She looked at the vial in her hand and stated, "No, this belongs to another patient." She returned the Lantus to the medication cart and began looking for Resident #13's insulin. She stated, "There is no insulin here for her." LPN #2 placed the medication cup with the prepared medication in the medication cart and the cup of Lactulose. She shut the cart and locked it. She was asked what she was going to do. She stated, "I am going to see if I can find her insulin." She went to the medication room and was unable to locate any insulin for Resident #13. She stated, "I do not have the Lantus or the Lispro for her. I will call the pharmacy." At 10:00 a.m., LPN #2 called the pharmacy. When she hung up the phone she stated, "They are not sending the Lantus, her insurance will not pay for it. They told me they faxed something here but it went downstairs because our fax machine is broken." LPN #2 returned to the medication cart and removed the prepared medications. She stated, "I mix these with applesauce for her."	F 759		

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At 10:15 a.m., Resident #13 was given her medications. LPN #2 then stated we will go to the next patient. She was asked if Resident #13 had eaten breakfast. She stated, "Yes, she would have eaten while we were downstairs." A CNA (certified nursing assistant) was in the hallway. LPN #2 asked him, "Did [name of Resident #13] eat?" He stated, "Yes, one hundred percent." LPN #2 was asked if Resident #13 was going to receive her morning insulin. She stated, "I need to talk to my supervisor." LPN #2 then went down the hallway to speak with RN (registered nurse) #2. LPN #2 was observed parking her medication cart in the hallway and and walking away with RN #2. LPN #2 was asked where she was going. RN #2 stated, "A member of the survey team wants to speak with her downstairs." RN #2, the unit manager was asked if LPN #2 had discussed Resident #13's unavailability of her insulin for her morning doses. She stated, "No, I was not aware of that...I will check on it."

At 10:41 a.m., LPN #2 obtained a blood sugar reading from Resident #13, with a reading of 230.

At 10:45 a.m., RN #2 stated, "I called the pharmacy. The information was faxed to another floor. The insurance does not want to cover the vial of Lispro, they want us to use a pen. That information was faxed here on August 25. I am changing the order now. The pen for the Lantus should already be here." RN #2 and LPN #2 looked in the medication refrigerator and the medication cart and were unable to locate any insulin for Resident #13.

At 10:55 a.m., RN #2 sent LPN #2 to the second floor to obtain insulin from the dispensing

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machine. LPN #2 returned at 11:00 a.m. RN #2 asked her if she had checked to see if she could get the potassium and the Bumetadine out of the machine. LPN #2 stated, "No, I will go back." LPN #2 went back downstairs and returned at 11:15 a.m., and stated, "I still can not get them out of the machine." RN #2 was looking at Resident #13's orders, she called the pharmacy and stated, "They are sending the potassium, the Bumetadine and the insulin today."

At 11:20 a.m., LPN #2 and RN #2 were asked if Resident #13's morning doses of insulin were going to be given. RN #2 instructed LPN #2 to go and recheck Resident #13's blood sugar. The blood sugar recheck at 11:26 a.m. was 224. LPN #2 stated, "I am going to give her her sliding scale."

At 11:30 a.m., she opened the Humalog kwikpen and used an insulin syringe to withdraw 4 units of insulin for Resident #13. The insulin was administered at 11:35 a.m.

LPN #2 returned to the medication cart at the nurse's station. She was asked if she was done with Resident #13's 9:00 a.m. morning medication pass. She stated, "Yes." She was asked what was going to be done about the scheduled Lantus that had not been given at 9:00 a.m. RN #2 called the physician at 11:43 a.m., and stated,"He said not to give it now, it is too late."

Concerns were voiced to the unit manager, RN #2 that all the medications scheduled for Resident #13 at 9:00 a.m., were either not available or given late. She was asked what the accepted window of medication administration

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F 759	Continued From page 66 was for a medication ordered for 9:00 a.m.. She stated, "An hour before or an hour after." Concerns were also voiced that LPN #2 had used an insulin syringe to withdraw insulin from a Kwikpen. At approximately 12:15 p.m., LPN #2 was interviewed regarding the use of an insulin syringe to withdraw insulin from the KwikPen. She stated, "I don't have any needles here for the pen." She was asked if that meant there were no needles for the pens in the facility. She stated, "I have to ask [name of other staff #13], he has all of that in supply." The facility policy on medication administration contained the following: "Read transcribed physician order on MAR [medication administration record]: patient name, medication name, dosage, route and interval ordered...Administer medications in accordance with frequency prescribed by the physician-within 60 minutes before or after prescribed dosing time." The above information was discussed with the DON (director of nursing) and the administrator during a meeting on 09/09/2021 at approximately 11:30 a.m. No further information was obtained prior to the exit conference on 09/15/2021.	F 759		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse	F 773	F 773 Lab Srvcs Physician Order/Notify of Results	

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F 773	Continued From page 67 practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and during the course of a complaint investigation, the facility staff failed to ensure laboratory services were provided as ordered by the physician on two separate occasions, for one of 21 residents in the survey sample, Resident #9. Findings include: Resident #9 was admitted to the facility on 03/25/21 and discharged from the facility on 04/04/21. Diagnoses for Resident #9 included, but were not limited to: CHF (congestive heart failure), morbid obesity, diabetes mellitus, hypothyroidism, anxiety, depression, OSA (obstructive sleep apnea), pulmonary edema and high blood pressure. The most current MDS (minimum data set) was an admission assessment dated 03/30/21. This MDS assessed the resident as having a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills. Resident #9's clinical records included a physician's order dated 03/28/21 which	F 773	**I** **Corrective Action** Resident #9 no longer resides at the facility. **II** **Identification** All residents have the potential to be affected. Facility will audit all outstanding labs orders from 9/1/2021 to validate compliance. **III** **System Change** ADON/designee will educate licensed nurses on lab process/guidelines to validate compliance. Labs orders will be review by the IDT meeting x 4 weeks, monthly x 2, and randomly thereafter. **IV** **Monitoring** DON/designee will monitor weekly x 4, monthly x 2, and randomly thereafter. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or audit plan. **V** **10/27/2021**	

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documented, "...CBC/CMP [complete blood count/complete metabolic panel] in the morning every Fri [Friday] for routine lab..." Based on this order, the lab should have been drawn on the following Friday, 04/02/21. The treatment record was signed off on 04/02/21 by LPN (Licensed Practical Nurse) #9. No laboratory results were found for Resident #9 for 04/02/21.

A physician's order dated 04/03/21 (Saturday) and timed 1:55 AM documented, "...CBC/CMP in AM, in the morning until 04/03/21 11:59 PM..." This lab should have been drawn on the morning of 04/03/21. The treatment record was signed off on 04/03/21 by LPN #10. No laboratory results were located for Resident #9 for 04/03/21.

An NP (nurse practitioner) progress note dated 04/01/21 at 5:05 PM documented, "...CHF, pulmonary hypertension, hypoventilation...SOB [shortness of breath], pulmonary congestion..AKI on CKD [acute kidney injury/chronic kidney disease] monitor kidney function...furosemide 60 milligrams bid [twice daily], monitor electrolytes... [signature of NP]."

On 09/08/21 at 12:50 PM, the NP was interviewed regarding the lab orders for Resident #9 and was asked if labs should have been completed for this resident. The NP stated that for "a patient like her" labs should have been drawn at least once or twice a week. The NP stated that on admission the residents are usually ordered labs weekly, and sometimes more depending on what a resident has going on, maybe two or three times a week. The NP stated that he wasn't sure why labs were not drawn on Resident #9 as ordered. The NP was asked how do they monitor kidney function and electrolytes.

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The NP stated that one way is through labs.

LPN #11, the nurse that worked with Resident #9 on multiple occasions was interviewed on 09/13/21 at 1:25 PM. LPN #11 was asked about labs being drawn for Resident #9. LPN #11 stated that he could not say for sure if Resident #9 had labs drawn on a particular day, but stated that "routinely labs are taken twice a week on that unit" [the unit where Resident #9 lived].

On 09/13/21 at 2:45 PM, LPN #9 was interviewed regarding the labs for Resident #9 that were to be been drawn on 04/02/21, per the physician's order. LPN #9 stated that she remembered the resident and that if her initials were documented/signed off, that meant the labs were drawn for the resident. LPN #9 was made aware that no labs were found. LPN #9 stated that maybe she had made a nursing note about the lab. LPN #9 was made aware that the progress notes were reviewed from admission to discharge and no notes were found regarding labs on that day. LPN #9 then stated, "When I sign, that means the labs were drawn."

On 09/13/21 at approximately 3:00 PM, the DON (director of nursing) was made aware of the above information and was asked for assistance in locating lab results for the dates in question, for Resident #9.

On 09/13/21 at 3:30 PM, the DON stated that she could not find any lab results or documentation regarding Resident #9's missing labs. The DON stated that she called the laboratory and that according to their records, no labs were drawn for Resident #9 for those dates.

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F 773	Continued From page 70 No further information and/or documentation was presented prior to the the exit conference to evidence that the facility staff obtained labs on the dates above for Resident #9 as ordered by the physician.	F 773		
F 842 SS=E	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. (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;	F 842	F 842 Resident Records - Identifiable Information **I** **Corrective Action** Resident #4 and Resident #9 no longer resides at the facility. **II** **Identification** All residents have the potential of being affected. Facility will audit all standing orders to validate they are transcript according to NP/MD order. DON/designee will audit NP's wound notes from 9/1/2021 to validate NP's wound notes are in PCC timely. **III** **System Change** Administrator/designee will educate the NP on timely documentation of wound notes into the EMR.	

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F 842	Continued From page 71 (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 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, staff interview and facility document review, the facility staff failed to ensure a complete and accurate clinical record for two of 21 residents in the survey sample,	F 842	ADON/designee will provide education to licensed nurses on accurate transmission of physician's order into a resident's MAR. **IV** **Monitoring** DON/designee will monitor the transmission of physician's order into a resident's MAR and NP's wound notes for timely documentation in EMR weekly x 4, monthly x 2, and randomly thereafter. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or audit plan. **V** **10/27/2021**	

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F 842	Continued From page 72 Resident's #9 and #4. Findings include: 1. Resident #9 was admitted to the facility on 03/25/21 and discharged from the facility on 04/04/21. Diagnoses for Resident #9 included, but were not limited to: CHH [congestive heart failure], morbid obesity, diabetes mellitus, hypothyroidism, anxiety, depression, OSA [obstructive sleep apnea], pulmonary edema and high blood pressure. The most current MDS [minimum data set] was an admission assessment dated 03/30/21. This MDS assessed the resident as having a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills. The resident's physician's orders were reviewed and included an order dated 3/26/21 for: "...Lasix Tablet (Furosemide) Give 60 mg [milligrams]....two times a day for HTN [hypertension] unsupervised [self-administration] .." The resident's clinical records were further reviewed. No medication self administration assessment could be located for Resident #9. Resident #9's MARs/TARs (medication administration records/treatment administration records) were then reviewed from admission (03/25/21) through discharge (04/04/21). The MARs documented the medication Lasix 60 mg twice a day on the March MAR, starting on the 26th through 31st and documented on the April MAR starting on the 1st through the 4th with the initials of U-SA [UNOBSERVED-SELF	F 842		

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ADMINISTRATION]. There were no nursing initials on the MAR to evidence that the staff administered the resident Lasix 60 mg twice daily.

The comprehensive care plan was then reviewed. There was no information regarding self administration of medications.

On 09/08/21 at 12:30 PM, LPN (Licensed Practical Nurse) #6, a nurse that had administered medications to the resident in the past was interviewed. LPN #6 was asked if Resident #9 self administered medications. LPN #6 stated that the resident did not self administer medications. LPN #6 was asked to the look at the resident's MARs and explain "U-SA" that was listed on the MAR under the Lasix 60 mg order. LPN #6 stated that she did not know and that, if she did not give the medication, it would have been because the resident's blood pressure was low. LPN #6 was asked again if she knew what the initials populated on the MAR for the Lasix administration meant. LPN #6 stated, "I'm sorry, I don't remember, I can't explain what that is."

On 09/08/21 at 12:50 PM, the NP (nurse practitioner) was interviewed regarding the above information. The NP stated that the facility staff "do not do that, we do not let patients administer themselves, that's why we have nurses." The NP stated that nurses put in the orders and they don't order like that.

On 09/08/21 at 4:40 PM, the DON (director of nursing) and administrator were interviewed regarding the above information and asked what U-SA on the MAR meant. The DON stated that, "that she was taking the medication on her own." The administrator stated that he thought it may

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have been how the medication was entered and further stated that he thought it had to do with the way the order was written. The DON was asked for a policy on medication order accuracy and reconciliation.

The policy titled, "Medication Reconciliation" was presented and documented, "...is a process for creating a complete and accurate list of a patient's current medications at admission...to ensure medication safety...Review discrepancies with admitting attending physician for disposition and reconciliation...document orders in the patient's clinical record...24 hour chart check guide-electronic and paper...Review each patients' orders received over the last 24 hours for accuracy and appropriateness...Correct any abnormalities and report results to the oncoming licensed nurse..."

On 09/08/21 at 5:00 PM, the pharmacy was called for a medication reconciliation. The pharmacy provided evidence that the medication (Lasix) ordered versus the medication returned to the pharmacy indicated that the resident did receive this medication.

On 09/08/21 at 5:30 PM, the DON stated that the medication was input wrong into the system and that the U-SA (Unobserved-Self Administration) self populates and doesn't leave a space for the nurse to sign off that this medication was administered by the nurse. The DON stated that this was listed under the order entry screen and that it was marked self administration, instead of provider administration. The DON was asked why this order was not clarified. The DON stated that the order should have been clarified and corrected as soon as the nurses saw it and a

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F 842	Continued From page 75 medication reconciliation should have been completed. No further information and/or documentation was provided prior to the exit conference to evidence a complete and accurate clinical record regarding medication administration was maintained for Resident #9. 2. Resident #4 was admitted to the facility on 05/28/2019 with diagnoses that included senile degeneration of brain, hypertension, osteoporosis, muscle spasm of back, low back pain, unspecified psychosis, obstructive and reflux uropathy, intervertebral disc disorders with radiculopathy, lumbosacral region, L4 compression fracture, and lumbar spinal stenosis. The most recent minimum data set (MDS) dated 07/23/2020 was the discharge assessment and assessed Resident #4 as alert and oriented to person only. Under Section M - Skin Conditions, the MDS assessed Resident #4 as having 4 - stage 3 pressure ulcers. On 09/08/2021 Resident #4's closed clinical record was reviewed. Observed within the clincial record were progress notes from rounds with the wound care team. Some of the progress notes documented the wound care nurse practitioner (NP) was present during the rounds with the wound care team while other notes documented the wound care NP was updated on the wounds and the plan of care was discussed. A review of the clinical record did not include all of the wound care NP's progress notes. On 09/08/2021 at 4:00 p.m., the director of nursing (DON) was interviewed regarding the missing wound care NP's progress notes. The	F 842		

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DON stated Resident #4 had a special insurance, that provided a contracted wound care (NP) and physician for all of its covered residents at the facility. The DON stated the facility's wound care team rounded on the residents weekly and provided written documentation within the electronic health record (EHR). The DON was asked if the wound care nurse was present during those rounds. The DON stated, "yes, sometimes she is present, but the team updates her on the wound if she isn't present." The DON was asked how the wound care NP provided progress notes/documentation to the facility. The DON stated it was documented in a different system through the insurance provider. The DON was asked if the documentation was scanned or uploaded into the (EHR) or placed in the paper/hard copy chart. The DON stated, "we've had some problems getting them to provide us their notes." The DON was asked to provide the wound care NP notes for 2020.

On 09/09/2021 at 3:00 p.m., the administrator and DON provided notes from the wound care NP dated 7/23/2020, 7/15/2020, 6/26/2020, 6/18/20, and 6/27/2019. The DON was asked for the remaining notes from 2020. The DON stated, "I'll be honest we have to accept who the [Insurance Provider] sends us. This provider has some challenges getting us her notes." The DON was asked what was the policy regarding notes from outside providers or those who used other documentation systems. The administrator stated, "here is a copy of our policy for documentation. They are expected to follow our facility protocol and documentation should be provided to the facility in a timely manner."

A review of the policy "Clinical Record Resource

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F 842	Continued From page 77 Manual" (02/2017) documented the following: "... Documentation in the clinical record is expected to be timely and to accurately reflect each patient's condition. Any individual who provides care to the patient may document care in the record...." Under the section titled "Physician Visits and Progress Notes, the following was documented, ".. The physician or alternate enters into the EHR (electronic health record) or writes, dates and signs a progress notes at each visit. The progress note includes an evaluation of the patients' condition, current treatment plan, identification of risk factors contributing to conditions, functional decline, deterioration or potential for deterioration, improvement or lack of improvement and whether conditions are avoidable or unavoidable .." On 09/15/2021 the above findings were discussed with the administrator and director of nursing (DON) during a meeting. No other information was provided to the survey team prior to exit on 09/15/2021 at 2:45 p.m. This is a complaint deficiency.	F 842		
F 850 SS=E	Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2) §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special	F 850	F 850 Qualifications of Social Worker >120 Beds I **Corrective Action** Facility now has a qualified full-time social worker.	

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F 850	Continued From page 78 education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to have a qualified social worker available on a full-time basis for a facility greater than 120 beds. For the period of August 24, 2021 through September 13, 2021, the facility staff had part-time social worker working only 20 hours per week. The findings include: On 09/08/2021 at approximately 9 a.m., the administrator was asked about the facilit social worker. He stated the facility's new full-time social worker tested positive for COVID-19 during her first day at work and was currently out sick. The administrator was asked if the facility employed another social worker. The administrator stated the facility currently had a part-time social worker Other Staff (OS) #4 who worked about 20 hours a week. The administrator was asked for a contact number to speak with the current part-time social worker (OS #4). The administrator stated he would contact OS #4 and follow-up with the survey team. On 09/08/2021 at approximately 10 a.m., the part-time social worker (OS #4) was interviewed. OS #4 was asked how long she had been working part-time. OS #4 stated she could not remember exactly, but it had been a few months because of family issues and she worked another	F 850	**II** **Identification** Facility now has a qualified full-time social worker. **III** **System Change** Facility will use outside staffing resources; should the need arises to ensure compliance. **IV** **Monitoring** Administrator will monitor for a qualified full time Social Worker weekly x 4, monthly x 2 and thereafter. Findings will be forwarded to the QAA committee for review and action, as appropriate. The QAA committee will determine the need for further audits and/or audit plan. **V** **10/27/2021**	

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job. OS #4 stated she was previously employed full-time at the facility and then went part-time and in the past she had worked PRN (as needed) with the previous full-time social workers who were no longer employed by the facility. OS #4 stated she currently worked about 20 hours per week at the facility.

On 09/14/2021 at 12:05 p.m., the human resources director (OS #9) was interviewed regarding the facility's employed social work staff. OS #9 was asked how the last day of employment for the previous full-time social worker. OS #9 stated, "[SW Name] last day was August 24, 2021." OS #9 was asked when did the new full-time social worker start work. OS #9 stated, "she started orientation on 09/01/2021 and tested positive for COVID-19 the same day and was taken of work. She returned to work on yesterday (09/13/2021)." OS #9 was asked if the facility employed another social worker during the time of August 24, 2021 through September 13, 2021. OS #9 stated, "yes, we had [OS #4], she works part-time, about 20 hours per week."

During the period of time the survey team was on-site 09/07/2021 through 09/09/2021, a full-time social worker was not observed on-site at the facility.

On 09/15/2021 the above findings were discussed with the administrator and director of nursing (DON) during a meeting. The administrator stated he needed to research this because he thought the facility could go 30 days without having a full-time social worker.

No other information was provided to the survey team prior to exit on 9/15/2021 at 2:45 p.m.

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F 850	Continued From page 80 This is a complaint deficiency.	F 850		