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BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/04/2021 through 05/11/2021. Corrections are required for Emergency Preparedness compliance with 42 CFR Part 483 Federal Long Term Care requirements. No emergency preparedness complaints were investigated during the survey. The census in this 60 bed facility was 43 at the time of the survey.	E 000		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training	E 036		6/14/21

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

Electronically Signed | 06/04/2021

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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E 036	Continued From page 1	E 036		

and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.
This REQUIREMENT is not met as evidenced by:

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E 036	Continued From page 2 Based on record review and staff interview, the facility staff failed to offer training and testing based on the emergency preparedness risk assessment. A review of the facility's emergency preparedness plan revealed there was no offering of trainingor testing based on the facility risk assessment for emergency preparedness. During an interview on 05/10/21 at 4: 22 P.M. with the administrator, he was asked for documentation of training and testing program in emergency preparedness risk assessment policies and procedures for five existing staff. The administrator stated, the facility had not offered testing or training program for emergency preparedness based on completion of the facility risk assessment. The facility risk assessment was conducted on 3/2020 and revised on 9/21/2020.	E 036	Training and testing have been offered to the 5 existing employees based on the facility risk assessment for emergency preparedness. An audit was conducted to ensure staff have been offered training and testing based on the facility risk assessment. The Director of Maintenance has been re-educated on the importance of offering training and testing for staff. The Administrator /designee will complete weekly audits for 2 months to ensure staff are offered training and testing based on the facility risk assessment for emergency preparedness. Audit findings will be submitted monthly to the QAPI committee for review and recommendations	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness	E 037		6/14/21

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E 037	Continued From page 3	E 037		

policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

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E 037	Continued From page 4	E 037		

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

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E 037	Continued From page 5 *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 6 *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to offer initial emergency preparedness training and annual emergency preparedness training.	E 037	Initial emergency training and annual emergency training have been offered to the 5 existing employees.	

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E 037	Continued From page 7 A review of the facility's emergency preparedness plan revealed there was no documentation of intial and/or annual emergency preparedness training. During an interview on 05/10/21 at 4: 22 P.M. with the administrator, he was asked for documentation of training in regards to the facility's emergency preparedness policies and procedures. The administrator was asked for five existing staff Emergency Preparedness training records on the updated policies and procedures. The administrator stated, the facility had not offered training on the facility's emergency preparedness policies and procedures. The policies and procedures were updated on 3/2020 and revised on 9/21/2020.	E 037	An audit was conducted to ensure staff have been offered initial emergency training and annual emergency training. The Director of Maintenance has been re-educated on the importance of offering initial emergency training and annual emergency training. The Administrator /designee will complete weekly audits for 2 months to ensure staff are offered initial emergency training and annual emergency training. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/04/2021 through 05/11/2021. Two complaints were investigated during survey. VA00048642 and VA0004840 were substantiated with deficiencies. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 bed facility was 43 at the time of the survey. The standard survey sample consisted of 27 current resident reviews and 7 closed record reviews.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the	F 553		6/14/21

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F 553	Continued From page 8 development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review staff interviews and family interview the facility staff failed to ensure one resident's daughter was called for a zoom care plan meeting after an invitation was sent for 1 of 34 residents in the survey sample, Resident #5.	F 553	Resident # fives□s daughter was invited and participated in a care plan meeting. An audit was conducted of current residents in the last 30 days to ensure the resident and / or resident representative	

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F 553	Continued From page 9 The findings included: Resident #5 was admitted to the facility on 2/28/19 with diagnoses to included but not limited to Major Depressive Disorder, Dementia, Anxiety Disorder and Hypertension. The most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 2/10/21. The Brief Interview for Mental Status (BIMS) for Resident #5 was coded as a 15 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making. On 05/3/21 at 09:53 AM a phone interview was conducted with Resident #5. During the interview Resident #5 stated, "My last care plan meeting my daughter received an invite but the facility never called her for the meeting." On 5/6/20 at 9:46 A.M. a phone interview was conducted with Resident #5's Daughter about the most recent care plan meeting. Resident #5's Daughter stated, 'I received a care plan invitation by mail like I always do. The meeting was scheduled for February 18th at 10:15 a.m. Since COVID we have been doing the meetings via phone from my mother's room. Well on February 18th I was all ready for the call, but no one from the facility ever called. My mom likes me on the calls because she forgets things at times. I don't know what happened but I never received a call for her care plan or even a call that it was moved to another day." Resident #5's Care Plan Invitation provided by the facility was reviewed and is documented in part,	F 553	have been offered the opportunity to participate in a care plan meeting. The social worker will be re-educated on the importance of offering residents and their representatives the opportunity to participate in care plan meetings. The administrator/designee will complete weekly audits for 2 months to ensure residents and their representatives have been offered the opportunity to participate in their care plan meeting. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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as follows:

Date: 01/27/2020
Dear Name (Resident #5's Daughter),
I am sending you this letter to notify you of the upcoming care plan meeting for Name (Resident #5). The meeting has been scheduled for Feb. 18, 2021 at 10:15 a.m. As we are currently still not allowing visitors on the nursing unit, this meeting will be held via phone conference. We will call you when the care plan meeting is ready to begin.

Resident #5's Care Plan Attendance Record provided by the facility was reviewed and is documented in part, as follows:

Dietary: Blank
Nursing: Blank
MDSC (Minimum Data Set Coordinator): Blank
Family: Blank
Resident: Blank
Social Worker: Blank
Activities: Blank
Rehab: Blank

Resident Name: Name (Resident #5)
Date: 02/18/2021

Resident #5's electronic medical record progress notes were reviewed for 2/18/21, 2/19/21 and 2/21/21 and there was no note to reference the Resident #5's care plan meeting that was scheduled for 2/18/2021 at 10:15 a.m.

The facility policy titled "Family Involvement in Resident Care" effective 11/2020 was reviewed and is documented in part, as follows:

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F 553	Continued From page 11 Policy: Residents and their representative will be provided with an opportunity to participate in the care planning process and be included in decisions, changes of care, treatment, and/or interventions. Care plan meetings will be held to accommodate residents. Facility staff will attempt to meet all reasonable request for Care Plan meetings (time, place, etc.) Family members will be invited to quarterly Care Plan Meetings or Care Plan Meetings that occur due to a change in resident condition. On 5/10/21 at 12:15 P.M. a pre-exit debriefing via phone was conducted with the Interim Administrator, the Acting Director of Nursing and the Regional Director of Clinical Services where the above information was shared. The Interim Administrator was asked what would have been the expectation for ensuring that Resident #5's daughter was included in the care plan meeting.. The Acting Director of Nursing stated, "The daughter should have been called, if she received an invite then the call should have happened on the day listed on the invite." Prior to exit no further information was provided.	F 553		
F 555 SS=D	Right to Choose/Be Informed Attendg Physician CFR(s): 483.10(d)(1)-(5) §483.10(d) Choice of Attending Physician. The resident has the right to choose his or her attending physician. §483.10(d)(1) The physician must be licensed to practice, and	F 555		6/14/21

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F 555	Continued From page 12 §483.10(d)(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. §483.10(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. §483.10(d)(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, a medical record view, staff interviews and family a interview the facility staff failed to follow-up with a resident's choice of an attending physician in March of 2020 to determine if the provider could meet the requirements for care for 1 of 34 residents in the survey sample, Resident #9.	F 555	Resident # nine was offered the opportunity to select another attending physician. An audit of all new current resident admissions for the last 30 days will be conducted to ensure they have been	

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F 555	Continued From page 13 The finding included: Resident #9 was admitted to the facility on 3/11/19 with diagnoses to included but not limited to Major Depressive Disorder, Diabetes Mellitus, Anxiety Disorder and Hypertension. The most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 3/18/21. The Brief Interview for Mental Status (BIMS) for Resident #9 was coded as a 12 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making. On 5/4/21 at 2:00 P.M. a phone interview was conducted with Resident #9's daughter who is also the Complainant. Resident #9's daughter stated, "I took my mother to a primary care physician outside of the facility on my own in march because she was having abdominal pain. After the appointment I told the facility Social Worker that I wanted to change my mother's primary care physician to Name (Outside Nurse Practitioner) when we returned. A few days later I received a call from the Social Worker stating that I could not change my mother's primary care physician because it would be a conflict of interest." Resident #9's Progress Notes were reviewed and are documented in part, as follows: 3/8/2020 12:26 General Note Late Entry: Note Text: SOCIAL SERVICES NOTE Conversation with the daughter about the upcoming appointment with the outside PCP. Social services mentioned that she cannot have	F 555	offered a choice of an attending physician. The Admission Director and Social Worker will be re-educated on the resident□s right to choose an attending physician and to ensure proper follow-up when necessary. The administrator/designee will complete weekly audits for 2 months to ensure residents have been given the right to choose their attending physician and proper follow-up occurs when necessary. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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an outside PCP while she remains in the facility. Told her that Name (Current Facility Primary Care Physician) is her PCP (primary care physician), and that any information was given to the NP(Facility Nurse Practitioner) for her to review. Per staff and Name (Current Facility Primary Care Physician) that is the policy.

3/9/2020 13:57 General Note Note Text: SOCIAL SERVICES NOTE Conversation with the daughter to state that while the resident is at Bayside that the resident cannot have another PCP as Name (Current Facility Primary Care Physician) is her PCP. The daughter stated that she is now aware of that and that she will call the Dr. (doctor's) office to let them know she will not be coming to them. Continue to follow.

On 5/10/21 at 5:59 P.M. a phone interview was conducted with the outside Nurse Practitioner. The outside Nurse Practitioner was asked if anyone from the facility called her in March of 2020 and asked if she would be willing to take Name (Resident #9) on as a patient while in the facility and follow all regulations required if so. The outside Nurse Practitioner stated, "No, no one every called me from the facility and asked if I would take her on as a patient in the facility."

On 5/10/21 at 12:15 P.M. a pre-exit debriefing via phone was conducted with the Interim Administrator, the Acting Director of Nursing and the Regional Director of Clinical Services where the above information was shared. The Interim Administrator was asked what would have been the expectation when Name (Resident #9's) daughter requested changing primary care physicians. The Acting Director of Nursing stated, "To have the Social Worker contact the primary

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F 555	Continued From page 15 care physician and ask if they were interested in following the resident and adhering to all regulations." The Acting Administrator was also asked if there was a facility policy for a resident's choice of a primary care physician. The Acting Administrator stated, "No we do not have a policy we go by the Resident's Rights and the regulations." Prior to exit no further information was shared.	F 555		
F 558 SS=D	THIS IS A COMPLAINT DEFICIENCY 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 observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure call bells were within resident reach for two of 34 residents in the survey sample, Resident #17 and #42. The findings included: 1. Resident #17 was admitted to the facility on 9/26/13 and readmitted on 12/31/20 with diagnoses that included but were not limited to type two diabetes without complications, obesity due to excess calories, atrial fibrillation, post COVID -19, and cognitive social or emotional	F 558	One to one education has been provided to the CNAs who care for resident # 17 and # 42 regarding ensuring call bells are within their reach. Current residents who reside at the facility are at risk to be affected by this practice. CNAs and LPNs will be re-educated on the importance of ensuring call bells are within residents reach. The DON/designee will complete weekly audits for 2 months to ensure residents call bells are positioned within their reach.	6/14/21

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F 558	Continued From page 16 deficit following unspecified cerebrovascular disease. Resident #17's most recent MDS (Minimum Data Set) assessment was an annual assessment with an ARD (Assessment reference date) of 12/31/20. Resident #17 was coded as being severely impaired in cognitive function scoring 05 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #17 was coded as requiring total dependence on two staff members with bed mobility, bathing, personal hygiene, and toileting and extensive assistance with one staff member with eating. Resident #17 was coded in Section H (Bowel and Bladder) as always being incontinent of bowel and bladder. Review of Resident #17's care plan dated 12/27/13 documented the following: "(Name of Resident #17) has a physical functioning deficit related to: Self Care impairment and obesity...Interventions: call bell within reach..." On 5/4/21 at 12: 15 p.m. and 1:13 p.m., an observation was made of Resident #17. His call bell was observed to be on the floor. On 5/5/21 at 1:14 p.m. and 2:00 p.m., an observation was made of Resident #17. His call bell was wrapped around his side rail with the button hanging off the bed at the level of his mattress. When asked Resident #17 if he was able to reach over and grab the bell cord and pull it towards him, Resident #17 stated, "No." When asked if he could try to reach over and grab his bell, Resident #17 could not demonstrate. When asked if it would be easier for him if his call bell was clipped to his bed closer to him; Resident #17 stated, "Yes." Resident #17 stated that he could use his bell if it was in front of him in close	F 558	Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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reach.

Review of an OT (Occupational) Therapist Discharge Summary dated 2/5/21 documented in part, the following: "Patient continues to require maximum assistance for all aspects of bed mobility and ADLS. Patient has progressed with self-feeding tasks requiring assistance with set up."

On 5/6/21 at 1:36 p.m., an interview was conducted with OSM (Other Staff Member) #6, the Therapy Director. OSM #6 stated that Resident #17 did not have full ROM of his upper extremities, OSM #6 stated that he could eat meals independently after set up but didn't think he would be able to reach over and grab a call bell hanging off to he side of him.

On 5/7/21 at 11:24 a.m., an interview was conducted with RN (Registered Nurse) #1, an agency nurse. When asked what nursing staff should ensure is near the resident prior to leaving a room, RN #1 stated that all staff should make sure items that the resident frequently uses and the call bell is within reach for each resident who is able to utilize the call bell. When asked some of the consequences for not having the call bell in reach, RN #1 stated that resident's can have falls and not be able to call the nurse or they cannot call the nursing staff to make any of their needs known. When asked if Resident #17 had full ROM (Range of Motion) of his upper extremities, RN #1 stated that Resident #17 "Doesn't seem to move." RN #1 stated that she hasn't seen Resident #17 even feed himself. When asked if she thought Resident #17 could reach over and grab his call bell that is hanging off the bed railing, RN #1 stated that she would have to say

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no to that question.

On 5/7/21 at 1:28 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #3, a CNA assigned to Resident #17. When asked what she will check for prior to leaving any resident's room; CNA #3 stated that she will make sure that the call bell, bedside table and water pitcher are within reach of the resident. When asked some of the consequences if the call bell is not within reach to a resident; CNA #3 stated, "You don't know if they have an emergency such as choking; it's the only way to make needs known." When asked if Resident #17 had full ROM (Range of Motion) of his upper extremities and could reach the call bell if it was hanging over the side of railing, CNA #3 stated that she thought that he could, however he will refuse to move.

On 5/10/21 at 5:59 p.m., ASM (Administrator Staff Member) #1, the Interim Administrator, ASM #2, the Acting DON (Director of Nursing) and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns.

2. Resident #42 was admitted to the facility on 7/11/16 with diagnoses that included but were not limited to atherosclerotic heart disease, high blood pressure, hypothyroidism, unspecified convulsions, history of falling, and muscle weakness. Resident #42's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 1/8/21. Resident #42 was coded as being moderately impaired in cognitive function scoring 13 out of possible 15 on the

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BIMS (Brief Interview for Mental Status exam. Resident #42 was coded as requiring extensive assistance from two or more staff with bed mobility, transfers, dressing, and personal hygiene; and total dependence on two or more staff with bathing and toileting. Resident #42 was coded as being "Not steady, only able to stabilize with human assistance" when moving from a "Standing to sitting" position. Resident #42 was coded as not having any falls since the last MDS assessment dated 12/2/20.

Review of Resident #42's ADL care plan dated 7/11/16 documented the following: "I have a physical functioning deficit related to: Self care impairment due to dx (diagnoses) of Dementia and Mobility impairment....Call bell within reach..."

On 5/4/21 at 12:30 p.m., an observation was made of Resident #42 on tour. Her call bell was clipped high on her privacy curtain, not within reach of the resident; if the resident was sitting in her wheelchair.

On 5/4/21 at 2:00 p.m., an observation was made of Resident #42 on tour. Her call bell was clipped high on her privacy curtain, not within reach of the resident; if the resident was sitting in her wheelchair.

On 5/4/21 at 2:30 p.m., an interview was conducted with Resident #42. Resident #42 had a complaint regarding call bell response time. Resident #42 then stated to look at her call bell (which was still clipped to the privacy curtain). Resident #42 stated that she could not reach where it was placed. Resident #42 then stated that if it was clipped to her bed, at least she could propel to it and ring it.

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On 5/7/21 at 11:24 a.m., an interview was conducted with RN (Registered Nurse) #1, an agency nurse. When asked what nursing staff should ensure is near the resident prior to leaving a room, RN #1 stated that all staff should make sure items that the resident frequently uses and the call bell is within reach for each resident who is able to utilize the call bell. When asked some of the consequences for not having the call bell in reach, RN #1 stated that resident's can have falls and not be able to call the nurse or they cannot call the nursing staff to make any of their needs known. When asked if it was ever okay to clip the call bell up high on the privacy curtain, RN #1 stated that it was never okay. RN #1 stated that she wonders if the nursing aides had clipped the call bell while making the bed and forgot to put it back.

On 5/7/21 at 1:28 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #3, a CNA assigned to Resident #17. When asked what she will check for prior to leaving any resident's room; CNA #3 stated that she will make sure that the call bell, bedside table and water pitcher are within reach of the resident. When asked some of the consequences if the call bell is not within reach to a resident; CNA #3 stated, "You don't know if they have an emergency such as choking; it's the only way to make needs known. When asked if it was ever okay to clip a call bell high onto the privacy curtain; CNA #3 stated that was never okay.

On 5/10/21 at 5:59 p.m., ASM (Administrator Staff Member) #1, the Interim Administrator, ASM #2, the Acting DON (Director of Nursing) and ASM #4, the Regional Director of Clinical

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F 558	Continued From page 21 Services were made aware of the above concerns. A policy could not be provided regarding call bells in reach. A "Fall Interventions" policy was given to this writer that documented the following: "Call light within reach at all times." No further information was presented prior to exit.	F 558		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced	F 577		6/14/21

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F 577	Continued From page 22 by: Based on staff interview, and facility document review, it was determined that facility staff failed to ensure that the state inspection results were easily accessible to all residents. The findings included: On 5/5/21 at 9:57 a.m., a group interview was conducted with five residents. The five residents interviewed were not aware of where the state inspection results were located. On 5/5/21 at 11:00 a.m., observation of the state inspection results were conducted. The state survey results was in a large three ring binder sitting in a wall mount affixed to the wall. There was no table or anywhere to place the binder once it was out of the wall mount. The wall mount was at a level where it would be difficult for some residents to reach if sitting in a wheelchair. The survey result book also felt heavy. On 5/6/21 at approximately 3:55 p.m., a Resident that was in group (Resident #5); was asked if she could reach the state survey results. Resident #5 was wheelchair bound and had all ROM (Range of Motion) of her upper extremities. Resident #5 stated that she wouldn't be able to quite reach the book from her wheelchair; as she would have to lift the book up and out of the wall mount. Resident #5 stated if she stood up, she would be able to reach it, however she was not supposed to stand on her own. This writer lifted the book up for the resident. Resident #5 was able to hold the book. Resident #5 denied it being too heavy for her to carry. On 5/7/21 at 1:15 p.m., an interview was	F 577	Resident # five has been informed that the State inspections results have been relocated and are easily accessible to residents. Current residents who reside at the facility are at risk to be affected by this practice. Residents will be informed in resident council meeting that the State inspection results have been relocated to a table in the lobby and are easily accessible. The Social Worker will be re-educated on the importance of State survey results being easily accessible to residents. The Administrator /designee will complete weekly audits for 2 months to ensure State inspection results are easily accessible to residents. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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conducted with the Activities Director, OSM (Other Staff Member) #8. When asked where the state survey results were located, OSM #8 stated that the survey results were located in the binder hanging on the wall. OSM #8 stated the results were in a big binder and also confirmed that the binder was heavy. When asked if she thought most residents could reach the state survey binder by lifting the book up and out of the wall mount and then manage the binder (flipping through pages) on their lap; OSM #8 stated, "I don't think a lot of residents could do that." OSM #8 then stated that the staff could help each resident access the binder. When asked if residents should have to ask staff to see the survey results binder, OSM #8 stated that they shouldn't have to.

On 5/10/21 at 2:58 p.m., it was observed that the survey results binder was moved to a low table in the front lobby easily accessible for residents to flip through the pages while on the table.

On 5/10/21 at 5:59 p.m., ASM (Administrator Staff Member) #1, the Interim Administrator, ASM #2, the Acting DON (Director of Nursing) and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns.

Review of the "List of Resident Rights Under Federal Law" document presented by OSM #8, documented in part, the following: "The resident has the right to examine the results of the most recent survey of the Facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the Facility."

No further information was presented prior to exit.

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F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		6/14/21

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F 578	Continued From page 25 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and facility document review the facility failed to ensure that 5 of 34 residents in the survey sample were afforded the opportunity to formulate an Advance Directive upon admission, Residents' #5, #9, #19, #346, and #15. The findings included: 1. Resident #5 was admitted to the facility on 2/28/19 with diagnoses to included but not limited to Major Depressive Disorder, Dementia, Anxiety Disorder and Hypertension. The most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 2/10/21. The Brief Interview for Mental Status (BIMS) for Resident #5 was coded as a 15 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making. Resident #5's electronic medical record was reviewed and there was no advance directive document located. Resident #5's current comprehensive care plan was review and is documented in part, as follows: Focus: Name (Resident #5) has an advance Directive as evidenced by Full code order. Date Initiated: 3/26/2019 On 5/6/21 at 10:23 A.M. during a phone interview the Interim Administrator was asked if Resident	F 578	Resident #9, #5, #19, and #15 have been afforded the opportunity to formulate an advance directive. Resident #346 was discharged on May 8, 2021. An audit was conducted to ensure current residents have been afforded the opportunity to formulate an advance directive. The social worker and the Director of Admissions will be re-educated on the importance of affording residents the opportunity to formulate an advance directive. The Social Worker/designee will complete weekly audits for 2 months to ensure residents have been afforded the opportunity to formulate an advance directive. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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#5's advance directive had been located, The Interim Administrator stated, "No, Name (Resident #5) does not have an advance directive."

On 5/10/21 at 12:15 P.M. a pre-exit debriefing via phone was conducted with the Interim Administrator, the Acting Director of Nursing and the Regional Director of Clinical Services where the above information was shared. The Interim Administrator was asked what would have been the expectation for advance directives. The Acting Director of Nursing stated, "We usually meet with the resident upon admission and get the advance directive or help to formulate one."

Prior to exit no further information was shared.

2. Resident #9 was admitted to the facility on 3/11/19 with diagnoses to included but not limited to Major Depressive Disorder, Diabetes Mellitus, Anxiety Disorder and Hypertension.

The most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 3/18/21. The Brief Interview for Mental Status (BIMS) for Resident #9 was coded as a 12 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making.

Resident #9's electronic medical record was reviewed and there was no advance directive document located.

Resident #9's current comprehensive care plan was review and is documented in part, as follows:

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Focus: Name (Resident #9) has an advance Directive as evidenced by Full code order. Revision date: 7/1/2019

On 5/6/21 at 1:52 P.M. via email correspondence the Interim Administrator stated, "Name (Resident #9), does not have an advance directive."

On 5/10/21 at 12:15 P.M. a pre-exit debriefing via phone was conducted with the Interim Administrator, the Acting Director of Nursing and the Regional Director of Clinical Services where the above information was shared. The Interim Administrator was asked what would have been the expectation for advance directives. The Acting Director of Nursing stated, "We usually meet with the resident upon admission and get the advance directive or help to formulate one."

Prior to exit no further information was shared.

3. Resident #19 was admitted to the facility on 1/22/19 with diagnoses that included but were not limited to muscle weakness, anxiety disorder, depression, low back pain, COVID-19, vitamin D deficiency. Resident #19's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (Assessment reference date) of 1/8/21. Resident #19 was coded as being severely impaired in cognitive function scoring a 5 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 5/6/21 at approximately 10:00 a.m., a family interview was conducted with Resident #19's representative, her husband. He could not recall the facility going over advanced directives at the

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time of admission or since thereafter. Resident #19's RP had stated that all he did was make her a DNR (Do Not Resuscitate) as opposed to a Full Code.

Review of Resident #19's POS (Physician Order Summary) revealed an order for a DNR dated 7/20/20 that documented the following: "DNR - Do Not Resuscitate."

Review of Resident #19's care plan dated 6/27/19 documented in part, the following: "(Name of Resident #19) has an advance directive as evidence by DNR...Follow facility protocol for identification of code status. Obtain Advanced Directives with physician order and resident/responsible party signature."

Review of Resident #19's clinical record revealed no evidence that Resident #19 was afforded the opportunity to formulate an advanced directive.

On 5/7/21 at 1:22 p.m., an interview was conducted with OSM (Other Staff Member #5), the facility social worker. OSM #5 stated that advanced directives should be gone over with the resident and/or the representative upon admission. OSM #5 stated that she had started at the facility last Monday and had only done advanced directives for a couple new admissions so far. OSM #5 stated that advanced directives was more than just going over code status and included items such as IV (intravenous fluids), enteral nutrition and other life prolonging measures. When asked if a resident refuses to formulate an advanced directive if she would revisit the conversation; OSM #5 stated that during quarterly care plan meetings advanced directives should be revisited as well as

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documented. OSM #5 stated that she was not sure if the previous social worker was going over advanced directives with residents. OSM #5 could not provide evidence Resident #19's representative was given the opportunity to formulate an advanced directive.

On 5/10/21 at 5:59 p.m., ASM (Administrator Staff Member) #1, the Interim Administrator, ASM #2, the Acting DON (Director of Nursing) and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns.

No further information was presented prior to exit.

4. Resident #346 was admitted to the nursing facility on 05/03/21. Diagnosis for Resident #346 included but not limited to Acute Kidney Failure. Diagnosis for Resident #346 included but not limited to Muscle weakness. The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #346's admission assessment dated 05/03/21 documented the resident was independent in decisions regarding task of daily life, indicating no cognitive impairment.

Review of Resident #346's Physician Order Sheet (POS) for May 2021 revealed the following order with a start date of 05/03/21: Full Code.

The review of Resident #346's clinical record did not show evidence of an Advance Directive.

A phone interview was conducted with the Social

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Worker (SW) on 05/06/21 at approximately 10:35 a.m. When asked if Resident #346 had an Advance Directive or given the opportunity to formulate an Advance Directive, she said let me review his clinical record. After reviewing Resident #346's clinical record, she replied, "He is a Full Code but I do not see an Advance Directive." When asked who was responsible for ensuring Resident #346 was given the opportunity to formulate an Advance Directive, she replied, "Not me, I believe the Director of Admission is responsible for reviewing the Advance Directive on admission." On the same day at approximately 11:43 a.m., a phone interview was conducted with the Director of Admission who stated, "I did not review an Advance Directive with Resident #346; I did not know, no one ever told me I was suppose too."

A phone interview was conducted with the Administrator and Director of Nursing (DON) on 05/10/21 at approximately 4:10 p.m. The Administrator said the SW is responsible for ensuring the resident is educated and given the opportunity to formulate Advance Director upon admission.

The facility's Administration team was informed of the finding during a debriefing on 05/07/21 at approximately 6:30 p.m. The facility staff did not present any further information about the findings.

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5. Resident #15 was admitted to the facility on 9/13/19 with diagnoses that included chronic obstructive pulmonary disease, alcoholic cirrhosis of liver without ascities, acute and chronic respiratory failure with hypoxia, anxiety, insomnia and delirium. The facility staff failed to give Resident #15 an opportunity to formulate an Advance Directive.

Resident #15 Quarterly Minimum Data Set (MDS) dated 03/18/21 assessed this resident as having scored a (5) on the Brief Interview for Mental Status (BIMS).

A review of the clinical records did not indicate an Advance Directive had been formulated for this resident.

During an interview with the Administrator on 05/07/21 at 11:15 A.M., he stated the facility staff were not able to locate information that an Advance Directive had been offered or that Resident #15 had an Advance Directive.

The facility staff failed to give Resident #15 an opportunity to formulate an Advance Directive.

Facility policy titled, "Advanced Directives-Admissions/Social Service," documented in part, the following: "Upon admission, social services must inform residents, family members or responsible parties of: A. Their right to make choices concerning health care and treatments,

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F 578	Continued From page 32 including life sustaining treatments. The policy of the company regarding advance directives and withholding or withdrawal of treatment. They must be given a copy of this policy...Advanced directives will be reviewed at least annually as part MDS review."	F 578		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		6/14/21

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F 582	Continued From page 33 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 3 of 34 residents (Resident #348, Resident #5 and Resident #9) in the survey sample. The findings included: 1. The facility staff failed to issue a NOMNC (Notice of Medicare Provider Non-Coverage), letter to Resident #348 who was discharged from skilled services with Medicare days remaining. Resident #348 was admitted to the nursing facility on 01/25/21. Diagnosis for Resident #348	F 582	Resident #348 no longer resides at the facility. The Social Worker reviewed the NOMNC with resident # nine and # five and explained changes in charges if applicable. An audit was conducted of current residents for the last 30 days who were denied Medicare coverage to ensure NOMNCs were issued timely. Charges will be reviewed if applicable. The Social Worker will be re-educated on the importance of issuing NOMNCs timely.	

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F 582	Continued From page 34 included but not limited to Muscle weakness. Resident #348's Minimum Data Set (MDS) an OBRA Admission Assessment with an Assessment Reference Date (ARD) date of 02/01/21 coded Resident #348 a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident with no cognitive impairment. Review of the SNF Beneficiary Notification Review provided by the facility to surveyor, was noted that Resident #348 was not listed for having been issued a NOMNC (Notice of Medicare Provider Non-Coverage.) Resident #348 started a Medicare Part A stay on 01/25/21 and the last covered day of this stay was 02/11/21. Resident #348 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #348 had only used 17 days of her Medicare Part A services with 83 days remaining. Resident #348 should have been issued a NOMNC. A phone interview was conducted with the Social Worker (SW) on 05/10/21 at approximately 9:30 a.m. The SW reviewed Resident #348's clinical record. After the SW reviewed Resident #348's clinical record, she replied, "Resident #348 should have been issued an NOMNC." A phone interview was conducted with the Administrator and Director of Nursing (DON) on 05/10/21 at approximately 4:10 p.m., who were made aware the facility failed to issue Resident #348 a NOMNC letter. A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and	F 582	The administrator /designee will complete weekly audits for 2 months to ensure NOMNCs are issued to residents timely. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit.

2. Resident #5 was admitted to the facility on 2/28/19 with diagnoses to included but not limited to Major Depressive Disorder, Dementia, Anxiety Disorder and Hypertension.

The most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 2/10/21. The Brief Interview for Mental Status (BIMS) for Resident #5 was coded as a 15 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making.

Resident #5's electronic medical record was reviewed and the following Medicare Notices of Non-Coverage were reviewed and are documented in part, as follows:

1. THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT SKILLED SERVICES WILL END: 12/12/2020

Telephone Notification Date: 01/25/2021 Time: 12:13 P.M.
Spoke to: Name (Resident #5's) Daughter
Explained Notice of Non-Coverage and appeal rights. Made aware of effective date of 12/22/2020 as date of skilled service ending and

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date financial liability to begin 12/12/2020. Informed that a request for an immediate appeal should be made as soon as possible, but no later than noon on the day before the effective date. Signed by previous Director of Social Services.

2. THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT SKILLED SERVICES WILL END: 12/14/2020

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO (Quality Improvement Organization).

Signature of Patient or Representative: Resident #5's (Daughter's name) via telephone at 1:04 P.M. Date: 12/30/2020 signed by previous Director of Social Services.

On 5/5/21 at 2:50 P.M. a phone interview was conducted with facility Director of Social Services regarding resident Notices of Medicare Provider Non-Coverage's. The Director of Social Services was asked to review let this surveyor know if the above noted Notices of Medicare Provider Non-Coverage's for Resident #5 were given timely. The Director of Social Services stated, "No, they were not given timely. They should be given at least 48 hours prior to the last covered skilled day so that the resident or family has enough time to appeal the decision."

On 5/10/21 at 12:15 P.M. a pre-exit debriefing via phone was conducted with the Interim Administrator, the Acting Director of Nursing and the Regional Director of Clinical Services where

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the above information was shared. The Interim Administrator was asked what would have been the expectation for Medicare Notices of Non-Coverage's to residents. The Acting Director of Nursing stated, "The Notice is to be given 48 hours prior to the last covered day so that they can plan for discharge.

Prior to exit no further information was shared.

3. Resident #9 was admitted to the facility on 3/11/19 with diagnoses to included but not limited to Major Depressive Disorder, Diabetes Mellitus, Anxiety Disorder and Hypertension.

The most recent Minimum Data Set (MDS) was an Annual with an Assessment Reference Date (ARD) of 3/18/21. The Brief Interview for Mental Status (BIMS) for Resident #9 was coded as a 12 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making.

Resident #9's electronic medical record was reviewed and the following Medicare Notices of Non-Coverage were reviewed and are documented in part, as follows:

1. THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT SKILLED SERVICES WILL END: 12/14/2020

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO (Quality Improvement Organization).

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F 582	Continued From page 38	F 582		

Signature of Patient or Representative: Resident #9's signature, note under signature (Name Resident #9's Daughter) via telephone at 12:54 P.M.
Date: 12/30/2020

On 5/5/21 at 2:50 P.M. a phone interview was conducted with facility Director of Social Services regarding resident Notices of Medicare Provider Non-Coverage's. The Director of Social Services was asked to review let this surveyor know if the above noted Notice of Medicare Provider Non-Coverage for Resident #9 were given timely. The Director of Social Services stated, "No, it was not given timely. They should be given at least 48 hours prior to the last covered skilled day so that the resident or family has enough time to appeal the decision."

The facility policy titled "Notice of Medicare Provider Non-Coverage-Generic Notice effective date 11/2020 was reviewed and is documented in part, as follows:

Policy: A Notice of Medicare Provider Non-Coverage-Generic Notice will be utilized to notify resident of non-Medicare coverage.

Procedure: 1. The facility will give a completed copy of the notice to the resident receiving services no later than 2 days before the termination of skilled services.

On 5/10/21 at 12:15 P.M. a pre-exit debriefing via phone was conducted with the Interim Administrator, the Acting Director of Nursing and the Regional Director of Clinical Services where the above information was shared. The Interim Administrator was asked what would have been

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F 582	Continued From page 39 the expectation for Medicare Notices of Non-Coverage's to residents. The Acting Director of Nursing stated, "The Notice is to be given 48 hours prior to the last covered day so that they can plan for discharge. Prior to exit no further information was shared.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		6/14/21

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F 583	Continued From page 40 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility's staff failed to ensure privacy during wound care for 1 of 34 residents (Resident #7), in the survey sample. The findings included: Resident #7 was originally admitted to the facility 10/21/20 and has never been discharged from the facility. The current diagnoses included; glaucoma, a seizure disorder, end stage renal disease requiring dialysis, diabetes and coronary artery disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/28/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making was intact. In section"G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, toileting, and bathing, total care of one with off unit locomotion, extensive assistance of two people with bed mobility and dressing, extensive assistance of one person with personal hygiene and locomotion on unit, and supervision after set-up with eating. In section "M" (Skin Condition) the MDS assessment was coded No at "M1040C", Other open lesion(s) on the foot (e.g.,	F 583	Resident # seven□s privacy curtain was repaired and closes completely. An audit was conducted of resident room privacy curtains to ensure they close completely. Staff will be re-educated to report privacy curtains that do not close completely to housekeeping and / or maintenance so they can be repaired. The Maintenance Director / designee will complete weekly audits for 2 months to ensure privacy curtains close completely. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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F 583	Continued From page 41	F 583		

cuts, fissures). At "M1200I", the resident was coded for Application of dressings to feet (with or without topical medications).

On 5/5/21, at approximately 1:45 p.m., a wound care observation was made of Resident #7's right ankle wound. Licensed Practical Nurse (LPN) #7 cleaned the bedside table, applied a barrier, and assembled needed supplies. LPN #7 and LPN #1 positioned the resident to expose the right ankle wound. LPN #7 removed the negative pressure wound vacuum system, cleaned the wound with saline soaked gauze, skin prepped the outer edges of the wound, applied a wet to dry dressing and a border dressing. LPN #1 stated the above treatment was ordered until the negative pressure system became available. The right lateral ankle wound wasn't measured but the wound bed presented with light red tissue with a moderate amount of serous drainage. The resident didn't indicate the wound was painful. During the entire wound observation the privacy curtain remained opened except between the two residents. Off and on the two nurses went outside the door to obtain various items which allowed the resident's lower body to be viewable from the door.
An interview was conducted with LPN #7, about the privacy curtain immediately after wound care was completed. LPN #7 offered no rationale for not closing the curtain completely before the resident's wound was exposed.

An interview was also conducted with the resident at approximately 2:20 p.m., about the privacy curtain not closed during the wound care observation. Resident #7 stated the curtain doesn't close completely, "if I had been asked I could have told them that". The resident further

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F 583	Continued From page 42 stated it closes enough that I can't see my roommate and he can't see me but it can't move beyond the left corner at the foot of the bed. An interview was conducted with the Housekeeping supervisor on 5/5/21 at 2:35 p.m., the inability to close privacy curtain. The Housekeeping Supervisor stated she hadn't been informed of a problem with the privacy curtain but she took a look at it. She stated there was a problem with the curtain's track and she would have maintenance fix it. The Housekeeping supervisor stated it is necessary for staff to notify them of problems like the privacy curtain issue. At approximately 5:15 p.m., on 5/5/21, the Maintenance Director informed me the privacy curtain tract in Resident #7's room had been repaired and it was capable closing completely. On 5/10/21 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Director of Clinical Services. An opportunity was afforded the facility to provide additional documentation but they did not.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		6/14/21

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F 584	Continued From page 43 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on general observations, clinical record review, staff and resident interviews, the facility staff failed to ensure resident rooms were maintained clean comfortable and homelike for 3 resident rooms on the quarantine unit, Room #202 (A&B), #204 (B) and #207 (A).	F 584	Resident rooms for residents #202(A&B), #204 (B) and #207 (A) have been cleaned and maintained in a comfortable homelike environment. An audit was conducted of resident rooms to ensure they are being maintained in a	

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F 584	Continued From page 44 The findings included: On 5/4/21 at 11:00 a.m., during the orientation tour, through 5/6/21 at 2:00 p.m., the biohazard receptacles were the over flowing trash and soiled linen in the resident's bathroom in room 204 and 207 as well as trash and other debris on the floors. Blood stains, trash, feces and other debris were identified on the floor in room 202. Resident #147 who resided in room 202, unlike the residents in room 204 and 207 was able to express his discontent with the condition of his room. This resident was admitted on 4/30/21 with diagnoses that included type 2 diabetes mellitus, chronic diabetic wounds of right and left foot with status post bilateral transmetatarsal amputations and skin graft infections, end stage renal disease with dependence on renal dialysis. The 5-day Minimum Data Set (MDS) assessment was dated 4/30/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident had the necessary cognitive skills for daily decision making. The resident had no problems understanding the staff and was understood. The resident was assessed without mood or behavioral problems. The assessment was signed by the MDS Coordinator as completed on 5/10/21. On 5/4/21 at 1:05 p.m., Resident #147 was observed sitting on the side of the bed with a full lunch meal tray, his call light was on. The call light over his door was visibly operational and could be heard from the nurse's station. The left and right foot dressing exhibited serous bloody drainage which was also visible on the floor where the	F 584	clean comfortable homelike environment. Director of Maintenance and housekeeping staff will be re-educated on maintaining resident rooms in a clean comfortable environment. The administrator / designee will complete weekly audits for 2 months to ensure resident rooms are maintained in a clean comfortable environment. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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F 584	Continued From page 45	F 584		

resident placed his feet. There was also brown chunked material on the floor between the two beds along with trash, debris, alcohol wipes, chuck pad and accumulated dried blood that remained until inquired by Surveyor #2 on 5/6/21. The resident also stated he ask for someone to clean his floor of the blood from his foot wounds and pick up the fecal material. A foul order was apparent upon entering the room and it was discovered the biohazard trash and linen receptacles in the bathroom were full, over flowing and soiled items of trash and linen pilled on top of the receptacles. This also remained until inquiry by Surveyor #2 on 5/6/21.

On 5/6/21 at 1:50 p.m., an interview was conducted with a housekeeper (#1). He stated that he was new, but worked for the "past several days" on the quarantine unit. According to this housekeeper, his job duties in the bathrooms and resident's rooms included daily sweeping and mopping floors, and emptying trash. He stated he went into each room at least twice and if there were any spills or special housekeeping concerns, he would take care of them. The Housekeeping Director was in the area and also asked about cleaning rooms. She confirmed that housekeeper #1 was new, but knew the protocol for cleaning room.

On 5/6/21 at approximately 2:00 p.m., the Administrator donned full PPE and was shown the condition of the resident's rooms and the over flowing trash and soiled linen in the biohazard receptacles in the resident's bathroom, as well as blood, trash, feces and other debris identified on the floor. The Administrator requested the housekeeper to assist to empty the biohazard receptacles and clean the room. The

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F 584	Continued From page 46 Housekeeping Director stated it was the responsibility of the nursing staff to empty the biohazard bags in the biohazard containers in the dirty utility room, but that they were able to retrieve those bags from her department. On 5/6/21 at approximately 2:10 p.m., Certified Nursing Assistant (CNA #6), who was one of the CNA's assigned to the quarantine unit, said she was new and had not been oriented to the quarantine unit that used the red bags, but stated housekeeping emptied all trash that included the "red bags." On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. The DON stated Administrator concurred that it was an expectation that rooms are maintained clean and biohazard bags disposed of in the specified containers in the dirty utility rooms. The facility's policy and procedures titled "Housekeeping Procedures" dated 6/2016 indicated that "proper cleaning technique prevents the spread of infection and that every room to be cleaned is that resident's home-treat as such...the goal of cleaning is infection control..."	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		6/14/21

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F 600	Continued From page 47 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interviews, the facility staff neglected to provide the necessary care and services for 1 of 34 residents (R#147) in the survey sample and failed to ensure a resident was free from abuse resulting in needless pain for 1 of 34 residents (Resident #36), in the survey sample. The findings included: 1. Resident #147 was admitted on 4/30/21 with diagnoses that included type 2 diabetes mellitus, chronic diabetic wounds of right and left foot with status post bilateral transmetatarsal amputations and skin graft infections, end stage renal disease with dependence on renal dialysis. The 5-day Minimum Data Set (MDS) assessment was dated 4/30/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident had the necessary cognitive skills for daily decision making. The resident had no problems understanding the staff and was understood. The resident was assessed without mood or behavioral problems. Resident	F 600	Resident #147 no longer resides at facility Resident #36 will be reviewed to assure medication available and reviewed for any pain issues by allegation of the compliance date. Current residents will be reviewed to assure needs are being met by nursing staff by the allegation of compliance date. Current licensed nurses and nursing assistants will be rein-serviced regarding abuse and neglect and in providing care needs to residents by the DON./designee by allegation of compliance date. The Administrator will monitor for abuse/neglect of residents by reviewing any concerns in morning meeting 5x/week for 4 weeks. Monitoring will also include review of 4 random residents every week for 4 weeks. Any variances will be corrected. The results will be reported to the QAPI committee for the need of continued review.	

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#147 required extensive assistance from 2 staff for bed mobility and toilet use. He was not assessed to be able to ambulate (walk in and out of room). He had bilateral lower extremity impairment in range of motion. The wheelchair was the resident's primary mode of transportation. The resident was coded with surgical wounds and infection of feet. The assessment was signed by the MDS Coordinator as completed on 5/10/21.

There was no care plan to include a baseline 48-hour care plan or interim care plan available to this surveyor during the time of the survey.

The following observations were made of Resident #147 that constituted neglect of goods and services:

On 5/4/21 at 1:05 p.m., Resident #147 was observed sitting on the side of the bed with a full lunch meal tray, his call light was on. The call light over his door was visibly operational and could be heard from the nurse's station. The left and right foot dressing exhibited serous bloody drainage which was also visible on the floor where the resident placed his feet. The Kling wrap on the left foot was unraveled and intertwined itself around the wheels of his over bed table. The resident stated that his dressing had been in that condition all night and he had been asking someone to change his dressings. The foot of his bed exhibited the same drainage on his sheets at the foot of the bed. There was also brown chunked material on the floor between the two beds along with trash, debris, alcohol wipes, chuck pad and accumulated dried blood that remained until inquired by Surveyor #2 on 5/6/21. The resident also stated he ask for someone to

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F 600	Continued From page 49	F 600		

clean his floor of the blood from his foot wounds and pick up the fecal material. A foul order was apparent upon entering the room and it was discovered the biohazard trash and linen receptacles in the bathroom were full, over flowing and soiled items of trash and linen piled on top of the receptacles. This also remained until inquiry by Surveyor #2 on 5/6/21.

During the above observation, the Resident #147 stated when they served him his lunch meal around 12:15 p.m., he took one bite from a pork chop and could not consume it because it was tough with no taste, and thus he spit it out. He also stated he wanted coffee and they gave him iced tea with no sugar substitute. He stated he put his call light on around 12:20 p.m. and again at 12:30 and both times no one came in, but when the licensed Practical Nurse (LPN) #1 came to hang my IV antibiotic a few minutes ago that was due at 9:00 a.m., turned off the light, never asked him what he wanted, at which time he stated he told her he had been calling to get someone to send for a different meal, at which time she told him she was behind and did not have time. He stated, "So I tried again after she left out because I am so hungry." The IV was infusing via the IV pump. The IV infusion pump beeped around 1:40 p.m. and the nurse entered the room at 2:03 p.m. (58 minutes from Surveyor #2's observation) she hesitated and made eye contact with this surveyor (Surveyor #2), turned off the light, took down the IV, flushed the central line and said, "While I am here, what can I do for you." The resident responded, "You can get me what I asked for when you came in to hang my IV antibiotic and said you were busy and did not have time. I would like a different meal for my lunch." LPN #1 stated she would come back to

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perform the dressing changes to his feet later. At approximately 2:10 p.m., the assigned Certified Nursing Assistant (CNA) # 6 was outside the resident's room donning her Personal Protective Equipment (PPE). CNA #6 entered the room, proceeded to pick up the resident's tray when it was asked if she would get the resident another meal. CNA #6 said, "It is late and I don't think I can get a meal now. I am not sure how that works in this building." The resident told CNA #6 he had to eat something. CNA #6 stated she would try but could not promise he would get a meal. CNA #6 also stated that she did not see the call light over and it was difficult to view through the plastic partition. CNA #6 also stated the call light did not light up and she did not think it sounded at the nurse's station. She added that she was relatively new to the facility and had not been oriented to the resident's on the quarantine unit.

On 5/4/21 at 7:30 p.m., it was determined Resident #147 did not receive anything to eat until 2:30 p.m. He stated he got a hamburger and told the CNA to make sure it did not take place of his dinner. In addition, the resident said he was told he would receive double portions, but to date he had not. Random call lights were checked in each hallway to be fully operational as lit over the resident's door, as well as lit and heard at the nurse's station.

On 5/5/21 at 9:30 a.m., Resident #147 arrived from dialysis. LPN #1 hung the resident's IV antibiotic at around 10:00 a.m. She stated, "I am agency staff and yesterday was my first day. I did not know anything about this building or the residents and I got behind in passing my medications. That's why his 9:00 a.m. IV antibiotic was hung at 1:00 p.m. I was not sure if he was

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getting this antibiotic through a midline or a central line because it was in his neck and I wanted to flush it correctly." The LPN was not able to explain why she could not have had the aide or another nurse to offer and provide the alternate/substitute meal.

On 5/6/21 at 12:42 p.m., the Wound Care Physician (WCP), accompanied by a first day agency LPN (#2). When the WCP cut the soiled outer Kling wrap off of the resident's feet, the taped portion revealed a date of 5/4/21 which indicated the facility staff neglected to perform the resident's wound care once a day and as needed per physician's order dated 5/3/21. The wound exhibited a foul odor with heavy serous exudate.

On 5/6/21 at approximately 2:00 p.m., the Administrator donned full PPE and was shown the condition of the resident's room and the over flowing trash and soiled linen in the resident's bathroom, as well as blood, trash, feces and other debris identified on the floor. The Administrator requested the housekeeper to assist to empty the biohazard receptacles and clean the room. The Administrator was informed that this Surveyor #2 performed random checks of the call light system to reveal no problems. The Administrator was also informed of all of the aforementioned issues that constituted neglect of care and services for Resident #147; call bell response time, refusing to retrieve an alternate meal, late administration of the IV antibiotic, infection control issues of blood and feces on the floor and over flowing trash and linen in the bathroom, and lack of daily dressing changes to foot wounds and as needed.

On 5/10/21 at 5:59 p.m., a debriefing was

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conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. The DON stated and the Administrator concurred that it was an expectation that call bells were answered timely, rooms are clean, and treatments and medications are to be performed as ordered by the physician.

The facility's policy and procedures titled "Resident Abuse-Staff to Resident" dated 2/2017 and revised 4/2020 indicated that neglect was the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. It may include, but not limited to... "Failing to answer call bells to provide needed assistance."

2. Resident #36 was originally admitted to the facility 7/14/21 and readmitted 11/12/21 after an acute care hospital stay. The current diagnoses included; lower back pain, lumbar diskitis, arthritis, polyneuropathy and a history multiple back surgeries.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/2/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15.

Review of the Facility's Reported Incidents revealed, Resident #36 voiced a complaint against Licensed Practical Nurse (LPN) #18 on 3/4/21. The FRI stated on 3/3/21, the LPN #18 refused to apply as needed medication in a timely manner and had also withheld a narcotic pain medication when requested by the resident.

The physician's order summary revealed;

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Resident #36 had the following medications ordered for administration;

Order Date 11/12/2020 - Bio freeze Gel 4 % (a menthol topical pain medication), apply to effected areas topically every 8 hours as needed for pain

Order Date 11/12/20 - oxycodone HCl Tablet 5 MG, Give 1 tablet by mouth every 4 hours as needed for post op pain related to LOW BACK PAIN (M54.5)

Order Date 11/12/20 - Acetaminophen Tablet Give 650 mg by mouth every 8 hours as needed for pain related to LOW BACK PAIN (M54.5)

The resident had a person-centered care plan problem dated 5/15/20 which read; the resident needs Pain management and monitoring related to: chronic lower back pain, polyneuropathy, and osteoarthritis of foot and ankle. The goal read; the resident will maintain adequate level of comfort as evidenced by no signs/symptoms of unrelieved pain or distress, or verbalizing satisfaction with level of comfort through next review, 8/10/21. The interventions included; Administer Pain medication as ordered, Utilize pain monitoring tool to evaluate effectiveness of interventions and Evaluate and Establish level of pain on numeric scale/evaluation tool.

On 5/5/21 at approximately 1:00 p.m., an interview was conducted with Resident #36. The resident stated on 3/3/21, he asked for the ordered BioFreeze gel (a menthol topical pain medication) to be applied but LPN #18, sat there and didn't administer it until she decided to do so. The resident explained that BioFreeze is

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F 600	Continued From page 54 instrumental in cooling and decreasing his pain to enable him to function. The resident also stated LPN #18 has behaved the same way when he has request his oral pain medication and he felt it was her means of controlling him while causing him to be in pain longer than he really has to. Resident #36 stated other residents in the community experiences the same problem with LPN #18. The facility's investigation revealed LPN #18 stated the BioFreeze wasn't available on 3/3/21, when requested by the resident and LPN #18 hadn't instituted the facility's protocol for obtaining medications when they were not readily available. The investigation also revealed LPN #18 was often unprofessional (not nice, banged on resident doors and verbally inappropriate) with Resident #36, others residents and family members. The facility's investigation substantiated Resident #36's allegation and LPN #18 was terminated from the company and other staff were in-serviced on the abuse policy and on how to obtain over the counter medications. On 5/10/21 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Director of Clinical Services. An opportunity was afforded the facility to provide additional information but they did not.	F 600		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 602		6/14/21

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F 602	Continued From page 55 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, observations, clinical record review, staff interviews and review of facility documentation, the facility staff failed to ensure 4 of 34 residents (#152, #151, #30, #43) were free of the misappropriation of their narcotic medications, and ensure their standards and practices prevented reoccurrence. The findings include: 1. The facility staff failed to ensure Resident #152 was free of the misappropriation of her narcotic medication, *Oxycodone (Percocet). Resident #152 was admitted to the nursing facility on 10/7/20 for short-term rehabilitation. She had diagnoses that included UT not limited to intervertebral disc disorders with radiculopathy in the lumbar region. The resident was discharged on 11/6/2020. The Admission Minimum Data Set (MDS) assessment dated 10/14/20 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 10 out of a possible score of 15 which indicated the resident was moderately impaired in the skills needed for daily decision making. Resident #152's care plan dated 10/19/20 identified the resident was at risk for pain related to intervertebral disc disorders with radiculopathy	F 602	Residents #152 and #151 no longer reside at the facility. Residents #30 and #43 will be reviewed to assure there is no misappropriation of narcotic medications by allegation of compliance date. Current residents receiving narcotic medications will be reviewed to assure there is no misappropriation of medications by allegation of compliance date. Licensed Nurses will be rein-serviced regarding misappropriation of resident narcotic medications and the process to prevent by the DON/designee by the allegation of the compliance date. The DON/designee will monitor residents with narcotic medications to assure no misappropriation has occurred and the process remains in place weekly for 4 weeks.	

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in the lumbar region. The goal set by the staff was that she would maintain an adequate level of comfort as evidenced by no signs or symptoms of unrelieved pain or distress and verbalized satisfaction with level of comfort through the next review. One of the interventions to accomplish this goal included administer her pain medication as ordered by the physician.

The previous Director of Nursing (DON) conducted a random narcotic count on 11/3/2020 and discovered that Resident #152's as needed (PRN) Oxycodone that was ordered PRN 6 hours for pain had been discontinued on 10/26/2020 by Licensed Practical Nurse (LPN) #12. The facility's investigation summary dated 11/6/2020 indicated LPN #12 said the narcotic was discontinued by the resident's attending physician for lack of use. It was discovered by the DON that the whole card of Oxycodone tablets and the Controlled Narcotic sheet was missing and never found. The investigation indicated that the DON confirmed with the physician that he did not discontinue the narcotic. The pharmacy manifest indicated that 90 tablets of Oxycodone was sent to the facility on 10/13/20 and only one tablet was signed off as administered on 10/21/20 which would have left 89 tablets. The LPN that wrote the order to discontinue the narcotic was confronted about the discontinuing the the narcotic without a valid physician's order. The other nurses were interviewed and none of them saw the Oxycodone tablets or the Controlled Narcotic sheet. LPN #12's drug test proved positive for Oxycodone. The LPN was removed from the schedule, the local police department notified. The physician reordered Oxycodone for Resident #152.

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2. The facility staff failed to ensure Resident #151 was free of the misappropriation of his narcotic medication, *Marinol (Dronabinol).

Resident #151 was admitted to the nursing facility on 10/30/2020 with diagnoses that included palliative care, swallowing problems and Alzheimer's disease. The resident expired in the facility on 11/4/2020.

Resident #151's most recent Minimum Data Set (MDS) assessment was dated 10/28/20 and coded severely impaired in long and short term memory.

The care plan dated 12/27/19 identified the resident was at risk for imbalanced nutrition. The goal set by the staff for this problems was that the resident would maintain adequate nutritional status. Some of the approaches to accomplish this goal included monitor intake every meal, dietician assess as needed and medications as ordered by the physician.

The resident had physician's orders dated 10/30/20 for Marinol 5 milligrams (mg), one capsule every day for weight loss to increase appetite.

On During a random narcotic count conducted by the previous DON on 11/3/2020, it was discovered through an investigation that Resident #151's Marinol was found in LPN#12's personal bag. The facility was unable to determine when the resident's Marinol was confiscated from him due to the medication was signed out as administered daily and the resident did not exhibit any negative consequences as a result of the medication diversion. Three Controlled Records

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were in the facility's investigation packet for a total of 30 tablets of Marinol without obvious errors in administration based on the signatures of the licensed nurses. LPN #12 was no longer employed by the facility.

3. The facility staff failed to ensure Resident #30 was free of the misappropriation of his narcotic medication, *Klonopin (Clonazepam).

Resident #30 was admitted to the nursing facility on 8/31/19 with diagnoses that included but not limited to Huntington's disease, major depression and anxiety disorder. Resident #30 was a current resident in the facility.

Resident #30's most recent Minimum Data Set (MDS) assessment was a quarterly dated 2/11/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 9 out of a possible score of 15 which indicated the resident was moderately impaired in the skills needed for daily decision making.

The care plan dated 3/27/20 identified the resident had a diagnosis of anxiety. The goal set by the staff for the resident was that his psychosocial well-being would be minimized through the next review. One of the interventions to accomplish this goal included to administer his medications as ordered.

The resident had physician's orders dated 6/30/20 for Klonopin 1 mg for anxiety disorder every day at bedtime.

On During a random narcotic count conducted by the previous DON on 11/3/2020, it was discovered through an investigation that Resident

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#30's Klonopin was found in LPN#12's personal bag. The facility was unable to determine when the resident's Klonopin was confiscated from him due to the medication was signed out as administered daily and the resident did not exhibit any negative consequences as a result of the medication diversion. One Controlled Record that reflected the timeframe 10/12/20 through 11/9/20 was in the facility's investigation packet for a total of 30 tablets of Klonopin without obvious errors in administration based on the signatures of the licensed nurses. LPN #12 was no longer employed by the facility.

4. The facility staff failed to ensure Resident #43 was free of the misappropriation of her narcotic medication, *Oxycodone (Percocet).

Resident #43 was admitted to the nursing facility on 7//2/18 with diagnoses that included but not limited to chronic pain.

Resident #43's most recent Minimum Data Set (MDS) assessment was a quarterly dated 1/5/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 12 out of a possible score of 15 which indicated the resident was moderately impaired in the skills needed for daily decision making.

The care plan dated 8/10/18 and 10/29/21 identified the resident had a diagnosis of chronic back pain due to neuropathy and chronic back pain. The goal set by the staff for the resident was that she would maintain adequate levels of comfort as evidenced by no signs and symptoms of unrelieved pain of distress through the next review. Some of the interventions to accomplish this goal included to administer pain medication

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as ordered by the physician.

The resident had physician's orders dated 7/18/18 for Oxycodone, one tablet as needed (PRN) every 8 hours for pain.

During a random narcotic count conducted by the previous DON on 11/3/2020, it was discovered through an investigation that Resident #43's Oxycodone was found in LPN#12's personal bag. The facility was unable to determine when the resident's Oxycodone was confiscated from her due to the medication was signed out as administered PRN and the resident did not exhibit any negative consequences as a result of the medication diversion. Resident #43's Controlled Narcotic sheets for the Oxycodone during this timeframe were not in the facility's investigation packet and could not be located to be presented during the survey. LPN #12 was no longer employed by the facility.

On 5/4/21 at 7:00 p.m. narcotic counts were observed by this surveyor (#2) for the facility's 2 medication carts, 100 and 200/300. All narcotics were accounted for in a affixed compartment on the locked medication cart except a discovered Morphine Sulfate 20 milligrams (mg)/1 milliliters (ml), give .5 ml (10 mg) every 4 hours by mouth (po) for a resident that was admitted for respite care (Resident #146), located in the bottom drawer of the medication cart 200/300. The Morphine Sulfate was found in a bag with several of Resident #146's personal non-narcotic medications. Licensed practical Nurse (LPN #4) said she knew it was there, but there should have been a "Controlled Record" narcotic flow sheet for the resident's narcotic medication and counted along with the other narcotics, 18 milliliters (ml)

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recorded as the count for Resident #146's Morphine Sulfate. It was also determined that the Morphine Sulfate was not maintained in the separate affixed compartment in the medication cart as the other resident's narcotics. It was also observed that the narcotic shift counts were not consistently co-signed with another licensed nurse.

On 5/5/21 at 10:00 a.m., this surveyor (#2) requested to review 6 months of narcotic count sheets. After review of the sheets, it was discovered too numerous to count missing licensed nurse co-signatures and some shifts with no signatures.

On 5/6/21 at 10:30 a.m., the Director of Nursing (DON) said per their policy and the standard of practice, it was expected that licensed nurses co-sign with two signatures, oncoming and off going to ensure the counts were accurate for the resident's narcotics and medications that had the potential for abuse. He stated Resident #146's narcotic medication brought from home should have been locked in the narcotic box with a slip and counted along with the other narcotics until picked up by the family or in the aforementioned case, picked up by hospice. He took this surveyor (#2) to demonstrate that the medication for resident's Morphine Sulfate narcotic was transferred behind a double lock and counted along with the other narcotics. The amount of Morphine Sulfate was as observed on 5/4/21, 18 ml remained. This resident was discharged home on 5/5/21.

On 5/5/21 at 12:12 p.m., this surveyor (#2) asked the Administrator to provide any investigation that may have taken place for the aforementioned

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misappropriation of narcotics and or drug diversion. He stated he did not know where the info was because he had been Interim Administrator for one day. Upon further search, he located the investigation packet. It was also requested if the facility addressed the issue during a Quality Assurance and Performance Improvement (QAPI) committee meeting at the time of the incident. The Administrator located a large binder and pulled from a large QA binder an AD HOC meeting minutes dated 10/26/20 with training titled "Allegations of Abuse, Not Reported Per Policy." He stated that misappropriation of narcotics would be under abuse. Upon review of the AD HOC minutes and sign in sheet indicated the only training that was conducted regarded "Reporting Abuse" and no reference to misappropriation of narcotics or drug diversion.

On 5/6/12 at 11:30 a.m., the Administrator presented another AD HOC meeting minutes with no date or time, but in a box labeled issues was written "Drug Diversion." He said that Registered Nurse (RN) #3 located the packet in the previous DON's office. The Administrator stated he was concerned that there was no date as to when the AD HOC meeting took place. Upon review, this surveyor (#2) stated the presented information was the same information in the investigation packet, except it indicated that 100% of all nursing staff would be educated on the facility's narcotic policy, nurse managers will review all discharge orders in morning meeting, nurse management will audit narcotic sheets 5 times a week for 4 weeks for accuracy, DON will perform random narcotic audits to ensure residents are receiving medications and to review in QAPI.

Based on the review of the above undated AD

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HOC, only 3 nurses out of 10 staff (remaining 7 staff were non-nursing) signed in as receiving the education on the facility's narcotic policy. As a matter of record, there was no information provided to the survey team that represented how many nursing staff (licensed and certified) were employed at the time of the discovery of the misappropriation of the resident's narcotics. There was no evidence provided that nurse managers reviewed discharge orders in the morning meetings, audited 5 times a week for 4 weeks for accuracy, random narcotic audits to ensure residents are receiving medications or that any of the results were reviewed in QAPI. Review of the current staffing sheets reviewed from 4/30/21 through 5/6/21 revealed there were at least 46 licensed and certified nurses employed which may have estimated the number of nurses that should have signed in as received the education on the facility's narcotic policy.

During the above interview on 5/6/21 at 11:30 a.m., the Administrator stated they could not locate any additional nurse inservices or audits to support a monitored corrective action plan for drug diversion. In addition, there was clear evidence that the destruction/waste of narcotics was consistently signed by the current DON along with another licensed nurse, but inconsistencies in 2020. It was stated that the Controlled Drug Record should be kept in the resident's medical records, but many of them could not be located for 2020. The pharmacy shipping manifests for the delivery of narcotics for Resident #152, #151, #30 and #43 were requested for 2020 to current. When they were presented to this surveyor (#2), for any of there was difficulty finding many of the aforementioned resident's Controlled Drug Records for 2020. There was no evidence that

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this was a part of the monitoring to ensure the narcotic drug records matched the shipping manifests.

On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. There aforementioned issues were re-reviewed and the DON and Administrator reiterated their expectations of the licensed nurses. There was no further documents or added information presented prior to survey's remote exit on 5/11/21.

The facility's policy and procedures titled "Ordering and Receiving Controlled Medications" dated 2007 indicated that medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by stat law, are subject to special ordering, receipt, and record keeping requirements in the nursing care center, in accordance with federal and state laws and regulations. The nursing care center obtains and keeps current on file any permits required by state agencies.

The facility's policy and procedures titled "Controlled Substances" dated 2007 indicated that Controlled Substances are substances that have an accepted medical use (DEA drug enforcement schedules II-V), those with the potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. These medications are subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations.

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F 602	Continued From page 65 *Oxycodone is a Semi-synthetic opioid drug prescribed for pain as Tylox®, Percodan®, Oxycontin®. Derived from the poppy plant, has high potential for abuse (retrieved on 5/13/21 from source https://www.dea.gov/factsheets/oxycodone). *Marinol is a Schedule III drug under the Controlled Substances Act. Syndros is an oral Dronabinol (THC) solution that is used for the treatment of anorexia associated with weight loss in patients who have failed to respond adequately to conventional antiemetic treatments (Retrieved on 5/13/21 from source https://www.dea.gov/sites/default/files/2020-06/Marijuana-Cannabis-2020.pdf). *Klonopin is a Schedule IV drug, Klonopin's medical benefits are recognized, as is its relatively low potential for abuse; however, its dangers and risk for abuse require federal oversight and regulation. As a result, Clonazepam/Klonopin is officially a controlled substance in the United States (Retrieved on 5/13/21 https://www.deadiversion.usdoj.gov/schedules). *Oxycodone is a Semi-synthetic opioid drug prescribed for pain as Tylox®, Percodan®, Oxycontin®. Derived from the poppy plant, has high potential for abuse (retrieved on 5/13/21 from source https://www.dea.gov/factsheets/Oxycodone). COMPLAINT DEFICIENCY	F 602		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		6/14/21

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§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the

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facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.

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F 622	Continued From page 68 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to send all the necessary documentation; including care plan goals with the resident upon transfer to the hospital for 2 of 34 residents in the survey sample, Resident #17 and #346. The findings included: 1. Resident #17 was admitted to the facility on 9/26/13 and readmitted on 12/31/20 with diagnoses that included but were not limited to type two diabetes without complications, obesity due to excess calories, atrial fibrillation, post COVID -19, and cognitive social or emotional deficit following unspecified cerebrovascular disease. Resident #17's most recent MDS (Minimum Data Set) assessment was an annual assessment with an ARD (Assessment reference date) of 12/31/20. Resident #17 was coded as being severely impaired in cognitive function scoring 05 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #17's clinical record revealed that he was sent out to the hospital on 12/17/20 at 9:45 p.m. The following nursing note was documented: "R (Resident) lethargic, will not close mouth to drink water, starting off to the right. R vitals b/p (blood pressure) 88/43, P	F 622	Resident #17 has been re-admitted to facility no effect noted. Resident #346 no longer resides at facility. Residents being discharged to hospital will have transfer/discharge information, including care plan and care plan goals, to the appropriate receiving entity. Licensed nurses will be rein-serviced regarding information needed for transfer/discharge including care plan and care plan goals to receiving entities by the DON/designee by allegation of compliance date. The DON/designee will monitor discharged residents for 4 weeks to assure care plan and care plan goals are included with the transfer/discharge information. Any variances will be corrected. The results will be reported to the QAPI committee for the continued need of monitoring.	

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(pulse) 56, R(16), T(Temp)-97.1, 02 (Oxygen) Sats 87. R c/o (complaints), sob (short of breath), chest pain. NP (Nurse Practitioner) (Name) notified, new order to send to er (emergency room) for eval (evaluation) and treat...Transport arrived at 2145 (9:45 p.m.) to transport resident "R"..."

There was no evidence that all the required documentation; including care plan goals was sent with Resident #17 at the time of discharge.

Further review of Resident #17's clinical record revealed a nursing note dated 12/18/20 (following day) that documented the following: "Note Text: Recv'd (received) request from (Name of hospital) and residence (sic) medication list, code status and last notes prior to transfer to the ER. All documents faxed to (Number)."

There was still no evidence that care plan goals were sent with Resident #17 at the time of transfer.

On 5/6/21 at 2:52 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #9, the nurse who discharged Resident #17 to the hospital. When asked if she had discharged Resident #17 to the hospital, LPN #9 stated, "I think I did, he was in acute respiratory distress." When asked if she sent any documents with Resident #17 to the hospital; LPN #9 stated that she sent the resident's medication list, treatment list, face sheet, by fax to the hospital. LPN #9 confirmed that she had sent these items after he had been transferred when the hospital physician had called and asked for any recent lab tests. LPN #9 stated that Resident #17 had to be sent out urgently and that the facesheet was the only

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document that was actually sent with the resident at the time of transfer. When asked if she had send the care plan or care plan goals; LPN #9 stated, "No, not from me. I don't know what staff did in terms of paperwork." LPN #9 stated that she didn't work at the facility full time, that she picked up shifts if needed.

2. The facility staff failed to ensure Resident #346's Plan of Care Summary to include his care plan goals was sent upon or shortly after transfer/discharge to the hospital on 05/08/21.

Resident #346 was admitted to the facility on 05/03/21. Diagnosis for Resident #346 included but not limited to Acute Renal Failure.

The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #346's Admission Assessment dated 05/03/21 documented the residents was independent in decisions regarding task of daily life, indicating no cognitive impairment.

The Discharge MDS assessments was dated for 05/08/21 - discharged with return anticipated.

On 05/08/21 at approximately 1:28 p.m., according to the facility's documentation, Resident #346 was administered Tylenol 500 mg for an elevated temperature of 100.8 and was unable to sit up without having severe pain. Resident #346 was reassessed, temperature at 101.7. The physician was notified of change in condition with new order to send to (name of hospital) for evaluation for fever and shaking.

A phone interview was conducted with the Administrator and Director of Nursing (DON) on

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F 622	Continued From page 71 05/10/21 at approximately 4:10 p.m. The DON said Resident #346's Care Plan Summary should have been sent to with him to the hospital or shortly after. He said the Care Plan Summary allows the receiving provider to maintain and continue with continuity of care. A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit. Facility policy titled, "Transfer of Residents from the Facility" did not address the above concerns.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		6/14/21

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F 625	Continued From page 72 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold Policy upon discharge/transfer for 1 of 34 resident's (Resident #346) after being transferred and admitted to the hospital. The findings included: The facility staff failed to ensure that Resident #346 or his resident's representative was provided a copy of the bed hold policy upon discharge/transfer to the hospital on 05/08/21. Resident #346 was admitted to the facility on 05/03/21. Diagnosis for Resident #346 included but not limited to Acute Renal Failure. The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #346's Admission Assessment dated 05/03/21 documented the residents was independent in decisions regarding task of daily life, indicating no cognitive impairment. The Discharge MDS assessments was dated for 05/08/21 - discharged with return anticipated. On 05/08/21 at approximately 1:28 p.m., according to the facility's documentation, Resident #346 was administered Tylenol 500 mg	F 625	Resident #346 no longer resides at facility. Current residents being discharged to the hospital will be issued a bed hold policy at the time of discharge. Licensed nursing staff will be rein-serviced regarding issuing bed hold policy upon discharge to the hospital by the DON/designee by the allegation of the compliance date. The medical records designee will monitor residents discharges weekly for 4 weeks for issuance of bed hold policies. Any variances will be corrected. The results will be reported to the QAPI committee for the need of continued monitoring.	

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F 625	Continued From page 73 for an elevated temperature of 100.8 and was unable to sit up without having severe pain. Resident #346 was reassessed, temperature at 101.7. The physician was notified of change in condition with new order to send to (name of hospital) for evaluation for fever and shaking. A phone interview was conducted with the Administrator and Director of Nursing (DON) on 05/10/21 at approximately 4:10 p.m. The Administrator said the Bed Hold policy should have been given or sent shortly after discharge to the hospital. When asked, "What the purpose of giving the bed hold policy" the Administrator, replied" It gives the resident/representative the opportunity to do a bed hold while they are in the hospital." A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit.	F 625		
F 655 SS=E	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	F 655		6/14/21

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F 655	Continued From page 74 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 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 resident and staff interviews, clinical record review and facility document review, the facility staff failed to ensure the baseline care plan summary was completed for 3 out of 34 residents (Resident #346, Resident #347 and Resident #147) in the survey sample. The findings included:	F 655	Residents #347 baseline care plan summary will be completed by allegation of compliance date. Residents #346 and #147 no longer reside at the facility. Residents newly admitted will be reviewed to assure baseline care plan summaries	

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F 655	Continued From page 75 1. The facility staff failed to complete a newly admitted resident, (Resident #346), a baseline care plan summary. The summary must include the initial goals for the resident, a list of current medications, dietary instructions, services and treatments to be administered by the facility. The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #346's Admission Assessment dated 05/03/21 documented the residents was independent in decisions regarding task of daily life, indicating no cognitive impairment. The review of Resident #346's Admission Order for May 2021, included but not limited to the following medications, dietary instructions and treatment: Medications include but not limited to: -Oxycodone 5 mg by mouth every 4 hours as needed for pain -Lantus - 15 units subcutaneous daily in the morning and 10 units daily at bedtime for Type II diabetes -Lovenox 30 mg - inject 1 syringe subcutaneous daily Treatment include but not limited to: -Dialysis every Tuesday, Thursday and Saturday -Sacrum wound - apply to sacrum every day - cleanse wound with Dakins - apply Sanyl to moist Dakins roll gauze pack and apply abd pad, secure with tape. -Colostomy care every shift Dietary instructions: Consistent Carb Diet (CCD) 2 gram sodium diet,	F 655	have been completed as required by allegation of compliance date. Licensed nurses will be rein-serviced regarding requirement of baseline care plan summary completion by the DON/designee by allegation of compliance date. The DON/designee will monitor for the completion of baseline care plan summaries for newly admitted residents weekly for 4 weeks. Any variance will be completed. The results will be reported to the QAPI committee for the need of continued monitoring.	

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regular texture.

2. The facility staff failed to complete a newly admitted resident, (Resident #347), a baseline care plan summary. The summary must include the initial goals for the resident, a list of current medications, dietary instructions, services and treatments to be administered by the facility.

The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #347's Admission Assessment dated 04/30/21 documented the residents was independent in decisions regarding task of daily life, indicating no cognitive impairment.

The review of Resident #347's Admission Order for April 2021, included but not limited to the following medications, dietary instructions and treatment:

Medications include but not limited to:
Aspirin 325 mg - give 1 tablet by mouth daily for Atrial Flutter.
Norvasc 5 mg - give 1 tablet by mouth daily for Hypertension.
Zyprexa 2.5 mg - give 1 tablet by mouth daily at bedtime for Vascular Dementia with Behavioral Disturbances.
Coreg 6.25 mg - give 1 tablet by mouth twice a day for Hypertension.

Treatment instructions include but not limited to:
Oxygen 2 liters via nasal cannula (n/c) as needed for SOB starting on 05/01/21.

Therapy instructions include but not limited to:
Occupational Therapy (OT) and treat as indicated starting on 04/30/21.

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Speech Therapy (ST) and treat as indicated starting on 04/30/21.
Physical Therapy (PT) and treat as indicated starting on 04/30/21.

Dietary instructions:
Heart Healthy diet, regular texture.

3. The facility staff failed to complete a newly admitted resident, (Resident #147), a baseline care plan summary. The summary must include the initial goals for the resident, a list of current medications, dietary instructions, services and treatments to be administered by the facility.

Resident #147 was admitted on 4/30/21 with diagnoses that included type 2 diabetes mellitus, chronic diabetic wounds of right and left foot with status post bilateral transmetatarsal amputations and skin graft infections, end stage renal disease with dependence on renal dialysis.

The 5-day Minimum Data Set (MDS) assessment was dated 4/30/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident had the necessary cognitive skills for daily decision making. The resident had no problems understanding the staff and was understood. The resident was assessed without mood or behavioral problems. Resident #147 required extensive assistance from 2 staff for bed mobility and toilet use. He was not assessed to be able to ambulate (walk in and out of room). He had bilateral lower extremity impairment in range of motion. The wheelchair was the resident's primary mode of transportation. The resident was coded with surgical wounds and infection of feet. The

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F 655	Continued From page 78 assessment was signed by the MDS Coordinator as completed on 5/10/21. There was no care plan to include a baseline 48-hour care plan or interim care plan available to this surveyor during the time of the survey. Resident #147 had complicated wound care procedures, was on hemodialysis, Intravenous (IV) antibiotics via a central line (internal jugular), dietary recommendations and oxygen therapy. None of these areas were represented through care planning to meet professional standards of care. A phone interview was conducted with the Director of Nursing (DON) on 05/06/21 at approximately 11:09 a.m. The DON stated that baseline care plans should have been completed 48 hours after admission. On 05/10/21 at approximately 4:10 p.m., phone interview was conducted with the Administrator and (DON.) When asked who is responsible for developing the 48 hour baseline care plan, the DON stated, "The admitting nurse and if she runs out of time; the next nurse coming should completed the care plan; they only have 48 hours to complete the baseline care plan. A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		6/14/21

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F 657	Continued From page 79 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in 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: The facility staff failed to ensure a comprehensive care plan was developed within seven (7) days after completion of the comprehensive assessment for 1 of 34 residents in the survey sample, Resident 40. 1. For Resident #40, the facility staff failed to ensure resident had a comprehensive care plan developed within 7 days after completion of the comprehensive assessment. Resident #40 was admitted to the facility on 03/30/2021. Diagnosis	F 657	Resident #40 will have a comprehensive care plan completed by the allegation of compliance date. Current residents will be reviewed to assure comprehensive care plans are in place by allegation of compliance date. MDS nurse will be rein-serviced regarding the completion of the comprehensive care plan by the DON/designee by the	

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included but were not limited to Vascular Dementia Without Behavioral Disturbance, Cerebrovascular Disease, Unspecified and Type 2 Diabetes Mellitus With Other Circulatory Complications. Resident #40's Admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 04/05/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #40 as requiring supervision of 1 with eating, extensive assistance of 2 for bed mobility, transfer and dressing, total dependence of 1 for personal hygiene and bathing and total dependence of 2 for toilet use.

On 05/05/2021 at approximately 10:00 a.m. review of Resident #40's Admission Minimum Data Set revealed the following: A2300. Assessment Reference Date Observation end date: 4/5/2021

On 05/05/2021 at approximately 10:00 a.m. review of Resident #40's clinical record was reviewed and revealed no evidence of comprehensive care plan.

On 05/05/2021 at 2:00 p.m., an interview was conducted with MDS Coordinator. When asked for a copy of Resident #40's comprehensive care plan, MDS Coordinator stated, "I just started today." This surveyor reviewed with MDS Coordinator that Resident #40 was admitted to the facility on 03/30/2021. When asked when should Resident #40's comprehensive care plan be completed, MDS Coordinator stated, "Within 14 days of admission." When asked does Resident #40 have a comprehensive care plan,

allegation of the compliance date.

The MDS will monitor residents for the completion of comprehensive care plans for 4 weeks. Any variances will be corrected. The results will be reported to the QAPI committee for the need of continued monitoring.

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F 657	Continued From page 81 MDS Coordinator stated, "I don't see the completed comprehensive care plan. It was initiated on 03/30 but was not completed." MDS Coordinator provided a copy of Resident #40's Baseline Care Plan to surveyor. The Interim Administrator, Interim Director of Nursing and Corporate Nurse was informed of the finding on 05/10/2021 at approximately 8:30 p.m. at the pre-exit meeting. When asked should the resident have a completed comprehensive care plan, Corporate Nurse stated, "Yes, 7 days after the MDS was completed." The facility did not present any further information about the findings.	F 657		
F 658 SS=E	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 resident interview, staff interviews, clinical record review and facility documentation review, the facility staff failed to follow professional standards of nursing for 2 of 34 residents (Resident #346 and Resident #22) in the survey sample. The findings included: 1. The facility staff failed to follow a physician's orders for wound vac treatment of an abdominal surgical incision for Resident #346.	F 658	Resident #346 no longer resides at facility. Resident #22 will be reviewed to assure lab and medication orders are followed as per physician orders by the allegation of the compliance date. Current residents with orders for wound vac orders and UA and C&S orders will be reviewed to assure orders are being followed as per physician orders by	6/14/21

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F 658	Continued From page 82 Resident #346 was admitted to the facility on 05/03/21. Diagnosis for Resident #346 included but not limited to surgical aftercare of an Exploratory Laparotomy. The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #346's Admission Assessment dated 05/03/21 documented the residents was independent in decisions regarding task of daily life, indicating no cognitive impairment. In addition, the Admission Assessment was coded for having an abdominal surgical wound requiring surgical wound care (wound vac.) The Admission Assessment under skin was coded for having an abdominal surgical wound - area measured 2.8 cm x 3.8 cm x 1.1 cm. Resident #346's record did not reveal a 48 hour baseline care or an interim care plan. Review of Resident's #346 discharge summary 05/03/21 read in part: Instructions for follow-up (Routine wound vac changes to midline abdomen surgical wound.) On 05/06/21 at approximately 7:50 p.m., surveyor #2 observed wound care with License Practical Nurse (LPN) #13 and LPN #14. As they entered the room, a foul odor was observed. It was said by LPN #13 that she thought the colostomy bag had opened and stool had seeped toward the center of the resident's body due to large amount of brown material visible through the dressing. Once the dressing was removed, an approximated amount of drainage was observed and described by LPN #13 to be "a cup full of brown foul smelling drainage." LPN #14 stated	F 658	DON/designee by allegation of compliance date. Licensed nurses will be rein-serviced regarding completing wound vac orders and lab orders as per physician orders by DON/designee by allegation of compliance date. The DON/designee will monitor the following of wound vac and lab orders by review of new orders daily 5x/week for 4 weeks. Any variances will be corrected. The results will be reported to the QAPI committee for the need of continued monitoring.	

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she was going to call the physician for some orders. She did not return and stated at 8:45 p.m. that she got busy with other issues. LPN #13 cleansed the wound with normal saline and several ABD pads were applied secured with paper tape.

A phone interview was conducted with the Director of Nursing (DON) on 05/05/21 at approximately 1:26 p.m. The
DON stated, "If the wound vac was not available then the physician should have been notified for alternative order until the wound vac arrived."
2. The facility's staff failed to follow a physician's orders for obtaining labs and administering medications for Resident #22.

Resident #22 was originally admitted to the facility 05/13/2019 and readmitted 01/25/2021 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; End Stage Renal Disease and Aphasia.

The significant change, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 01/31/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #22 cognitive abilities for daily decision making were moderately impaired.

In section"G"(Physical functioning) the resident was coded as requiring extensive assistance of two persons with bed mobility, transfers, locomotion, toileting, personal hygiene, extensive assistance of one person with dressing, supervision after set-up help with eating and requires total dependence with bathing.

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The care plan dated 1/12/21 reads that resident has Urinary Tract Infections, potential due to: Use of indwelling catheter-18F 10cc balloon-has dx of obstructive and reflux uropathy. Resident performs own catheter care (resolved) The goals for resident #22 are: Resident is at risk for UTI related to Foley catheter use, will be minimized through next review. The Interventions are: Catheter care q shift and as needed. Observe and report s/s of UTI: changes in color, odor, or consistency of urine, dysuria, fever, pain. Offer fluids frequently throughout the day. Urology consult as needed.

A review of the MAR (Medication Administration Record) Reads: May obtain UA/C&S (Urinalysis/Culture and Sensitivity) in the evening for side pain/bloody urine for 1 day. Order Date: 3/03/21. Time: 1846 (6:46 PM). The MAR show's no evidence of labs being obtained for this order.

A review of progress note reveals the following concerning the UC&S (Urine Culture and Sensitivity): On 3/3/2021 18:02 (6:02 PM) General Note: Received call from dialysis that foley was bloody urine temp taken 98.9 resident c/o side pain. resident returned from dialysis and temp taken 99.5 ax but that was with coat and blanket on. taken orally after 15 minutes temp was 99.0 vitals 104/74 96hr 20rr 98%02. foley flushed and urine returned light pink then yellow. On-call notified and new order from NP (Nurse Practitioner) for UA/C&S and place in book for in NP in morning. resident tolerated all medications and food this shift. will continue to assess as needed and on-coming shift informed of status.

A review of the MAR reads: Azireonam Solution

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F 658	Continued From page 85 Reconstituted 1 GM. Inject 1 Gram intramuscularly every 12 hours for UTI (Urinary Tract Infection) until 3/22/21 2359 (11:59 PM). Order Date: 3/15/21. Time: 1602 (4:02 PM). Resident #22 received all doses of his prescribed antibiotic at 0900 (9:00 AM) March 16th through March 22, 2021. Resident #22 received all doses of his prescribed antibiotic at 2100 (9:00 PM) from March 15th through March 22, 2021 except on March 16th. (no initials were present on the MAR indicating Resident #22 received his antibiotic). An interview was conducted with the ADON on 5/11/21 at approximately 4:00 PM concerning the above issues. He stated, "I'll look into it. The surveyor also informed the ADON that she was not able to review the POS (Physicians Order Summary) for March 2021 in PCC (Point Click Care). He stated, "I'll email it to you." The ADON was contacted several times concerning the POS for March 2021. Document not received. On 5/11/21 at approximately 9:30 AM the above findings were shared with the Administrator and The Acting Director of Nursing (ADON) An opportunity was offered to the facility's staff to present additional information but no additional information was provided. The ADON stated, "We should have gotten an order for the UC&S. No documentation was found. Nurses should have identified the physician order prior to. Vital signs should have been monitored for the effectiveness of the antibiotics."	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		6/14/21

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F 684	Continued From page 86 § 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 resident interview, staff interviews, clinical record review, and review of facility's documents, the facility staff failed to ensure 1 of 34 residents in the survey sample (Resident #346's) abdominal surgical wound had an alternate treatment until the primary treatment (a negative pressure wound vac) was available. 2. The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #346's Admission Assessment dated 05/03/21 documented the residents was independent in decisions regarding task of daily life, indicating no cognitive impairment. In addition, the Admission Assessment was coded for having an abdominal surgical wound requiring surgical wound care (wound vac.) The Admission Assessment under skin was coded for having an abdominal surgical wound - area measured 2.8 cm x 3.8 cm x 1.1 cm. Resident #346's record did not reveal a 48 hour baseline care or an interim care plan. Review of Resident's #346 discharge summary 05/03/21 read in part: Instructions for follow-up (Routine wound vac changes to midline abdomen	F 684	Resident #346 no longer resides at facility. Current residents with wound vac orders will be reviewed to assure wound vac and/or alternative orders are in place in case of the unavailability of wound vac by the allegation of compliance date. Licensed Nurses will be rein-serviced regarding wound vac and alternative treatments in the event wound vac is unavailable by the DON/designee by allegation of compliance date. The DON will monitor residents with orders for wound vac to assure wound vac in place and/or alternative orders in place weekly for 4 weeks. Any variances will be corrected. The results will be reported to the QAPI committee for the need of continued monitoring.	

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surgical wound.)

On 05/05/21 at approximately 9:25 a.m., a phone interview was conducted with Resident #346. Resident #346 said, he was shot in the stomach and had surgery; there is a wound to my stomach but it's not being treatment. He said there was a machine attached to my stomach when I was in the hospital (wound vac.)

Review of Resident #346's Physician Order Summary (POS) and Treatment Administration Record (TAR) for May 2021 did not include an abdominal wound treatment or a wound vac.

A phone interview was conducted with the Director of Nursing (DON) on 05/05/21 at approximately 1:26 p.m. The
DON stated, "If the wound vac was not available then the physician should have been notified for alternative order until the wound vac arrived."

A phone interview was conducted with the medical supply clerk on 05/05/21 at approximately 3:05 p.m. She stated, "The agency nurse informed me on Monday, 05/03/21 that Resident #346 was being admitted and needed a wound vac. She said I was not sure if we rented the machine or if we had one here in the facility. She proceed to stay; I was waiting for the order so I could order the wound vac but an order was never given to me.

On 05/10/21 at approximately 2:25 p.m., a phone interview was conducted with Chief Clinical Officer of Operations (CCOO). She said on Sunday (05/09/21) the staff informed her that a wound vac was needed for Resident #346 and there wasn't one in the building. The CCOO

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F 684	Continued From page 88 stated, "We had a back-up wound vac in the building." The CCOO said she walked into the supply room, the wound vac was located on the bottom shelf in a box (ready to go.) When asked how the box was labeled, she replied, "The box was labeled Cardinal - Negative Pressure Wound Therapy (NPWT) and next to the wound vac was a plastic container with wound vac supplies." The CCOO said she walked the supply clerk to the supply room and showed her where the wound vac was located. A phone interview was conducted with the central supply clerk on 05/10/21 at approximately 3:29 p.m. She said there was a backup wound vac in the medical supply room. She said, "The box was not labeled as a wound vac and that was what I was looking for." A phone interview was conducted with the Administrator and Director of Nursing (DON) on 05/10/21 at approximately 4:10 p.m., and was informed that Resident #346's discharge summary dated 05/03/21 revealed to continue with a wound vac to the mid-line surgical wound; but the treatment for the wound vac was never initiated. They were also made aware that there was a wound vac in the supply room the day Resident #346 entered the building but the staff did not realize the Cardinal - Negative Pressure Wound Therapy (NPWT) was actually the wound vac. No further information was provided A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		6/14/21

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F 686	Continued From page 89 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 observations, staff interviews, facility documentation review and clinical record review the facility staff failed to ensure 3 residents (Resident #43, #17, #7) of 34 residents in the survey sample, received care to prevent pressure ulcers from developing prior to an advanced stage which constitutes harm; facility staff failed to do initial and weekly assessments for 1 of 34 residents in the survey sample, Resident #19 and facility staff failed to provide pressure ulcer care as ordered by the physician for 1 of 34 residents in the survey sample, Resident #346. The findings included: 1. For Resident #43, the facility staff failed to prevent pressure ulcer on the sacrum from developing to an advanced stage which constitutes harm.	F 686	Resident 343, #17 and #7 continues to receive treatments to wounds as per physician orders. These residents continue to be seen by VOHRA wound physician. Current residents continue at risk for development of pressure areas will be reviewed to assure care is provided to prevent the development of an advanced stage wound by the DON/designee by allegation of compliance date. Current residents with pressure areas will be reviewed to assure treatments are provided as per physician orders by the DON/designee by allegation of the compliance date. Licensed nurses will be rein-serviced regarding providing care to prevent	

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F 686	Continued From page 90 Resident #43 was initially admitted to the facility on 07/12/2018. Resident #43 was discharged to the hospital on 04/04/2021 and readmitted to the facility on 04/08/2021. Diagnosis included but were not limited to, Unspecified Fracture of Left Femur and Depression. Resident #43's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/12/2021 was not coded with a BIMS (Brief Interview for Mental Status) score. The Minimum Data Set coded Resident #43 as requiring extensive assistance of 1 for eating, extensive assistance of 2 for bed mobility, transfer and toilet use and total dependence of 2 for dressing, personal hygiene and bathing. On 5/04/2021 review of Resident #43's clinical record revealed the following: Review of Progress Notes for Resident #43 revealed General Note dated 5/01/2021 time 19:34 which read as follows: Note Text: This nurse noticed two open areas on Resident #43's bottom. AN open are on the coccyx bone and one on the right butt cheek. Notified MD (Medical Doctor) (Other #2) N. O. (New Order) to apply barrier cream and see wound doctor. This nurse made RP (Responsible Party) aware. Review of Progress Notes for Resident #43 revealed Weekly Skin Review dated 5/3/2021 time 15:17 which read as follows: Weekly Skin Review Info (Information): Sacrum - Pressure: Length = 1.5 cm (Centimeter), Width = 2.5 cm, Depth = 0, - Stage Unstageable Healed? No Drainage? No drainage..... . No tunneling or undermining. Barrier cream. No complaints/evidence of pain r/t (Related To) pressure area..... The wound has no	F 686	advanced stage wounds and providing treatments to pressure areas as per physician orders by the DON/designee by the allegation of compliance date. The DON/designee will monitor residents weekly to assure care is provided to prevent advanced staged wounds, and will monitor by observation that treatments are being provided as ordered to pressure wounds weekly for 4 weeks. Any variances will be corrected. The results will be provided to the QAPI committee for the need of continued monitoring.	

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change. Unable to evidence any previous Weekly Skin Reviews since Resident #43's readmission to facility on 4/8/2021.

Resident #43's Pressure Injury Weekly Measurement (rev) - V 4 dated 5/3/2021 time 15:17 was reviewed and revealed the following: A. Pressure Injury 2b. Location of Pressure Injury Site 53) Sacrum Type Pressure Length 1.5 cm Width 2.5 cm Depth 0 Stage Unstageable. (There is a definition for Unstageable on the form that reads as follows: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and /or eschar (tan, brown or black) in the wound bed.) 6. TX. (Treatment) barrier cream.

Resident #43's Initial Non - Decubitus Skin Injury Record dated 5/3/2021 time 15:21 was reviewed and revealed the following: A. 1. Date first observed: 5/2/2021 2. Date Physician notified: 5/2/2021 3. Description of site/location r (Right) gluteal 4. Describe type of skin condition popped blister 5. Size in CM (Length x Width x Depth) 2.0 cm x 2.5 cm x 0.1 cm 6. Drainage: No 7. Odor 0 8. Color: red

Review of Clinical Physician Orders on 05/04/2021 did not evidence an order for barrier cream.

On 05/05/2021 review of Weekly Skin Integrity Check dated 5/4/2021 time 17:01 for Resident #43 revealed the following: 1. Weekly Skin Integrity Checks 1. Skin clear, no change of condition assessed. 2. New wound/change of condition noted. See skin/Condition Assessment Form, for initial/ongoing documentation of assessed Wound or Skin Condition. 3.

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Wound/Skin condition Present/No new change of condition. Documentation already established on all existing Wound/Skin Conditions.

On 05/05/2021 at approximately 9:00 a.m. requested Resident #43's Treatment Administration Record (TAR) for May 2021?

On 05/05/2021 received copy of Treatment Administration Record for May 2021 as requested. Review of the Treatment Administration Record revealed that it was printed on May 5, 2021 at 11:13:35 EDT (Eastern Daylight Time). Review of the Treatment Administration Record did not evidence a treatment order for the resident's buttocks, coccyx or sacrum or for barrier cream.

On 05/05/2021 at approximately 12:00 p.m., Resident #43 was observed sitting on Comfort Pro Cushion in wheelchair.

An interview was conducted with Licensed Practical Nurse (LPN) #7 on 05/05/2021 at 2:45 p.m. When asked what treatment is being done to Resident #43's sacrum, LPN #7 stated, "She gets barrier cream. It's applied 3 times a day and PRN (A Needed)." When asked to provide a copy of the order, LPN #7 stated, "I noticed today that she didn't have an order but I saw the nurse note and transcribed the order." LPN #7 provided surveyor copy of order dated 05/05/2021. Review of order revealed the following: Order Date: 5/5/2021 12 29 Description: apply barrier cream to sacrum/coccyx until seen by wound MD. Order Summary: apply barrier cream to sacrum/coccyx until seen by wound MD every shift for wound care.

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On 05/05/2021 at 3:41 p.m., at Resident #43's bedside to observed LPN #7 perform wound care on Resident #43. LPN #7 cleaned overbed table. LPN #7 performed hand hygiene, obtained needed wound care supplies and placed on overbed table. LPN #7 performed hand hygiene and gloved. LPN #7 cleansed open area on right buttock with Peri Care Rinse Free Peri Cleanser and gauze pad. Area noted to be pink in color with some light white coloring in the center. LPN #7 cleansed wound on sacrum with Peri Care Rinse Free Peri Cleanser and gauze pad. Wound on sacrum noted to have gray black necrotic tissue in the center. LPN #7 cleansed area on coccyx with Peri Care Rinse Free Peri Cleanser and gauze pad, unable to determine if area was open. LPN #7 removed her gloves and performed hand hygiene, regloved and applied Derma Cream Skin Protectant Cream to all areas.

On 05/06/2021 at 7:51 a.m., review of Treatment Administration Record for May 2021 in Resident #43's clinical record revealed the following: Apply barrier cream to sacrum/coccyx until seen by wound MD every shift for wound care. Order Date 05/05/2021 1229.

On 05/06/2021 at 10:00 a.m., an interview was conducted over the telephone with LPN #6. When asked were you the nurse for Resident #43 on 05/01/2021, LPN #6 stated, "Yes." LPN #6 stated, "The CNA told me that the resident had an area on her coccyx and right butt cheek. I called other #2 and he told me to order barrier cream." When asked did you write the order for barrier cream, LPN #6 stated, "I was told by (Nurse Name) LPN #8 that barrier cream order was already in place in the facility and didn't need to

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write the order." LPN #6 stated, "All of the residents get barrier cream applied after each incontinent episode by the CNA's." When asked did the physician give parameters of how often to apply the barrier cream and when to apply the barrier cream, LPN #6 stated, "No." When asked do the CNA's document when they apply barrier cream, LPN #6 stated, "I don't know how the CNA's document." When asked did you apply barrier cream to Resident #43 that evening, LPN #6 stated, "No, I told the CNA's to apply." When asked to explain what the areas looked like on Resident #43, "LPN #6 stated, "The coccyx had a small scab and the cheek, looked like a blister that popped."

On 05/06/2021 at approximately 11:00 a.m., when asked if the facility had any standing orders, Corporate Staff Member #5 stated, "I will have to find out and get back to you."

On 05/06/2021 at 1:00 p.m., Corporate Staff Member #5 stated, "No standing orders in facility."

An interview was conducted with Certified Nursing Assistant (CNA) #4 on 05/06/2021 at 2:05 p.m. When asked is Resident #43 incontinent of Bowel and bladder, CNA #4 stated, "Yes and she goes to the bathroom." When asked how often do you check her for incontinent episodes, CNA #4 stated, "Every 2 hours because she does have dementia." When asked do you apply barrier cream to Resident #43, CNA #4 stated, "Yes but I can't say everyone does."

An interview was conducted with CNA #3 on 05/06/2021 at 2:25 p.m. When asked if Resident #43 needs assistance with transferring, CNA #3

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stated, "(Resident Name) can transfer with stand by assist and will transfer on her own at times." When asked if Resident #43 is confused, CNA #3 stated, "Yes." When asked is Resident #43 incontinent, CNA #3 stated, "Yes, she is incontinent of bowel and bladder." When asked how often you offer to toilet Resident #43, CNA #3 stated, "She will let you know when she needs to go to the restroom." When asked do you apply barrier cream to Resident #43, CNA #3 stated, "Apply barrier cream to residents after they have incontinent episodes."

On 05/06/2021 Resident #43 was seen in the facility by other #7. An interview was conducted with other #7 on 05/06/2021 at 3:25 p.m. When asked what stage is Resident #43's wound on her sacrum, other #7 stated, "Unstageable." When asked what the wound on the sacrum due to was, other #7 stated, "Pressure." When asked what was the wound on the right buttocks due to, other #7 stated, "Friction." When asked what the area on the coccyx due to was, other #7 stated, "DTI (Deep Tissue Injury)." When asked for wound measurements from today's visit, other #7 stated, "Measurements on the right buttocks 2 x 2 x 0.1, sacrum 2 x 1 x 0.2 and coccyx 0.5 x 0.5." Other #7 said that she only makes recommendations and the resident's physician gives the orders. When asked what treatments she was recommending, other #7 stated, "Santyl to the sacrum, Skin Prep to the Coccyx and Hydrogel for the right buttocks." Other #7 also said that she would recommend a gel cushion for Resident #43. Other #7 stated, "The nurses try to wait for me to stage pressure ulcers. The nurses usually tell me they have an Unstageable." Other #7 stated, "R.N.'s (Registered Nurses) can stage." Other #7 stated, "I come once a week."

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On 05/06/2021 copy of facility policy and procedure on pressure ulcers was requested.

On 05/06/2021 received copy of Trio Healthcare Policy and Procedure Manuals - Wound Prevention Program. Review of manual revealed the following: SKIN PROGRAM Page 6 - Residents with wounds will have appropriate treatment.

On 05/07/2021 requested copy of Wound Physician Progress Notes for 05/06/2021.

An interview was conducted with RN #1 on 05/07/2021 at 12:35 p.m. When asked to review Pressure Injury Weekly Measurement note for Resident #43 dated 05/03/2021, RN #1 stated, "I was sent to get the measurements on 05/03/2021 by the Director of Nursing (DON) after they viewed the notes from the weekend." When asked to describe what the areas on Resident #43 looked like, RN #1 stated, "Right butt cheek looked like a popped blister and I documented it on a Non-Pressure form on 05/03/2021." When asked did you measure an area on the coccyx bone, RN #1 stated, "I did not see an area on the coccyx bone, I measured the area on the sacrum." RN #1 stated, "I had been asked to measure the area on the sacrum." It was discussed that the progress note from 05/01/2021 identified an area on the coccyx bone but not the sacrum. RN #1 stated, "I didn't think anything about it because nurses uses the term sacrum and coccyx and mean the same thing." When asked to describe what the sacrum looked like, RN #1 stated, "It looked dry, had some yellow tinge on the left and blackened area was on the right." When asked was the physician made

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aware of the area on the sacrum, RN #1 stated, "Yes, talked to the Nurse Practitioner (Name) (Other #8)." When asked did you document that the Nurse Practitioner was made aware, RN #1 stated, "No." When asked was an order obtained for the sacrum, RN #1 stated, "No, per my understanding the DON and Corporate Nurse were working on getting the Wound Nurse to come out. That was Monday." When asked why you contacted the Nurse Practitioner on Monday if you thought the sacrum wound was the coccyx wound that was in the note, RN #1 stated, "Just to follow up and cover the bases." RN #1 stated, "I made the Nurse Practitioner aware that the wound was identified as unstageable and made her aware of the order for barrier cream and asked her did she want another treatment order and the Nurse Practitioner said no, that's all right someone will be in to see it tomorrow." When asked did you apply barrier cream to the wounds on Monday, RN #1 stated, "I don't know." When asked did you document applying the barrier cream, RN #1 stated, "Yes on the TAR." Surveyor provided copy of May 2021 TAR to RN #1 to review. After RN #1 reviewed TAR RN #1 stated, "No, it just stated to put dry dressing on staples." When asked did you apply barrier cream to Resident #43 yesterday, Thursday, RN #1 stated, "No. I knew you wanted wound measurements and the wound doctor came in." When asked have you seen new orders written for wound care for Resident #43 today, RN #1 stated, "No, I have not."

On 05/07/2021 at 3:20 p.m. An interview was conducted with CNA #3. When asked how was it communicated to you to apply barrier cream to Resident #43, CNA #3 stated, "Already knew to apply barrier cream to residents after incontinent

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episodes." When asked did you document applying barrier cream to Resident #43, CNA #3 stated, "No ma'am."

On 05/07/2021 at 3:45 p.m., reviewed concerns with Interim Administrator and Corporate Nurse regarding Resident #43's unstageable wound located on the sacrum and looking at possible harm. Discussed unable to locate treatment orders for wounds identified on 05/01/2021 and no documented evidence that treatment was done. Corporate Nurse stated, "They wrote an order and documented treatments." Requested evidence of orders written for 05/01/2021 and documented evidence that treatments were provided.

On 05/10/2021 at approximately 10:00 a.m., requested copy of Wound Physician Progress Notes for Resident #43 for 05/06/2021. Also requested any new orders obtained for Resident #43's wounds on her sacrum, coccyx and right buttocks.

On 05/10/2021 at approximately 11:45 a.m. An interview was conducted with CNA #4. When asked how is it communicated to you to apply barrier cream to Resident #43, CNA #4 stated, "We apply barrier cream as precautions, if any body's bottom gets red we put cream on." When asked where do you document that you have applied the barrier cream, CNA #4 stated, "Nowhere on the kiosk to document putting on barrier cream."

On 05/10/2021 received copy of Wound Physicians Initial Wound Evaluation and Management Summary Dated 5/6/2021. Received new orders written for Resident #43.

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Review of new orders revealed the following: Order Date: 5/10/2021 1245 Description: Clean wound/DTI to sacrum with normal saline, pat dry. Apply Santyl to wound bed, skin prep surrounding skin. Cover with dry dressing. Order Date: 5/10/2021 1245 Description: Clean right lateral buttock with normal saline, pat dry. Apply Hydrogel to wound bed and cover with dry dressing. Order Date: 5/10/2021 1245 Description: Apply skin prep to DTI over coccyx.

The Interim Administrator, Interim Director of Nursing and Corporate Nurse was informed of the findings on 05/10/2021 at approximately 8:30 p.m. at the pre-exit meeting. When asked if they had any further information to provide, Corporate Nurse stated, "Order put barrier cream on and continued barrier cream until physician seen her and order changed today."

On 05/11/2021 at 12:35 p.m. an interview was conducted by telephone with the Interim Director of Nursing. When asked concerning the wounds identified on 05/01/2021, did the resident have a treatment order for the open areas on the buttocks, sacrum and coccyx, Interim Director of Nursing stated, "No specific order, were applying barrier cream. On 05/05/2021 received order to continue barrier cream." When asked do you have evidence that barrier cream was applied, Corporate Nurse stated, "In the progress note." When asked was barrier cream an appropriate treatment for an unstageable pressure ulcer, Corporate Nurse stated, "This is the order the doctor gave." When asked what your expectations of nurses are when wounds are identified, Interim Director of nursing stated, "Assess the wound, obtain measurements and notify the physician for treatment orders. To

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provide pressure relief to any area of concern, offloading heels, floating heels." The Corporate Nurse stated, "We replaced the cushion in her chair with a gel cushion on 05/03 or 05/04." The facility did not present any further information about the finding.

2. For Resident #17, the facility staff failed to provide necessary care and services to prevent a pressure ulcer from developing at an advanced stage which constitutes harm.

Resident #17 was admitted to the facility on 9/26/13 and readmitted on 12/31/20 with diagnoses that included but were not limited to type two diabetes without complications, obesity due to excess calories, atrial fibrillation, post COVID -19, and cognitive social or emotional deficit following unspecified cerebrovascular disease. Resident #17's most recent MDS (Minimum Data Set) assessment was an annual assessment with an ARD (Assessment reference date) of 12/31/20. Resident #17 was coded as being severely impaired in cognitive function scoring 05 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #17 was coded as requiring total dependence on two staff members with bed mobility. Resident #17 was coded in Section M (Skin Conditions) as having (1) one unstageable pressure ulcer* (1).

Review of Resident #17's clinical record revealed that the only Braden Scale for Predicting Pressure Ulcer Risk was on 11/27/18. Resident #17 was coded as being at high risk for developing pressure sores scoring a "12.0."

Review of Resident #17's clinical record revealed that it was documented that Resident #17

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developed MASD (Moisture Associated Skin Damage) to the right buttock starting on 11/3/20 and documented as "Resolved" on 11/10/20. An order was put into place to: "Clean right buttock with soap and water blot dry apply zinc and silver sulfadiazine every shift." This order was initiated on 10/27/20 and continued even after the MASD was resolved on 11/10/20.

There was no evidence that Resident #17 had developed any other skin areas until 12/17/20 when a Stage 3 (2) pressure ulcer was documented as being identified to his right buttock.

Review of the "Initial Pressure Injury Record" dated 12/17/20 documented the following: "Date first observed: 12/17/20. Location: right buttock. Stage: 3 Length in CM (centimeters): 2. Width in CM: 2. Depth in CM: 0 (zero) Drainage: none. Odor: none. Granulation. None. Describe current treatment plan: cleanse left buttock with N/S (normal saline) apply medihoney (3) and calcium alginate (4) and dry dressing daily and PRN (as needed)." This assessment was documented by a LPN (Licensed Practical Nurse).

There was no evidence that an RN (Registered Nurse) had went behind the LPN to reassess the wound.

The weekly skin assessment directly prior to 12/17/20 was dated 12/14/20. The following was documented: "Wound/Skin Condition Present/No new change of condition. Documentation already established on all existing Wound/Skin Conditions."

There was no evidence in the clinical record that

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after 11/10/20 and directly prior to 12/17/20 an existing wound condition was present.

Review of Resident #17's December 2020 TAR (Treatment Administration Record) revealed that staff were applying his zinc and silver sulfadiazine cream every shift on 12/16/20 through 12/17/20 until the wound was found on 12/17/20 day shift. Further review of Resident #17's December TAR revealed 7 blank spaces on 12/1, 12/2, 12/3, 12/8, 12/9 and 12/15; indicating the cream was not applied on those shifts to Resident #17.

Review of Resident #17's pressure ulcer care plan dated 9/27/13 documented the following interventions prior to the development of his documented "Stage 3" wound: "(Name of Resident #17) is a risk for pressure ulcers due to decreased mobility and obesity and co morbidity diagnosis of HTN (high blood pressure), Diabetes...CNA (Certified Nursing Assistant) to observe skin during care/bathing with a report to the nurse of any areas of skin breakdown, bruising or redness....Conduct weekly skin inspections...Ensure skin folds are kept clean and dry...provide pressure reduction/relieving mattress...treatments as ordered...Turning and repositioning schedule per assessment..."

Further review of Resident #17's clinical record revealed a dietary note dated 12/11/20 that documented the following: "Review for weight loss, 5.5%... x 30 days, Diet: CCD with recent decreased intake 30% average. supervision needed and now more total dependence in recent days...Recommend to d/c (discontinue) ice cream with lunch and dinner, add Mighty Shake with breakfast and lunch, add vitamin C 500mg BID and zinc 220 x 14 days." Review of Resident

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#17's record revealed these recommendations were implemented on 12/14/20.

Further review of Resident #17's clinical record revealed his weight (last recorded weight) prior to the development of the pressure ulcer was on 12/4/20. Resident #17 weighed 232.0 pounds.

Review of a physician note dated 12/16/20 revealed an order for a CBC (Complete Blood Count), CMP (Complete Metabolic Panel), AC (average blood glucose) and TSH (Thyroid stimulating Hormone) for an increase in fatigue. There was no evidence that this order was followed up on prior to the resident's hospitalization on 12/17/20 at 9:45 p.m.

Further review of Resident #17's clinical record revealed that he was sent out to the hospital on 12/17/20 at 9:45 p.m. The following nursing note was documented: "R (Resident) lethargic, will not close mouth to drink water, starting off to the right. R vitals B/P (blood pressure) 88/43, P (pulse) 56, R (16), T (Temp)-97.1, 02 (Oxygen) Sats 87. R c/o (complaints), sob (short of breath), chest pain. NP (Nurse Practitioner) (Name) notified, new order to send to ER (emergency room) for eval (evaluation) and treat...Transport arrived at 2145 (9:45 p.m.) to transport resident "R"..."

Review of Resident #17's hospital discharge summary dated 12/27/20 documented in part, the following: "Per HPI (history and physical): ...The patient is not responsive, so all history was obtained from the ED report...The ED was able to get in touch with a worker at the NH (Nursing Home) who states he is normally talkative and interactive, but has not been eating, drinking or

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interacting for the last several days...Per EMS, they were told he has COVID pneumonia...In the ED he was afebrile...CXR (Chest x-ray) looks clear to my eye...On exam he does have sacral decub (decubitus) ulcers, however they do not appear to be infected at this time...Wound Buttocks...Pre-existing: Yes."

Further review of the hospital discharge summary revealed that on 12/27/20 it was documented that Resident #17's buttock wounds had "Eschar, open, red; Pink...Drainage...Small....Primary discharge diagnosis: Sepsis with acute renal failure and acute respiratory failure and acute respiratory failure with hypoxia, with septic shock due to COVID -19 infection..."

Review of Resident #17's clinical record revealed that he was admitted back to the facility on 12/28/20.

Review of Resident #17's Initial Pressure Injury Record dated 12/28/20 revealed that Resident #17 arrived back to the facility with an unstageable pressure ulcer to his sacrum. The following was documented: "Date First Observed: 12/28/20. Location: sacrum. Length in CM: 9. Width in CM 7. Depth in CM 0. Drainage: 0 Odor: none. Granulation: 0 Describe current treatment plan: alginate."

Review of Resident #17's clinical record revealed that the wound care physician had seen the wound on 1/7/21. The following was documented: "Pressure...Unstageable Necrosis...9 x 7 x not measurable...Periwound radius: Odor...Exudate: Heavy Serous...Thick adherent black tissue: 100 % (percent)."

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On 5/6/21 at 11:46 a.m., wound care observation was made with OSM #7, the wound care nurse. Resident #17's wound was now a stage 4 pressure ulcer (5) with the following measurements in centimeters: "4.4 x 4 x 1.8." The wound was documented as having "No Change" on the weekly wound summary and surgical debridement was performed at the bedside to assist with healing.

On 5/6/21 at 3:05 p.m., an interview was conducted with the Wound Care Physician, OSM (Other Staff Member) #7. OSM #7 stated she was not following Resident #17's wound until he arrived back from the hospital with an unstageable. When asked if LPNs could stage wounds, OSM #7 stated that typically the RNs (Registered Nurses) staged wounds or staff would make a description of the wound when first found and wait for her to come in to stage. When shown OSM #7 the documented paperwork on 12/17/20 from the LPN regarding Resident #17's wound; OSM #7 stated that a stage three would have depth to it and the nurse documented a zero for depth. OSM #7 also stated that the treatment ordered however was for a wound at a three or higher. OSM #7 stated that Medihoney would be used to debride sloth and the calcium alginate would be used for drainage. OSM #7 also observed that it was documented that there was no drainage to this wound on 12/17/20. OSM #7 stated that the treatment orders wouldn't make sense if the wound was less than a three and if there was no drainage.

On 5/7/21 at 9:00 a.m., an interview with conducted with LPN (Licensed Practical Nurse) #7, the nurse who first identified the wound to Resident #17's right buttock on 12/17/20. When

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asked what she saw upon the initial assessment, LPN #7 stated that she saw "A lot of necrotic tissue" upon her initial assessment. When asked if LPNs were allowed to stage wounds, LPN #7 stated that LPNs were not allowed to stage wounds, that an RN would have to go behind her and assess the wound as well. When asked why her documentation noted that a "Stage 3" pressure was first identified to Resident #17's right buttock, LPN #7 stated she is not sure why she would document that; that she was not allowed to stage wounds. When asked if there was any depth or drainage to the wound when first seen, LPN #7 stated that she could not remember; that she didn't remember measuring the wound. LPN #7 stated that all she knew is that there was "A lot of slough" observed. When asked who was responsible for applying the Zinc cream that was ordered prior to the development of the wound, LPN #7 stated that the nurses were responsible. LPN #7 confirmed that she had worked the day before 12/16/20 and signed that she had applied the zinc cream the 7-3 shift prior to 12/17/20. When asked if she noticed any skin areas then developing to Resident #17 right buttock, LPN #7 stated that she wouldn't know because there was already cream applied and rather than washing the cream off; she just applied more cream. LPN #7 stated that it wasn't until the next 7-3 shift that she saw the area right after the nursing aides had just cleaned him. LPN #7 stated that was when she realized that this was area was now a pressure area. LPN #7 stated that she made the RN wound care nurse aware but she wasn't sure if the wound care nurse was able to assess him before he left for the hospital. LPN #7 stated that she didn't put the wound care orders in, that she was limited on what she could do because she worked the

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COVID hall and didn't have access to the nursing station. LPN #7 stated that she believed she had called the family regarding the wound.

On 5/7/21 at 9:20 a.m. ASM (Administrative Staff Member) #4, the Regional Director of Clinical Services was made aware for the potential for harm.

On 5/10/21 at 11:26 a.m., an interview was conducted with RN #3, the former wound care nurse. RN #3 stated that if a new skin area is identified, the staff are supposed to alert an RN or at the time her as the wound care nurse, so she can go back behind and do an assessment. RN #3 stated that LPNs were not allowed to stage; only able to give a description of the wound.

On 5/10/21 at 3:25 p.m., further interview was conducted with RN (Registered Nurse) #3, the former wound care nurse. RN #3 stated that she didn't get the time to reassess Resident #17's wound before he was sent out to the hospital. RN #3 could not recall the specifics of when the wound was found. This writer pointed out that the wound was found on the 7-3 shift on 12/1/20 and that the resident did not go out to the hospital until 9:45 p.m. When asked the timeframe an RN should go behind the LPN to reassess the wound; RN #3 stated as soon as available.

On 5/10/21 at 6:41 p.m., an interview was conducted with the Acting DON (Director of Nursing) ASM #2. When asked if LPNs were allowed to stage wounds, ASM #2 stated that they were not. ASM #2 stated that if a CNA or LPN finds a new skin area, the area should be assessed by description and an RN and physician should be made aware to go back and assess.

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ASM #2 stated that he would then expect nursing staff to obtain orders and to continue to monitor the wound until resolved.

On 5/10/21 at 5:59 p.m., ASM (Administrator Staff Member) #1, the Interim Administrator, ASM #2, the Acting DON (Director of Nursing) and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns.

No further information was presented prior to exit.

Facility policy titled, "Skin Program" documented in part, the following: "Identify residents at risk utilizing Braden scale. Implement Plan of Care interventions for residents identified at risk for Pressure Ulcers. A Licensed Nurse will complete a total body assessment on each resident on admission and weekly. C.N.A. (Certified Nursing Assistant) will observe resident skin condition daily during care and report skin conditions to the Licensed Nurse...All open areas will be identified and document on the appropriate forms- Pressure Ulcer Record/Non-Decubitus skin Condition Record. Resident(s) with wounds will have appropriate treatment. If there is deterioration, or no change in a change in a wound within 2 weeks, the treatment will be changed. Resident(s) with a wound acquired in the facility will be assessed to determine if pressure ulcers are unavoidable...Pressure Ulcer: Stage III First line of treatment...debriding agents...Stage III (3) -IV (4) First line of treatment...Calcium Alginate...UTS (Unstageable) First line of treatment Debride agent..."

*Pressure Ulcer/Injury- A pressure injury is localized damage to the skin and underlying soft

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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 tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. https://npuap.org/page/PressureInjuryStages.

The following below information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm

(1) Unstageable Pressure Ulcer- Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed

(2) Stage 3 -Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occipital and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop

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extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

(3) Medihoney- "MEDIHONEY® Gel Wound & Burn Dressing is indicated for dry to moderately exuding wounds such as: diabetic foot ulcers, leg ulcers (venous insufficiency ulcers, arterial ulcers and leg ulcers of mixed etiology), pressure ulcers (partial- and full-thickness), first- and second-degree partial-thickness burns, donor sites...This information was obtained from https://www.woundsource.com/product/medihoney-gel-wound-burn-dressing.

(4) Calcium Alginate- "Calcium alginate is a highly absorbent, biodegradable alginate dressing derived from seaweed...more commonly thought of as the dressing that can absorb 20 times its weight in exudate, soak up loose debris from the wound bed, provide an optimal environment for healing, and provide a painless dressing change." This information was obtained from https://www.o-wm.com/content/wonder-calcium-alginate.

(5) Stage IV (4) Pressure-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occipital and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was obtained from National Pressure

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Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

3. For Resident #7, the facility staff failed to provide necessary care and services to prevent a pressure ulcer from developing at an advanced stage which constitutes harm.

Resident #7 was originally admitted to the facility 10/21/20 and has never been discharged from the facility. The current diagnoses included; glaucoma, a seizure disorder, end stage renal disease requiring dialysis, diabetes and coronary artery disease.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/28/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making was intact. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, toileting, and bathing, total care of one with off unit locomotion, extensive assistance of two people with bed mobility and dressing, extensive assistance of one person with personal hygiene and locomotion on unit, and supervision after set-up with eating. In section "M" (Skin Condition) the MDS assessment was coded No at "M1040C", other open lesion(s) on the foot (e.g., cuts, fissures). At "M1200I", the resident was coded for Application of dressings to feet (with or without topical medications).

On 5/4/21 at approximately 3:45 p.m., an interview was conducted with Resident #7. The

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resident stated he lost his left leg due to a really bad diabetic ulcer which would not heal. He motioned to his prosthetic leg in the corner and stated I haven't used it in a long time. The resident further stated he has dialysis on Tuesdays, Thursdays and Saturdays and he returns to the facility between 2:30 p.m. and 3:00 p.m. Resident #7 further stated there was a wound now on the right ankle (a bony prominence) and he was concerned because he didn't want to lose the right leg. The resident also stated he is 6' 6" tall and upon admission he was given a bed too short for his height. He stated as a result of the too short bed and him sliding down in the bed his foot rubbed against (friction) the footboard, causing the right ankle to become an open wound.

Review of clinical documentation revealed on 11/10/2020 07:32 a nurse's note stating Resident #7 has an open wound on the outer ankle. He states he got it from rubbing his foot against the bed while sleeping. Bacitracin and dry dressing applied. The physician and Power-of-Attorney (POA) will be made aware. Another nurse's note date 11/10/2020 07:42 read; The Resident and the day shift Certified Nursing Assistant (CNA) reported wound was reported to nurse a few days ago and the Resident state nobody came in to look at it.

On 5/10/21 at approximately 2:15 p.m., an interview was conducted with RN #3, who was the facility's former wound care nurse. RN #3 stated based on the nurse who wrote the nurse's note dated 11/10/20, about Resident #7's wound I will not say the information is accurate and we don't know who the Certified Nursing Assistant (CNA) was she made reference to therefore; we

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were unable to verify the information. RN #3 also stated the nurse who wrote the 11/10/20 note about the observations of Resident #7's right ankle wasn't a reliable nurse and the treatment initiated by the nurse Bacitracin (an antibiotic ointment) wasn't the appropriate treatment therefore; the treatment was changed to Metrogel® (an anti-inflammatory as well as anti-infective used to reduce unpleasant odor from an infected wound) and Silver Alginate (silver incorporated into wound dressings for treatment of infected wound or a wound at risk for infection). RN #3 also stated they believe the right ankle wound etiology was friction caused by a too short bed therefore; and extender was added to the resident's bed. RN #3 stated the right ankle wound was classified as "Infection".

The weekly Skin Integrity Check, assessment dated 10/26/20 revealed, skin clear, no change of condition assessed.

The weekly Skin Integrity Check, assessment dated 10/29/20 revealed a Wound/Skin condition was present but there were no new change of condition and documentation already established on all existing Wound/Skin Conditions. (There was no evidence in the clinical record on or before 10/29/20, the resident had wound/skin conditions except a healed abrasion/scar tissue to the left gluteus)

The 11/5/20 Weekly Skin Integrity Check, assessment wasn't available.

The weekly Skin Integrity Check, assessment dated 11/12/20 revealed a Wound/Skin condition was present but there were no new change of condition and documentation already established

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on all existing Wound/Skin Conditions.

Review of the clinical record revealed on 11/17/20, Resident #7's right ankle wound was assessed for the first time by a wound care physician. The chief complaint was a wound on his right, lateral ankle with moderate serous exudate. The wound's documented etiology was infection. The wound measured 1.6 x 1.2 x 0.6 centimeters, surface area 1.92 cm², 10% thick adherent devitalized necrotic tissue, 10% slough, 20% granulation tissue and 60% other viable tissues. Surgical excision debridement to remove necrotic tissue and establish the margins of viable tissue was performed during the visit. The wound care physician's order documented 11/17/20 was for Metronidazole gel apply once daily for 30 days; Alginate calcium with silver apply once daily for 30 days followed by a Gauze island with border, apply once daily for 30 days. The following was the wound care physician's goal for this wound; is healing as evidenced by a decrease in surface area of the wound and/or a decrease in the percentage of necrotic tissue. The wound care physician's documentation on 11/17/20, recommendations were off-load wound; reposition per facility's protocol; turn side to side and front to back in bed every 1-2 hours if able; Antibiotic choice; Doxycycline 100 milligrams (mg) by mouth two times each day for 14 days. The wound care physician also documented the following; per report area started as friction. Area was examined with the Assistant Director of Nursing (ADON) and the Wound Care Nurse (WCN).

The Doxycycline 100 milligrams recommendation was dated 11/17/20 but the medication wasn't ordered and started until 11/19/20.

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The right ankle Non-Decubitus Skin Injury (NDSIR), type of skin condition was referred to by the facility's staff as "Infection".

The Initial Non-Decubitus Skin Injury Record (NDSIR) dated 11/10/20 revealed a right outer ankle pink opened wound measuring 3x3x0 centimeters (cm) and without odor or drainage.

The 11/17/20, NDSIR revealed the resident was with a pink right ankle "Infection" and it continued to measure 3x3x0 cm, and was without odor or drainage, the progress was improved.

The 11/24/20, NDSIR revealed the right ankle "Infection" measured 3 x 3, was pink in color and without odor or drainage, the progress was improved.

The 12/1/20, NDSIR revealed the right ankle "Infection" measured 3 x 3 cm had no color, odor or drainage, the progress was no changes.

The 12/8/20, NDSIR revealed the right ankle "Infection" measured 3 x 3 cm was pink in color, odor or drainage, the progress was no changes.

The 12/15/20, NDSIR revealed the right ankle "Infection" measured 3 x 3 cm had no color, was without odor or drainage, the progress was improved.

The 12/22/20, NDSIR revealed the right ankle "Infection" measured 3 x 3 cm, had no color, and no odor or drainage, the progress was no change.

The 12/29/20, NDSIR revealed the right ankle

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"Infection" measurements remained 3x3x0 cm, without color, odor or drainage, the progress was deteriorated.

The 1/7/21, NDSIR revealed the right ankle "Infection" measurements remained 3x3x0 cm, without odor or drainage but the progress was no change.

The 1/15/21, NDSIR revealed the right ankle "Infection" measurements remained 3x3x0 cm, without odor or drainage but the progress was deteriorated.

The 1/22/21, NDSIR revealed the right ankle "Infection" NDSIR revealed the right ankle "Infection" was red, with slough, measured 6.5 x 4.5 x 0.4 cm, was without odor or drainage and the progress was deteriorated. (This is information based on the wound physician's 1/20/21 assessment. Prior to this assessment the wound had consistently measured 3x3x0)

The facility's wound tracking system "NDSIR" remained the same until the return of the wound care physician. When the progress was documented as deterioration 12/29/21 and 1/15/21. The treatment remained the same.

From 11/23/20 until 1/6/20. Resident #7 received no Wound care physician visits. The record contained a note dated 11/23/20 which stated; the resident's visit has been rescheduled secondary to COVID-19 restrictions. Available for telemedicine for facility as possible. On 1/7/21 and 1/14/21, the resident's record had the following note; the resident's visit has been rescheduled. The Resident is at dialysis.

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Wound care wasn't signed off as completed on the TAR for; 11/12/20, 12/2/20, 12/9/20, 12/12/20, 12/13/20, 12/14/20, 12/15/20, 12/20/20, 12/23/20, 12/28/20, 1/3/21, 1/15/21, and 1/20/21.

The 1/20/21, wound physician's summary revealed the chief complaint was a wound on the right lateral ankle. The etiology was infection. It measured 6.5 x 4.5 x 0.4 cm, surface area 29.25 cm², 10% thick adherent devitalized necrotic tissue, 10% slough, 20% granulation tissue and 60% other viable tissues. The wound had deteriorated.
The wound care physician changed the treatment plan to the following; Discontinue Metronidazole Gel and Alginate Calcium with silver. Add Santyl (a medicine that removes dead tissue from wounds), apply once daily for 30 days; Alginate calcium apply once daily for 30 days followed by a Gauze island with border, apply once daily for 30 days

Review of the Medication Administration Record (MAR) revealed the Metronidazole Gel 1%/ Metrogel® wasn't discontinued until 2/14/21.

The 2/24/21, wound physician's summary revealed the chief complaint was a wound on the right lateral ankle. The etiology was infection. It measured 6 x 6 x 0.4 cm, surface area 36.00 cm², 10% thick adherent devitalized necrotic tissue, 10% slough, 20% granulation tissue, 60% other viable tissues and heavy serous drainage. The wound deteriorated.
The wound care physician continued the treatment plan of; Santyl, apply once daily for 23 days; Alginate calcium apply once daily for 23 days followed by a Gauze island with border,

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apply once daily for 23 days and added Metrogel® once daily for 30 days.

The resident refused wound debridement. The resident was made aware of risks of not removing necrosis including infection; sepsis; limb loss or death. (The resident stated debridement was refused because he lost the left leg as a result of the doctors cutting on it.)

Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) revealed the Metronidazole Gel 1%/ Metrogel® wasn't started on 2/24/21. The MAR also revealed on 3/1/21, the resident started Doxycycline 100 mg by mouth two times each day for 10 days, for a wound infection.

The wound physician's summary dated 3/3/21 revealed the wound on the right lateral ankle wound's etiology was infection. It measured 6 x 5.5 x 0.3 cm, surface area 33.00 cm², 10% thick adherent devitalized necrotic tissue, 10% slough, 20% granulation tissue, 60% other viable tissues and moderate serous drainage. The wound improved. (The wound improved this week though the resident didn't allow wound debridement the prior week)
The wound care physician continued the treatment plan of; apply Santyl, once daily for 16 days; Alginate calcium apply once daily for 16 days followed by a Gauze island with border, apply once daily for 16 days and Metrogel® once daily for 23 days.

Goal of treatment is healing evidenced by an 8.3% decrease in surface area within the wound bed.

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On 3/4/21, the following order was instituted; Cleanse right outer ankle with wound cleanser and apply Metrogel and Alginate and wrap with kerlix every night shift. It wasn't signed off as completed 3/4/21, 3/5/21, 3/7/21, 3/9/21, and 3/11/21. The order was discontinued 3/12/21.

The 3/10/21, wound physician's summary revealed the chief complaint was a wound on the right lateral ankle. The etiology was infection. It measured 6 x 5.5 x 0.3 cm, surface area 33.00 cm², 10% thick adherent devitalized necrotic tissue, 10% slough, 20% granulation tissue, 60% other viable tissues and moderate serous drainage. The wound showed no change.
The wound care physician continued the treatment plan of; Santyl apply once daily for 30 days; Alginate calcium apply once daily for 9 days followed by a Gauze island with border, apply once daily for 9 days.

The 4/14/21, wound physician's visit was rescheduled because the resident was at an appointment.

The 4/21/21, wound physician's summary revealed the chief complaint was a wound on the right lateral ankle. The etiology was infection. It measured 6 x 5 x 0.2 cm, surface area 30.00 cm², 10% thick adherent devitalized necrotic tissue, 5% slough, 25% granulation tissue, 60% other viable tissues and moderate serous drainage. The wound deteriorated.
The previous wound care treatment was discontinued. The wound care physician's treatment plan PICO (single use Negative Pressure Wound Therapy System), Once Weekly for 7 days.
Applied negative pressure wound therapy on this

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wound during this visit with the expectation of this treatment being in place for one week at which time it will be re-evaluated.

Wound care wasn't signed off as completed on the TAR for; 1/26/21, 2/3/21, 2/9/21, 2/10/21, 2/11/21, 2/12/21, 2/20/21, 2/23/21, 2/25/21, 2/26/21, 2/27/21, 5/6/21, 5/8/21, 5/9/21 and 5/10/21.

An interview was conducted with the current wound care physician on 5/6/21 at approximately 12:15 p.m., that the wound was assumed from a colleague and the colleague stated the wounds etiology was infection therefore she continued to treat it as such. The wound care physician stated had the facility's staff told her the resident was rubbing and pressing against the bed when the wound was identified, the etiology would have been changed to "pressure". The wound care physician stated Resident #7 had diagnoses of diabetes and peripheral vascular disease as well but the wound was not caused by either but the diseases have contributed to slow healing of the wound and currently the wound is improving well with the consistent oversight and use of the negative pressure wound therapy. The wound care physician also stated the periods of deterioration in the wound were related to lack of a physician's oversight during periods she wasn't making visits to the facility but tele-health services were available.

On 5/5/21, at approximately 1:45 p.m., a wound care observation was made of Resident #7's right ankle wound. Licensed Practical Nurse (LPN) #7 cleaned the bedside table, applied a barrier, and assembled needed supplies. LPN #7 and LPN #1 positioned the resident to expose the right

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ankle wound. LPN #7 removed the negative pressure wound vacuum system, cleaned the wound with saline soaked gauze, skin prepped the outer edges of the wound, applied a wet to dry dressing and a border dressing. LPN #1 stated the above treatment was ordered until the negative pressure system became available. The right lateral ankle wound wasn't measured but the wound bed presented with light red tissue with a moderate amount of serous drainage. The resident didn't indicate the wound was painful.

Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are contributors to pressure ulcer/injury development. The underlying health of a resident's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries. (MDS 3.0 Resident Assessment Instrument user's manual, Chapter 3 page M-1, October 2019).

Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; microclimate, malnutrition, and hydration deficits; and a healed ulcer. (MDS 3.0 Resident Assessment Instrument user's manual, Chapter 3 page M-2, October 2019).

Resident #7 has the following risk factors;

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end-stage renal disease, diabetes; coronary artery disease, exposure of skin to urinary and fecal incontinence and impaired bed mobility.

The resident's BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK dated 10/21/2020, score was 16.0, this categorized the resident at a low risk, 10/28/2020, score was 17.0, this categorized the resident at a low risk, and the 11/4/2020, score was 17.0, which this categorized the resident at a low risk.

Resident #7's current care plan dated 4/26/2021, had a problem which read; altered skin integrity non pressure related to: infected wound on the right ankle. The goal read; Affected area will heal without complications by next review 8/21/21. The interventions included; Treatments as ordered, Turning and repositioning schedule per assessment, Weekly Wound assessment and Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings.

Another current care plan dated 4/26/2021, had a problem which read; resident is at risk for pressure ulcers due to impaired mobility and co-morbidity diagnoses of ASHD, HRN, ESRD, and Diabetes. The goal read; resident's risk for pressure ulcers will be minimized through next review, 8/7/21. The interventions included; Assist resident with turning and repositioning in bed at least every 2 hours, Provide pressure reduction/relieving mattress and Provide thorough skin care after incontinent episodes and apply barrier cream.

On 5/10/21 at approximately 7:00 p.m., the above findings were shared with the Administrator,

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Director of Nursing and Corporate Director of Clinical Services. An opportunity was afforded for the facility to provide additional documentation but they did not.

4. For Resident #19, the facility staff failed to complete initial and weekly assessments on acquired pressure injuries (Stage 1 & 2).

Resident #19 was admitted to the facility on 1/22/19 with diagnoses that included but were not limited to muscle weakness, anxiety disorder, depression, low back pain, COVID-19, vitamin D deficiency. Resident #19's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (Assessment reference date) of 1/8/21. Resident #19 was coded as being severely impaired in cognitive function scoring a 5 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of a nursing note dated 1/5/21 documented the following: "Note Text: Writer summoned to residence (sic) room to evaluate an area noted to the R (right) buttocks. Area is redden and open and appears to be a stage two (1) wound. No c/o (complaints) pain from the resident. Supervisor. MD (Medical Doctor), RP (Responsible Party) notified. Received new treatment order.

Further review of the POS (Physician Order Summary) revealed a treatment order dated 1/2/21 not 1/5/21 for Resident #19's right hip and right buttock. The following was documented: "Cleanse right hip and buttocks with wound

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cleanser apply sulfadiazine and zinc to redden area of right hip, and right buttocks" This order was discontinued on 2/2/21.

Review of an initial pressure ulcer report dated 1/2/21 revealed that Resident #19 had developed a stage one (2) to her right hip on 1/2/21. There were no concerns related to this wound.

Further review of Resident #19's clinical record revealed no evidence of an initial wound assessment for the possible stage two pressure ulcer or any other assessments thereafter. There was no evidence documenting that the pressure area to the right buttock was resolved.

On 5/10/21 at 11:26 a.m. an interview was conducted with RN #3, the former wound care nurse. RN #3 stated that if a new skin area is identified, the staff are supposed to alert an RN or at the time her as the wound care nurse, so she can go back behind and do an assessment. RN #3 stated that LPNs were not allowed to stage; only able to give a description of the wound. RN #3 stated that she was the wound care nurse at the time of 1/5/21 and that staff were supposed to notify her so she could do an assessment to determine if it was a true pressure area. RN #3 stated that she would have to go back and look into Resident #19's record to track Resident #19's stage two. RN #3 stated that she knew at one point Resident #19 had some excoriation. RN #3 stated that she would also expect to find an initial wound assessment and then weekly until resolved.

On 5/10/21 at 1:03 p.m., further interview was conducted with RN #3. RN #3 confirmed that she could not find any further evidence of an initial

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wound assessment for the possible stage two or any other documentation regarding the new skin area.

On 5/10/21 at 3:30 p.m., observation of Resident #19's right buttock was conducted with RN (Registered Nurse) #3, the former wound care nurse. There were no additional skin areas or concerns.

On 5/10/21 at 6:41 p.m., an interview was conducted with the Acting DON (Director of Nursing) ASM #2. When asked if LPNs were allowed to stage wounds, ASM #2 stated that they were not. ASM #2 stated that if a CNA or LPN finds a new skin area, the area should be assessed by description and an RN and physician should be made aware to go back and assess. ASM #2 stated that he would then expect nursing staff to obtain orders and to continue to monitor the wound until resolved.

On 5/10/21 at 5:59 p.m., ASM (Administrator Staff Member) #1, the Interim Administrator, ASM #2, the Acting DON (Director of Nursing) and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns.

No further information was presented prior to exit.

Facility policy titled, "Skin Program" documented in part, the following: "Identify residents at risk utilizing Braden scale. Implement Plan of Care interventions for residents identified at risk for Pressure Ulcers. A Licensed Nurse will complete a total body assessment on each resident on admission and weekly. C.N.A. (Certified Nursing Assistant) will observe resident skin condition

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daily during care and report skin conditions to the Licensed Nurse...All open areas will be identified and document on the appropriate forms- Pressure Ulcer Record/Non-Decubitus skin Condition Record. Resident(s) with wounds will have appropriate treatment. If there is deterioration, or no change in a change in a wound within 2 weeks, the treatment will be changed. Resident(s) with a wound acquired in the facility will be assessed to determine if pressure ulcers are unavoidable...All skin conditions will be assessed weekly with documentation of: Date, Stage, and Length x Width x Depth, Drainage, Odor, Progress/Remarks, Current treatment plan. Weekly skin meeting will be held. Weekly wound meeting will be held and during meeting a QAPI wound meeting from will be filled out..."

The National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm defines the following:

(1) Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* this stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. *Bruising indicates suspected deep tissue injury

(2) Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Further description: The area

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may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

5. For Resident #346, the facility staff failed to provide pressure ulcer care as ordered by the physician.

Resident #346 was admitted to the facility on 05/03/21. Diagnosis for Resident #346 included but are not limited to Stage IV sacral pressure ulcer. The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #346's Admission Assessment dated 05/03/21 documented the residents was independent in decisions regarding task of daily life, indicating no cognitive impairment.

In addition, during the review of Resident #346's Admission Assessment dated 05/03/21 documented the following under skin: sacral pressure ulcer measuring 11.5 cm x 8 cm x 3 cm (stage IV pressure ulcer.)

Resident #346's record did not reveal a 48 hour baseline care or an interim care plan.

A phone interview was conducted with Resident #346 on 05/05/21 at approximately 9:25 a.m., who stated, "The nurse did not do my treatment to sacrum (butt area) yesterday; 05/04/21.

Review of Resident #346's Treatment Administration Record (TAR) for May 2021 revealed the following treatment order:
Sacral ulcer: Santyl ointment - apply to sacrum

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topically every day shift - cleanse sacral wound with Dakin's, apply Santyl to moist Dakin's roll gauze, pack and apply ABD pad and secure with tape.

Further review of the May 2021's (TAR) was not initialed and documented that Resident #346's sacral wound treatment as being completed on 05/04/21 (day or evening shift.) Review of the nurses notes did not indicated the reason why Resident #346's sacral ulcer treatment was not done.

A phone interview was conducted with the Director of Nursing (DON) on 05/05/21 at approximately 11:09 a.m. If the resident stated the nurse did not do his treatment and the nurse did not signed off as treatment being completed or a clinical note saying why the treatments was not done; then I have to believe his treatment was not done. The DON provided the phone number for License Practical Nurse (LPN) #1, who was assigned to Resident #346 on 05/04/21 (7a-7p shift.) On the same day at approximately 12:03 p.m. a phone call was placed to LPN #1, unable to leave a message, (this number is no longer is service or temporally unavailable.)

On 05/05/21 the following sacral order was written: Clean sacrum wound with wound cleanser and apply medihoney to sacral wound then apply ABD pad and secure with tape every shift for wound care until Santyl is available.

On 05/06/21 at approximately 7:50 p.m., surveyor #2 observed wound care with License Practical Nurse (LPN) #13. An excessive amount of drainage was observed through the existing dressing. Once removed, the sacral area and

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bilateral buttocks fell open to be a large surface area with necrosis and slough, as well as brown drainage. This area was cleansed with normal saline and medihoney, but the LPN stated she did not have near enough medihoney due to the size of the pressure ulcer cavity. She covered the wound with large ABD pads and secured it with paper tape.

A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit.

Definitions:
Pressure Injury - Stage 4 (Full-thickness skin and tissue loss)
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. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages.)

Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.)

Dakin's solution is a type of hypochlorite solution.

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F 686	Continued From page 130 It is made from bleach that has been diluted and treated to decrease irritation. Chlorine, the active ingredient in Dakin's solution, is a strong antiseptic that kills most forms of bacteria and viruses (http://www.webmd.com/drugs/2/drug-62261/dakin's-misc/details.)	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interviews, the facility staff failed to follow physician orders to provide foot care for 1 of 34 residents (R#147) in the survey sample. The findings included: Resident #147 was admitted on 4/30/21 with diagnoses that included type 2 diabetes mellitus, chronic diabetic wounds of right and left foot with status post bilateral transmetatarsal amputations and skin graft infections, end stage renal disease with dependence on hemodialysis.	F 687	Resident #147 no longer at facility. Current residents with physician orders for foot care will be reviewed to assure physician orders are being followed by allegation of compliance date. Licensed nurses will be rein-serviced regarding providing foot care as per physician orders by the DON/designee by allegation of compliance date. The DON/designee will monitor residents with physician orders for foot care by	6/14/21

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F 687	Continued From page 131 The 5-day Minimum Data Set (MDS) assessment was dated 4/30/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident had the necessary cognitive skills for daily decision making. Resident #147 had no problems understanding the staff and was understood. Resident #147 was assessed without mood or behavioral problems. Resident #147 required extensive assistance from 2 staff for bed mobility and toilet use. Resident #147 was not assessed to be able to ambulate (walk in and out of room). Resident #147 had bilateral lower extremity impairment in range of motion. The wheelchair was Resident #147's primary mode of transportation. Resident #147 was coded with surgical wounds and infection of feet. The assessment was signed by the MDS Coordinator as completed on 5/10/21. There was no care plan to include a baseline 48-hour care plan or interim care plan available to this surveyor during the time of the survey. The following observations were made of Resident #147's foot: On 5/4/21 at 1:05 p.m., Resident #147 was observed sitting on the side of the bed. The left and right foot dressing exhibited serous bloody drainage which was also visible on the floor where the resident placed his feet. The Kling wrap on the left foot was unraveled and intertwined itself around the wheels of his over bed table. Resident #147 stated that his dressing had been in that condition all night and he had been asking someone to change his dressings. The foot of his bed exhibited the same drainage	F 687	observation to assure foot care is being provided as ordered weekly for 4 weeks. Any variances will be corrected. The results will be reported to QAPI committee for the need of continued review.	

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F 687	Continued From page 132 on his sheets at the foot of the bed. On 5/6/21 at 12:42 p.m., the Wound Care Physician (WCP), accompanied by a first day agency LPN (#2). When the WCP cut the soiled outer Kling wrap off of Resident #147's foot, the taped portion revealed a date of 5/4/21 which indicated the the facility staff failed to perform the resident's wound care once a day and as needed per physician's order dated 5/3/21. The wound exhibited a foul odor with heavy serous exudate. On 5/6/21 at approximately 2:00 p.m., the Administrator was informed of the facility's failure to follow physician orders for Resident #147's foot care. On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. The DON stated and the Administrator concurred that it was an expectation that treatments are to be performed as ordered by the physician.	F 687		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		6/14/21

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F 690	Continued From page 133 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on a resident interview and staff interviews the facility staff failed to ensure 1 of 34 residents in the survey sample received appropriate sized incontinent products for 3 days, Resident #5. The findings included: Resident #5 was admitted to the facility on 2/28/19 with diagnoses to included but not limited to Major Depressive Disorder, Dementia, Anxiety Disorder and Hypertension. The most recent Minimum Data Set (MDS) was	F 690	1. Resident #5 has appropriate fitting incontinent products. 2. Audit of current residents that wear incontinent products completed to ensure appropriate fit. 3. Licensed staff will be re-educated on how to appropriately measure residents for incontinent products. 4. Random audits of residents with incontinent products will be conducted by DON/Designee to ensure appropriate fit weekly for four weeks then monthly for three months. Results of audits will be reviewed at the monthly QAPI meeting for	

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F 690	Continued From page 134 an Annual with an Assessment Reference Date (ARD) of 2/10/21. The Brief Interview for Mental Status (BIMS) for Resident #5 was coded as a 15 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making. Under Section H Bladder and Bowel H0300 Urinary Continence and H0400 Bowel Incontinence Resident #5 was coded as a 2 Frequently Incontinent. Resident #5's current comprehensive care plan was reviewed and is documented in part, as follows: Focus: Name (Resident #5) has an alteration in elimination of bladder related to urinary urgency due to use of Diuretic as evidenced by urinary incontinence-at risk for skin breakdown. 2/18/2021 Interventions: Check resident frequently for incontinence and assist with incontinence care as needed. 11/23/2020 On 5/4/21 at 2:00 P.M. during an onsite interview about resident supplies Resident 5# stated, "They are always running short on pull ups. Name (Central Supply Staff Member) does her best but supplies never get here on time. One time I had to wear the wrong size briefs for 3 days." On 5/5/21 at 1:29 P.M. a phone interview was conducted with the Central Supply Staff Member regarding Resident #5's claim that she had to wear the wrong size pull up for 3 days. Central Supply Staff Member stated, "There was an issue, we had a bad storm a few months ago I	F 690	three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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F 690	Continued From page 135 think in early February and the trucks were late. Name (Resident #5) wears 2 extra large pull ups and during that time she had to wear a men's extra large for about 2 to 3 days. The aids let me know she was running low on the briefs and I let them know her right size had come in and they could give her the right size now." On 5/10/21 at 12:15 P.M. a pre-exit debriefing via phone was conducted with the Interim Administrator, the Acting Director of Nursing and the Regional Director of Clinical Services where the above information was shared. The Interim Administrator was asked what would have been the expectation for ensuring that Resident #5 had appropriate incontinent supplies. The Acting Director of Nursing stated, "If we did not have her size we would need to go to Walmart or somewhere else to get what would fit her." The Interim Administrator was asked if there was a facility policy for maintaining resident supplies and he stated, "No, we do not have a policy." Prior to exit no further information was shared.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation, the facility staff failed to ensure 1 of 6 residents (Resident #346) in the	F 698	1. Resident #346 has dialysis orders and care plan. 2. Audit of current residents on dialysis	6/14/21

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F 698	Continued From page 136 survey sample had dialysis orders. The findings included: The facility staff failed to ensure dialysis order were obtained for Resident #346. Resident #346 was admitted to the facility on 05/03/21. Diagnosis for Resident #346 included but are not limited to Acute Kidney Failure (on dialysis). The resident's Minimum Data Set (MDS) assessment was not due. Review of Resident #346's Admission Assessment dated 05/03/21 documented the residents was independent in decisions regarding task of daily life, indicating no cognitive impairment. In addition, the Admission Assessment under special treatment was coded for dialysis. The facility did not provide a dialysis care plan. Review of Physician Progress note dated 05/06/21 read in part: Resident #346 has a right IJ temporal dialysis catheter placement as his renal function worsened and he was started on hemodialysis. Review of Resident #346's Physician Order Summary (POS) for May 2021 did not include orders for Dialysis. On 05/05/21 at approximately 10:45 a.m., a phone interview was conducted with License Practical Nurse (LPN) #7. LPN #7 was asked to review Resident #346's current dialysis orders. After LPN #7 reviewed Resident #346's orders, she replied, "I'm not able to locate dialysis orders for Resident #346." She said, I have never been assigned to Resident #346 as his nurse but there	F 698	completed to ensure orders and care plan completed. 3. Licensed nurses will be re-educated on correctly inputting physician orders and initiating care plans, MDS Coordinator will be rein-serviced on updating care plan. 4. Audit of dialysis residents will be conducted by DON/Designee to ensure orders and care plan are in appropriately weekly for four weeks then monthly for three months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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F 698	Continued From page 137 should be orders for dialysis to include his days to attend dialysis and to monitor his dialysis site every shift for s/s of infection. A phone interview was conducted with the Director of Nursing (DON) on 05/05/21 at approximately 1:26 p.m. The DON said Resident #346 should have had dialysis orders on the day of his admission (05/03/21) to include the following: location of the dialysis site, day(s) the resident is to attend dialysis, chair time, and to assess the dialysis site every shift. During the clinical record review for Resident #346, revealed the following order dated 05/05/21 at 3:38 p.m.: Dialysis on Tuesday, Thursday and Saturday; transport (name of company) to pick up at 10:30 a.m., with a chair time of 11:30 a.m. A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit.	F 698		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		6/14/21

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F 727	Continued From page 138 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The findings included: A review of the facility as-worked staffing documentation during a 30-day lookback revealed that there were no RN coverage within a 24-hour period on the following days in April 2021: 04/11/21, 04/24/21 and 04/25/21. On 05/10/21 at approximately 4:10 p.m., a phone interview was conducted with the Administrator and Director of Nursing (DON.) When asked about the facility not having 8 hours of RN coverage on 04/11/21, 04/24/21 and 04/25/21, they replied, "We are not able to provide evidence that there was RN coverage on the days mentioned." A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit.	F 727	1. There is RN coverage 7 days a week for 8 hours per day. 2. The Director of Nursing/Designee will complete a daily review to ensure appropriate RN coverage. 3. Re-education of appropriate staff to contact the DNS when an RN calls in. The staffing coordinator will be in-serviced to ensure an RN is scheduled 7 days a week for 8 hours per day. 4. Audits will be submitted at the QAPI meeting weekly for four weeks then monthly for three months to ensure compliance. 5. Compliance Date: 6/14/2021	
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure	F 741		6/14/21

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F 741	Continued From page 139 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 §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interviews and facility documentation, the facility staff failed to assure the 5 agencies were sufficiently oriented to the facility's operational systems necessary to provide care and services. The findings include: The following examples demonstrated the agency staff's expression of the lack of orientation to the facility which directly affected the care and services rendered to the residents:	F 741	1. The 5 agency staff were oriented to the facilities operational systems. 2. Audit of current agency staff utilized in the facility to ensure oriented to facilities operational systems. 3. Current agency company□s utilized will be re-educated on orientation process for agency nurses and CNA□s to complete to include agency orientation binder. 4. Audit of agency staff will be conducted by DON/Designee to ensure orientation was completed weekly for four weeks then monthly for three months. Results of	

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F 741	Continued From page 140 1. On 5/4/21 at 11:00 a.m., during the orientation tour, through 5/6/21 at 2:00 p.m., the biohazard receptacles were overflowing with trash and soiled linen in the resident's bathroom in room 204 and 207 on the quarantine unit. These rooms also had a foul odor upon entry. On 5/4/21 at 1:05 p.m., a foul order was apparent upon entering Resident #147's room, who resided on the quarantine unit, and it was discovered the biohazard (red bags) trash and linen receptacles in the bathroom were full, overflowing and soiled items of trash and linen piled on top of the receptacles. This also remained until inquiry by Surveyor #2 on 5/6/21. On 5/6/21 at approximately 2:00 p.m., the Administrator donned full PPE and was shown the condition of the resident's rooms and the overflowing trash and soiled linen in the biohazard receptacles in the resident's bathroom, as well as blood, trash, feces and other debris identified on the floor. The Administrator requested the housekeeper to assist to empty the biohazard receptacles and clean the room. The Housekeeping Director stated it was the responsibility of the nursing staff to empty the biohazard bags in the biohazard containers in the dirty utility room, but that they were able to retrieve those bags from her department. On 5/6/21 at approximately 2:10 p.m., Certified Nursing Assistant (CNA #6), who was one of the CNA's assigned to the quarantine unit, said she was new and had not been oriented to the quarantine unit that used the red bags, but stated housekeeping emptied all trash that included the "red bags."	F 741	audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance date: 06/14/2021	

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F 741	Continued From page 141	F 741		

2. On 5/4/21 at 2:10 p.m., the assigned Certified Nursing Assistant (CNA) # 6 was outside Resident #147's room, donning her Personal Protective Equipment (PPE). The CNA entered the room, proceeded to pick up the resident's tray when it was asked if she get get the resident another meal. She said, "It is late and I don't think I can get a meal now. I am not sure how that works in this building." The resident told her he had to eat something. She stated she would try but could not promise he would get a meal. CNA also stated that she did not see the call light over and it was difficult to view through the plastic partition. She also stated the call light did not light up and she did not think it sounded at the nurse's station. She added that she was relatively new to the facility and had not been oriented to the resident's on the quarantine unit.

3. On 5/5/21 at 9:30 a.m., Resident #147 arrived from dialysis. LPN #1 hung the resident's IV antibiotic at around 10:00 a.m. She stated, "I am agency staff and yesterday was my first day. I did not know anything about this building or the residents and I got behind in passing my medications. That's why his 9:00 a.m. IV antibiotic was hung at 1:00 p.m. I was not sure if he was getting this antibiotic through a midline or a central line because it was in his neck and I wanted to flush it correctly."

4. On 5/6/21 at 7:50 p.m., LPN #13 and #14 proceeded to perform wound care for Resident #346. They both stated it was their first time in the building and had no idea where supplies were located for the wound care. Both nurse's scrambled in and out of the medication room searching for wound care supplies. They told this

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F 741	Continued From page 142 surveyor (#2) there were 12 hours in their shift and it would take them all of 12 hours to learn what to do. They stated that, "Practically all of us and agency staff and maybe there is one here that is regular staff." When asked if they received any information from the facility through their respective agency about the facility or where to access information about resident care or procedures, she stated, "Only the nurse's report from the previous shift, but I feel stressed. They called us and said they needed nurse's and that was it. So, here we are!" On 5/10/21 at 8:00 p.m., the Administrator was asked if there was any form of orientation for the agency staff, as well as how many nursing agencies they used. He presented an email that indicated they used licensed and certified staff from 5 separate agencies. He stated he just found out there was an orientation binder at the nurse's station. This binder was retrieved from a mix of multiple binders and reviewed by this surveyor (#2). In the front of the binder, it indicated that if it was the nurse's first time in the facility, they were to come in 30 minutes early to read the binder and sign the agency attestation sheet. The Administrator stated that the binder was the extent of agency orientation and information was not forwarded to the agencies. He was shown that only one CNA signed the attestation sheet on 5/9/21. There was no additional signed sheets provided prior to survey's remote exit on 5/11/21. No additional information was provided prior to survey exit.	F 741		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		6/14/21

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F 755	Continued From page 143 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and review of facility documentation, the facility staff failed to ensure the system and disposition of all controlled drugs was in place and implemented to enable accurate	F 755	1. Resident #146 no longer resides at the facility and the morphine has been destroyed per policy and Resident #20 Rosuvastain, Decadron, Hydroxyzine and Metoprolol Succinate ER are available	

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F 755	Continued From page 144 reconciliation for 1 out of 34 residents (#146), as well as during the facility's physical inventory of their stored controlled medications at each shift change AND The facility staff failed to provide routine pharmacy services for Resident #20. The findings included: 1. Resident #146 was admitted on 4/30/21 to receive respite/palliative care. He was discharged home on 5/5/21. There was no completed Minimum Data Set (MDS) assessment due to the resident's short-stay. The History and Physical (H&P) dated 5/3/21 indicated that the resident was in the facility under the care of hospice for respite. He was alert and responsive. No Intravenous fluids to be given or laboratory specimens obtained. Resident #146 was ordered Morphine Sulfate 20 mg/ml, give 0.5 ml by mouth every 4 hours as needed for pain or shortness of breath. On 5/4/21 at 7:00 p.m. narcotic counts were observed by this surveyor (#2) for the facility's 2 medication carts, 100 and 200/300. Morphine Sulfate 20 milligrams (mg)/1 milliliters (mg) 18 ml was found in a bag with several of Resident #146's personal non-narcotic medications. The bag was in the bottom drawer of the medication cart 200/300. Licensed practical Nurse (LPN #4) said she knew it was there, but there should have been a "Controlled Record" narcotic flow sheet for the resident's narcotic medication and counted along with the other narcotics.	F 755	and are being administered per physician order. 2. An audit of controlled substances to ensure the system and disposition of controls and reconciliation is in place and implemented; Current residents will be reviewed to assure routine pharmacy services are provided to ensure medications are available and administered per physician's orders. 3. Licensed nursing staff will be re-inserviced on the controlled substance policy and ensure pharmacy services are being provided and are available and administered per physician's order. 4. Audits of residents on controlled substances and residents that have medication orders will be conducted by DON/Designee weekly for four weeks then monthly for three months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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On 5/5/21 at 10:00 a.m., this surveyor (#2) requested to review 6 months of narcotic count sheets. After review of the sheets, it was discovered too numerous to count, missing licensed nurse co-signatures and some shifts with no signatures.

On 5/6/21 at 10:30 a.m., the Director of Nursing (DON) said per their policy and the standard of practice, it was expected that licensed nurses co-sign with two signatures, oncoming and off going to ensure the counts were accurate for the resident's narcotics and medications that had the potential for abuse. He stated Resident #146's narcotic medication brought from home should have been locked in the narcotic box with a slip and counted along with the other narcotics until picked up by the family or in the aforementioned case, picked up by hospice. The amount of Morphine Sulfate was as observed on 5/4/21, 18 ml remained. This resident was discharged home on 5/5/21.

On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. There aforementioned issues were re-reviewed and the DON and Administrator reiterated their expectations of the licensed nurses. There was no further documents or added information presented prior to survey's remote exit on 5/11/21.

The facility's policy and procedures titled "Controlled Substances" dated 2007 indicated controlled medication accountability records (Resident Controlled Narcotic Sheet) and audit records are kept by the nursing center. When completed these audit and accountability records

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are kept on file according to state and federal regulations. At each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record.

COMPLAINT DEFICIENCY

2. Resident #20 was admitted to the facility on 08/10/16 with diagnoses which included atherosclerotic heart disease, angina, hypertension, hyperlipidemia, reflux, Hospice, vascular dementia and anxiety. The facility staff failed to provide physician ordered medications for Resident #20.

Resident #20 had a Quarterly Minimum Data Set (MDS) dated 03/21/21. Resident #20 was noted to be cognitively impaired as documented on the MDS.

A Care Plan dated 12/28/20 indicated the following: Focus- Resident #20 is at risk for imbalanced nutrition due to Dementia, hypertention, hyperlipidemia, TIA, Cerebral Infarction, insomnia, and history of vitamin deficiency. Goals-Maintain nutritional status and body weight through next review. Interventions- Medication as ordered.

Focus- Sometimes I have behaviors which include confusion. She lost her dentures twice, and these were found by staff. She was complaining of chest pain, vital signs stable. later states she is fine. She occasionally refuses to

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shower, she doesn't want to mess her hair up. Resident can't make up her mind whether she likes eggs or not. Resident was hitting / kicking at care giver. Goal- I will calm down with staff intervention when behaviors occur through next review date. Interventions- Make sure I am not in pain or uncomfortable. Give me my medications as my doctor has ordered.

Focus- Resident #20 needs pain management and monitoring related to: Chronic Back Pain aggravated by Osteorthritis and end of life care. Goal- Resident #15 will maintain adequate level of comfort as evidenced by no s/sx of unrelieved pain or distress, or verbalizing satisfaction with level of comfort through next review. Goal- Administer Pain medication as ordered. Evaluate need to provide medications prior to treatment or therapy.

Resident #20 had a physician's order for the following medication: Decadron Tablet 4 (mg) milligrams give 1 tablet by mouth in the morning for pain.

Resident #20 had a physician's order for the following medication: hydroxyzine HCl tablet 25 mg give 1 tablet by mouth at bedtime for insomnia.

Resident #20 had a physician order for the following medication: Metoprolol Succinate ER tablet Extended Release 24 hour 25 mg give 12.5 mg by mouth one time a day for 12.5 mg total.

A review of the clinical record (Nursing Notes) dated 12/25/20 and Medication Administration Record (MAR) Notes, Indicated: "Rosuvastain Calcium tablet 20 mg give 1 tablet by mouth at

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bedtime for Hyperlipeidemia not available medication being ordered."

A review of the clinical record (Nursing Notes) dated 12/27/20 and MAR Notes, Indicated: "Rosuvastain Calcium tablet 20 mg - give 1 tablet by mouth at bedtime for Hyperlipidemia awaiting arrival from pharmacy."

A review of the clinical record (Nursing Notes) dated 12/28/20 and MAR Notes, Indicated: "Rosurvastain Calcium tablet 20 mg - give 1 table by mouth at bedtime for Hyperlipidemia medication on order."

A review of the clinical record (Nursing Notes) dated 01/06/21 and MAR Notes, Indicated: "Decadron tablet 4 mg give 1 tablet by mouth in the morning for pain, medication unavailable, awaiting delivery from pharmacy."

A review of the clinical record (Nursing Notes) dated 01/05/21 and MAR Notes, Indicated: "Decadron tablet 4 mg give 1 tablet by mouth in the morning for pain. Medication on order, awaiting delivery."

A review of the clinical record (Nursing Notes) dated 01/02/21 and MAR Notes, Indicated: "Decadron tablet 4 mg give 1 tablet by mouth in the morning for pain. Medication on order."

A review of the clinical record (Nursing Notes) dated 03/22/21 and MAR Notes, Indicated: "HydrOxyzine HCl tablet 25 mg give 1 tablet by mouth at bedtime for insomnia, unavailable."

A review of the clinical record (Nursing Notes) dated 4/13/21 and MAR Notes, Indicated:

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(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 755	Continued From page 149 "Metoprolol Succcinate ER tab 12.5 mg one time a day, Not available." A review of the Facility's Pharmacy Policy indicated: Policy- "The facility must make every effort to ensure that a medication ordered for the resident is available to meet their needs. Procedures: 1.- The pharmacy staff shall: A.- Call and/or provide written notification to the nursing staff that the physician ordered product(s) is/are unavailable."	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		6/14/21

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F 756	Continued From page 150 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure the physician reviewed pharmacy recommendations for 2 residents (Resident #4, #43) of 34 residents in the survey sample. The findings included: 1. Resident #4 was admitted to the facility on 08/14/2020. Diagnosis included but were not limited to, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Major Depressive Disorder. Resident #4's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/09/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 08 indicating moderate cognitive impairment. The Minimum Data Set coded Resident #4 as requiring extensive assistance of 2 for bed mobility and dressing, total dependence of 1 for	F 756	1. The physician reviewed Resident #4 and #43 pharmacy recommendations. 2. Audits of pharmacy recommendations from last 30 days to ensure physician follow-up. 3. DON and Unit Manager will be re-educated on pharmacy review process. 4. Audits of pharmacy recommendations will be conducted by DON/Designee monthly for three months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance date: 6/14/2021	

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F 756	Continued From page 151	F 756		

eating and total dependence of 2 for transfer, toilet use, personal hygiene and bathing.

On 05/05/2021 at approximately 2:00 p.m., review of Resident #4's clinical record revealed the following:

Pharmacy Review dated 02/07/2021 was reviewed and revealed the following: 1. Patient Recommendations 2. Recommendations made, review Clinical Pharmacy Report.

On 05/06/2021 requested Clinical Pharmacy Report for Pharmacy Review dated 02/07/2021.

On 05/10/2021 at approximately 10:00 a.m., requested copy of facility policy and procedure regarding Medication Regimen Reviews.

On 05/10/2021 at approximately 10:15 a.m., Clinical Pharmacy Report for Pharmacy Review dated 02/07/2021 was received and review revealed the following: MRR Date: 2/7/2021 This resident has been taking Citalopram, Ativan, and Amitriptyline since 8/14/2020. Please evaluate to see if any can be reduced.

On 05/10/2021 at approximately 11:00 a.m. review of Medication Administration Record for August 2020 revealed the following: Citalopram Hydrobromide Tablet 20 MG (Milligram) Give 1 tablet via PEG-Tube one time a day for depression Order Date - 08/14/2020 1205.

On 05/10/2021 at approximately 11:00 a.m. review of Medication Administration Record for September 2020 revealed the following: Amitriptyline HCl Tablet 25 MG Give 2 tablet via PEG-Tube at bedtime for depression Order Date

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F 756	Continued From page 152	F 756		

- 09/02/2020 2304; Ativan Tablet 1 MG (Lorazepam) Give 1 tablet via G-Tube three times a day for Restlessness/Agitation Order Date - 09/17/2020 0555.

On 05/10/2021 at approximately 11:00 a.m. review of Medication Administration Record for May 2021 revealed the following: Amitriptyline HCl Tablet 25 MG Give 2 Tablet via PEG-Tube at bedtime for depression Order Date - 09/02/2020 2304; Citalopram Hydrobromide Tablet 20 MG Give 1 tablet via PEG-Tube one time a day for depression Order Date - 08/14/2020 1205; Ativan Tablet 1 MG (Lorazepam) Give 1 tablet via G-Tube three times a day for Restlessness/Agitation Order Date - 09/17/2020 0555.

On 05/10/2021 at approximately 11:15 a.m. review of Physician Progress Notes in Resident #4's clinical record did not evidence documentation that the attending physician reviewed the identified irregularity and what, if any, action was taken to address it. Unable to locate evidence of documented rationale for no change in the medication.

The Interim Administrator, Interim Director of Nursing and Corporate Nurse was informed of the finding on 05/10/2021 at approximately 8:30 p.m. at the pre-exit meeting. When asked what is the process for Medication Regimen Reviews, Interim Director of nursing stated, "Pharmacy comes in, DON (Director of Nursing) to review and give to attending physician to agree or disagree with recommendation." The facility did not present any further information about the finding.

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F 756	Continued From page 153	F 756		

2. Resident #43 was initially admitted to the facility on 07/12/2018. Resident #43 was discharged to the hospital on 04/04/2021 and readmitted to the facility on 04/08/2021. Diagnosis included but were not limited to, Unspecified Fracture Of Left Femur and Depression. Resident #43's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/12/2021 was not coded with a BIMS (Brief Interview for Mental Status) score. The Minimum Data Set coded Resident #43 as requiring extensive assistance of 1 for eating, extensive assistance of 2 for bed mobility, transfer and toilet use and total dependence of 2 for dressing, personal hygiene and bathing.

On 05/05/2021 at approximately 3:00 p.m., review of Resident #43's clinical record revealed the following:

Medication Administration Record for May 2021 was reviewed and revealed the following: Xanax Tablet 0.25 MG (Alprazolam) Give 1 tablet by mouth every 24 hours as needed for anxiety. Order Date - 04/08/2021 1940.

Pharmacy Review dated 4/12/2021 was reviewed and revealed the following: 1. Patient Recommendations 2. Recommendations made, review Clinical Pharmacy Report.

On 05/06/2021 requested Clinical Pharmacy Report for Pharmacy Review dated 04/12/2021.

On 05/10/2021 at approximately 10:00 a.m., requested copy of facility policy and procedure

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F 756	Continued From page 154 regarding Medication Regimen Reviews. On 05/10/2021 at approximately 10:15 a.m., Clinical Pharmacy Report for Pharmacy Review dated 04/12/2021 was received and review revealed the following: MRR (Medication Regiment Review): 4/12/2021 CMS (Centers For Medicare & Medicaid Services) regulations require a 14 day stop on all PRN orders for psychoactive medications, including orders for hospice patients. A longer stop date can be ordered if a rationale for the extended time is documented in the patient's medical records. Please consider one of the following for this patient's Xanax PRN order. On 05/10/2021 at approximately 2:00 p.m., after review of Resident #43's clinical record, unable to locate documented evidence that the attending physician reviewed the identified irregularity and what, if any, action was taken to address it. Unable to locate evidence of documented rationale for continued use. On 05/10/2021 at approximately 5:00 p.m., requested copy of facility policy and procedure regarding Medication Regimen Reviews. The Interim Administrator, Interim Director of Nursing and Corporate Nurse was informed of the finding on 05/10/2021 at approximately 8:30 p.m. at the pre-exit meeting. When asked what is the process for Medication Regimen Reviews, Interim Director of Nursing stated, "Pharmacy comes in, DON (Director of Nursing) to review and give to attending physician to agree or disagree with recommendation." The facility did not present any further information about the finding.	F 756		

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		6/14/21

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F 758	Continued From page 156 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure that PRN (As Needed) orders for psychotropic medication was not ordered for longer than 14 days without a documented rationale for continued use for 1 resident (Resident #43) of 34 residents in the survey sample AND failed to implement Gradual Dose Reduction (GDR) interventions for the use of psychotropic medication as used by Resident #15. The findings included: 1. Resident #43, the facility staff failed to ensure PRN (As Needed) Xanax was not ordered for longer than 14 days, without a documented rationale for continued use. Resident #43 was initially admitted to the facility on 07/12/2018. Resident #43 was discharged to the hospital on 04/04/2021 and readmitted to the facility on 04/08/2021. Diagnosis included but were not limited to, Unspecified Fracture Of Left Femur and Depression. Resident #43's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 04/12/2021 was not coded with a BIMS (Brief Interview for Mental Status) score. The Minimum Data Set coded Resident #43 as requiring extensive assistance of	F 758	1. Resident #43 PRN Xanax was discontinued on June 3, 2021. Resident #15 GDR for Olanzapine was completed on June 3, 2021. 2. An audit of residents using PRN psychoactive medications will be conducted to ensure a review is conducted for continued use every 14 days of a PRN psychoactive medications and for GDR completion. 3. DON and Unit Manager will be re-educated on ensuring a review is conducted for continued use every 14 days of a PRN psychoactive medication and GDR completion. 4. Audits of PRN psychoactive medication and scheduled psychoactive medication will be conducted by the DON/Designee weekly for four weeks then monthly for three months to ensure PRN psychoactive medications have stop dates and GDRs completed. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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F 758	Continued From page 157	F 758		

1 for eating, extensive assistance of 2 for bed mobility, transfer and toilet use and total dependence of 2 for dressing, personal hygiene and bathing.

On 05/05/2021 at approximately 3:00 p.m., review of Resident #43's clinical record revealed the following:

Medication Administration Record for May 2021 was reviewed and revealed the following: Xanax Tablet 0.25 MG (Milligram) (Alprazolam) Give 1 tablet by mouth every 24 hours as needed for anxiety. Order Date - 04/08/2021 1940.

Pharmacy Review Dated 4/12/2021 was reviewed and revealed the following: 1. Patient Recommendations 2. Recommendations made, review Clinical Pharmacy Report.

On 05/06/2021 requested Clinical Pharmacy Report for Pharmacy Review dated 04/12/2021.

On 05/10/2021 Clinical Pharmacy Report for Pharmacy Review dated 04/12/2021 was received and review revealed the following: MRR (Medication Regiment Review): 4/12/2021 CMS (Centers For Medicare & Medicaid Services) regulations require a 14 day stop on all PRN orders for psychoactive medications, including orders for hospice patients. A longer stop date can be ordered if a rationale for the extended time is documented in the patient's medical records. Please consider one of the following for this patient's Xanax PRN order.

On 05/10/2021 at approximately 2:00 p.m., after review of Resident #43's clinical record, unable to locate evidence of documented rationale for

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F 758	Continued From page 158 continued use. The Interim Administrator, Interim Director of Nursing and Corporate Nurse was informed of the finding on 05/10/2021 at approximately 8:30 p.m. at the pre-exit meeting. Corporate Nurse stated, "Initial order for set number of days can continue if a medical need and after the physician reviews it." The facility did not present any further information about the findings. 2. The facility staff failed to implement Gradual Dose Reduction intervention for the use of psychotropic medication. Resident #15 was admitted to the facility on 9/13/19 with diagnoses that included chronic obstructive pulmonary disease, alcoholic cirrhosis of liver without ascities, acute and chronic respiratory failure with hypoxia, anxiety, insomnia and delirium. Resident #15 Quarterly Minimum Data Set (MDS) dated 03/18/21 assessed this resident as having scored a (5) on the Brief Interview for Mental Status (BIMS). A Care Plan dated 03/24/21 indicated: Focus- Resident #15 has the potential for drug related complications associated with use of psychotropic medications: Anti-psychotic medication- Goals- Resident #15 risk for psychotropic drug related complications will be minimized through next review- Interventions- Monitor for side effects and report to physician: Anti-anxiety/Hypnotic medications-drowsiness, morning, hang over, ataxia, dry mouth, constipation, blurred vision,	F 758		

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F 758	Continued From page 159 urinary retention, headache, vertigo, nausea, hypotension, weakness, sedation, lethargy, confusion, memory loss and dependence. Nursing to continue to review/follow-up recommendations from monthly pharmacy review of medication regimen with physician. Obtain consent from patient/responsible party for use of psychotropic medications. A review of the clinical records indicated Resident #15 received Olanzapine tablets 10 mg (milligrams) at bed time for mood disorder. A review of the clinical records indicated this resident began receiving Olanzapine tablets 10 mg on 4/20/20. A review of the clinical records did not indicate a GDR had been attempted. During an interview on 05/11/21 with the Administrator he stated, no information could be found that Resident #15 had a GDR attempted.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure 2 of 34 residents (Resident #347 and Resident #147) in the survey sample were free of significant medication errors. The findings included: 1. The facility staff failed to follow physician	F 760	1. Resident #347 order for 325mg aspirin was discontinued on 5/5/21. Resident #147 is receiving IV antibiotic per physician order. 2. Med pass observation audits will be conducted on licensed staff to ensure medication given per MD order. 3. Licensed staff will be re-educated on the policy of medication administration to	6/14/21

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F 760	Continued From page 160 orders to decrease Aspirin 325 mg to 81 mg. Resident #347's Minimum Data Set (MDS-an assessment protocol) a 5-day assessment with an Assessment Reference Date of 05/05/21 coded the resident with a 00 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. In addition, the MDS coded Resident #347 total dependent of two with bathing, personal hygiene and toilet use, extensive assistance of two with bed mobility, transfer and dressing and supervisor with one assist with eating. Resident #347's care plan dated 05/06/21 documented resident at risk for complications related to anticoagulant or antiplatelet medications due to Atrial Fibrillation. The goal: will remain without complications from bleeding or injury. One intervention/approaches to manage goal included: monitor medication regimen. During the review of Resident #347's Medication Administration Record (MAR) for May 2021 revealed the following 2 (two) antiplatelet medications and 1 (one) anticoagulation medication order: Aspirin 325 mg tablet - give 1 tablet by mouth daily for Cerebral Infarction starting on 04/30/21. Aspirin EC 81 mg - give 1 tablet by mouth daily for Atrial Flutter starting on 05/04/21. Eliquis 2.5 mg tablet - give 1 tablet twice a day for Atrial Fibrillation starting on 05/04/21. The review of Resident #347's Eliquis order included the following Drug-to-Drug Interaction Details read: The use of Eliquis tablet 2.5 mg and Aspirin 325	F 760	include following physician order. 4. Audits of staff during medication administration will be conducted by DON/designee weekly for four weeks then monthly for three months to ensure physician orders are followed. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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mg may increase the risk of bleeding.

Review of the physician's progress note dated 05/03/21 read in part under assessment: I have decreased Aspirin from 325 mg down to 81 mg by mouth daily.

Further review of Resident #347's MAR for May 2021 revealed the following medications were administered:
Aspirin 325 mg tablet given at 9:00 a.m., on 05/04/21 and 05/05/21.
Aspirin EC 81 mg tablet given at 9:00 a.m., on 05/04/21 and 05/05/21.
Eliquis 2.5 mg tablet given at 9:00 a.m., and 5:00 p.m., on 05/04/21 and 05/05/21.

A phone interview was conducted with the Director of Nursing (DON) on 05/05/21 at approximately 1:26 p.m. The DON reviewed Resident #347's physician orders and stated, "The nurses should have notified the physician for clarification due to Resident #347 taking 2 (two) different doses of Aspirin at the same time (Aspirin 81 mg and Aspirin 325 mg.) On the same day at approximately 3:44 p.m., a new order was written to discontinue the Aspirin 325 mg tablet.

A phone interview was conducted with the Administrator and Director of Nursing (DON) on 05/10/21 at approximately 4:10 p.m. No further information was provided.

A pre-exit conference was conducted with the Administrator, Director of Nursing (DON) and Cooperate Nurse on 05/10/21 at approximately 6:30 p.m. No further information was provided prior to exit.

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Definition:
Atrial Fibrillation is a problem with the speed or rhythm of the heartbeat (https://medlineplus.gov/atrialfibrillation.html.)
2. Resident #147 was admitted on 4/30/21 with diagnoses that included type 2 diabetes mellitus, chronic diabetic wounds of right and left foot with status post bilateral transmetatarsal amputations and skin graft infections, end stage renal disease with dependence on hemodialysis.

The 5-day Minimum Data Set (MDS) assessment was dated 4/30/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident had the necessary cognitive skills for daily decision making. The resident had no problems understanding the staff and was understood. The resident was assessed without mood or behavioral problems. Resident #147 required extensive assistance from 2 staff for bed mobility and toilet use. He was not assessed to be able to ambulate (walk in and out of room). He had bilateral lower extremity impairment in range of motion. The wheelchair was the resident's primary mode of transportation. The resident was coded with surgical wounds and infection of feet. The assessment was signed by the MDS Coordinator as completed on 5/10/21.

There was no care plan to include a baseline 48-hour care plan or interim care plan available to this surveyor during the time of the survey.

On 5/4/21 at 1:05 p.m., Resident #147 was observed sitting on the side of the bed. The resident stated that the Licensed Practical Nurse

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(LPN) #1 came to hang his IV antibiotic around 1:00 p.m. The IV was infusing via the IV pump. The IV infusion pump beeped around 1:40 p.m. and the nurse entered the room at 2:03 p.m. (58 minutes from Surveyor #2's observation). The LPN took down the IV and flushed the central line.

On 5/5/21 at 9:30 a.m., Resident #147 arrived from dialysis. LPN #1 hung the resident's IV antibiotic at around 10:00 a.m. She stated, "I am agency staff and yesterday was my first day. I don't know anything about this building or the residents and I got behind in passing my medications. That's why his 9:00 a.m. IV antibiotic was hung at 1:00 p.m. I was not sure if he was getting this antibiotic through a midline or a central line becuase it was in his neck and I wanted to flush it correctly."

Upon review of the clinical record, Resident #147 had admission physician's orders dated 4/30/21 for Cefepime 1 gram in sodium chloride 0.9% 100 ml IVPB every 24 hours. The Medication Administration Record (MAR) indicated that the IV antibiotic was signed off as administered late on 5/4/21 at 1:34 p.m., on 5/7/21 at 6:29 p.m. and 5/9/21 at 12:44 p.m.

On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. The DON stated and the Administrator concurred that it was an expectation that treatments and medications are to be performed as ordered by the physician.

The facility's policy and procedures titled Medication Administration dated 2007 indicated

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F 760	Continued From page 164 medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. Cefepime Injection should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. Cefepime Injection should be administered intravenously over approximately 30 minutes. On hemodialysis days, Cefepime Injection should be administered following hemodialysis. Whenever possible, Cefepime Injection should be administered at the same time each day to maintain therapeutic range and to allow for compensation for the slower rate of renal elimination in hemodialysis patients (Retrieved on 5/14/21 from source dated 9/2012 https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/050817s004lbl.pdf).	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		6/14/21

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F 761	Continued From page 165 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, observations, resident interview and facility documentation, the facility staff failed to provide a separately locked, permanently affixed compartment for all controlled drugs to include those brought from resident homes on admission for 1 of 34 residents (Resident #146) in the survey sample. The findings included: Resident #146 was admitted on 4/30/21 to receive respite/palliative care. He was discharged home on 5/5/21. There was no completed Minimum Data Set (MDS) due to the resident's short-stay. The History and Physical (H&P) dated 5/3/21 indicated that the resident was in the facility under the care of hospice for respite. He was alert and responsive. No Intravenous fluids to be given or laboratory specimens obtained.	F 761	1. Resident #146 was discharged on 5/5/2021 2. An audit of controlled drugs was conducted to ensure they are separately locked in a permanent affixed compartment. 3. Licensed Nursing will be re-educated on storage of controlled drugs. 4. Audits of controlled drugs will be conducted by DON/Designee weekly for four weeks then monthly for three months to ensure correct storage of controls. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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Resident was ordered Morphine Sulfate 20 mg/ml, give 0.5 ml by mouth every 4 hours as needed for pain or shortness of breath.

On 5/4/21 at 7:00 p.m. narcotic counts were observed by this surveyor (#2) for the facility's 2 medication carts, 100 and 200/300. All narcotics were accounted for in a affixed compartment on the locked medication cart except a discovered Morphine Sulfate 20 milligrams (mg)/1 milliliters (ml), give .5 ml (10 mg) every 4 hours by mouth (po) for a resident that was admitted for respite care (Resident #146), located in the bottom drawer of the medication cart 200/300. The Morphine Sulfate was found in a bag with several of Resident #146's personal non-narcotic medications. Licensed practical Nurse (LPN #4) said she knew it was there, but there should have been a "Controlled Record" narcotic flow sheet for the resident's narcotic medication and counted along with the other narcotics, 18 milliliters (ml) recorded as the count for Resident #146's Morphine Sulfate. It was also determined that the Morphine Sulfate was not maintained in the separate affixed compartment in the medication cart as the other resident's narcotics.

On 5/6/21 at 10:30 a.m., the Director of Nursing (DON) said Resident #146's narcotic medication brought from home should have been locked in the narcotic box with a slip and counted along with the other narcotics until picked up by the family or in the aforementioned case, picked up by hospice. He took this surveyor (#2) to demonstrate that the medication for resident's Morphine Sulfate narcotic was transferred behind a double lock and counted along with the other narcotics. The amount of Morphine Sulfate was as observed on 5/4/21, 18 ml remained. This

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F 761	Continued From page 167 resident was discharged home on 5/5/21. On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. There aforementioned issues were re-reviewed and the DON and Administrator reiterated their expectations of the licensed nurses. There was no further documents or added information presented prior to survey's remote exit on 5/11/21. The facility's policy and procedures titled "Storage of Medication" dated 2007 indicated that controlled medications must be stored separately from non-controlled medications. The access system (key, security codes) used to lock Schedule II medications and other medications subject to abuse, cannot be the same access system used to obtain the non-scheduled medications. Schedule II medications and preparations must be stored in a separately locked affixed compartment. Schedules III-IV and non-controlled medications that have been identified by the nursing care center, as having the potential for abuse may also be stored with the Schedule II medication.	F 761		
F 804 SS=D	COMPLAINT DEFICIENCY Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804		6/14/21

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F 804	Continued From page 168 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: 2. Resident #147 was not able to chew and consume the meat served to him during the lunchmeal on 5/4/21. Resident #147 was admitted on 4/30/21 with diagnoses that included type 2 diabetes mellitus, chronic diabetic wounds of right and left foot with status post bilateral transmetatarsal amputations and skin graft infections, end stage renal disease with dependence on renal dialysis. The 5-day Minimum Data Set (MDS) assessment was dated 4/30/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident had the necessary cognitive skills for daily decision making. The resident had no problems understanding the staff and was understood. The resident was assessed without mood or behavioral problems. Resident #147 required extensive assistance from 2 staff for bed mobility and toilet use. He was not assessed to be able to ambulate (walk in and out of room). He had bilateral lower extremity impairment in range of motion. The wheelchair was the resident's primary mode of transportation. The resident was coded with surgical wounds and infection of feet. The assessment was signed by the MDS Coordinator as completed on 5/10/21. There was no care plan to include a baseline 48-hour care plan or interim care plan available to this surveyor during the time of the survey.	F 804	1. Resident #147 is able to chew meat that is served to him. Resident #36 is aware of food being served and it□s palatable. 2. Current residents at the facility have the potential to be affected. 3. Dietary staff and nursing staff will be re-educated on serving meals that are palatable for their enjoyment and having/serving an accurate menu. 4. Audits of meal pass will be conducted weekly for four weeks then monthly for three months by Department heads/Designee to ensure palatable food and menu accurateness. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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F 804	Continued From page 169 On 5/4/21 at 1:05 p.m., Resident #147 stated when they served him his lunch meal around 12:15 p.m., he took one bite from a pork chop and could not consume it because it was tough with no taste, thus he spit it out. He also stated he wanted coffee and they gave him iced tea with no sugar substitute. On 5/4/21 at 7:30 p.m., it was determined Resident #147 did not receive anything to eat until 2:30 p.m. He stated he got a hamburger and told the CNA (#6) to make sure it did not take place of his dinner. In addition, the resident said he was told he would recieve double portions, but to date he had not. On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. They were informed of the issues with the resident's meal that was served to him on 5/4/21. No further information was provided prior to survey exit. Based on observation, resident interview, and staff interviews, the facility's staff failed to ensure the midday meal served 5/5/21, at an appetizing temperature and palatable enough to encourage each resident to increase meal consumption for 2 of 34 residents (Resident #36 and #147), in the survey sample. The findings included: 1. On 5/4/20 at approximately 12:40 p.m., observations of the midday meal were made in the main dining room. The menu read Baked ziti with meat sauce, Caesar salad, garlic bread and a strawberry shortcake square but they received	F 804		

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herbed pork chop, sliced carrots, mashed potatoes and fruit. Eleven residents in the dining room received the regular (non-chopped or mechanically altered) meal and ten didn't consumed the pork chop.

Resident #36 was originally admitted to the facility 7/14/21 and readmitted 11/12/21 after an acute care hospital stay. The current diagnoses included; Parkinson's Disease, depression, low back pain, lumbar diskitis, and arthritis.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/2/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15.

On 5/4/20 at approximately 1:15 p.m., an interview was conducted with Resident #36. Resident #36 stated, we ever know what we will be served and it's always terrible. Resident #36 further stated before the pandemic they took trips to Wal-Mart frequently, there he purchased snacks and items to consume when the meals were totally unacceptable. Resident #36 also stated there are never alternatives listed on the menus outside the dining room door therefore; you have no idea if to request the alternate or what the alternate is. The resident stated on occasion he had requested the alternate, to be told by the dietary staff that a one hour notice is necessary to get the alternate. The resident stated most of his weight loss was a result of the terrible food and no one has discussed with him preferences or substitutes for food dislikes.

On 5/5/21, at approximately 10:00 a.m., a group interview was conducted with 4 residents. The

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consensus of the group was the food quality is not good, the vegetables are always mushy from being over-cooked and even if you consume your meals in the dining room the food comes out of the kitchen cold.

As a result of the voiced concerns about meal; a test tray was obtained at the midday meal on 5/5/21. It was the last tray served, arriving at approximately 1:00 p.m. The meal consisted of barbeque pork regular texture, chopped pork and pureed pork, okra, mashed potatoes and broccoli. The kitchen temperatures readings were as followed; regular pork 190.5 degrees , okra 202 degrees, mashed potatoes 196 degrees and the Tater tots were 155 degrees.

On 5/5/21 at 12:20 p.m., the last food cart arrived on 100 hall. Trays were passed out and moved to 200 hall. On 5/5/21 at 12:47 p.m., the last person was served their lunch on the 200 hall. On 5/5/21 at 12:51 p.m., the test plate observed to have a lid but no bottom warmer, the items were obtained in the conference room by the District Dietary Manager. Food temperatures were as follows in degrees Fahrenheit:
Pork on a bun: 99.8, Mashed Potatoes: 112.1, Tator Tots: 90.6, Puree Pork: 100.0. The food was tasted by three surveyors at 12:55 p.m. All items were at an unpalatable temperature. The tator tots were extremely hard and the mashed potatoes were bland. When asked the District Dietary Manager stated he thought a temperature of , "115 degrees on everything." was considered palatable to hold and serve food.

After the test tray and the results were discussed with the District Dietary Manager, he request another opportunity to prove himself with the

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F 804	Continued From page 172 meal for he stated it shouldn't have taken so long for the meal trays to be distributed to the resident. Another test tray wasn't request but meal distribution time was reassessed 5/7/21, during the breakfast meal. The last tray to be delivered to the resident was 8:54 a.m., that was well over one hour after leaving the kitchen. On 5/10/21 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Director of Clinical Services. The Director of Nursing stated it was their expectation that resident meals arrive at a temperature and taste that's appealing and enjoyable.	F 804		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to offer and provide Resident #147 with an alternative or substitute for his lunchmeal. Resident #147 was admitted on 4/30/21 with diagnoses that included type 2 diabetes mellitus, chronic diabetic wounds of right and left foot with status post bilateral transmetatarsal amputations	F 806	1. Resident #147 is being offered an alternative or substitute for lunch and is receiving double portions. Resident #7 is receiving coffee with breakfast. 2. Audit of current resident□s preferences to ensure documented and served appropriately. 3. Dietary and nursing staff will be	6/14/21

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F 806	Continued From page 173 and skin graft infections, end stage renal disease with dependence on renal dialysis. The 5-day Minimum Data Set (MDS) assessment was dated 4/30/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident had the necessary cognitive skills for daily decision making. The resident had no problems understanding the staff and was understood. The resident was assessed without mood or behavioral problems. Resident #147 required extensive assistance from 2 staff for bed mobility and toilet use. He was not assessed to be able to ambulate (walk in and out of room). He had bilateral lower extremity impairment in range of motion. The wheelchair was the resident's primary mode of transportation. The resident was coded with surgical wounds and infection of feet. The assessment was signed by the MDS Coordinator as completed on 5/10/21. There was no care plan to include a baseline 48-hour care plan or interim care plan available to this surveyor during the time of the survey. On 5/4/21 at 1:05 p.m., Resident #147 was observed sitting on the side of the bed with a full lunch meal tray, his call light was on. The resident stated when they served him his lunch meal around 12:15 p.m., he took one bite from a pork chop and could not consume it because it was tough with no taste, thus he spit it out. He also stated he wanted coffee and they gave him iced tea with no sugar substitute. He stated he put his call light on around 12:20 p.m. and again at 12:30 and both times no one came in, but when the licensed Practical Nurse (LPN) #1 came to hang	F 806	re-educated on alternative or substitutes and preferences. 4. Audits of meals will be conducted weekly for four weeks then monthly for three months by Department heads/Designee to ensure alternates are offered when needed and preferences are being served. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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my IV antibiotic a few minutes ago that was due at 9:00 a.m., turned off the light, never asked him what he wanted, at which time he stated he told her he had been calling to get someone to send for a different meal, at which time she told him she was behind and did not have time. He stated, "So I tried again after she left out because I am so hungry." The IV was infusing via the IV pump. The IV infusion pump beeped around 1:40 p.m. and the nurse entered the room at 2:03 p.m. (58 minutes from Surveyor #2's observation) she hesitated and made eye contact with this surveyor (Surveyor #2), turned off the light, took down the IV, flushed the central line and said, "While I am here, what can I do for you." The resident responded, "You can get me what I asked for when you came in to hang my IV antibiotic and said you were busy and did not have time. I would like a different meal for my lunch." At approximately 2:10 p.m., the assigned Certified Nursing Assistant (CNA) # 6 was outside the resident's room donning her Personal Protective Equipment (PPE). The CNA entered the room, proceeded to pick up the resident's tray when it was asked if she could get the resident another meal. She said, "It is late and I don't think I can get a meal now. I was not told how that works in this building." The resident told her he had to eat something. She stated she would try but could not promise he would get a meal. She added that she was relatively new to the facility and had not been oriented to the resident's on the quarantine unit.

On 5/4/21 at 7:30 p.m., it was determined Resident #147 did not receive anything to eat until 2:30 p.m. He stated he got a hamburger and told the CNA (#6) to make sure it did not take place of his dinner. In addition, the resident said

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he was told he would recieve double portions, but to date he has not.

On 5/5/21 at 9:30 a.m., Resident #147 arrived from dialysis. LPN #1 stated that 5/4/21 was her first day and she did not know anything about the resident's or the building. The LPN was not able to explain why she could not have had the aide or another nurse to offer and provide the alternate/substitute meal.

On 5/10/21 at 12:15 p.m., this surveyor (#2) and the Food Service District Manager interviewed the resident about the facility's failure to consistently provide his meals especially on his hemodialysis days, Monday, Wednesday and Friday. The Food Service District Manager stated that he knew Resident #147's breakfast was served early in the AM before the resident left on his dialysis days. The resident stated it was inconsistent and somedays received breakfast after he returned from dialysis and he is having to ask repeatedly for the nursing staff to bring his meal. He stated he would prefer the early breakfast meal before dialysis due to his diabetes where he felt his blood sugar drops during the end of his dialysis treatments. This surveyor (#2) was present when the resident returned from dialysis treatment on 5/5/21 at 9:30 a.m. The resident requested his breakfast and did not receive it until 10:45 p.m. He stated he was weak and shaky, but the staff seem to be "put upon" because he asked to eat. The Food District Manager stated he would make sure his breakfast was prepared and delivered to him no later than 5:30 a.m. Monday, Wednesday and Friday.

On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of

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Nursing (DON) and the Regional Director of Clinical Services. The DON stated and the Administrator indicated that alternates and substitutes are available for every meal and should be offered if the resident did not eat or they requested a different meal. He stated meals are prepared for dialysis residents, and either picked up or delivered to them per their preference before or after dialysis. The Administrator said, "Resident's can be given something to eat at anytime."

Based on observation, resident interview, staff interviews, and review of facility documents, the facility's staff failed to ensure residents received foods/drinks which accommodates their preferences for 1 of 34 residents (Resident #7), in the survey sample.

The findings included:

1. Resident #7 was originally admitted to the facility 10/21/20 and has never been discharged from the facility. The current diagnoses included; glaucoma, a seizure disorder, endstage renal disease requiring dialysis, diabetes and coronary artery disease.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/28/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making was intact. In section"G" (Physical functioning) the resident was coded as requiring total care of two people with transfers,

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toileting, and bathing, total care of one with off unit locomotion, extensive assistance of two people with bed mobility and dressing, extensive assistance of one person with personal hygiene and locomotion on unit, and supervision after set-up with eating. On 5/5/21, at approximately 10:35 a.m., Resident #7 stated he didn't understand why dining services continued to serve him milk for breakfast when he doesn't like milk and would rather have coffee. Again on 5/7/21, at approximately 8:35 a.m., Resident #7 stated he received milk instead of coffee. The resident also stated he hasn't received coffee for breakfast since he sustained the coffee burn.

On 5/7/21 at approximately 9:00 a.m., the District Dining Services Manager stated he met with Resident #7 regarding his preferences and stated his tray card was updated to reflect his dislike for milk and added coffee as a preference for breakfast.

An interview was conducted with Certified Nursing Assistant (CNA) #6 on 5/10/21 at approximately 10:00 a.m., CNA #6 stated she as well as most of the CNA staff is aware Resident #7 doesn't drink milk and prefers coffee for breakfast. CNA #6 also stated most breakfast meals Resident #7 received a box of milk and apple juice and it was the CNA staff responsible to get coffee from the service cart to serve the resident. CNA #6 stated they were not instructed not to serve Resident #7 coffee but they were instructed to ensure all coffee cups lids were secure before serving the resident and Resident #7 was sitting up before serving coffee.

On 5/10/21 at approximately 7:00 p.m., the above findings were shared with the Administrator,

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F 806	Continued From page 178 Director of Nursing and Corporate Director of Clinical Services. The Director of Nursing stated it was their expectation that the resident received they food/drink preferences in accordance with the ordered diet.	F 806		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility documents, the facility's staff failed to ensure on 5/10/21, the dishwasher temperature reached the appropriate wash temperature to sanitize the after breakfast dishes. The findings included: On 5/10/21 at approximately 9:50 a.m.,	F 812	1. The dishwasher temperature is reaching the appropriate temperature to sanitize dishes. 2. Current residents at the facility have the potential to be affected. 3. Dietary staff re-educated on appropriate dishwasher temperature to sanitize dishes. 4. Audits of dishwasher temperature will	6/14/21

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F 812	Continued From page 179 observations of were made of the dishwashing machine during washing of the resident serving trays. After the first set of trays entered the cycle the dietary aide recorded the high wash temperature as 111 degrees and the high rinse temperature as 191 degrees. The trays were removed and placed on a rack which suspended each tray separately after-which another set of trays were put in the dishwasher, this time the high wash temperature only reached 109 degrees. On 5/1/21, at approximately 9:57 p.m., an interview was conducted with the Dietary Aide who stated the wash temperature requirement is 150 degrees and the rinse requirement temperature was 180 degrees. The Dietary Aide stated she would notify the District Dietary Manager that the dishwasher not reaching the recommended temperature and he would determine how she should proceed with getting the dishes washed. On 5/10/21 at approximately 1:40 p.m., the District Dietary Manager stated the dishwasher had been out of service quite a bit over the last few months and they had invested a large amount of money repairing it therefore; the company who services the dish machine was contacted about the wash temperature. The District Dietary Manager stated the representative for the dishwashing machine company stated the dishwasher ran off of a heat sanitizing system therefore the temperature had to reach 150 degrees to sanitize the dishes. The District Dietary Manager also stated he would initiate use of disposable products until the machine was repaired.	F 812	be conducted by the Dietary manager/Designee weekly for four weeks then monthly for three months to ensure appropriate temperature. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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F 812	Continued From page 180 On 5/10/21 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Director of Clinical Services. On 5/11/21 the District Dietary Manager stated the dishwashing machine was repaired in time for the evening meal 5/10/21.	F 812		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based record review and staff interview the facility staff failed to ensure the Quality assurance and performance (QAPI) program include monitoring, and measuring performance activities. The findings included: 1. The facility staff failed to maintain a QAPI plan	F 865	The facility implemented a monitoring and audit process to ensure an ongoing account of narcotics and other drugs. The facility implemented an ongoing surveillance program for weekly pressure sore assessment to prevent wounds at advanced stages. The facility will document ongoing monitoring and audit newly admitted residents at risk for	6/14/21

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F 865	Continued From page 181 for correcting quality deficiencies. During the survey conducted 05/04/21 through 05/12/21 indicated: In the area of (F-881) A review of the antibiotic Infection Control Surveillance Infection report log showed only the months of March, April, and May were available to view. During an interview on 05/10/21 at 6:00 PM with the Administrator, ADON and RDCS concerning Antibiotic Stewardship Program. They were asked if the ongoing review for antibiotic stewardship prior to the survey was complete. The ADON stated, "We need to continue our reviews for February 2021. "I don't see any other documentation from what was provided." The RDCS stated, "They are working on it. April wasn't completed." In the area of (F-882) The facility staff failed to designate at least one qualified Infection Preventionist. Received Infection Prevention and Control Certificates of training. In the area of (F-880) The facility staff failed to ensure infection control practices were followed in 3 resident rooms on the quarantine unit. In the area of (F-886) The facility staff failed to perform COVID-19 testing on staff. In the area of (F-761) The facility staff failed to include monitoring and audit performance strategies following the diversion of narcotics. The facility failed to ensure scheduled II medication were secured in a separately permanent affixed compartment. During an interview on 05/10/21 at 5:00 PM with	F 865	accidents of hot liquid spills. Current residents who reside at the facility are at risk to be affected by this practice. RNs and LPNs will be reeducated on monitoring and auditing narcotics and other drugs, the surveillance program for weekly assessment to prevent wounds at advanced stage, and documenting ongoing monitoring and auditing newly admitted residents at risk for accidents of hot liquid spills. The DON/designee will complete weekly audits for 2 months to ensure the following is completed: monitoring and auditing of narcotics and other drugs, on going surveillance of weekly pressure sore assessment to prevent wounds at an advance stages, and staff documents ongoing monitoring and audits newly admitted residents at risk for accidents of hot liquids. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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F 865	Continued From page 182	F 865		

the Administrator, he was asked about the follow-up investigation of a drug diversion investigation. The Administrator was asked about documentation for monitoring staff to ensure Narcotics were not being diverted. The Administrator stated, "He did not have any documentation for monitoring of drug diversion."

In the area of (F-755) The facility staff failed to include monitoring and audit process to ensure an ongoing account of narcotics and other drugs for abuse were implemented'

In the area of (F-686) The facility staff failed to provide an on going surveillance program for weekly pressure sore assessment to prevent wounds at advance stages.

In the area of (F-689) The facility staff failed to have documentation of on going monitoring and audit of newly admitted residents at risk for accidents of hot liquids spills following an incident of a resident receiving a second degree burn.

The facility developed the following Ad Hoc strategies; to in-service Dietary staff on coffee temperatures, In-service all staff on the importance of placing the lids securely for all beverages, especially hot beverages and to assess all residents for hot liquids.

The Dietary staff in-service was completed on 4/30/21, it was titled "Temperature Logs, Coffee Logs". The education read; temperature of food and hot liquids should be obtained everyday before leaving the kitchen. There should not be any gaps (blank spaces) in any log. Failure to do the above will result in a write-up, (disciplinary action). All staff wasn't in-serviced, including

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F 865	Continued From page 183 many of the facility's direct care staff, as well as the Contract staff. The "Hot Liquid Safety Evaluation" wasn't completed for all residents admitted after the coffee spill. There was no documentation of monitoring to ensure lids were secure on cups distributed to residents. A review of the QAPI policy and procedures indicated: "PIP (Performance Improvement Plan) action plans- The PIP's are implemented and monitored through: Staff training and development of changes to protocols Monitoring and feed back mechanisms Review and revision of plans of action when needed"	F 865		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced	F 868		6/14/21

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F 868	Continued From page 184 by: Based record review and staff interview the facility staff failed to implement corrective action and monitor to ensure the Quality assurance and performance (QAPI) program to ensure performance goals or targets are achieved. activities. The findings included: 1. The facility staff failed to maintain a QAPI plan for correcting quality deficiencies. During the survey conducted 05/04/21 through 05/12/21 indicated: In the area of (F-881) A review of the antibiotic Infection Control Surveillance Infection report log showed only the months of March, April, and May were available to view. During an interview on 05/10/21 at 6:00 PM with the Administrator, ADON and RDCS concerning Antibiotic Stewardship Program. They were asked if the ongoing review for antibiotic stewardship prior to the survey was complete. The ADON stated, "We need to continue our reviews for February 2021. "I don't see any other documentation from what was provided." The RDCS stated, "They are working on it. April wasn't completed." In the area of (F-882) The facility staff failed to designate at least one qualified Infection Preventionist. Received Infection Prevention and Control Certificates of training. In the area of (F-880) The facility staff failed to ensure infection control practices were followed in 3 resident rooms on the quarantine unit.	F 868	The facility will implement corrective action and monitoring to ensure the Quality Assurance and Performance Program to ensure performance goals or targets are achieved. Corrective actions and monitoring have been implemented for the following: QAPI plan for Antibiotic Infection Control Surveillance, designated on qualified Infection Preventionist, Infection control practices in residents rooms, provide COVID-19 testing on staff, monitoring and audit process to ensure on ongoing account of narcotics and other drugs, surveillance program for weekly pressure sore assessment to prevent wounds at advance stages, and document monitoring and audit of newly admitted residents at risk for accidents of hot liquid spills. Current residents who reside at the facility are at risk to be affected by these practices. The QAPI committee has been re-educated on implementing corrective action and monitoring to ensure the Quality Assurance and Performance Program to ensure performance goals or targets are achieved. The Administrator will complete weekly audits for 2 weeks to ensure corrective action and monitoring of the Quality Assurance Program and to ensure that performance goals or targets are achieved.	

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F 868	Continued From page 185 In the area of (F-886) The facility staff failed to perform COVID-19 testing on staff. In the area of (F-761) The facility staff failed to include monitoring and audit performance strategies following the diversion of narcotics. The facility failed to ensure scheduled II medication were secured in a separately permanent affixed compartment. During an interview on 05/10/21 at 5:00 PM with the Administrator, he was asked about the follow-up investigation of a drug diversion investigation. The Administrator was asked about documentation for monitoring staff to ensure Narcotics were not being diverted. The Administrator stated, "He did not have any documentation for monitoring of drug diversion." In the area of (F-755) The facility staff failed to include monitoring and audit process to ensure an ongoing account of narcotics and other drugs for abuse were implemented' On 5/5/21 at 12:12 p.m., surveyor (#2) asked the Administrator to provide any investigation that may have taken place for the aforementioned misappropriation of narcotics and or drug diversion. He stated he did not know where the info was because he had been Interim Administrator for one day. Upon further search, he located the investigation packet. It was also requested if the facility addressed the issue during a Quality Assurance and Performance Improvement (QAPI) committee meeting at the time of the incident. The Administrator located a large binder and pulled from a large QA binder an AD HOC meeting minutes dated 10/26/20 with training titled "Allegations of Abuse, Not Reported	F 868	Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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Per Policy." He stated that misappropriation of narcotics would be under abuse. Upon review of the AD HOC minutes and sign in sheet indicated the only training that was conducted regarded "Reporting Abuse" and no reference to misappropriation of narcotics or drug diversion.

On 5/6/12 at 11:30 a.m., the Administrator presented another AD HOC meeting minutes with no date or time, but in a box labeled issues was written "Drug Diversion." He said that Registered Nurse (RN) #3 located the packet in the previous DON's office. The Administrator stated he was concerned that there was no date as to when the AD HOC meeting took place. Upon review, this surveyor (#2) stated the presented information was the same information in the investigation packet, except it indicated that 100% of all nursing staff would be educated on the facility's narcotic policy, nurse managers will review all discharge orders in morning meeting, nurse management will audit narcotic sheets 5 times a week for 4 weeks for accuracy, DON will perform random narcotic audits to ensure residents are receiving medications and to review in QAPI.

Based on the review of the above undated AD HOC, only 3 nurses out of 10 staff (remaining 7 staff were non-nursing) signed in as receiving the education on the facility's narcotic policy. As a matter of record, there was no information provided to the survey team that represented how many nursing staff (licensed and certified) were employed at the time of the discovery of the misappropriation of the resident's narcotics. There was no evidence provided that nurse managers reviewed discharge orders in the morning meetings, audited 5 times a week for 4 weeks for accuracy, random narcotic audits to

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ensure residents are receiving medications or that any of the results were reviewed in QAPI. Review of the current staffing sheets reviewed from 4/30/21 through 5/6/21 revealed there were at least 46 licensed and certified nurses employed which may have estimated the number of nurses that should have signed in as received the education on the facility's narcotic policy.

During the above interview on 5/6/21 at 11:30 a.m., the Administrator stated they could not locate any additional nurse inservices or audits to support a monitored corrective action plan for drug diversion. In addition, there was clear evidence that the destruction/waste of narcotics was consistently signed by the current DON along with another licensed nurse, but inconsistencies in 2020. It was stated that the Controlled Drug Record should be kept in the resident's medical records, but many of them could not be located for 2020. The pharmacy shipping manifests for the delivery of narcotics for Resident #152, #151, #30 and #43 were requested for 2020 to current. When they were presented to surveyor (#2), for any of there was difficulty finding many of the aforementioned resident's Controlled Drug Records for 2020. There was no evidence that this was a part of the monitoring to ensure the narcotic drug records matched the shipping manifests.

In the area of (F-686) The facility staff failed to provide an on going surveillance program for weekly pressure sore assessment to prevent wounds at advance stages.

In the area of (F-689) The facility staff failed to have documentation of on going monitoring and

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F 868	Continued From page 188 audit of newly admitted residents at risk for accidents of hot liquids spills following an incident of a resident receiving a second degree burn. The facility developed the following Ad Hoc strategies; to in-service Dietary staff on coffee temperatures, In-service all staff on the importance of placing the lids securely for all beverages, especially hot beverages and to assess all residents for hot liquids. The Dietary staff in-service was completed on 4/30/21, it was titled "Temperature Logs, Coffee Logs". The education read; temperature of food and hot liquids should be obtained everyday before leaving the kitchen. There should not be any gaps (blank spaces) in any log. Failure to do the above will result in a write-up, (disciplinary action). All staff wasn't in-serviced, including many of the facility's direct care staff, as well as the Contract staff. The "Hot Liquid Safety Evaluation" wasn't completed for all residents admitted after the coffee spill. There was no documentation of monitoring to ensure lids were secure on cups distributed to residents. A review of the QAIP policy and procedures indicated: "PIP (Performance Improvement Plan) action plans- The PIP's are implemented and monitored through: Staff training and development of changes to protocols Monitoring and feed back mechanisms Review and revision of plans of action when needed"	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/14/21

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F 880	Continued From page 189 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 190 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and review of facility documents, the facilitys staff failed to ensure infection control measures and practices were in place in the laundry room and 3 resident rooms on the quarantine unit (Room's 202, 204 and 207), in the survey sample. 1. The facility failed to ensure that all laundry was handled, stored, and processed in a safe and sanitary method.	F 880	One on One re-education was provided for the laundry worker to ensure infection control measures and practices are being followed. The housekeeper assigned to resident rooms 202, 204 and 207 is no longer employed at the facility. An audit was conducted of the laundry area and resident rooms to ensure infection control measures and practices are being followed.	

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F 880	Continued From page 191 During the initial of the laundry on 5/4/21 at approximately 1:15 p.m., the following observations were made with the Housekeeping Supervisor present; Multiple Hoyer slings were observed on top of numerous pillows in the corner against the wall beside the washing machines. The Housekeeping supervisor stated they were slings which were no longer used therefore; they needed to be stored someplace and the pillows were there to be washed and returned to service. Many other Hoyer slings were hanging on the wall facing the washers and they made contact with the floor. The Housekeeping supervisor stated they were the slings currently in service and staff would pick them up when needed. Directly beside the washers was a red biohazard container and a regular 13 gallon trash container overflowing with clear plastic bags. The Housekeeping supervisor stated the clear plastic bags were there because the laundry aide had just removed the resident's personal clothing from them and put them in the large laundry basket which was storing the soiled resident clothing. To the left of the washers was a large laundry type basket on wheels with dirty resident personal laundry climbing the wall, just a few inches from the ceiling. To the left of the sink was a shelf which housed open disinfectant bottles. The Housekeeping supervisor stated she left the opened containers there and she would put them away. In front of the sink before you get to the dryers	F 880	The laundry and housekeeping staff will be re-educated on laundry and housekeeping policies and procedures including infections control measure and practices. A root cause analysis was conducted by the QAPI committee including the Infection Preventionist and corrective actions initiated. The Administrator/designee will complete weekly audits for 2 months to ensure infection control measures and practices are being followed for the laundry area and resident rooms. Audit findings will be submitted monthly to the QAPI committee for review and recommendations.	

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was 4 yellow mop pails, one contained brown water which covered the bottom of the pail. The Housekeeping supervisor stated the housekeeping staff shared that area with the laundry but; she wasn't sure why one bucket contained the water.

Beneath the laundry detergents and on the floor were many pillows. The Housekeeping supervisor stated they were pillows which were removed from service and due to be discarded.

Near the dryer was a container of clean resident clothing which needed to be hung and distributed to the residents. Another container was also present, it contained resident clothing items which had no identifiable information, preventing them from being returned to the rightful owner.

Directly across from the dryers were 2 three tier carts of socks, slippers, and mop heads and other miscellaneous things. Finally in front of the clean laundry exit door was another cart full of unfolded personal clothing. The Housekeeping aid stated the items on the three tier carts were items the previous housekeeping staff had held on to.

On 5/5/21 at approximately 11:20 a.m., observations were again made of the laundry room. The slings and pillows in the corner next to the washers had been removed. The soiled resident's clothing was no longer present, the disinfectant bottles had been put away and the pillows due to be discarded were no longer there.

On 5/10/21 at approximately 7:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Director of

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Clinical Services. An opportunity was afforded the facility's staff to provide additional information but they did not.

2. The facility staff failed to ensure infection control measures and practices were followed for 3 resident rooms on the quarantine unit, Room #202 (A&B), #204 (B) and #207 (A).

On 5/4/21 at 11:00 a.m., during the orientation tour, through 5/6/21 at 2:00 p.m., the biohazard receptacles were the over flowing trash and soiled linen in the resident's bathroom in room 204 and 207 as well as trash and other debris on the floors. Blood stains, trash, feces and other debris were identified on the floor in room 202.

Resident #147 who resided in room 202, unlike the residents in room 204 and 207, was able to express his discontent with the condition of his room. This resident was admitted on 4/30/21 with diagnoses that included type 2 diabetes mellitus, chronic diabetic wounds of right and left foot with status post bilateral transmetatarsal amputations and skin graft infections, end stage renal disease with dependence on renal dialysis.

The 5-day Minimum Data Set (MDS) assessment was dated 4/30/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident had the necessary cognitive skills for daily decision making. The resident had no problems understanding the staff and was understood. The resident was assessed without mood or behavioral problems. The assessment was signed by the MDS Coordinator as completed on 5/10/21.

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On 5/4/21 at 1:05 p.m., Resident #147 was observed sitting on the side of the bed with a full lunch meal tray, his call light was on. The call light over his door was visibly operational and could be heard from the nurse's station. The left and right foot dressing exhibited serous bloody drainage which was also visible on the floor where the resident placed his feet. The Kling wrap on the left foot was unraveled and intertwined itself around the wheels of his over bed table. The resident stated that his dressing had been in that condition all night and he had been asking someone to change his dressings. The foot of his bed exhibited the same drainage on his sheets at the foot of the bed. There was also brown chunked material on the floor between the two beds along with trash, debris, alcohol wipes, chuck pad and accumulated dried blood that remained until inquired by Surveyor #2 on 5/6/21. The resident also stated he ask for someone to clean his floor of the blood from his foot wounds and pick up the fecal material. A foul order was apparent upon entering the room and it was discovered the biohazard trash and linen receptacles in the bathroom were full, over flowing and soiled items of trash and linen pilled on top of the receptacles. This also remained until inquiry by Surveyor #2 on 5/6/21.

On 5/6/21 at approximately 2:00 p.m., the Administrator donned full PPE and was shown the condition of the resident's rooms and the over flowing trash and soiled linen in the biohazard bags in the resident's bathrooms, as well as blood, trash, feces and other debris identified on the floor. The Administrator requested the housekeeper to assist to empty the biohazard receptacles and clean the rooms. The Housekeeping Director stated it was the job of the

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F 880	Continued From page 195 nursing staff to empty the biohazard bags in the biohazard containers in the dirty utility room, but that they were able to retrieve those bags from her department. On 5/10/21 at 5:59 p.m., a debriefing was conducted with the Administrator, the Director of Nursing (DON) and the Regional Director of Clinical Services. The DON stated Administrator concurred that it was an expectation that rooms are maintained clean and biohazard bags disposed of in the specified containers in the dirty utility rooms. The facility's policy and procedures titled "Biohazardous waste" dated 2/2017 indicated that disposable items that contain soiling with liquid ore semi-liquid blood or other potentially infectious material, that if compressed are capable of releasing these materials during handling. The policy did not specify which employees were responsible to transfer the biohazard bags to the dirty utility room to be placed in the biohazard receptacles.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 881		6/14/21

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F 881	Continued From page 196 Based on staff interview and a review of facility documents, the facility's staff failed to conduct an ongoing review for antibiotic stewardship for one person in a survey sample of 43 residents. The findings included: On 5/10/21 at approximately 12:45 PM., an appointment was made with the administrator concerning the Antibiotic Stewardship Program for 2:00 PM. On 5/10/21 A review of the antibiotic Infection Control Surveillance infection report log showed that only the months of March, April and May were available to view. The months of January and February were not available. No other supporting documents or forms were available to view per onsite surveyor. On 5/10/21 at approximately 3:25 PM a review of the Antibiotic Stewardship Program was conducted with the ADON (Acting Director of Nursing) and with the Regional Director of Clinical Services (RDCS). The Director of Clinical Services stated, "If a staff recognize a person is suspicious for infection they go to the DON (Director of Nursing) for Skin infections, UTI's (Urinary Tract Infections) or fever of unknown origin we do a Mcgreers form and we keep a tracking and trending log." The surveyor asked the ADON if he could get a list of people currently on antibiotics and if they had the Antibiotic Stewardship binder with them. The RDCS stated, "There is no one with infections right now that I know of. "We didn't bring it (Binder). It's down the hall." The ADON and RDCS never returned calls to	F 881	1. The antibiotic infection control surveillance infection report logs are complete and current. 2. A review of new antibiotic orders in the last 30 days completed to ensure accuracy and proper documentation is made in the antibiotic infection control surveillance infection report logs. 3. Appropriate Licensed staff will be re-educated on proper documentation on the antibiotic infection control surveillance infection report logs. 4. Audits of the antibiotic infection control surveillance infection report logs will be conducted by the DON/Designee weekly for four weeks then monthly for three months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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resume our meeting.

A review of Infection Control Surveillance Monthly logs show from March to May (2021) show a total of 15 infections were listed. (Including 2 infections for the month of May 2021)

On 5/10/21 at approximately 6:00 PM a team meeting was held with the Administrator, ADON and RDCS concerning the Antibiotic Stewardship Program. They were asked by the surveyor if they were conducting an ongoing review for antibiotic stewardship prior to this survey? The ADON stated,"We need to continue our reviews for February 2021. "I don't see any other documentation from what I sent you." (Surveyor only received the Infection Control Surveillance Infection logs)The RDCS stated, "They are working on it. April wasn't completed." (April only list 1 Resident with an infection).

The facility's policy titled/date: Infection Control Program-Antibiotic Stewardship F-881. Dated: 2/2018. Policy Statement: This facility has established an infection prevention and control program that includes protocols to establish a system for the use and monitoring of adverse effects of antibiotics.

Residents whom need antibiotics are prescribed an antibiotic.

Antibiotic Stewardship: A set of commitments and actions designed to optimize this treatment of infections while reducing the adverse effects associated with antibiotic use.
Mcgreer Criteria: Surveillance criteria.
Epidemiology worksheet: RCA process to evaluate infections.

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F 881	Continued From page 198 Procedure: The basic tenants of an antibiotic stewardship program include: a. Appropriate prescribing. b. Appropriate Administration c. Management practices to reduce inappropriate use to ensure that residents receive the right antibiotic for the right indication, right dose and right duration. Core elements on an antibiotic stewardship program: Appropriate staff accountable for promoting and overseeing antibiotic stewardship; Track measures of antibiotic use on the facility,one process and one outcome measure; The antibiotic stewardship program will be reviewed annually. On 5/11/21 at approximately 9:30 AM the above findings were shared with the Administrator and The Acting Director of Nursing (ADON) An opportunity was offered to the facility's staff to present additional information but no additional information was provided. The ADON stated, The ADON Stated, "We're missing February's Surveillance."	F 881		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F 882		6/14/21

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F 882	Continued From page 199 §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and a review of facility documents, the facility staff failed to designate at least one qualified Infection Preventionist. The findings included: On 5/06/21 at approximately 9:15 AM an interview was conducted with the ADON (Acting Director of Nursing) Concerning the Infection Preventionist (IP). He stated, We had an Infection Control Nurse (RN #3) but she left abruptly on April 28th. I'm assuming the role. I registered for class on yesterday." I'm going to try to start the training this weekend." He was asked by the said surveyor if he could email the Infection Control Training certificate of the former Infection Control Preventionist as well as a copy of his registration for the Infection Control class. He stated, "Okay."	F 882	1. Facility has designated one qualified Infection Preventionist. 2. Current residents that reside at the facility with infection have the potential to be affected. 3. Appropriate Licensed staff will be re-educated on need for a qualified Infection Preventionist for facility. 4. Audit of completed certificate for the Infection and Prevention Program will be conducted by Administrator weekly for four weeks then monthly for three weeks. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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F 882	Continued From page 200	F 882		

Received Infection Prevention and Control Certificates of Training on 5/07/21 for RN #3. The certificates show that out of fifteen modules only 14 were completed. Module #7 was not available.

The following email was sent to the Administrator on 5/07/21 at approximately 9:38 AM after receiving RN #3's Infection Prevention Training documents. It read: Good morning! I'm missing module 7 of RN (Registered Nurse) #3, Former Infection Preventionist Training. Did you find out if she has the completion certificate? When did she leave your facility? You also mentioned that the MDS Coordinator had completed the training-where is the completion certificate?

On 5/07/21 an interview was conducted with the administrator concerning the incomplete training certificates on RN #3 and the Antibiotic Stewardship program. He stated, I'll assign someone today."

Several attempts were made throughout the survey to speak with someone concerning the Infection and Prevention Program without much success.

On 5/07/21 at approximately, 11:00 AM an interview was conducted with RN #3. She was informed of the said surveyor receiving her incomplete IFC (Infection Control) Modules. She stated, that she no longer worked at the said facility but is now working at a sister facility. "I'm helping out today." I will have them email you my completed certificate (IPC).

No IPC completion certificate was received during the survey.

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F 882	Continued From page 201 On 5/11/21 at approximately 9:30 AM., the above findings were shared with the ADON and the Administrator. The ADON (Acting Director of Nursing) stated, "We had an Acting DON, I'm not sure if she had the infection control program completed. The new DON started today. There was a gap of a week. The person walked out and I assumed the role for a couple of days." An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 882		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;	F 886		6/14/21

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F 886	Continued From page 202 (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility documentation. The facility staff failed to	F 886	1. Current staff are being tested for COVID-19.	

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F 886	Continued From page 203 implement COVID-19 testing to all staff. The findings include: The facility staff failed to test five nursing staff during their twice weekly COVID-19 testing. Therefore, increasing the chances of spreading COVID-19. A review of the as worked schedule and Employee COVID-19 consent forms reveal that the following nursing staff were not tested for COVID-19. LPN (License Practical Nurse) #15, CNA (Certified Nurses Aide) #1 and CNA #7 worked on 5/03/21 (Monday). LPN #3 worked on 5/05/21 (Wednesday). LPN #1 and LPN #7 worked on 5/06/21 (Thursday). LPN #15 and CNA #5 worked on 5/07/2. CNA #5 worked on 5/09/21. An interview was conducted on 5/06/21 at approximately 2:55 PM with CNA (Certified Nursing Assistant) #1 concerning the COVID-19 test. She stated, "We get tested twice weekly. Monday and Thursday. I received my first COVID19 vaccine shot on yesterday." An interview was conducted with LPN (Licensed Practical Nurse) #15 on 5/10/21 at approximately 9:15 PM., Concerning the COVID-19 testing at the facility. She stated, " I get tested once a week. Initially it was twice a week. They did a courtesy call today to tell me that they're testing tomorrow between 7:00 AM and 11:00 AM.. I wasn't tested last week. I did work. I waited around after getting off work and the person that does the testing wasn't there. I waited until 8 am."	F 886	2. An audit of current staff completed to ensure COVID-19 testing completed. 3. Current staff will be re-educated on the COVID-19 testing requirements for the facility. 4. Audits of as worked schedule will be conducted by the DON/Designee weekly for four weeks then monthly for three months to ensure staff testing. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 6/14/2021	

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F 886	Continued From page 204 On 5/10/21 (Monday) at approximately, 9:20 PM an interview was conducted with CNA #5, concerning the COVID-19 test. She stated, "The next test is Friday. They told me to come fifteen minutes early for the test. I'm new here. I started two days ago on a Saturday I think. I wasn't tested for COVID-19 yet. I haven't received the vaccine either. They told me I will get tested Friday here." On 5/11/21 at approximately 9:30 AM the above findings were shared with the Administrator and the Acting Director of Nursing (ADON) An opportunity was offered to the facility's staff to present additional information but no additional information was provided. The administrator stated, "I have not been involved in reviewing the testing." The ADON stated, "They should have been tested."	F 886		