STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495315	A. BUILDING _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

(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 10/19/2021 through 10/26/2021. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
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 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	E 037		12/1/21

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

Electronically Signed | 11/18/2021

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E 037	Continued From page 1	E 037		

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.

*[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

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E 037	Continued From page 2	E 037		

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.

*[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

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E 037	Continued From page 3 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. *[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	E 037		

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E 037	Continued From page 4 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 staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. The findings include: On 10/20/2021 at approximately 2:30 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, executive director. Review of the facility's emergency preparedness plan failed to evidence	E 037	1. Emergency Preparedness Training completed by 12/01/2021 2. No residents were affected by this deficient practice 3. Staff re-education by the ED/designee On Annual Emergency Preparedness training by 12/01/2021. 4. The Administrator is responsible for maintaining compliance. Administrator will ensure that Emergency Preparedness In-service on annual calendar. Annual In-services will be monitored through Quality Assurance Process Improvemen.t Pro schedule annual Emergency Preparedness Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality	

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E 037	Continued From page 5 documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. ASM # 1 stated that they were not able to provide evidence of training. On 10/20/2021 at 4:50 p.m., ASM [administrative staff member] # 1, executive director, ASM # 2, director of clinical services, ASM # 3, regional vice president of operations, ASM # 4, clinical nurse, and ASM # 5, interim assistant director of nursing, were made aware of the above findings. No further information was provided prior to exit.	E 037	Monitoring schedule modified based on findings. 5. 12/01/2021.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/19/2021 through 10/26/2021. Three complaints (VA00051181- unsubstantiated with no deficiencies, VA00051670- unsubstantiated with no deficiencies, VA00053403- substantiated with deficiencies), were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 88 certified bed facility was 82 at the time of the survey. The survey sample consisted of 35 current resident reviews and seven closed record reviews. On 10/21/21 at 4:28 p.m., Immediate Jeopardy was identified in the area of Behavioral Health	F 000		

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F 000	Continued From page 6 Services at the Scope and Severity Level four pattern, and the facility administration was informed. 10/22/2021 at 6:37 p.m. the Immediate Jeopardy was abated and was lowered to a Level II pattern. The Life Safety survey/report will follow.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		12/1/21

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F 550	Continued From page 7 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to provide care in a manner to ensure dignity for one of 41 residents in the survey sample, Resident #28. The facility staff failed to maintain Resident #28's Foley urinary catheter (1) in a dignified manner. Urine in the catheter bag was observed from the hall while Resident #28 was lying in bed. The findings include: Resident #28 was admitted to the facility on 4/21/20. Resident #28's diagnoses included but were not limited to congestive heart failure, muscle weakness and dementia. Resident #28's quarterly minimum data set assessment with an assessment reference date of 8/31/21, coded the resident's cognition as moderately impaired. Review of Resident #28's clinical record revealed a physician's order dated 3/23/21 for a Foley catheter due to urinary retention. Resident #28's comprehensive care plan dated 3/15/21 documented, "(Resident #28) has	F 550	1. Resident #28 had a dignity bag placed on catheter bag on 10/20/2021. 2. Quality review completed and no other residents affected by catheter without privacy cover on 10/20/2021. 3. Staff re-education by the DON/designee completed on catheter care and resident dignity 11/18/2021 4. The Administrator is responsible for maintaining compliance. The Director of Nursing/designee to complete quality monitoring using daily round sheets to ensure catheters with dignity bag in place 3 times weekly for 4 week then monthly for 6 months to ensure compliance maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021.	

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Indwelling Foley Catheter r/t (related to) obstructive uropathy...Position catheter bag and tubing below the level of the bladder and away from entrance room door."

On 10/19/21 at 8:48 a.m. and 9:49 a.m., Resident #28 was observed in bed and was not able to be interviewed. The resident's Foley catheter bag was observed attached to the bed frame and was located on the side of the bed that was facing the door. The urine in the catheter bag was visible from the hall.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated a privacy bag should cover a resident's Foley catheter bag and she would feel embarrassed if she had a catheter and the urine in the bag was visible to others.

On 10/20/21 at 2:32 p.m., an interview was conducted with RN (registered nurse) #1, the employee who documented Resident #28's care plan. RN #1 stated she documented to keep Resident #28's catheter bag and tubing aware from the entrance room door for privacy.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services, [director of nursing]) were made aware of the above concern.

The facility policy regarding urinary catheter care failed to document information regarding catheters and dignity.

No further information was presented prior to exit.

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F 550	Continued From page 9 Reference: (1) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm	F 550		
F 558 SS=D	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, facility document review and clinical record review, it was determined that the facility staff failed to provide accommodation of needs for two of 41 residents in the survey sample, Residents #8 and #28. The facility staff failed to ensure Resident #8 and Resident #28's call bell or ring bell was within reach. The findings include: 1. The facility staff failed to ensure Resident #8's hand held ring bell was within the resident's reach. Resident #8 was admitted to the facility on 8/13/20. Resident #8's diagnoses included but were not limited to major depressive disorder, diabetes and muscle weakness. Resident #8's	F 558	1. Resident #8 and #28 call bells and/or ringing bell placed in reach by the nursing staff on 10/20/2021. 2. Quality review completed and no other residents affected by call bell not being 3. Staff re-education completed on 11/18/2021 by DON/designee on call bell system and ensuring the call bells and/or ringing bells within the resident reach. 4. The Administrator is responsible for maintaining compliance. The DON/designee will complete quality monitoring of call bells and/or ringing bells, using daily round sheets 3 times per week for 4 weeks then monthly for 6 months to ensure compliance. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality	12/1/21

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F 558	Continued From page 10 annual minimum data set assessment with an assessment reference date of 8/2/21, coded the resident as being cognitively intact. Section G coded Resident #8 as requiring extensive assistance of two or more staff with bed mobility. Resident #8's electric call bell was not operational during the survey. On 10/19/21 at 10:09 a.m., Resident #8 was lying in bed. An interview was conducted with the resident who stated that he sometimes uses his call bell. On 10/19/21 at 10:50 a.m. and 3:45 p.m., Resident #8 was lying in bed. A hand held ring bell was observed on a night stand that was positioned against the wall, to the side and behind the head of Resident #8's bed. The ring bell was not within Resident #8's reach. Resident #8's comprehensive care plan dated 8/26/20 documented, "(Resident #8) is at risk for falls r/t (related to) impaired mobility...Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed." On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated residents should have call bells or ring bells within reach so they have an easy way to get a hold of staff. On 10/19/21 at 3:47 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated she checks to ensure call bells are within residents' reach when she completes her rounds. CNA #1 stated call bells should be within residents' reach in case there is	F 558	Monitoring schedule modified based on findings. 5. 12/01/2021	

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F 558	Continued From page 11	F 558		

an emergency and because some residents are not mobile. CNA #1 was shown the ring bell on Resident #8's nightstand. CNA #1 stated the ring bell was not within the resident's reach and placed it on an over bed table within the resident's reach.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

The facility policy regarding the call bell system documented, "Resident must have, at all times, a system to notify staff when assistance is needed. Hand bells or tap type bells will be placed within reach of any resident affected by an inoperable call bell..."

No further information was presented prior to exit.

2. The facility staff failed to ensure Resident #28's call bell was within reach.

Resident #28 was admitted to the facility on 4/21/20. Resident #28's diagnoses included but were not limited to congestive heart failure, muscle weakness and dementia. Resident #28's quarterly minimum data set assessment with an assessment reference date of 8/31/21, coded the resident's cognition as moderately impaired. Section G coded Resident #28 as requiring extensive assistance of one staff with bed mobility.

On 10/19/21 at 8:48 a.m. and 11:07 a.m., Resident #28 was observed in bed. The resident's call bell was on the floor on the left side of the resident's bed and was not within the

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F 558	Continued From page 12 resident's reach. Resident #28 was not able to be interviewed during the survey. Resident #28's comprehensive care plan dated 4/29/20 documented, "(Resident #28) is at risk for falls r/t (related to) a h/o (history of) falls...Be sure his call light is within reach and encourage him to use it for assistance as needed. Due to blindness, be sure you tell him where the call bell is." On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated residents should have call bells or ring bells within reach so they have an easy way to get a hold of staff. On 10/19/21 at 3:47 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated she checks to ensure call bells are within residents' reach when she completes her rounds. CNA #1 stated call bells should be within residents' reach in case there is an emergency and because some residents are not mobile. On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. No further information was presented prior to exit.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		12/1/21

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representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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F 580	Continued From page 14 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to notify the physician of a possible need to alter treatment for two of 41 residents in the survey sample, Residents #24 and #129. The facility staff failed to notify Resident #24's physician when the medication Eliquis was not available for administration on 7/5/21 and 7/29/21, and failed to notify Resident #129's physician when the medication guaifenesin was not available for administration on 9/28/21, 9/29/21 and 9/30/21. The findings include: 1. Resident #24 was admitted to the facility on 3/29/20. Resident #24's diagnoses included but were not limited to diabetes, atrial fibrillation (1) and a history of stroke. Resident #24's quarterly minimum data set assessment with an assessment reference date of 8/27/21, coded the resident's cognitive skills for daily decision making as modified independence. Review of Resident #24's clinical record revealed a physician's order dated 3/12/21 for Eliquis (1) 2.5 mg (milligrams) - one tablet by mouth two times a day for peripheral vascular disease (2). Resident #24's July 2021 MAR (medication	F 580	1. Resident #24 and #129 physician was notified on 10/26/2021 of medication not being available. 2. Quality review of in-house residents to ensure physician notification of any medications not available. Residents identified will have notification to the physician. 3. Staff re-education on physician notification and steps to take when medications not available by the DON/designee. 4. The Administration is responsible for maintaining compliance. The DON/designee will complete quality monitoring of progress notes during morning meeting weekly for 4 weeks then monthly for 6 months to ensure compliance. Follow-up based on findings and reported to the monthly QAPI meeting. Quality monitoring schedule modified based on findings. 5. 12/01/2021	

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administration record) documented the order for Eliquis 2.5 mg- one tablet by mouth two times a day. On 7/5/21 at 5:00 p.m. and 7/29/21 at 5:00 p.m., the nurse did not document the medication as being administered. The MAR documented the code, "9=other/See Nurse Notes." A nurse's note dated 7/5/21 documented, "out of medication and was reordered." A nurse's note dated 7/29/21 documented, "not available."

Further review of Resident #24's clinical record failed to reveal the physician was notified on the above dates when Eliquis was not administered.

Resident #24's comprehensive care plan dated 8/2/20 documented, "(Resident #24) has Peripheral Artery Disease. Give medications for improved blood flow or anticoagulants as ordered..." The care plan failed to document information regarding physician notification if the medication was not administered.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the physician should be notified when a medication is not available for administration to a resident because the physician may want to change the order.

On 10/21/21 at 8:30 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

The facility policies regarding medical care and medication administration failed to document specific information regarding physician notification for medications not available for administration.

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No further information was presented prior to exit.

References:

(1) "Apixaban (Eliquis) is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613032.html

(2) Peripheral vascular disease is a condition of the blood vessels that supply the feet and legs. This information was obtained from the website: https://medlineplus.gov/ency/article/000170.htm

2. Resident #129 was admitted to the facility on 4/22/21. Resident #129's diagnoses included but were not limited to high blood pressure, diabetes and COVID-19. Resident #129's quarterly minimum data set assessment with an assessment reference date of 10/3/21, coded the resident's cognition as severely impaired.

Review of Resident #129's clinical record revealed a physician's order dated 9/27/21 for guaifenesin (1) liquid 100 mg (milligrams)/5 ml (milliliters). Give 10 ml by mouth every four hours for a cough for 15 days.

Resident #129's September 2021 MAR (medication administration record) documented the order for guaifenesin liquid 100 mg (milligrams)/5 ml (milliliters). Give 10 ml by

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mouth every four hours for a cough for 15 days. On 9/28/21 at 12:00 p.m. and 4:00 p.m., 9/29/21 at 4:00 a.m. and 8:00 p.m., and 9/30/21 at 12:00 a.m. and 4:00 a.m., the nurse did not document the medication as being administered. The MAR documented the code, "9=other/See Nurse Notes."

A nurse's note dated 9/28/21 documented, "on order from supply." Another nurse's note dated 9/28/21 documented, "on supply order." A nurse's note dated 9/29/21 documented, "drug not available." Another nurse's note dated 9/29/21 documented, "drug not available." A nurse's note dated 9/30/21 documented, "drug not available."

Further review of Resident #129's clinical record (including nurses' notes) failed to reveal the physician was notified on the above dates when guaifenesin was not administered.

Resident #129's comprehensive care plan dated 6/25/21 failed to document information regarding physician notification if guaifenesin was not administered.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the physician should be notified when a medication is not available for administration to a resident because the physician may want to change the order.

On 10/21/21 at 8:30 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

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F 580	Continued From page 18 No further information was provided. Reference: (1) Guaifenesin is used to treat chest congestion. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682494.html	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §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	F 622		12/1/21

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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 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

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F 622	Continued From page 20 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. (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 the facility staff failed to evidence transfer discharge requirements transfer to the hospital for one of forty-one residents in the survey sample, Resident #71. The facility staff failed to evidence required transfer documentation/documents, to include: contact information of the practitioner responsible for the care of the resident, resident information including contact information, advance directives, comprehensive care plan goals, special care instructions, and all other necessary information as applicable to ensure safe and effective transition of care for Resident #71, were provided to the receiving hospital on 9/26/21, when the resident was transferred to the hospital . 	F 622	1. The facility was not able to provide documentation for Resident #71 for the facility initiated transfer. 2. Quality review completed for facility initiated transfers since 11/01/2021 to identify any other residents affected by the practice. Residents identified information sent to the receiving facility. 3. Licensed staff re-education Transfer/discharge policy completed on 11/18/2021 by the DON/designee. 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete the transfer/discharge quality monitor for facility initiated Transfer/Discharges to ensure compliance is maintained weekly	

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F 622	Continued From page 21 The findings include: Resident #71 was admitted to the facility on 9/8/21. Resident #71's diagnoses included but were not limited to: chronic obstructive pulmonary disease 'COPD' (chronic non-reversible lung disease) (1), cellulitis (inflammation of the skin beneath the tissue) (2), cirrhosis of the liver (chronic condition in which the normal liver tissue is replaced by fibrous tissue and nodules interfering with normal blood flow and function) (3) and bundle branch block (defect in the electrical tissues of the heart that results in abnormal conduction) (4). Resident #71's most recent MDS (minimum data set) assessment, a five day Medicare admission assessment, with an assessment reference date of 9/15/21, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. Review of Resident #71's clinical record revealed the resident was transferred to the hospital on 9/26/21 for shortness of breath and hypoxia. A review of the nursing progress note dated 9/26/21 at 11:47 PM, documented in part, "Resident stated that he was SOB [shortness of breath], O2 [oxygen] on 5L [liter] was 85%, resident stated, "I feel funny." When asked if resident wanted to go to the hospital, resident stated, "yes." Writer completed vital signs 150/97 [blood pressure], Oxygen at 5 liters with saturation of 85 percent, pulse 136. Nurse Practitioner made aware. Gave report to hospital emergency department charge nurse, called 911	F 622	for 4 weeks then monthly for 6 months. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021.	

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and EMT (emergency medical technicians) arrived, and transported resident on a stretcher to the hospital.

On 10/20/21 at 7:36 AM, ASM (administrative staff member) #1, the executive director, brought in requested paperwork for Resident #71, with a note documenting, "Resident #71, no transfer papers. Second staff person helped me check, the papers are no-where to be found."

An interview was conducted on 10/20/21 at 2:55 PM with OSM (other staff member) #4, the social services manager. When asked about transfer paperwork for residents' sent to the hospital, OSM #4 stated, "I believe there is care plan goals and a form that is filled out."

An interview was conducted on 10/21/21 at 6:55 AM with LPN (licensed practical nurse) #8. When asked what documentation is sent with a resident upon transfer to a hospital, LPN #8 stated, "Care plan goals, there is a transfer form, we notify the physician and family of the transfer."

On 10/20/21 at 5:10 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3 the regional vice president of operations and ASM #4 the regional clinical nurse were made aware of the concerns.

The facility's "Transfer/ Discharge Notification and Right to Appeal" policy dated 3/6/2018, documented in part, "When the center transfers or discharges a resident under any of the circumstances listed, the facility will ensure that the transfer or discharge is documented and appropriate information is communicated to the

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F 622	Continued From page 23 receiving health care institution or provider. This information must include but is not limited to: contact information of the practitioner responsible for the care of the resident, resident information including contact information, advance directives, comprehensive care plan goals, special care instructions, and all other necessary information as applicable to ensure safe and effective transition of care." No further information was provided prior to exit References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 108. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 121. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 91.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		12/1/21

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(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

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including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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F 623	Continued From page 26 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). 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 evidence notification to the ombudsman of hospital transfer/discharges for four of 41 residents in the survey sample, Residents #331, #71, #129, and #45. 1. The facility staff failed to notify the ombudsman of Resident #331's discharge to the hospital on 9/17/21. 2. The facility staff failed to provide written notification of transfer to the ombudsman for Resident #71, when the resident was transferred to the hospital on 9/26/21. 3. Resident #129 was transferred to the hospital on 9/20/21. The facility staff failed to provide written notification of the transfer to the ombudsman. 4. The facility staff failed to evidence that the ombudsman was notified of a facility-initiated transfer on 08/05/2021 for Resident # 45. The findings include: 1. Resident #331 was admitted to the facility on 5/26/21, and most recently readmitted on 10/19/21 with diagnoses including a broken right arm, diabetes, and history of a stroke. On the	F 623	1. The facility was unable to provide documentation the RR and Ombudsman were notified for resident #71, #129, #331 and #45. 2. Quality review completed on transfer/discharges on 11/18/2021 for all facility initiated transfers since 11/01/2021. Residents identified information sent to RR and Ombudsman. 3. Licensed nurse re-educated on issuing transfer notices and Social Services re-educated on notification of RR and Ombudsman on 11/18/2021 by DON/designee 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete the transfer/discharge quality monitor for any discharges to ensure compliance is maintained weekly for 4 weeks then monthly for 6 months. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021.	

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most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/30/21, the resident was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status.

A review of Resident #331's clinical record revealed the following progress note: "9/17/21 Nursing Progress Note Text: This nurse was called to the resident room by NP (nurse practitioner) because resident was choking on non-thickened ginger ale that was given to her by her family. On arriving to the resident room, resident had been placed on her side...The rescue squad was called. The rescue squad came and transported the resident to the hospital."

Further review of the resident's census information provided by the facility revealed she was hospitalized from 9/17/21 until she was readmitted to the facility on 10/12/21.

On 10/20/21 at 3:12 p.m., OSM (other staff member) #4, the social services manager, was interviewed. She stated it is her responsibility to email the ombudsman when a resident is discharged to the hospital. OSM #4 also stated she has the option of sending a fax to the ombudsman to notify of a resident discharge. She stated she keeps copies of these ombudsman notifications in a book. OSM #4 was asked to provide evidence the ombudsman had been notified in writing regarding Resident #331's discharge to the hospital on 9/17/21.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2,

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the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns.

On 10/21/21 at 8:36 a.m., ASM #2 stated the facility did not have evidence of the ombudsman notification of Resident #331's discharge to the hospital on 9/17/21.

A review of the facility policy, "Transfer/Discharge Notification and Right to Appeal," revealed, in part: "Before a center transfers or discharges a resident the center must...send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman."

No further information was provided prior to exit.
2. Resident #71 was admitted to the facility on 9/8/21. Resident #71's diagnoses included but were not limited to: chronic obstructive pulmonary disease 'COPD' (chronic non-reversible lung disease) (1), cellulitis (inflammation of the skin beneath the tissue) (2), cirrhosis of the liver (chronic condition in which the normal liver tissue is replaced by fibrous tissue and nodules interfering with normal blood flow and function) (3) and bundle branch block (defect in the electrical tissues of the heart that results in abnormal conduction) (4).

Resident #71's most recent MDS (minimum data set) assessment, a five day Medicare admission assessment, with an assessment reference date of 9/15/21, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact.

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Review of Resident #71's clinical record revealed the resident was transferred to the hospital on 9/26/21 for shortness of breath and hypoxia.

On 10/20/21 at 7:36 AM, ASM (administrative staff member) #1, the executive director, brought in requested paperwork for Resident #71, with note documenting, "Resident #71, no ombudsman notification found."

An interview was conducted on 10/20/21 at 2:55 PM with OSM (other staff member) #4, the social services manager regarding notification to the ombudsman for Resident discharges/transfers. OSM #4 stated, "There is transfer paperwork, RP (responsible party), ombudsman notification and bed hold." When asked when she had taken on this role, OSM #4 stated, "I was in activities in July, then both social workers walked out and they put me in that position to keep up with the discharges."

An interview was conducted on 10/21/21 at 7:15 AM with OSM #4. When asked the if the ombudsman notification for Resident #71 had been found, OSM #4 stated, "There is no ombudsman notification for this resident."

On 10/20/21 at 5:10 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3 the regional vice president of operations and ASM #4 the regional clinical nurse were made aware of the concerns.

No further information was provided prior to exit

References:

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 108.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 121.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 91.
3. Resident #129 was admitted to the facility on 4/22/21. Resident #129's diagnoses included but were not limited to high blood pressure, diabetes and COVID-19. Resident #129's quarterly minimum data set assessment with an assessment reference date of 10/3/21, coded the resident's cognition as severely impaired.

Review of Resident #129's clinical record revealed a nurse's note dated 9/20/21 that documented the resident was discharged to the hospital on 9/20/21, due to an elevated temperature, an elevated heart rate and respiratory complications.

Further review of Resident #129's clinical record failed to reveal written notification of the transfer was provided to the ombudsman.

On 10/20/21 at 2:55 p.m., an interview was conducted with OSM (other staff member) #4, the social services manager. OSM #4 stated she faxes or emails the ombudsman with notice of resident transfers and places the notice in a binder. OSM #4 was asked to provide evidence of ombudsman notification when Resident #129 was transferred to the hospital on 9/20/21.

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On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.
4. Resident # 45 was admitted to the facility with diagnoses included but were not limited to: low iron, intestinal bleeding and muscle weakness. Resident # 45's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/22/2021, coded Resident # 45 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

A nurse's note for Resident # 45 dated 08/05/2021 at 12:41 p.m., documented, "resident to be admitted to [Name of Hospital] for GI [gastrointestinal] bleed [1]."

Review of the clinical record and the EHR (electronic health record) for Resident # 45 failed to evidence notification to the ombudsman for the facility-initiated transfer on 08/05/2021 for Resident # 32.

On 10/20/21 at 2:55 p.m., an interview was conducted with OSM (other staff member) #4, the social services manager. OSM #4 stated she faxes or emails the ombudsman with notice of resident transfers and places the notice in a binder.

On 10/20/2021 at approximately 4:09 p.m., an interview was conducted with OSM [other staff member] # 4, social services manager. When

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F 623	Continued From page 32 asked about the documentation for the ombudsman notification regarding the facility-initiated transfer of Resident #45 on 08/05/2021, OSM # 4 stated that they did not have evidence of notification to the ombudsman." On 10/20/2021 at 4:50 p.m., ASM [administrative staff member] # 1, executive director, ASM # 2, director of clinical services, ASM # 3, regional vice president of operations, ASM # 4, clinical nurse, and ASM # 5, interim assistant director of nursing, were made aware of the above findings. No further information was provided prior to exit. Reference; [1] GI bleeding is not a disease, but a symptom of a disease. There are many possible causes of GI bleeding, including hemorrhoids, peptic ulcers, tears or inflammation in the esophagus, diverticulosis and diverticulitis, ulcerative colitis and Crohn's disease, colonic polyps, or cancer in the colon, stomach or esophagus. This information was obtained from the website: https://medlineplus.gov/gastrointestinalbleeding.html.	F 623		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		12/1/21

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F 655	Continued From page 33 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's 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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a baseline care plan for three of 41 residents in the survey	F 655	1. Baseline care plan completed on residents #130 and #229 by the Resident Assessment Coordinator on 10/21/2021. Resident #230 no longer at the facility.	

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F 655	Continued From page 34 sample, Residents #130, #229 and Resident #230. 1. The facility staff failed to develop a baseline care plans for Resident #130 who was admitted to the facility on 10/14/21. 2. The facility staff failed to develop a baseline care plans for Resident #229 admitted to the facility on 10/13/21. 3. The facility staff failed to develop a baseline care plan to address Resident #230's mood and statements regarding self harm. The findings include: 1. Resident #130 was admitted to the facility on 10/14/21. Resident #130's diagnoses included but were not limited to congestive heart failure, diabetes and chronic kidney disease. Resident #130's admission MDS (minimum data set) assessment with an assessment reference date of 10/21/21, coded the resident as being cognitively intact. On 10/20/21, Review of Resident #130's clinical record failed to reveal a baseline care plan. A blank baseline care plan was present in Resident #130's paper clinical record but was not filled out. On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the nurses complete assessments and provide information for baseline care plans but do not develop baseline care plans. On 10/20/21 at 2:32 p.m., an interview was conducted with RN (registered nurse) #1, MDS	F 655	2. Quality review completed on new admissions in the past 2 weeks for base line care plan completion on 11/18/2021. Residents identified will have baseline care plan completed. 3. Licensed staff re-educated on Baseline Care Plan completion per F655 regulation 11/18/2021 by DON/designee. 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete Bed Hold quality monitor for any facility initiated discharges to ensure compliance weekly for 4 weeks then monthly for 6 months. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021	

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coordinator. RN #1 stated the nurse who admits a resident is supposed to initiate a baseline care on admission. RN #1 stated there is a blank baseline care plan form that should be completed within 48 hours of admission.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

The facility policy titled, "Plans of Care" documented, "Develop and implement an Individualized Person-Centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR (pre-admission screening and resident review) recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed."

No further information was presented prior to exit.
2. Resident #229 was admitted to the facility on 10/13/21 with diagnosis that included but were not limited to: Diabetes mellitus (inability of insulin to function normally in the body) (1), fracture right fibula (break in the outer bone of the leg) (2), chronic respiratory failure (chronic inability of the heart and lungs to maintain and adequate level of gas exchange) (3) and epilepsy (neurological disorder characterized by recurrent episodes of convulsive seizures) (4).

The most recent MDS (minimum data set)

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assessment, a five day Medicare assessment, with an ARD (assessment reference date) of 10/20/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, hygiene/bathing, dressing and as independent for eating. A review of MDS Section H- Bowel and Bladder coded the resident as always incontinent for bowel and for bladder.

Review of Resident #229's clinical record failed to evidence a completed baseline care plan prior to 10/19/21.

An interview was conducted on 10/19/21 at 2:40 PM with LPN (licensed practical nurse) #4. When asked to review the baseline care plan for Resident #229, LPN #4 stated, "I will look in the EMR (electronic medical record). It says there is no care plan. There may be one in her paper chart." LPN #4 was then observed reviewing Resident #229's paper clinical record, and stated, "Yes, this is the form and it is blank. I believe she came later in the evening." When asked about the purpose of the baseline care plan, LPN #4 stated, "It is to develop goals for the resident based on their individual needs, and orders." When asked who is responsible for the baseline care plan, LPN #4 stated, "The nurse is responsible to develop the baseline care plan."

An interview was conducted on 10/20/21 at 2:32 PM with RN (registered nurse) #1, the MDS coordinator. When asked who is responsible for developing baseline care plans, RN #1 stated, "The nurses on the floors initiate the baseline

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care plans and we do the comprehensive. The nurse who admits the patients starts the baseline care plan. The baseline care plan should be done within 48 hours of admission but is a work in progress until the comprehensive is completed."

On 10/20/21 at 5:10 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3 the regional vice president of operations and ASM #4 the regional clinical nurse were made aware of the concerns.

No further information was provided prior to exit

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 232, 234.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 502.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 199.

3. The facility staff failed to develop a baseline care plan to address Resident #230's mood and statements regarding self harm.

Resident #230 was admitted to the facility on 8/20/21 with diagnoses that included but were not limited to: Diabetes mellitus (inability of insulin to function normally in the body) (1), chronic obstructive pulmonary disease 'COPD' (chronic

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non-reversible lung disease) (2), end stage renal disease 'ESRD' (inability of the kidneys to excrete waste and to function in the maintenance of electrolyte balance in the body) (3) and abscess of testis and buttocks (accumulation of pus in the testis and buttocks) (4).

The most recent MDS (minimum data set) assessment, a five day Medicare assessment with an ARD (assessment reference date) of 8/26/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of MDS Section D-Mood-letter I: Thoughts that you would be better off dead, or of hurting yourself in some way coded the resident as "Yes" and frequency of symptoms coded the resident as "2-6 days".

This was reviewed as part of a complaint for Resident #230.

Review of Resident #230's clinical record failed to reveal a baseline care plan addressing Resident #230's expressed thoughts of self- injury documented on the MDS-Section D-Letter I., that was completed on 8/25/21 by the social worker no longer employed at the facility.

A review of the physician orders dated 8/20/21, documented in part "Psychiatry as needed. Psychology as needed." Further review of the clinical record failed to evidence any psychiatric and or psychology visits were provided for Resident #230.

A facility hospital transfer form dated 8/31/21 at 2:58 AM, documented in part, "Suicide attempt. Reason for transfer: Resident was found with

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light cord wrapped around his neck and when asked what he was doing he stated, 'trying to f .....[expletive] hand (Sic. [hang]) myself'.

Further review of the clinical record revealed a comprehensive care plan dated 9/2/21, that documented in part, "FOCUS-Resident is at risk for a decline in mood related to medical condition and current living arrangements. INTERVENTIONS-Arrange for psych [psychiatric] consult follow up as indicated."

An interview was conducted on 10/19/21 at 2:40 PM with LPN (licensed practical nurse) #4. When asked about the purpose of the baseline care plan, LPN #4 stated, "It is to develop goals for the resident based on their individual needs, and orders." When asked who is responsible for the baseline care plan, LPN #4 stated, "The nurse is responsible to develop the baseline care plan."

An interview was conducted on 10/20/21 at 6:55 AM with LPN (licensed practical nurse) #8. When asked the purpose of the base line care plan, LPN #8 stated, "To have a plan to meet the resident needs that everyone can see." When asked if mood and behavior issues should be included on the baseline plan, LPN #8 stated, "Yes, they should be included."

An interview was conducted on 10/20/21 at 2:40 PM with LPN #6, MDS coordinator. When asked the purpose of the baseline care plan, LPN #6 stated, "The purpose is to develop the plan of care for the resident to meet their needs." When asked about the MDS Section D Letter I coding completed on 8/25/21 and development of a care plan for Resident #230, LPN #6 stated, "Yes, that [comprehensive care plan] wasn't developed till

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9/2/21. When asked if there was any documentation that a baseline care plan had been developed to address Resident #230's mood and self injury statements before that date [9/2/21], LPN #6 stated, "None that I can see."

On 10/26/21 at 3:52 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services and ASM #3 the regional vice president of operations were made aware of the concerns.

The facility policy titled, "Plans of Care" documented, "Develop and implement an Individualized Person-Centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR (pre-admission screening and resident review) recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed."

A review of the facility's "Mental Health Referrals" policy, dated 11/2014, documented in part, "Resident's behavior and affect are observed by nursing home staff members and documented in the resident's chart."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and

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F 655	Continued From page 41 Chapman, page 160. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 498. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 4.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		12/1/21

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F 656	Continued From page 42 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for eight of 41 residents in the survey sample, Residents #53, #26, #33, #8, #24, #28, #129, and #59. The findings include: 1.a. The facility staff failed to implement Resident #53's comprehensive care plan to provide the resident a shower, multiple times in August and September 2021. Resident #53 was admitted to the facility on 2/8/21 with diagnoses including cerebral palsy, hardening and disintegration of the spinal cord bones, quadriplegia and nerve pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference	F 656	1. Residents #53 plan of care being implemented for his showers and administration of Diazepam, #26 preventative pressure ulcer treatment plan of care , laboratory services, fluid restriction and dialysis plan of care being implemented, #33 pressure ulcer treatment plan of care bing implemented, #8 and #28 call bell in reach plan of care being implemented , #24 plan of care for anticoagulants being implemented, #28 plan of care for Foley catheter being implemented, #129 weight plan of care being implemented and #59 plan of care updated for use of side rails care plan updated to accurately reflect resident. 2. Quality review of facility residents care plans for pressure ulcers prevention, call bell being in reach, fluid restrictions side rails, dialysis, weight monitoring, laboratory studies and medication	

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F 656	Continued From page 43 date) of 9/6/21, Resident #53 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). He was coded as being completely dependent on the assistance of staff for personal hygiene and bathing. On 10/24/21 at 4:26 p.m., Resident #53 and his parents requested to meet with the survey team. Resident #53's mother reported concerns regarding the staff's lack of ADL care for the resident, particularly in bathing/showering the resident. She stated the resident has gone a week or more without showering. She stated there were times when the staff had not washed the resident's hair for such a long time that the resident would have acne breakouts along his forehead because his hair was so dirty and greasy. She stated she has reported these concerns to both ASM (administrative staff member) #1, the executive director, and ASM #2, the DCS (director of clinical services). She stated there has been turnover in the DCS position, and "the facility just cannot keep any help." Resident #53 confirmed these statements, and added there are times when "nobody" is working the floor. He confirmed that he has gone through stretches of more than a week without being offered a shower, and without getting a bed bath. He stated he was not certain which days were his assigned bath days. He stated that he was not offered any kind of bed bath on "most" days, and that he did not feel clean with "just a bed bath." A review of Resident #53's comprehensive care plan dated 3/11/21, most recently updated on 4/30/21, revealed, in part: "[Resident #53] has an ADL self-care performance deficit...Bathing/Showering: Check nail length and	F 656	administration will be reviewed to ensure compliance with regulations and their plan of care. 3. Staff re-education on implementation of plan of care and timely development and revisions to the plan of care. 4. Random sample of 10 plans of care weekly for 4 weeks and monthly for 3 months to ensure that plan of care being implemented, developed and revised timely. Results of finding to QAPI for follow-up. 5. 12/01/2021	

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trim and clean on bath day and as necessary...provide sponge bath when a full bath or shower cannot be tolerated...the resident requires full assistance by staff with showering twice weekly/prn [as needed]."

A review of Resident #53's bathing records revealed no evidence of the resident being bathed and showered between the following dates: 8/12/21 through 8/23/21; 9/1/21 through 9/6/21; 9/10/21 through 9/15/21; 9/17/21 through 10/6/21.

A review of the bath day assignment sheet for Resident #53 revealed documentation stating he should ordinarily get a shower or bath on Mondays and Thursdays.

A review of Resident #53's progress notes revealed the following note, written on 10/7/21 by RN (registered nurse) #5: "PC (phone call) from mother...proceeded to tell me about her calling early regarding [Resident #53] needing a bath. Advised her that I heard about the call and it was already taken care of before she called in."

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked the purpose of a care plan, she stated a care plan enables the staff to offer the best possible care for a resident. She stated the care plan helps ensure all the resident's needs are being met. When asked how she makes sure a resident's comprehensive care plan is being implemented, LPN #1 stated she does her best to follow all of the physician's orders.

On 10/25/21 at 3:23 p.m., RN (registered nurse) #5 was interviewed. She stated the resident had

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recently reported to her that he had not been showering because there was not enough staff. She stated, as far as she knew, this was true. RN #5 stated Resident #53's unit has an assigned shower aide, but the aide is most often pulled to work a regular assignment, due to lack of staff. RN #5 stated when this happens, residents do not receive a bath or shower. She stated she had spoken multiple times to the CNAs (certified nursing assistants) about bathing Resident #53, "but they only have so much time in their day." RN #5 stated that on 10/7/21, Resident #53's mother had called to complain about Resident #53's not having received a bath/shower recently. She stated she had already spoken to the aides about this. She stated she assumes when the resident does not get a shower or bath, they receive a "wipe down" or bed bath. RN #5 stated she could not recall a CNA specifically reporting to her that Resident #53's bath or shower had not been completed. When shown Resident #53's bath records, RN #5 stated the records looked "about right," and she could not verify that the resident had received a bath during the long gaps of blanks on the shower records. When asked the purpose of a care plan, RN #5 stated the care plan tells the staff what the resident needs for his or her care. When asked who is responsible for implementing a resident's care plan, RN #5 stated, "All of us. The whole team."

On 10/25/21 at 3:42 p.m., CNA (certified nursing assistant) #12 was interviewed. She stated she has worked with Resident #53 since he was admitted to the facility. CNA #12 stated the resident has "for sure" gone for long stretches of time without a shower or bath. She stated she did not usually have the time to give him a bed bath. She stated if she did so, she would document it

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on the bath record. CNA #12 stated there was frequently not enough staff working the unit to give Resident #53 a bath or shower. When asked the purpose of a resident's care plan, she stated the care plan tells everyone how to take care of the resident. When asked the importance of following a resident's care plan, CNA #12 stated the care plan must be followed "so the resident can be their best."

On 10/26/21 at 3:50 p.m., ASM #1 and ASM #2 were informed of these concerns. Additional evidence verifying Resident #53 had received showers or baths during the gaps identified above, and the care plan as documented above was implemented, was requested.

A review of the facility policy, "Plans of Care," revealed, in part: "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s)...Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment...develop and implement an individual person-centered comprehensive plan of care by the Interdisciplinary Team that includes, but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident...as determined by the resident's needs."

No further information was provided prior to exit.

1. b. The facility staff failed to implement Resident

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#53's comprehensive care plan to administer Diazepam (1), a medication to treat anxiety, per a physician's order.

On 10/24/21 at 4:26 p.m., Resident #53 and his parents requested to meet with the survey team. Resident #53's mother reported concerns regarding Resident #53 not receiving his medications as ordered. She stated Resident #53 had not received Diazepam since Wednesday, 10/20/21. Resident #53 confirmed his mother's statement. Resident #53 stated he had been "miserable" since that time.

A review of Resident #53's comprehensive care plan dated 3/11/21 revealed, in part: "[Resident #53] uses anti-anxiety medications...Administer anti-anxiety medications as ordered by physician."

A review of Resident #53's physician's orders revealed, in part, the following: "Diazepam Tablet 5 mg (milligrams. Give 2 tablets by mouth at bedtime...related to anxiety disorder."

A review of Resident #53's October 2021 MAR (medication administration record) revealed the number 9 in the square for the Diazepam administration on 10/21/21, 10/22/21, and 10/23/21. The legend for the October 2021 MAR documented: "9 =Other/See Nurse Note."

A review of Resident #53's progress notes revealed, in part:

"10/21/2021 11:23 p.m...Medication Administration Note Text: medication not available."

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"10/22/2021 10:47 p.m...Medication Administration Note Text: medication not available."

"10/23/21 10:11 p.m...Medication Administration Note Text: medication not available."

Further review of Resident #53's progress notes revealed, in part, the following: "10/23/2021 18:00 (6:00 p.m.) Nursing Progress Note: Attempted calls to [ASM (administrative staff member) #8 (medical director and Resident #53's attending physician)] on numerous occasions to get Valium (Diazepam)...to be called to pharmacy for this resident. 1430 (2:30 p.m.), 1450 (2:50 p.m.), 1530 (3:30 p.m.), 1635 (4:35 p.m.) no answer, goes to voicemail that says that mailbox is full." The nurse who wrote this note was unavailable for interview at the time of the survey.

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked the purpose of a care plan, she stated a care plan enables the staff to offer the best possible care for a resident. She stated the care plan helps ensure all the resident's needs are being met. When asked how she makes sure a resident's care plan is being implemented, she stated she does her best to follow all of the physician's orders.

On 10/25/21 at 3:23 p.m., RN (registered nurse) #5 was interviewed. She stated she was taking care of Resident #53 that morning and that he is upset because he has not received his Diazepam the past few nights. She stated she had personally faxed the refill request to the NP (nurse practitioner), ASM (administrative staff member) #6, on Thursday, 10/21/21. RN #5

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stated she had called ASM #6 and told her Resident #53 would soon be completely out of the Diazepam, and needed a refill. She stated because Diazepam is a controlled substance, a refill required the NP or physician to directly contact the pharmacy to authorize it. RN #5 stated she did not work between Thursday, 10/21/21 and that morning (10/25/21), she had not had the opportunity follow up on this refill. She stated when she arrived at work at 7:00 a.m. on 10/25/21, she discovered the medication had finally been re-ordered on 10/24/21, but still had not been delivered to the facility. RN #5 stated she had looked for, but had not been able to locate the refill requests she had faxed to ASM #6 on 10/21/21. When asked whether Resident #53's care plan was being implemented if he was not receiving Diazepam as ordered, RN #5 stated, "No. I don't believe it is."

On 10/26/21 at 9:34 a.m., ASM #8, the medical director and Resident #53's attending physician, was interviewed. When asked about the process followed for authorizing refills for controlled medications, ASM #8 stated the facility nurses should communicate the refill needs a week before the medication runs out. He stated if he receives a request for a refill, he can send an electronic order directly to the pharmacy, or he can call the pharmacy to refill the medication. When asked what happens if the refill is urgently needed on a weekend, ASM #8 stated the nurses at the facility have his phone number, as well as the phone numbers for both nurse practitioners, and they should call one of the providers. When asked if he was aware that facility staff had attempted to call him over the weekend, he stated he was not. ASM #8 stated his voicemail had not been full over the weekend.

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On 10/26/21 at 12:19 p.m., ASM #6, the nurse practitioner, was interviewed. She stated if a resident needs a refill for a controlled medication, the staff prints out the paper prescription for the provider to sign on their next visit to the facility. She stated if the refill is needed urgently, the staff may call her, and she can directly transmit an electronic refill request to the pharmacy. ASM #6 stated she had not received any phone calls or faxes from facility nurses regarding Resident #53's Diazepam prescription.

On 10/26/21 at 3:42 p.m., ASM #2, the director of clinical services, was interviewed. She stated if a resident needs an urgent refill for a controlled substance, the nursing staff may all a provider and request the provider to transmit the refill request directly to the pharmacy. She stated she was not aware of any concerns regarding Resident #53's Diazepam. ASM #2 was informed that timely Diazepam administration was included on Resident #53's care plan.

On 10/26/21 at 3:50 p.m., ASM #1, the executive director, and ASM #2 were informed of these concerns. Additional evidence that Resident #53 had received the Diazepam as ordered was requested.

No further information was provided prior to exit.

REFERENCES
(1) "Diazepam is used to relieve anxiety and to control agitation caused by alcohol withdrawal. It is also used along with other medications to control muscle spasms and spasticity caused by certain neurological disorders such as cerebral palsy (condition that causes difficulty with

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movement and balance), paraplegia (inability to move parts of the body), athetosis (abnormal muscle contractions), and stiff-man syndrome (a rare disorder with muscle rigidity and stiffness)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682047.html.

2. a. The facility staff failed implement Resident #26's comprehensive care plan to provide preventative pressure ulcer treatments, and to provide treatments for Resident #26's pressure ulcer on multiple dates in August, September, and October 2021.

Resident #26 was admitted to the facility on 6/30/17, and most recently readmitted on 8/24/21, with diagnoses including diabetes, peripheral artery disease, and end stage kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/23/21, Resident #26 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). The resident was coded as requiring the assistance of staff for bed mobility, dressing, toileting, personal hygiene, and bathing. He was coded as having received dialysis services during the look back period. Resident #26 was coded as having two pressure ulcers (1), both at stage 3 (2).

Resident #26 refused surveyor observation of his pressure ulcers during the survey.

A review of Resident #26's comprehensive care plan dated 7/27/20, and most recently updated 9/24/21, revealed, in part: [Resident #26] has

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pressure injury...related to immobility and refusal to lay (sic) side to side...Administer treatments as ordered and monitor for effectiveness...[Resident #26] has potential impairment to skin...treatments per order."

A review of Resident #26's clinical record revealed the following physician's orders and medication administration records, as documented on the TARs (treatment administration records):

"Clean wound to right and left buttock with Normal saline, pat dry, apply maxorb (an absorbent material) and cover with foam dressing." This order was written 7/23/21 and discontinued 9/6/21. Resident #26's TARs revealed blanks for administration of this order on 8/9/21 and 8/12/21.

"Preventative skin care: apply skin barrier after each incontinent episode every shift and as needed to prevent skin breakdown." This order was written 12/9/20. Resident #26's TARs revealed blanks for administration of this order on 8/3/21, 8/4/21, 8/5/21, 8/10/21, 8/11/21, 9/14/21, 9/25/21, 9/27/21, 9/29/21, 9/30/21, 0/8/21, 10/9/21, 10/14/21, 10/15/21, 10/18/21, and 10/19/21."

"Clean stage 3 to coccyx with NS (normal saline), pat dry...Apply Silvadene (dressing) and cover with foam dressing. Change Q (every) day and prn (as needed)." This order was written 9/18/21 and discontinued 10/7/21. Resident #26's TARs revealed blanks for administration of this order on 9/22/21, 9/27/21, 9/28/21, 10/1/21, 10/3/21, and 10/7/21.

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"Left lower buttock: cleanse area with NS, pat dry, apply medihoney (medication to treat wounds) and cover with dry dressing. Change dressing if soiled or loosened prn every day shift." This order was written on 9/18/21 and discontinued on 10/7/21. Resident #26's TARs revealed blanks for administration of this order on 9/22/21, 9/27/21, 9/28/21, 10/1/21, 10/3/21, and 107/21.

"Right upper buttock: Cleanse area with NS, pat dry, apply silvadene, and cover with dry dressing. Change dressing if soiled or loosened prn every day shift." This order was written on 9/18/21 and discontinued on 9/28/21. Resident #26's TARs revealed blanks for administration of this order on 9/22/21, 9/27/21. 9/28/21, 9/30/21, 10/1/21, 10/3/21, and 10/7/21.

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked how she documents a pressure ulcer treatment once she has completed it, LPN #1 stated she signs it on the electronic medical record. She stated her signature shows up as her initials and a check mark in the box for the specific date and time a treatment is due. When asked how a blank on a TAR should be interpreted, LPN #1 stated: "There's no way of knowing. If it's not documented, it did not happen." When shown Resident #26's TARs for August, September, and October 2021, and asked to interpret the blanks for the resident's pressure ulcer treatments, LPN #1 stated, "If it's not documented, it was not done." When asked the purpose of a comprehensive care plan, she stated a care plan enables the staff to offer the best possible care for a resident. She stated the care plan helps ensure all the resident's needs are being met. When asked how she makes sure a resident's

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care plan is being implemented, she stated she does her best to follow all of the physician's orders. When asked if Resident #26's care plan to prevent and treat pressure ulcers was being followed, LPN #1 stated it was not.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns.

A review of the facility policy, "Clinical Guidelines Skin & Wound," revealed in part: "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated...Develop individualized goals and interventions."

No further information was provided prior to exit.

REFERENCES
(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .

(2) "Stage 3 Pressure Injury: Full-thickness skin

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loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This injury is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .

2. b. The facility staff failed to implement Resident #26's comprehensive care plan for dialysis services.

A review of Resident #26's comprehensive care plan dated 7/27/20 and updated 8/11/20, revealed, in part: "[Resident #26] needs dialysis r/t (related to) renal (kidney) failure...monitor vital signs...1200 ml/day fluid restriction. He is noncompliant at times."

A review of Resident #26's physician's orders, dialysis communication sheets, and MARs (medication administration records) for August, September, and October 2021 revealed, in part:

"PreDialysis assessment prior to appointment every day shift Monday, Wednesday and Friday." This order was written 7/7/21. Resident #26's clinical record contained no evidence of a pre-dialysis assessment, including vital signs and dialysis access site, or communication to the

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dialysis center on 8/30/21, 10/1/21, 10/8/21, and 10/11/21.

"PostDialysis assessment every day shift Monday, Wednesday and Friday." This order was written 7/7/21. Resident #26's clinical record contained no evidence of a post-dialysis assessment, including vital signs and dialysis access site, on 8/9/21, 8/30/21, 10/1/21, and 10/8/21.

Further review of Resident #26's physician's order revealed the following order, dated 12/9/20: "Fluid restriction: 1200 ml/day (milliliters per day). Dietary: Breakfast 240 ml, lunch 240 ml, dinner 240 ml = 720 with meals. Nursing 7a - 7p = 240. 7p - 7a = 240 = 480 ml with meds (medications) every shift for fluid restriction."

A review of Resident #26's MARs and Point of Care records for October 2021 revealed no evidence of the exact amount of fluids Resident #26 received on any shift, or for any 24 hour period in total.

A review of a dietary instruction slip for dinner on 10/21/21 revealed, in part: "6 oz (ounce) tea of choice...1200 ml fluid restriction."

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked how she calculates if a resident is compliant with a physician ordered fluid restriction, LPN #1 stated she only documents how much fluid she is giving with medications, or if she is offering the resident something to drink. When asked who documents how much fluid a resident receives on a meal tray, she stated the CNAs document this information on the point of care records. When

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asked who is responsible for calculating a total amount of fluids consumed by a resident for a 24 hour period, LPN #1 stated, "That's an excellent question." LPN #1 stated, "Someone should be," but she doesn't know who is actually doing it. When asked why it would be important to know exactly how much fluid a resident is drinking, she stated if the resident is on dialysis, too much fluid could harm their kidneys even more.

When asked what assessments she performs on a resident before the resident goes to dialysis, LPN #1 stated she checks vital signs, and checks the dialysis access site. LPN #1 stated, "She communicates this information, as well as any lab [laboratory] results, weights, and medication changes, to the dialysis center by way of a dialysis communication book." LPN #1 stated, "It's a form we all fill out. The dialysis center fills in their part and the book comes back to us." When shown the gaps in documentation for Resident #26's dialysis assessments and communication book, LPN #1 stated, "It does not look like things were done on those days." When asked the purpose of a care plan, she stated a care plan enables the staff to offer the best possible care for a resident. She stated the care plan helps ensure all the resident's needs are being met. When asked how she makes sure a resident's care plan is being implemented, LPN #1 stated she "does her best to follow all of the physician's orders."

On 10/20/21 at 2:26 p.m., LPN (licensed practical nurse) #7 was interviewed. When asked about the blanks in dialysis assessments and dialysis communication book for Resident #26, she stated if there are blanks, then she would have to say the assessments were not done.

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On 10/20/21 at 3:12 p.m., CNA (certified nursing assistant) #2 was interviewed. When asked what she documents for residents who are on a fluid restriction, CNA #2 stated she can only document the percentage of a meal the resident has eaten. She stated there is no place on the point of care system to document an exact amount of fluid a resident receives with meals.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns.

No further information was provided prior to exit.

2. c. The facility staff failed implement Resident #26's comprehensive care plan to obtain laboratory [lab] testing on 9/30/21.

A review of Resident #26's comprehensive care plan dated 7/27/20 revealed, in part: "Obtain and monitor lab/diagnostic work as ordered."

A review of Resident #26's physician's orders revealed the following: "CBC (complete blood count) with diff (differentiation), BMP (basic metabolic panel), CRP (C-reactive protein), Ferritin (Iron level), D-dimer (clotting level), Fibrinogen (helps clotting) one time a day every Thursday for 14 days. Start date 9/23/21."

Further review of Resident #26's September 2021 TARs (treatment administration records) and laboratory results revealed no results for the laboratory tests ordered for 9/30/21.

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On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the information for lab (laboratory) tests that need to be done is kept in a book at the nurses' desk. She stated the nurse who receives an order for a lab test fills out a request slip, and puts in the book. When the outside lab company staff arrive at the facility, they check the book and obtain blood specimens as ordered. She stated she is not sure why Resident #26's lab tests were not performed for 9/30/21, but she could not find any evidence that the tests were done. LPN #1 stated Resident #26's care plan was not being followed regarding laboratory testing.

On 10/21/21 at 8:36 a.m., ASM #2 confirmed the lab tests had not been done for Resident #26 on 9/30/21. She stated the night shift nurse is responsible for double checking that all lab requests for a particular day are accurate and in the book for the outside lab company. She stated she could not locate a lab test request sheet for Resident #26 for 9/30/21.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns.

No further information was provided prior to exit.

3. The facility staff failed to implement Resident #33's comprehensive care plan to provide to provide treatments for Resident #26's pressure ulcer on multiple dates in August, September, and

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October 2021.

Resident #33 was admitted to the facility on 1/6/16, and most recently readmitted on 6/23/20, with diagnoses of diabetes, history of a stroke, and dementia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/6/21, Resident #33 was coded as being severely cognitively impaired for making daily decisions; the resident was not able to be interviewed for the BIMS (brief interview for mental status). Resident #33 was coded as being dependent on staff assistance for all activities of daily living. She was coded as having a Stage 3 (1) pressure ulcer (2).

On 10/21/21 at 10:51 a.m., observation was made of RN (registered nurse) #5 providing wound care to Resident #33. RN #5 removed the old dressing from Resident #33's sacrum. She changed gloves, sanitized her hands, and donned new gloves. She cleansed the wound with acetic acid, applied Maxine Alginate to the wound, and covered the wound with an adhesive foam dressing. She removed her gloves and sanitized her hands. RN #5 measured the sacral wound at 1.4 cms (centimeters) X (by) 0.8 cms X 0.3 cms. The wound bed was 100% beefy red granulation (healing) tissue. No concerns were identified with technique or treatment during the observation.

A review of Resident #33's comprehensive care plan dated 6/9/20, with an updated date of 7/7/20, revealed, in part: [Resident #33] has pressure injury to her coccyx...Administer treatments as ordered and monitor for effectiveness.

A review of Resident #33's clinical record revealed the following physician's orders and

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medication administration records, as documented on the TARs (treatment administration records) for August, September, and October 2021:

"Acetic Acid Solution 2% 10 ml (milliliters) miscellaneous every day shift for Stage 3 PI (pressure injury) to sacrum. Cleanse Stage 3 PI to sacrum with 2% acetic acid, pat dry, apply collagen/maxorb (dressing), cover with foam dressing daily and prn (as needed)." This order was written 3/20/21. Resident #33's TARs revealed blanks for administration of this order on 8/7/21, 9/25/21, 9/26/21, 9/30/21, 10/1/21, 10/8/21, 10/9/21, 10/10/21, 10/15/21, and 10/18/21.

"Cleanse sacral wound with normal saline, pat dry, and apply collagen/maxorb covered by a foam dressing every day shift." This order was written on 6/9/21. Resident #33's TARs revealed blanks for administration of this order on 8/7/21, 9/25/21, 9/26/21, 9/30/21, 10/1/21, 10/9/21, 10/10/21, 10/15/21, and 10/18/21.

A review of Resident #33's wound tracking revealed no gaps in measurements and staging of the wound. The wound had not worsened during the period of August 2021 through survey entrance. No other wounds had developed during this time frame.

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked how she documents a pressure ulcer treatment once she has completed it, LPN #1 stated she signs it on the electronic medical record. She stated her signature shows up as her initials and a check mark in the box for the specific date and time a

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treatment is due. When asked how a blank on a TAR should be interpreted, LPN #1 stated, "There's no way of knowing. If it's not documented, it did not happen." When shown Resident #33's TARs for August, September, and October 2021, and asked to interpret the blanks for the resident's pressure ulcer treatments, LPN #1 stated, "If it's not documented, it was not done." When asked the purpose of a care plan, she stated a care plan enables the staff to offer the best possible care for a resident. She stated the care plan helps ensure all the resident's needs are being met. When asked how she makes sure a resident's care plan is being implemented, she stated she does her best to follow all of the physician's orders. When asked if Resident #26's care plan to prevent and treat pressure ulcers was being followed, she stated it was not.

On 10/20/21 at 2:26 p.m., LPN (licensed practical nurse) #7 was interviewed. When asked about the blanks in TARs for Resident #33, LPN #7 stated if there are blanks, then she would have to say the treatments were not done. When asked if Resident #33's care plan for treating pressure ulcers was being followed, she stated it was not.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. The facility staff were asked to provide evidence that Resident #33's treatments for pressure ulcers had been administered as ordered by the physician on the dates identified above.

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A review of the facility policy, "Clinical Guidelines Skin & Wound," revealed in part: "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated...Develop individualized goals and interventions."

No further information was provided prior to exit.

REFERENCES
(1) "Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This injury is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .

(2) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website

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https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf
.
4. The facility staff failed to implement Resident #8's comprehensive care plan for maintaining the resident's call bell within reach.

Resident #8 was admitted to the facility on 8/13/20. Resident #8's diagnoses included but were not limited to major depressive disorder, diabetes and muscle weakness. Resident #8's annual minimum data set assessment with an assessment reference date of 8/2/21, coded the resident as being cognitively intact. Section G coded Resident #8 as requiring extensive assistance of two or more staff with bed mobility.

Resident #8's comprehensive care plan dated 8/26/20 documented, "(Resident #8) is at risk for falls r/t (related to) impaired mobility...Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed."

On 10/19/21 at 10:50 a.m. and 3:45 p.m., Resident #8 was lying in bed. The resident's electric call bell was not operational. A hand held ring bell was observed on a night stand that was positioned against the wall, to the side and behind the head of Resident #8's bed. The ring bell was not within Resident #8's reach.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is to offer a plan of care for the best possible care for that person and to make sure all of their needs are met. LPN #1 stated residents' care plans are available for staff to reference but she had not reviewed every resident's care plan. LPN #1

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stated residents should have call bells or ring bells within reach so they have an easy way to get a hold of staff.

On 10/20/21 at 2:32 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is to drive the resident's plan of care. RN #1 stated all nurses have access to residents' care plans.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

5. The facility staff failed to implement Resident #24's comprehensive care plan for anticoagulant (blood thinning) medication administration.

Resident #24 was admitted to the facility on 3/29/20. Resident #24's diagnoses included but were not limited to diabetes, atrial fibrillation (1) and a history of stroke. Resident #24's quarterly minimum data set assessment with an assessment reference date of 8/27/21, coded the resident's cognitive skills for daily decision making as modified independence.

Resident #24's comprehensive care plan dated 8/2/20 documented, "(Resident #24) has Peripheral Artery Disease. Give medications for improved blood flow or anticoagulants as ordered..."

Review of Resident #24's clinical record revealed a physician's order dated 3/12/21 for Eliquis (1)

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2.5 mg (milligrams) - one tablet by mouth two times a day for peripheral vascular disease (2).

Resident #24's July 2021 MAR (medication administration record) documented the order for Eliquis 2.5 mg- one tablet by mouth two times a day. On 7/5/21 at 5:00 p.m. and 7/29/21 at 5:00 p.m., the nurse did not document the medication as being administered. The MAR documented the code, "9=other/See Nurse Notes." A nurse's note dated 7/5/21 documented, "out of medication and was reordered." A nurse's note dated 7/29/21 documented, "not available."

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is to offer a plan of care for the best possible care for that person and to make sure all of their needs are met. LPN #1 stated residents' care plans are available for staff to reference but she had not reviewed every resident's care plan. LPN #1 stated nurses can fax medication refill requests to the pharmacy or request a refill directly through the computer system.

On 10/20/21 at 2:32 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is to drive the resident's plan of care. RN #1 stated all nurses have access to residents' care plans.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

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References:

(1) "Apixaban (Eliquis- an anticoagulant medication) is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613032.html

(2) Peripheral vascular disease is a condition of the blood vessels that supply the feet and legs. This information was obtained from the website: https://medlineplus.gov/ency/article/000170.htm

6.a. The facility staff failed to implement Resident #28's comprehensive care plan for maintaining the resident's call bell within reach.

Resident #28 was admitted to the facility on 4/21/20. Resident #28's diagnoses included but were not limited to congestive heart failure, muscle weakness and dementia. Resident #28's quarterly minimum data set assessment with an assessment reference date of 8/31/21, coded the resident's cognition as moderately impaired. Section G coded Resident #28 as requiring extensive assistance of one staff with bed mobility.

Resident #28's comprehensive care plan dated 4/29/20 documented, "(Resident #28) is at risk for falls r/t (related to) a h/o (history of) falls...Be sure his call light is within reach and encourage him to use it for assistance as needed. Due to blindness,

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be sure you tell him where the call bell is."

On 10/19/21 at 8:48 a.m. and 11:07 a.m., Resident #28 was observed in bed. The resident's call bell was on the floor on the left side of the resident's bed and was not within the resident's reach. Resident #28 was not able to be interviewed during the survey.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is to offer a plan of care for the best possible care for that person and to make sure all of their needs are met. LPN #1 stated residents' care plans are available for staff to reference but she had not reviewed every resident's care plan. LPN #1 stated residents should have call bells or ring bells within reach so they have an easy way to get a hold of staff.

On 10/20/21 at 2:32 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is to drive the resident's plan of care. RN #1 stated all nurses have access to residents' care plans.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

6.b. The facility staff failed to implement Resident #28's comprehensive care plan for Foley urinary catheter (1) placement.

Resident #28's comprehensive care plan dated

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3/15/21 documented, "(Resident #28) has Indwelling Foley Catheter r/t (related to) obstructive uropathy...Position catheter bag and tubing below the level of the bladder and away from entrance room door."

Review of Resident #28's clinical record revealed a physician's order dated 3/23/21 for a Foley catheter due to urinary retention.

On 10/19/21 at 8:48 a.m. and 9:49 a.m., Resident #28 was observed in bed and not able to be interviewed. The resident's Foley catheter bag was observed attached to the bed frame and was located on the side of the bed that was facing the door. The urine in the catheter bag was visible from the hall.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is to offer a plan of care for the best possible care for that person and to make sure all of their needs are met. LPN #1 stated residents' care plans are available for staff to reference but she had not reviewed every resident's care plan.

On 10/20/21 at 2:32 p.m., an interview was conducted with RN (registered nurse) #1, the employee who documented Resident #28's care plan. RN #1 stated she documented to keep Resident #28's catheter bag and tubing aware from the entrance room door for privacy. RN #1 stated the purpose of the care plan is to drive the resident's plan of care. RN #1 stated all nurses have access to residents' care plans.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and

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ASM #2 (the director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

Reference:

(1) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

7. The facility staff failed to implement Resident #129's comprehensive care plan for obtaining a weight per physician's order.

Resident #129's comprehensive care plan dated 6/25/21 documented, "(Resident #129) is at risk for weight changes and altered nutritional/fluid status r/t (related to) dx (diagnosis) COVID, PNA (pneumonia, respiratory failure, diabetes...Weights and labs per order/protocol..."

Review of Resident #129's clinical record revealed a physician's order dated 6/19/21 for a weekly weight every day shift every Monday. Review of Resident #129's August 2021 weight list and August 2021 MAR (medication administration record) revealed the resident's weight was obtained on 8/9/21 and 8/23/21 but not on 8/16/21 (or any other date during that week). A nurse's note dated 8/16/21 documented the facility staff were unable to obtain Resident #129's weight on that date due to staffing issues.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse who documented the above note). LPN #1 stated the CNAs (certified nursing

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assistants) are responsible for obtaining resident weights but she tries to help when she can. LPN #1 stated 8/16/21 was a really bad day due to a lack of staffing and the staff was unable to obtain Resident #129's weight. LPN #1 stated the purpose of the care plan is to offer a plan of care for the best possible care for that person and to make sure all of their needs are met. LPN #1 stated residents' care plans are available for staff to reference but she had not reviewed every resident's care plan.

On 10/20/21 at 2:32 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is to drive the resident's plan of care. RN #1 stated all nurses have access to residents' care plans.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

8. The facility staff failed to develop the comprehensive care plan for bedrails for Resident #59. Resident #59 was observed in bed with 1/2 upper bedrails up on 10/19/21 at 10:15 AM and on 10/19/21 at 4:15 PM.

Resident #59 was admitted to the facility on 1/29/21 with diagnoses that included but were not limited to: Diabetes mellitus (inability of insulin to function normally in the body) (1), chronic obstructive pulmonary disease 'COPD' (chronic non-reversible lung disease) (2) and chronic respiratory failure (chronic inability of the heart and lungs to maintain and adequate level of gas exchange) (3).

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The most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 9/29/21, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, supervision for eating and total dependence for dressing, bathing and hygiene. A review of MDS Section H- bowel and bladder coded the resident as always incontinent for bowel and for bladder.

A review of the physician orders dated 9/14/21, documented in part "1/2 side rails to promote independence and bed mobility."

A review of Resident #59's comprehensive care plan failed to evidence development of a care plan to address the use of bed rails until 10/20/21.

On 10/20/21 the comprehensive care plan documents in part, "FOCUS-Resident has an ADL (activities of daily living) self-care performance deficit related to multiple co-morbidities and end of life. INTERVENTIONS- 1/2 bilateral side rails to promote independence and bed mobility."

An interview was conducted on 10/19/21 at 4:30 PM with LPN (licensed practical nurse) #5. When asked the purpose of the care plan, LPN #5 stated, "It is the plan of care that everyone sees to address the resident's needs and orders." When asked if side rails should be included on the comprehensive care plan, LPN #5 stated, "Yes, they should be included."

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An interview was conducted on 10/20/21 at 6:55 AM with LPN #8. When asked the purpose of the comprehensive care plan, LPN #8 stated, "To have a plan to meet the resident needs that everyone can see." When asked if the use of side rails should be included on the comprehensive care plan, LPN #8 stated, "Yes, they should be included."

On 10/20/21 at 5:10 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3 the regional vice president of operations and ASM #4 the regional clinical nurse were made aware of the concerns.

On 10/21/21 at 11:00 AM, ASM #1 provided a copy of the revised care plan for Resident #59, which included side rails.

A review of the facility's "Plans of Care" policy, dated 9/2017, documented in part, "Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment."

A review of the facility's "Side Rail/Bed Rail" policy, dated 4/2018, documented in part, "Side rail/bed rail may include but not limited to: side rails, bed rails, safety rails, grab bars and assist bars. Update the care plan and kardex."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the

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F 656	Continued From page 74 Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 502.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in 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.	F 657		12/1/21

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F 657	Continued From page 75 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 41 residents in the survey sample, Residents #331 and #8. The facility staff failed to revise the comprehensive care plan for Resident #331 to address a urinary catheter and failed to review and revise Resident #8's comprehensive care plan for the use of bed rails. The findings include: 1. Resident #331 was admitted to the facility on 5/26/21, and most recently readmitted on 10/19/21 with diagnoses including a broken right arm, diabetes, and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/30/21, Resident #331 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status. Resident #331 was coded as not having a catheter (1) in her bladder for urination during the look back period. On 10/19/21 at 11:15 a.m., Resident #331 was observed as she was being pushed in her wheelchair down the hall by a staff member. A catheter collection bag, covered with a privacy cover, was observed hanging on the wheelchair rim. A review of Resident #331's physician's orders	F 657	1. Care Plans for residents #8 updated to reflect side rail use and #331 updated for Foley catheter. 2. Quality review of residents with side rails and Catheters to ensure that plan of care updated 3. RAI re-education provided to RNAC and LPNAC by the Regional Nurse Assessment Coordinator 4. Random sample of 10 plans of care to ensure that Quality monitoring weekly for 4 weeks and monthly for 3 months to ensure ongoing compliance. Results to QAPI for follow-up. 5. 12/01/2021	

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revealed, in part: "Foley catheter 16 FR (French, designating catheter size)/10 cc (cubic centimeters) balloon." The order was written 10/13/21, and did not include a diagnosis for the need for the urinary catheter.

A review of Resident #331's comprehensive care plan dated 6/9/21 failed to reveal any information related to the resident having a urinary catheter.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns.

On 10/20/21 at 2:32 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. RN #1 stated she and LPN (licensed practical nurse) #6 work together on care planning. She stated it is up to her and LPN #6 to revise the resident care plans. She stated the team hears updates on resident changes during the daily morning clinical meetings. RN #1 stated a care plan should be updated to include a urinary catheter.

A review of the facility policy, "Plans of Care," revealed no information related to reviewing and revising an existing care plan.

No further information was provided prior to exit.

REFERENCES
1. "A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder." This information is taken from the website https://medlineplus.gov/ency/article/003981.htm.

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2. Resident #8 was admitted to the facility on 8/13/20. Resident #8's diagnoses included but were not limited to major depressive disorder, diabetes and muscle weakness. Resident #8's annual minimum data set assessment with an assessment reference date of 8/2/21, coded the resident as being cognitively intact. Section G coded Resident #8 as requiring extensive assistance of two or more staff with bed mobility.

Review of Resident #8's comprehensive care plan dated 8/26/20 (reviewed on 10/19/21) failed to reveal documentation regarding bed rails.

On 10/19/21 at 8:56 a.m., Resident #8 was observed lying in bed with bilateral 1/2 bed rails in the upright position.

Review of Resident #8's clinical record revealed a physician's order dated 10/20/21 for 1/2 bilateral side rails (bed rails) to promote independence and bed mobility.

On 10/20/21 at 2:32 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of a care plan is to drive the plan of care. RN #1 stated residents' care plans should be reviewed and revised for the use of bed rails.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

On 10/21/21 at approximately 7:45 a.m., ASM #1 presented Resident #8's revised care plan. The care plan was revised on 10/20/21 to include bed

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F 657	Continued From page 78 rails. The facility policy titled, "Side Rail/Bed Rail" documented, "Update the care plan and kardex." No further information was presented prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 41 residents in the survey sample, Resident #33. The facility staff failed to clarify two conflicting physician orders for treatment of a Stage 3 pressure ulcer. The findings include: Resident #33 was admitted to the facility on 1/6/16, and most recently readmitted on 6/23/20, with diagnoses of diabetes, history of a stroke, and dementia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/6/21, Resident #33 was coded as being severely cognitively impaired for making daily decisions; the resident was not able to be interviewed for the BIMS (brief interview for mental status). The resident was coded as being dependent on staff	F 658	1. Resident #33 treatment order clarified on 10/20/2021. 2. Quality review of residents with pressure ulcer treatments to ensure physician ordered treatments completed as ordered. 3. Licensed staff re-education on professional standards including clarification of pressure ulcer treatment by DON/designee on 11/18/2021. 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete treatment observations quality monitor weekly for 4 weeks then monthly for 6 months to ensure compliance maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on	12/1/21

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assistance for all activities of daily living. She was coded as having a Stage 3 (1) pressure ulcer (2).

On 10/21/21 at 10:51 a.m., observation was made of RN (registered nurse) #5 providing wound care to Resident #33. RN #5 removed the old dressing from Resident #33's sacrum. She changed gloves, sanitized her hands, and donned new gloves. She cleansed the wound with acetic acid, applied Maxine Alginate to the wound, and covered the wound with an adhesive foam dressing. She removed her gloves and sanitized her hands. RN #5 measured the sacral wound at 1.4 cms (centimeters) X (by) 0.8 cms X 0.3 cms. The wound bed was 100% beefy red granulation (healing) tissue. No concerns were identified with technique or treatment during the observation.

A review of Resident #33's clinical record revealed the following physician's orders and medication administration records, as documented on the TARs (treatment administration records) for August, September, and October 2021:

"Acetic Acid Solution 2% 10 ml (milliliters) miscellaneous every day shift for Stage 3 PI (pressure injury) to sacrum. Cleanse Stage 3 PI to sacrum with 2% acetic acid, pat dry, apply collagen/maxorb (dressing), cover with foam dressing daily and prn (as needed)." This order was written 3/20/21. Resident #33's TARs revealed nurse signatures indicating this treatment was administered on multiple dates in August, September, and October, 2021.

"Cleanse sacral wound with normal saline, pat dry, and apply collagen/maxorb covered by a foam dressing every day shift." This order was

findings.

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written on 6/9/21. Resident #33's TARs revealed nurse signatures indicating this treatment was administered on multiple dates in August, September, and October, 2021.

A review of Resident #33's comprehensive care plan dated 6/9/20, and updated 7/7/20, revealed, in part: [Resident #33] has pressure injury to her coccyx...Administer treatments as ordered and monitor for effectiveness."

On 10/20/21 at 9:55 a.m., ASM (administrative staff member) #1, the executive director, emailed the survey team with evidence that the facility uses Lippincott, seventh edition, as their professional standard of practice.

On 10/21/21 at 11:15 a.m., RN #5, who had just completed providing Resident #33's wound care, was interviewed. When asked to review Resident #33's TAR specifically for wound treatments, RN #5 stated she could not identify any concerns. When shown two orders for treatment of the same wound, one for the wound to be cleansed with acetic acid, and the other for the wound to be cleansed with normal saline, RN #5 stated, "Oh. Yes." When asked if she had signed both orders on previous shifts, RN #5 stated she had. When asked which order she had followed, RN #5 stated, "Well, I just looked at them as the same order. You know." She stated she used the normal saline first, then the acetic acid to cleanse the wound. Then applied the dressing. When reminded of the observation that had just been completed of her administering Resident #33's wound care, RN #5 stated, "Well, no. I didn't do both that time." She stated the orders were conflicting, and should have been clarified. RN #5 added, "But the normal saline isn't going to hurt

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it."

The physician who ordered both wound treatments for Resident #33 was not available for interview at the time of the survey.

On 10/21/21 at 12:07 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked about the process staff follows if a resident has two conflicting orders, LPN #2 stated she would contact the provider to get a clarification.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. A copy of the text from the facility's standard of practice regarding order clarification was requested.

On 10/26/21 at 2:11 p.m., ASM #1 stated he could not locate the requested information from Lippincott, seventh edition, regarding order clarification. He stated the facility follows their policy.

A review of the facility policy, "Physician Orders," revealed, in part: "The center will ensure that physician orders are appropriately and timely documented in the medical record."

No further information was provided prior to exit.

REFERENCES
(1) "Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and

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F 658	Continued From page 82 epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This injury is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf . (2) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure, shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview,	F 677	1. Resident #53 receiving his showers	12/1/21

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F 677	Continued From page 83 staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care assistance to one resident dependant on staff for care, (Resident #53), in a survey sample of 41 residents. Resident #53, who was coded as being dependent on the assistance of staff for personal hygiene and bathing, was not provided a shower or bed bath by facility staff on multiple occasions during August and September 2021. The findings include: Resident #53 was admitted to the facility on 2/8/21 with diagnoses including cerebral palsy, hardening and disintegration of the spinal cord bones, quadriplegia and nerve pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/6/21, Resident #53 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). He was coded as being completely dependent on the assistance of staff for personal hygiene and bathing. On 10/24/21 at 4:26 p.m., Resident #53 and his parents requested to meet with the survey team. Resident #53's mother reported concerns regarding the staff's lack of ADL care for the resident, particularly in bathing/showering the resident. She stated the resident has gone a week or more without showering. She stated there were times when the staff had not washed the resident's hair for such a long time that the resident would have acne breakouts along his forehead because his hair was so dirty and	F 677	per plan of care. 2. Quality review of residents showers to ensure showers are given per the plan of care on 11/18/2021 3. Nursing Staff re-education on providing activities of daily living for dependent residents including showers by DON/designee on 11/18/2021. 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete quality monitor weekly for 4 weeks and then monthly for 6 months to ensure compliance with showers per plan of care. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021	

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greasy. She stated she has reported these concerns to both ASM (administrative staff member) #1, the executive director, and ASM #2, the DCS (director of clinical services). She stated there has been turnover in the DCS position, and "the facility just cannot keep any help." Resident #53 confirmed these statements, and stated there are times when "nobody" is working the floor. Resident #53 stated that he has gone through stretches of more than a week without being offered a shower, and without getting a bed bath. He stated he was not certain which days were his assigned bath days. Resident #53 stated that he was not offered any kind of bed bath on "most" days, and that he did not feel clean with "just a bed bath."

A review of Resident #53's bathing records revealed no evidence of the resident being bathed and showered between the following dates: 8/12/21 through 8/23/21; 9/1/21 through 9/6/21; 9/10/21 through 9/15/21; 9/17/21 through 10/6/21.

A review of the bath day assignment sheet for Resident #53 revealed documentation stating he should ordinarily get a shower or bath on Mondays and Thursdays.

A review of Resident #53's progress notes revealed the following note, written on 10/7/21 by RN (registered nurse) #5: "PC (phone call) from mother...proceeded to tell me about her calling early regarding [Resident #53] needing a bath. Advised her that I heard about the call and it was already taken care of before she called in."

A review of Resident #53's comprehensive care plan dated 3/11/21, and most recently updated on

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4/30/21, revealed, in part: "[Resident #53] has an ADL self-care performance deficit...Bathing/Showering: Check nail length and trim and clean on bath day and as necessary...provide sponge bath when a full bath or shower cannot be tolerated...the resident requires full assistance by staff with showering twice weekly/prn [as needed]."

On 10/25/21 at 3:23 p.m., RN (registered nurse) #5 was interviewed. She stated the resident had recently reported to her that he had not been showering because there was not enough staff. RN #5 stated, as far as she knew, this was true. She stated Resident #53's unit has an assigned shower aide, but the aide is most often pulled to work a regular assignment, due to lack of staff. RN #5 stated when this happens,residents do not receive a bath or shower. RN #5 stated she had spoken multiple times to the CNAs (certified nursing assistants) about bathing Resident #53, "but they only have so much time in their day." She stated that on 10/7/21, Resident #53's mother had called to complain about Resident #53's not having received a bath/shower recently. She stated she had already spoken to the aides about this. RN #5 stated she assumes when the resident does not get a shower or bath, they receive a "wipe down" or bed bath. She stated she could not recall a CNA specifically reporting to her that Resident #53's bath or shower had not been completed. When shown Resident #53's bath records, RN #5 stated the records looked "about right," and she could not verify that the resident had received a bath during the long gaps of blanks on the shower records.

On 10/25/21 at 3:42 p.m., CNA #12 was interviewed. She stated she has worked with

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Resident #53 since he was admitted to the facility. CNA #12 stated the resident has "for sure" gone for long stretches of time without a shower or bath. She stated she did not usually have the time to give him a bed bath. She stated if she did so, she would document it on the bath record. She stated there was frequently not enough staff working the unit to give Resident #53 a bath or shower.

On 10/26/21 at 3:42 p.m., ASM (administrative staff member) #2, the director of clinical services, was interviewed. She stated all residents have a shower schedule, but sometimes, baths or showers need to be given on a different day, cue to either resident or staffing needs. She stated residents should be offered a bath or shower two days each week. ASM #2 stated the CNAs are responsible for giving showers, and for recording the baths as given in the resident's clinical record. She stated Resident #53's unit has a shower aide, and the shower aide is responsible for giving most of the showers on the unit. ASM #2 stated if showers are not accomplished, the CNA should report this to the nurse, and the nurse should document this in the resident's clinical record. She stated she was aware of some occasions when the shower aide had been assigned to other duties because of the need for additional staff.

On 10/26/21 at 3:50 p.m., ASM #1 and ASM #2 were informed of these concerns. Additional evidence verifying Resident #53 had received showers or baths during the gaps identified above was requested.

A review of the facility policy, "Bathing/Showering," revealed, in part:

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F 677	Continued From page 87 "Assistance with showering and bathing will be provided at least twice a week and PRN (as needed) to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing." No further information was provided prior to exit.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services to maintain the highest level of well-being for two of 41 residents in the survey sample, Residents #26 and #129. 1. The facility staff failed to monitor Resident #26's fluid intake as ordered by the physician. 2. a. The facility staff failed to ensure the medication guaifenesin (1) was available for administration to Resident #129 on 9/28/21, 9/29/21 and 9/30/21.	F 684	1. The physician was notified for Res # 26. Res #129's physician was notified. 2. Residents with physician's orders for fluid restrictions were reviewed. Residents being weighed weekly were reviewed to resident's obtained per physician's orders. Medication administration records (MAR) reviewed to ensure over-the counter medications are available and administered per the physician's orders. Follow up based on findings. 3. The Director of Nursing (DON)/ designee re-educated the nursing staff on	12/1/21

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F 684	Continued From page 88 2. b. The facility staff failed to obtain Resident #129's weekly weight per physician's order on 8/16/21. The findings include: 1. Resident #26 was admitted to the facility on 6/30/17, and most recently readmitted on 8/24/21, with diagnoses including diabetes, peripheral artery disease, and end stage kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/23/21, Resident #26 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having received dialysis services during the look back period. A review of Resident #26's physician's orders, revealed the following order, dated 12/9/20: "Fluid restriction: 1200 ml/day (milliliters per day). Dietary: Breakfast 240 ml, lunch 240 ml, dinner 240 ml = 720 with meals. Nursing 7a - 7p = 240. 7p - 7a = 240 = 480 ml with meds (medications) every shift for fluid restriction." A review of Resident #26's MARs [medication administration record] and Point of Care records for October 2021 failed to reveal evidence of the exact amount of fluids Resident #26 received on any shift, or for any 24 hour period in total. A review of a dietary instruction slip for dinner on 10/21/21 revealed, in part: "6 oz (ounce) tea of choice...1200 ml fluid restriction." A review of Resident #26's comprehensive care	F 684	following physician's orders, weighing residents, fluid restrictions, and the process for obtaining over-the-counter medications. 4. The DON/designee to conduct a random QI (Quality Improvement) monitoring of F684 to ensure care and services to maintain the highest level of well-being weekly for 4 weeks then monthly for 6 months. Findings to be reviewed via Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings. 5. 12/01/2021	

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plan dated 7/27/20 and updated 8/11/20, revealed, in part: "[Resident #26] needs dialysis r/t (related to) renal (kidney) failure...monitor vital signs...1200 ml/day fluid restriction. He is noncompliant at times."

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked how she calculates if a resident is compliant with a fluid restriction, she stated she only documents how much fluid she is giving with medications, or if she is offering the resident something to drink. When asked who documents how much fluid a resident receives on a meal tray, LPN #1 stated the CNAs document this information on the point of care records. When asked who is responsible for calculating a total amount of fluids consumed by a resident for a 24 hour period, LPN #1 stated, "That's an excellent question." LPN #1 stated "someone should be," but she doesn't know who is actually doing it. When asked why it would be important to know exactly how much fluid a resident is drinking, she stated if the resident is on dialysis, too much fluid could harm their kidneys even more.

On 10/20/21 at 3:12 p.m., CNA (certified nursing assistant) #2 was interviewed. When asked what she documents for residents who are on a fluid restriction, she stated she can only document the percentage of a meal the resident has eaten. CNA #2 stated there is no place on the point of care system to document an exact amount of fluid a resident receives with meals.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM

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#4, the regional clinical nurse, were informed of these concerns. The facility staff were asked to provide evidence of Resident #26's recorded fluid intake for the gaps identified above.

A review of the facility policy, "Fluid Restrictions," revealed, in part: "Residents receive adequate fluid intake within the limitations determined by the attending physician...Caregivers will be notified on limitations."

No further information was provided prior to exit.
2. a. Resident #129 was admitted to the facility on 4/22/21 and readmitted on 9/27/21. Resident #129's diagnoses included but were not limited to high blood pressure, diabetes and COVID-19. Resident #129's quarterly minimum data set assessment with an assessment reference date of 10/3/21, coded the resident's cognition as severely impaired.

Review of Resident #129's clinical record revealed a physician's order dated 9/27/21 for guaifenesin liquid 100 mg (milligrams)/5 ml (milliliters). Give 10 ml by mouth every four hours for a cough for 15 days.

Resident #129's September 2021 MAR (medication administration record) documented the order for guaifenesin liquid 100 mg (milligrams)/5 ml (milliliters). Give 10 ml by mouth every four hours for a cough for 15 days. On 9/28/21 at 12:00 p.m. and 4:00 p.m., 9/29/21 at 4:00 a.m. and 8:00 p.m., and 9/30/21 at 12:00 a.m. and 4:00 a.m., the nurse did not document the medication as being administered. The MAR documented the code, "9=other/See Nurse Notes."

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A nurse's note dated 9/28/21 documented, "on order from supply." Another nurse's note dated 9/28/21 documented, "on supply order." A nurse's note dated 9/29/21 documented, "drug not available." Another nurse's note dated 9/29/21 documented, "drug not available." A nurse's note dated 9/30/21 documented, "drug not available."

Resident #129's comprehensive care plan dated 6/25/21 failed to document information regarding guaifenesin administration.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse who documented the 9/28/21 nurses' notes). LPN #1 stated guaifenesin is an over the counter medication that is kept in stock in the facility. LPN #1 stated if an over the counter medication is due for administration and is not on the medication cart then the medication can be obtained from another medication cart or in the over the counter medication supply closet. In regards to Resident #129's guaifenesin not being available for administration in September 2021, LPN #1 stated Resident #129 had been readmitted to the facility and there was no guaifenesin stocked in house at the time so she was waiting to obtain the medication from the pharmacy.

Review of the facility over the counter medication stock list revealed guaifenesin was kept in stock in house.

On 10/21/21 at 8:30 a.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

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The facility policy for medication administration failed to document instructions for obtaining over the counter medications that are supposed to be kept in house.

No further information was presented prior to exit.

Reference:

(1) Guaifenesin is used to treat chest congestion. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682494.html

2. b. Review of Resident #129's clinical record revealed a physician's order dated 6/19/21 for a weekly weight every day shift every Monday.

Resident #129's comprehensive care plan dated 6/25/21 documented, "(Resident #129) is at risk for weight changes and altered nutritional/fluid status r/t (related to) dx (diagnosis) COVID, PNA (pneumonia, respiratory failure, diabetes...Weights and labs per order/protocol..."

Review of Resident #129's August 2021 weight list and August 2021 MAR (medication administration record) revealed the resident's weight was obtained on 8/9/21 and 8/23/21 but not on 8/16/21, or any other date during that week.

A nurse's note dated 8/16/21 documented the facility staff were unable to obtain Resident #129's weight on that date due to staffing issues.

On 10/20/21 at 1:41 p.m., an interview was

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F 684	Continued From page 93 conducted with LPN (licensed practical nurse) #1, the nurse who documented the above note. LPN #1 stated the CNAs (certified nursing assistants) are responsible for obtaining resident weights but she tries to help when she can. LPN #1 stated 8/16/21 was a really bad day due to a lack of staffing and the staff was unable to obtain Resident #129's weight. On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, "Weighing the Resident" documented, "Residents will be weighed unless ordered otherwise by the physician: -Admission/re-admission x3 days -Weekly x 4 weeks -Monthly thereafter -As needed." No further information was presented prior to exit.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		12/1/21

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F 686	Continued From page 94 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility failed to provide care and services for the treatment of a pressure ulcer for two of 41 residents in the survey sample, Residents #26 and #33. The facility staff failed to provide preventative pressure ulcer treatments, and failed to provide treatments for Resident #26's pressure ulcer and Resident #33's pressure ulcer on multiple dates in August, September, and October 2021. The findings include: 1. Resident #26 was admitted to the facility on 6/30/17, and most recently readmitted on 8/24/21, with diagnoses including diabetes, peripheral artery disease, and end stage kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/23/21, Resident #26 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). Resident #26 was coded as requiring the assistance of staff for bed mobility, dressing, toileting, personal hygiene, and bathing. He was coded as having received dialysis services during the look back period. He was coded as having two pressure ulcers (1), both at stage 3 (2). Resident #26 refused surveyor observation of his	F 686	1. The physician was notified for Res #26 & 33. 2. Facility review to identify and address declines in skin integrity was conducted to ensure care and services for the treatment of pressure ulcers. 3. Nursing staff were re-educated by the Director of Nursing (DON)/designee on the facility's Clinical Guideline for Skin & Wound. 4. The DON/ designee to conduct random QI monitoring of F686 to ensure preventative pressure ulcer or pressure ulcer treatments, as indicated, are in place weekly for 4 weeks then monthly for 6 months. Findings to be reviewed via Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings. 5. 12/01/2021	

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pressure ulcers during the survey.

A review of Resident #26's clinical record revealed the following physician's orders and medication administration records, as documented on the TARs (treatment administration records):

"Clean wound to right and left buttock with Normal saline, pat dry, apply maxorb (an absorbent material) and cover with foam dressing." This order was written 7/23/21 and discontinued 9/6/21. Resident #26's TARs revealed blanks for administration of this treatment order on 8/9/21 and 8/12/21.

"Preventative skin care: apply skin barrier after each incontinent episode every shift and as needed to prevent skin breakdown." This order was written 12/9/20. Resident #26's TARs revealed blanks for administration of this order on 8/3/21, 8/4/21, 8/5/21, 8/10/21, 8/11/21, 9/14/21, 9/25/21, 9/27/21, 9/29/21, 9/30/21, 0/8/21, 10/9/21, 10/14/21, 10/15/21, 10/18/21, and 10/19/21."

"Clean stage 3 to coccyx with NS (normal saline), pat dry...Apply Silvadene (dressing) and cover with foam dressing. Change Q (every) day and prn (as needed)." This order was written 9/18/21 and discontinued 10/7/21.
Resident #26's TARs revealed blanks for administration of this order on 9/22/21, 9/27/21, 9/28/21, 10/1/21, 10/3/21, and 10/7/21.

"Left lower buttock: cleanse area with NS, pat dry, apply medihoney (medication to treat wounds) and cover with dry dressing. Change dressing if soiled or loosened prn every day shift." This order

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was written on 9/18/21 and discontinued on 10/7/21. Resident #26's TARs revealed blanks for administration of this order on 9/22/21, 9/27/21, 9/28/21, 10/1/21, 10/3/21, and 107/21.

"Right upper buttock: Cleanse area with NS, pat dry, apply silvadene, and cover with dry dressing. Change dressing if soiled or loosened prn every day shift." This order was written on 9/18/21 and discontinued on 9/28/21. Resident #26's TARs revealed blanks for administration of this order on 9/22/21, 9/27/21. 9/28/21, 9/30/21, 10/1/21, 10/3/21, and 10/7/21.

A review of Resident #26's wound tracking revealed no gaps in measurements and staging of the wound. The wound had not worsened during the period of August 2021 through survey entrance. No other wounds had developed during this time frame.

A review of Resident #26's comprehensive care plan dated 7/27/20, and most recently updated 9/24/21, revealed, in part: [Resident #26] has pressure injury...related to immobility and refusal to lay (sic) side to side...Administer treatments as ordered and monitor for effectiveness...[Resident #26] has potential impairment to skin...treatments per order."

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked how she documents a pressure ulcer treatment once she has completed it, LPN #1 stated she signs it on the electronic medical record. She stated her signature shows up as her initials and a check mark in the box for the specific date and time a treatment is due. When asked how a blank on a TAR should be interpreted, LPN #1 stated,

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"There's no way of knowing. If it's not documented, it did not happen." When shown Resident #26's TARs for August, September, and October 2021, and asked to interpret the blanks for the resident's pressure ulcer treatments, LPN #6 stated, "If it's not documented, it was not done."

On 10/20/21 at 2:26 p.m., LPN (licensed practical nurse) #7 was interviewed. When asked about the blanks on the TARs for Resident #26, LPN #7 stated if there are blanks, then she would have to say the treatments were not done.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. The facility staff were asked to provide evidence that Resident #26's treatments for pressure ulcers had been administered as ordered by the physician on the dates identified above.

A review of the facility policy, "Clinical Guidelines Skin & Wound," revealed in part: "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated...Develop individualized goals and interventions."

No further information was provided prior to exit.

REFERENCES
(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an

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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." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .

(2) "Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This injury is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .

2. Resident #33 was admitted to the facility on 1/6/16, and most recently readmitted on 6/23/20, with diagnoses of diabetes, history of a stroke, and dementia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/6/21, Resident #33 was coded as being severely cognitively impaired for making daily decisions;

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the resident was not able to be interviewed for the BIMS (brief interview for mental status). The resident was coded as being dependent on staff assistance for all activities of daily living. Resident #33 was coded as having a Stage 3 (1) pressure ulcer (2).

On 10/21/21 at 10:51 a.m., observation was made of RN (registered nurse) #5 providing wound care to Resident #33. RN #5 removed the old dressing from Resident #33's sacrum. She changed gloves, sanitized her hands, and donned new gloves. She cleansed the wound with acetic acid, applied Maxine Alginate to the wound, and covered the wound with an adhesive foam dressing. She removed her gloves and sanitized her hands. RN #5 measured the sacral wound at 1.4 cms (centimeters) X (by) 0.8 cms X 0.3 cms. The wound bed was 100% beefy red granulation (healing) tissue. No concerns were identified with technique or treatment during the observation.

A review of Resident #33's clinical record revealed the following physician's orders and medication administration records, as documented on the TARs (treatment administration records) for August, September, and October 2021:

"Acetic Acid Solution 2% 10 ml (milliliters) miscellaneous every day shift for Stage 3 PI (pressure injury) to sacrum. Cleanse Stage 3 PI to sacrum with 2% acetic acid, pat dry, apply collagen/maxorb (dressing), cover with foam dressing daily and prn (as needed)." This order was written 3/20/21. Resident #33's TARs revealed blanks for administration of this order on 8/7/21, 9/25/21, 9/26/21, 9/30/21, 10/1/21, 10/8/21, 10/9/21, 10/10/21, 10/15/21, and

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10/18/21.

"Cleanse sacral wound with normal saline, pat dry, and apply collagen/maxorb covered by a foam dressing every day shift." This order was written on 6/9/21. Resident #33's TARs revealed blanks for administration of this order on 8/7/21, 9/25/21, 9/26/21, 9/30/21, 10/1/21, 10/9/21, 10/10/21, 10/15/21, and 10/18/21.

A review of Resident #33's wound tracking revealed no gaps in measurements and staging of the wound. The wound had not worsened during the period of August 2021 through survey entrance. No other wounds had developed during this time frame.

A review of Resident #33's comprehensive care plan dated 6/9/20, and updated 7/7/20, revealed, in part: [Resident #33] has pressure injury to her coccyx...Administer treatments as ordered and monitor for effectiveness.

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked how she documents a pressure ulcer treatment once she has completed it, LPN #1 stated she signs it on the electronic medical record. She stated her signature shows up as her initials and a check mark in the box for the specific date and time a treatment is due. When asked how a blank on a TAR should be interpreted, LPN #1 stated, "There's no way of knowing. If it's not documented, it did not happen." When shown Resident #33's TARs for August, September, and October 2021, and asked to interpret the blanks for the resident's pressure ulcer treatments, LPN #1 stated, "If it's not documented, it was not done."

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On 10/20/21 at 2:26 p.m., LPN (licensed practical nurse) #7 was interviewed. When asked about the blanks in TARs for Resident #33, LPN #7 stated if there are blanks, then she would have to say the treatments were not done.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. The facility staff were asked to provide evidence that Resident #33's treatments for pressure ulcers had been administered as ordered by the physician on the dates identified above.

A review of the facility policy, "Clinical Guidelines Skin & Wound," revealed in part: "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated...Develop individualized goals and interventions."

No further information was provided prior to exit.

REFERENCES
(1) "Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar

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F 686	Continued From page 102 obscures the extent of tissue loss this is an Unstageable Pressure Injury." This injury is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf . (2) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." This information is taken from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .	F 686		
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 ensure that- (i) A resident who enters the facility without an	F 690		12/1/21

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F 690	Continued From page 103 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 observation, staff interview and clinical record review, it was determined that the facility staff failed to provide care and services for a Foley catheter for two of 41 residents in the survey sample, Residents #28 and #331. 1. The facility staff failed to maintain Resident #28's Foley urinary catheter (1) tubing and bag in a manner to prevent infections. The resident's tubing and bag were observed directly touching the floor on 10/20/21. 2. The facility staff failed to ensure medical justification for Resident #331's indwelling catheter and failed to ensure the catheter was discontinued as soon as clinically warranted.	F 690	1. Res #28 suffered no apparent harm from catheter tubing and bag directly touching the floor. The physician was notified for Res # 331 and consult with urology ordered. 2. Facility review of residents with a Foley catheter was conducted to ensure medical justification and catheters are in a manner to prevent infections. 3. The DON/designee re-educated the nursing staff on obtaining medical justification for Foley catheters and to maintain catheters in a manner to prevent infections.	

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F 690	Continued From page 104 The findings include: 1. Resident #28 was admitted to the facility on 4/21/20. Resident #28's diagnoses included but were not limited to congestive heart failure, muscle weakness and dementia. Resident #28's quarterly minimum data set assessment with an assessment reference date of 8/31/21, coded the resident's cognition as moderately impaired. Review of Resident #28's clinical record revealed a physician's order dated 3/23/21 for a Foley catheter due to urinary retention. Resident #28's comprehensive care plan dated 3/15/21 documented, "(Resident #28) has Indwelling Foley Catheter r/t (related to) obstructive uropathy...Position catheter bag and tubing below the level of the bladder and away from entrance room door." The care plan did not document information regarding the catheter tubing and bag position in relation to the floor. On 10/20/21 at 11:29 a.m., Resident #28 was observed in a low bed. The resident's catheter tubing and bag was directly touching the floor. On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated a resident's catheter tubing and bag should not touch the floor because of infection control reasons and it is a tripping hazard. On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.	F 690	4. The DON/ designee to conduct random QI monitoring of F690 to ensure medical justification and catheters are in a manner to prevent infections weekly for 4 weeks then monthly for 6 months. Findings to be reviewed via Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings. 5. 12/01/2021	

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The facility policy regarding urinary catheter care failed to document specific information regarding catheter placement.

No further information was presented prior to exit.

Reference:

(1) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm
2. Resident #331 was admitted to the facility on 5/26/21, and most recently readmitted on 10/19/21 with diagnoses including a broken right arm, diabetes, and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/30/21, Resident #331 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status. Resident #331 was coded as not having a catheter in her bladder for urination during the look back period. She was coded as always incontinent of urine during the look back period.

On 10/19/21 at 11:15 a.m., Resident #331 was observed as she was being pushed in her wheelchair down the hall by a staff member. A catheter collection bag, covered with a privacy cover, was observed hanging on the wheelchair rim.

A review of Resident #331's physician's orders revealed, in part: "Foley catheter 16 FR (French, designating catheter size)/10 cc (cubic centimeters) balloon." The order was written

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10/13/21, and did not include a diagnosis for the need for the urinary catheter.

A review of Resident #331's comprehensive care plan dated 6/9/21 failed to reveal any information related to the resident having a urinary catheter.

On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns.

On 10/21/21 at 8:36 a.m., ASM (administrative staff member) #2, the director of clinical services, was interviewed. When asked why it is important to have a diagnosis that would indicate a need for a urinary catheter, ASM #2 stated catheters carry a risk of causing urinary tract infections for residents. She stated when a resident is readmitted from the hospital with a new catheter, the facility staff should look for an appropriate diagnosis. ASM #2 stated when Resident #331 was discharged to the hospital from the facility, she did not have a urinary catheter. When she returned from the hospital on 10/13/21, she had a urinary catheter in place. She stated the nurse practitioner looks through the chart and assesses the resident for the appropriate use of the catheter. If there is not an appropriate diagnosis, the catheter should be removed.

On 10/21/21 at 10:10 a.m., ASM #6, the nurse practitioner, was interviewed. When asked about the use of a urinary catheter, ASM #6 stated, "I know what the regulations say about that." She stated the use of the catheter is dependent on the reason for discharge to the hospital, and the

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F 690	Continued From page 107 resident's condition on readmission to the facility. She stated she had reviewed Resident #331's clinical record, and did not see any evidence of a qualifying diagnosis for the urinary catheter. She stated the catheter should have already been removed. A review of the facility policy, "Catheter Care, Urinary," revealed no information related to qualifying diagnoses for residents to utilize a urinary catheter. No further information was provided prior to exit. REFERENCES 1. "A urinary catheter (brand name Foley) is a tube placed in the body to drain and collect urine from the bladder." This information is taken from the website https://medlineplus.gov/ency/article/003981.htm.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record, it was determined that the facility staff failed to provide respiratory services consistent with professional	F 695	1. Res #129's physician was notified and order obtained. 2. Facility review of Residents receiving	12/1/21

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F 695	Continued From page 108 standards for one of 41 residents in the survey sample, Resident #129. The facility staff administered oxygen to Resident #129 without a physicians order. The findings include: Resident #129 was admitted to the facility on 4/22/21. Resident #129's diagnoses included but were not limited to high blood pressure, diabetes and COVID-19. Resident #129's quarterly minimum data set assessment with an assessment reference date of 10/3/21, coded the resident's cognition as severely impaired. Review of Resident #129's current physician orders failed to reveal a physician's order for oxygen. Resident #129's comprehensive care plan dated 6/25/21 failed to reveal documentation regarding oxygen administration. On 10/19/21 at 8:52 a.m. and 10:09 a.m., Resident #129 was observed in their room, receiving oxygen at 1.5 liters per minute via nasal cannula connected to an oxygen concentrator that was running. On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses must obtain an order for oxygen administration because oxygen is a medication that enters the body. On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were	F 695	oxygen was conducted to ensure respiratory services consistent with professional standards. Any issues identified were corrected immediately. 3. The DON/designee re-educated the nursing staff on the facility's oxygen therapy policy. 4. The DON/ designee to conduct random QI monitoring of F695 to ensure respiratory services consistent with professional standards weekly for 4 weeks then monthly for 6 months. Findings to be reviewed via Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings. 5. 12/01/2021	

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F 695	Continued From page 109 made aware of the above concern. The facility policy titled, "Medical Care/Standards of Practice" documented, "No medications or treatments shall be given without a doctor's order." The facility policy titled, "Oxygen Therapy" documented, "Physician's order for oxygen therapy shall include: -Administration modality -FiO2 (fraction of inspired oxygen) or liter flow -Continuous or PRN (as needed) -PRN orders must include specific guidelines as to when the resident is to use oxygen." No further information was presented prior to exit.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement a complete pain management program for one of 41 residents in the survey sample, Resident #70. The facility staff failed to attempt non-pharmacological interventions for Resident #70 prior to the administration of as needed	F 697	1. Res #70 was administered pain medication as ordered by the physician. 2. Facility review of residents receiving pain medications was conducted to ensure implementation of non-pharmacological interventions. Follow up based on findings. 3. The DON/designee re-educated the	12/1/21

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F 697	Continued From page 110 acetaminophen (Tylenol) on 9/19/21, 10/6/21, 10/12/21 and 10/16/21. The findings include: Resident #70 was admitted to the facility on 4/9/21. Resident #70's diagnoses included but were not limited to high blood pressure, diabetes and chronic pain syndrome. Resident #70's quarterly minimum data set assessment with an assessment reference date of 10/10/21, coded the resident as being cognitively intact, scoring a 15 on a scale from 0 to 15 on the brief interview for mental status. Section J documented Resident #70 reported occasional pain. Review of Resident #70's clinical record revealed a physician's order for acetaminophen 500 mg (milligrams) - one tablet by mouth every six hours as needed for pain. Review of Resident #70's September 2021 and October 2021 MARs (medication administration records) revealed the resident was administered as needed acetaminophen on 9/19/21, 10/6/21, 10/12/21 and 10/16/21. Further review of Resident #70's September 2021 and October 2021 MARs and nurses' notes failed to reveal evidence that the facility staff attempted non-pharmacological interventions prior to the administration of as needed acetaminophen on the above dates. Resident #70's comprehensive care plan dated 4/22/21 documented, "(Resident #70) has chronic pain r/t (related to) neuropathy. Encourage intermittent rest and LE (lower extremity) elevation as needed for pain relief ..."	F 697	licensed nurses on the facility's pain management policy. 4. The DON/ designee to conduct random QI monitoring of F697 to ensure complete pain management program with non-pharmacological interventions weekly for 4 weeks then monthly for 6 months. Findings to be reviewed via Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings. 5. 12/01/2021	

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F 697	Continued From page 111 On 10/20/21 at 11:22 a.m., an interview was conducted with Resident #70. Resident #70 stated a CNA (certified nursing assistant) massaged her leg one time but the nurses do not offer non-pharmacological interventions prior to the administration of as needed acetaminophen. On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1, a nurse who administered as needed acetaminophen to Resident #70 on one of the above dates. When asked what should be done prior to administering an as needed pain medication, LPN #1 stated she encourages repositioning and a lot of it has to do with knowing the resident. LPN #1 stated she sometimes offers snacks to Resident #70. LPN #1 stated she could not recall if she attempted non-pharmacological interventions with Resident #70 prior to the administration of as needed Tylenol in September 2021 or October 2021. On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, "Pain Management Guideline" documented, "Treatment: Develop patient centered interventions (pharmacologic and non-pharmacologic) to manage pain." No further information was presented prior to exit.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		12/1/21

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F 698	Continued From page 112 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 interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services related to dialysis consistent with the plan of care for one of 41 residents in the survey sample, Resident #26. The facility staff failed to ensure assessments of Resident #26 prior to, and post dialysis appointments as ordered, and failed to communicate with the dialysis center on multiple occasions during August, September, and October 2021. The findings include: Resident #26 was admitted to the facility on 6/30/17, and most recently readmitted on 8/24/21, with diagnoses including diabetes, peripheral artery disease, and end stage kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/23/21, Resident #26 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). Resident #26 was coded as having received dialysis services during the look back period. A review of Resident #26's physician's orders, dialysis communication sheets, and MARs (medication administration records) for August,	F 698	1. Resident #26's physician was notified. 2. Facility review of residents with dialysis services was conducted to ensure communication with dialysis center as well as resident assessment pre/post dialysis appointment. 3. The DON/designee re-educated the licensed nurses on the facility's dialysis coordination policy. The dialysis communication forms to be reviewed by a member of the IDT (Interdisciplinary Team) during morning clinical meeting. 4. The DON/ designee to conduct random QI monitoring of F698 to ensure resident assessment pre/post appointment as well as communication with the dialysis center weekly for 4 weeks then monthly for 6 months. Findings to be reviewed via Quality Assurance Performance Improvement (QAPI) Committee Meeting and updated as indicated. QI schedule modified based on findings. 5. 12/01/2021	

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September, and October 2021 revealed, in part:

A physician order for: "PreDialysis assessment prior to appointment every day shift Monday, Wednesday and Friday." This order was written 7/7/21. Resident #26's clinical record contained no evidence of a pre-dialysis assessment, including vital signs and dialysis access site, or communication to the dialysis center on 8/30/21, 10/1/21, 10/8/21, and 10/11/21.

A physician order for: "PostDialysis assessment every day shift Monday, Wednesday and Friday." This order was written 7/7/21. Resident #26's clinical record contained no evidence of a post-dialysis assessment, including vital signs and dialysis access site, on 8/9/21, 8/30/21, 10/1/21, and 10/8/21.

A review of Resident #26's comprehensive care plan dated 7/27/20 and updated 8/11/20, revealed, in part: "[Resident #26] needs dialysis r/t (related to) renal (kidney) failure...monitor vital signs...1200 ml/day fluid restriction. He is noncompliant at times."

On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked what assessments she performs on a resident before the resident goes to dialysis, LPN #1 stated she checks vital signs, and checks the dialysis access site. She stated she communicates this information, as well as any lab [laboratory test] results, weights, and medication changes, to the dialysis center by way of a dialysis communication book. LPN #1 stated, "It's a form we all fill out. The dialysis center fills in their part and the book comes back to us." When shown the gaps in documentation for Resident #26's

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F 698	Continued From page 114 dialysis assessments and communication book, LPN #1 stated, "It does not look like things were done on those days." On 10/20/21 at 2:26 p.m., LPN (licensed practical nurse) #7 was interviewed. When asked about the blanks in dialysis assessments and dialysis communication book for Resident #26, LPN #7 stated if there are blanks, then she would have to say the assessments were not done. On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. The facility staff were asked to provide evidence that Resident #26's dialysis assessments were performed for the gaps identified above. A review of the facility policy, "Coordination of Hemodialysis Services," revealed, in part: "The dialysis Communication form will be initiated by the facility for any resident going to an ESRD (end stage renal dialysis) facility for hemodialysis...Nursing will collect and complete the information regarding the resident to send to the ESRD center...Upon the resident's return to the facility, nursing will review the Dialysis Communication form and information completed by the dialysis center...Nursing will complete the post dialysis information on the Dialysis Communication form and file the completed form in the Resident's clinical record." No further information was provided prior to exit.	F 698		
F 725 SS=D	Sufficient Nursing Staff	F 725		12/1/21

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F 725	Continued From page 115 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide sufficient staffing to meet the needs of two of 41 residents in the survey sample, Residents #53 and #129. 1. The facility did not provide sufficient staffing to	F 725	1. Resident #53 has been provided a shower as of 11/15/2021 and will continue to receive showers as outlined in the plan of care. Resident #129 has a current weight and will be weighed in accordance with MD orders. 2. Residents in the facility have the	

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F 725	Continued From page 116 ensure a shower/bath was provided on multiple occasions in August and September 2021, to Resident #53, who was assessed as being dependent on the assistance of staff for personal hygiene and bathing. 2. The facility staff failed to provide sufficient staffing to obtain Resident #129's weight per the physician's order on 8/16/21. The findings include: 1. Resident #53 was admitted to the facility on 2/8/21 with diagnoses including cerebral palsy, hardening and disintegration of the spinal cord bones, quadriplegia and nerve pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/6/21, the resident was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). He was coded as being completely dependent on the assistance of staff for personal hygiene and bathing. On 10/24/21 at 4:26 p.m., Resident #53 and his parents requested to meet with the survey team. Resident #53's mother reported concerns regarding the staff's lack of ADL care for the resident, particularly in bathing/showering the resident. She stated the resident has gone a week or more without showering. She stated there were times when the staff had not washed the resident's hair for such a long time that the resident would have acne breakouts along his forehead because his hair was so dirty and greasy. She stated she has reported these concerns to both ASM (administrative staff member) #1, the executive director, and ASM #2,	F 725	potential to be affected. A quality review of scheduled showers will be conducted by the Director of Clinical services or designee to ensure compliance. Any resident not provided a shower will be completed immediately. A quality review of residents will be conducted by the DCS or designee to ensure weighs have been obtained as per MD order, any identified issues will be corrected immediately. 3. The DCS or designee will educate the certified nursing staff and licensed nursing staff completing task as ordered by the MD to include obtaining weights and on providing ADL care to include offering of showers, noting any refusals of care and services will require follow up by the nurse for a reattempt with documentation in the clinical record. The clinical team will review the shower schedule during the clinical review meeting as well residents with orders for daily, weekly and monthly weights to ensure task have been completed and are documented in the clinical record. This will be completed weekly x 4 weeks then monthly x 6 months. 4. The results of the quality monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations 5. 12/01/2021	

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the DCS (director of clinical services). She stated there has been turnover in the DCS position, and "the facility just cannot keep any help." Resident #53 confirmed these statements, and stated there are times when "nobody" is working the floor. Resident #53 stated that he has gone through stretches of more than a week without being offered a shower, and without getting a bed bath. He stated he was not certain which days were his assigned bath days.

A review of Resident #53's bathing records revealed no evidence of the resident being bathed and showered between the following dates: 8/12/21 through 8/23/21; 9/1/21 through 9/6/21; 9/10/21 through 9/15/21; 9/17/21 through 10/6/21.

A review of Resident #53's progress notes revealed the following note, written on 10/7/21 by RN (registered nurse) #5: "PC (phone call) from mother...proceeded to tell me about her calling early regarding [Resident #53] needing a bath. Advised her that I heard about the call and it was already taken care of before she called in."

A review of Resident #53's comprehensive care plan dated 3/11/21, and most recently updated on 4/30/21, revealed, in part: "[Resident #53] has an ADL self-care performance deficit...Bathing/Showering: Check nail length and trim and clean on bath day and as necessary...provide sponge bath when a full bath or shower cannot be tolerated...the resident requires full assistance by staff with showering twice weekly/prn [as needed]."

On 10/25/21 at 3:23 p.m., RN (registered nurse) #5 was interviewed. She stated the resident had

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recently reported to her that he had not been showering because there was not enough staff. She stated, as far as she knew, this was true. RN #5 stated Resident #53's unit has an assigned shower aide, but the aide is most often pulled to work a regular assignment, due to lack of staff. RN #5 stated when this happens, residents do not receive a bath or shower. She stated for residents to get basic care, the unit requires at least three CNAs. RN #5 stated she had spoken multiple times to the CNAs (certified nursing assistants) about bathing Resident #53, "but they only have so much time in their day." She stated that on 10/7/21, Resident #53's mother had called to complain about Resident #53's not having received a bath/shower recently. She stated she had already spoken to the aides about this. When shown Resident #53's bath records, RN #5 stated the records looked "about right," and she could not verify that the resident had received a bath during the long gaps of blanks on the shower records.

On 10/25/21 at 3:42 p.m., CNA #12 was interviewed. She stated she has worked with Resident #53 since he was admitted to the facility. CNA #12 stated the resident has "for sure" gone for long stretches of time without a shower or bath. She stated she did not usually have the time to give him a bed bath. She stated if she did so, she would document it on the bath record. CNA #12 stated there was frequently not enough staff working the unit to give Resident #53 a bath or shower. She stated the optimal number of CNAs for the unit is three, plus a bath aide. CNA #12 stated residents are not limited to only their "assigned" shower days, and, after reviewing Resident #53's shower records, stated he had received showers on days other than Mondays

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and Thursdays, his regular shower days. CNA #12 stated there is CNA who is tasked with giving all the showers, but that CNA is most often "pulled" to do "regular" CNA duties on her unit, or on the facility's other unit because of low staffing.

A review of the as-worked schedule for Resident #53's unit during August and September 2021 revealed, in part:
- On 8/16/21, only one CNA (certified nursing assistant) was documented working Resident #53's unit, and this staff member worked from 7:00 am just until 12:45 p.m. No CNA was documented as working the unit between 12:45 p.m. and 3:00 p.m.
- On 9/18/21, only one CNA (certified nursing assistant) was documented as working Resident #53's unit on all three shifts.

On 10/26/21 at 3:42 p.m., ASM #2 was interviewed. She stated all residents have a shower schedule, but sometimes, baths or showers need to be given on a different day, cue to either resident or staffing needs. She stated residents should be offered a bath or shower two days each week. ASM #2 stated the CNAs are responsible for giving showers, and for recording the baths as given in the resident's clinical record. She stated Resident #53's unit has a shower aide, and the shower aide is responsible for giving most of the showers on the unit. ASM #2 stated if showers are not accomplished, the CNA should report this to the nurse, and the nurse should document this in the resident's clinical record. She stated she was aware of some occasions when the shower aide had been assigned to other duties because of the need for additional staff. ASM #2 stated she could not add any information than what was documented in the

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clinical record and on the as worked schedules.

On 10/26/21 at 3:50 p.m., ASM #1 and ASM #2 were informed of these concerns. Additional evidence verifying the facility had provided sufficient staffing to meet Resident #53's showering needs was requested.

On 10/20/21 at 5:30 p.m., ASM #1 was asked to provide a policy related to sufficient staffing to meet the needs of residents. On 10/26/21 at 2:11 p.m., ASM #1 stated the facility did not have such a policy.

No further information was provided prior to exit.
2. Resident #129 was admitted to the facility on 4/22/21. Resident #129's diagnoses included but were not limited to high blood pressure, diabetes and COVID-19. Resident #129's quarterly minimum data set assessment with an assessment reference date of 10/3/21, coded the resident's cognition as severely impaired.

Review of Resident #129's clinical record revealed a physician's order dated 6/19/21 for a weekly weight every day shift every Monday.

Resident #129's comprehensive care plan dated 6/25/21 documented, "(Resident #129) is at risk for weight changes and altered nutritional/fluid status r/t (related to) dx (diagnosis) COVID, PNA (pneumonia, respiratory failure, diabetes...Weights and labs per order/protocol..."

Review of Resident #129's August 2021 weight list and August 2021 MAR (medication administration record) revealed the resident's weight was obtained on 8/9/21 and 8/23/21 but not on 8/16/21 (or any other date during that

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week).

A nurse's note dated 8/16/21 documented the facility staff were unable to obtain Resident #129's weight on that date due to staffing issues.

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who documented the above note. LPN #1 stated 8/16/21 was a really bad day. LPN #1 stated the CNAs (certified nursing assistants) are responsible for obtaining residents' weights but she tries to help when she can. LPN #1 stated if she documented the above note then there was probably only one or two CNAs either on the unit or in the building. LPN #1 stated Resident #129's weight was not obtained due to staffing and all the staff could do was to make sure the residents got their meals, were clean and dry, and not on the floor.

Review of the facility nursing staff schedule dated 8/16/21 revealed nurses worked 12 hour shifts and CNAs worked either 12 hour shifts or eight hour shifts. Further review of the facility nursing staff schedule for 8/16/21 revealed four nurses worked from 6:45 a.m. to 7:15 p.m., two CNAs worked from 7:00 a.m. to 3:00 p.m., one CNA worked from 7:00 a.m. to 12:45 p.m., two CNAs worked from 3:00 p.m. to 11:00 p.m., one nurse worked from 6:45 p.m. to 7:15 a.m., one nurse worked from 6:45 p.m. to 11:00 p.m., one nurse worked from 11:00 p.m. to 7:15 a.m., one CNA worked from 7:00 p.m. to 7:00 a.m. and one CNA worked from 11:00 p.m. to 7:00 a.m.

On 10/20/21 at 5:10 p.m., an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1

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F 725	Continued From page 122 stated that depending on the facility census, four or three nurses should work during the day and night shift, four CNAs should work during the day shift, three CNAs should work during the evening shift and two CNAs should work during the night shift. On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. No further information was presented prior to exit.	F 725		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to complete an annual CNA (certified nursing aide) performance review for one of three CNA record reviews, (CNA #6) The facility staff failed to complete an annual performance review for CNA #6. The findings include: CNA #6 was hired on 5/8/04. Review of CNA #6's record revealed the last performance review was	F 730	1. Employee CNA#6 has a completed annual performance review as of 11/18/2021. 2. Human Resource Manager or Designee will review all actively employed nurse aides to ensure that an annual performance review was conducted within the last year and in-service education was provided based on the outcome. Follow ups will be done based on findings. 3. Human Resources Manager will be	12/1/21

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F 730	Continued From page 123 completed on 7/1/10. On 10/20/21 at 9:36 a.m., an interview was conducted with OSM (other staff member) #3 (the human resources coordinator). OSM #3 stated performance reviews are supposed to be done annually. OSM #3 stated she began employment on 5/31/21 or 6/1/21. OSM #3 stated she audited employee files and noticed performance reviews had not been done. OSM #3 stated she has been trying to implement action for this but there has been so many other things to do. On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. The facility policy titled, "Employee Job Performance Evaluations" documented, "It is the policy of The Company to evaluate each employee's job performance on a continual and on-going basis. Employees will receive an evaluation of their performance prior to the completion of their Introductory Period and annually thereafter." No further information was presented prior to exit.	F 730	educated on ensuring that the facility completes a performance review of every nurse aide once every 12 months and provide regular in-service education based on the outcomes by Executive Director or Designee. Human Resource Manager or Designee to review all nurse aides to ensure performance review was completed on an annual basis and in-service education provided monthly x 6 Months. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. 12/01/2021	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked	F 732		12/1/21

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F 732	Continued From page 124 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to post current nurse staffing information. Nurse staffing information for 10/19/21 was not posted on 10/19/21. Instead, nurse staffing information for 10/8/21 was posted. The findings include:	F 732	1. The facility corrected the daily staffing sheet during survey. The daily staffing sheet is current and reflects the correct date and census. 2. No residents were affected. A quality review will be completed by the DON or designee the daily staffing sheet is	

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F 732	Continued From page 125 On 10/19/21 at 9:26 a.m.., observation of the nurse staff posting was conducted in the hall outside of the lobby. The nurse staff posting was dated 10/8/21 and contained staffing information for that date. On 10/19/21 at 3:57 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of clinical services). ASM #2 stated the scheduler is supposed to document and post the nurse staff information but the facility did not currently employ a scheduler. ASM #2 stated the human resources employee had recently been posting the nurse staffing information and she (ASM #2) tries to help the human resources employee with this task. ASM stated the nurse staffing information that was posted this morning was dated 10/8/21 and current nurse staffing information had not been posted because the facility did not currently have a scheduler. On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 were made aware of the above concern. On 10/20/21 at 5:30 p.m., ASM #1 was asked to provide a policy regarding the nurse staff posting. On 10/26/21 at 2:11 p.m., ASM #1 stated the facility did not have the requested policy. No further information was presented prior to exit.	F 732	accurately reflected. Any issues will be corrected immediately. 3. The Executive Director and DON will be educated by the Regional Director of Clinical Services on the regulation for daily posting requirements for nursing information. The DON or designee will conduct quality review of daily staff posting weekly x 4 weeks and monthly x 6 months to ensure continued compliance. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. 12/01/2021	
F 740 SS=K	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services.	F 740		12/1/21

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F 740	Continued From page 126 Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and during the course of a complaint investigation, it was determined that the facility staff failed to provide behavioral health services such as conducting individualized assessments and person centered planning, related to residents who demonstrated or expressed suicidal ideation, for six of 41 residents in the survey sample, Resident #230, Resident #59, Resident #20, Resident #24, Resident #61 and Resident #13. On 8/25/21, Resident #230 expressed thoughts of self- injury documented on the MDS-Section D-Letter I., and was not further assessed by facility staff. Safety interventions and behavioral health services were not put in place. On 8/31/21, Resident #230 was found by staff at approximately 3: 00 a.m., with a call bell cord wrapped around his neck, self-injurious behavior that is likely to cause serious injury, harm, impairment, or death to the resident, resulting in transportation to the emergency room for further evaluation. The hospital documented the resident was being discharged back to the facility with a safety plan; however, there was no documented plan in place upon the resident's return to the	F 740	1. The facility failed to implement behavioral health services for residents identified with feelings of self-injury as recorded on PHQ-9 for residents #230, #61, #59, #24, #13, and #20. Resident #230 was discharged on 9/3/21. Residents #61, #59, #24, #13, and #20 were evaluated by Psych services and deemed to be safe and not at risk for endangering themselves or others. 2 Residents in the facility have the potential to be affected. The Director of Nursing (DON) or designee will reviewed completed PHQ-9 assessments for all residents completed within the past 2 weeks for thoughts of self-injury or other present symptoms. Residents identified with feelings of self-injury as recorded on PHQ-9 or through documentation review will have MD/NP/RP notification and appropriate interventions in place and plan of care updated. 3. A) DON or designee will educate all staff on identifying changes in psychosocial behavior to include the	

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F 740	Continued From page 127 facility, and no care plan addressing suicidal ideation developed until 9/2/21. On 10/21/21 at 1:10 PM a request was made to ASM (administrative staff member) #1, the executive director for a list of residents receiving psychiatric services, and a list of residents who had expressed thoughts of self- injury documented on the MDS-Section D-Letter I. Seven other residents were identified by the facility as having been assessed on the MDS-Section D-Letter I., as having expressed thoughts of self- injury. Five of the seven, (Residents # 59, 20, 24 61 and 13), had no further immediate assessments, safety interventions and /or behavioral health services provided resulting in the findings of Immediate Jeopardy on 10/21/21 at 4:28 p.m. The IJ was abated on 10/22/2021 at 6:37 p.m. and lowered to an E. The findings include: 1. Resident #230 was admitted to the facility on 8/20/21 with diagnoses that included but were not limited to: Diabetes mellitus (inability of insulin to function normally in the body) (1), chronic obstructive pulmonary disease 'COPD' (chronic non-reversible lung disease) (2), end stage renal disease 'ESRD' (inability of the kidneys to excrete waste and to function in the maintenance of electrolyte balance in the body) (3) and abscess of testis and buttocks (accumulation of pus in the testis and buttocks) (4). The most recent MDS (minimum data set) assessment, a five day Medicare assessment with an ARD (assessment reference date) of 8/26/21, coded Resident #230 as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating Resident #230 was	F 740	completion of PHQ9 that identifies a resident expressing the desire to harm themselves education will also include the following: Staff to remain with resident until evaluated by a nurse, Physician or a qualified psychologist and documents that the resident is not suicidal or at risk of harming self or until the resident is transferred to a higher level of care. B) IDT will review 24 hour report and nurse notes of residents triggering for self-injury and any other symptom presence during the morning clinical meeting to ensure appropriate interventions are in place, MD/NP/RP notification and care plans reflect appropriate interventions. C) DON/designee to review completed PHQ-9□s to identify residents who may have triggered for self-injury during morning clinical meeting Monday through Friday. Weekend staff identifying residents who express the desire to harm themselves will follow the suicidal ideation policy. This will be an ongoing intervention. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. 12/01/2021	

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cognitively intact. A review of MDS Section D-Mood-letter I: Thoughts that you would be better off dead or of hurting yourself in some way coded Resident #230 as "Yes" for these questions and coded the frequency of symptoms for the resident as "2-6 days".

Resident #230 was reviewed as part of a complaint regarding a concern of attempted suicide.

A review of the physician orders dated 8/20/21, documented in part "Psychiatry as needed. Psychology as needed." Further review of Resident #230's clinical record failed to reveal any evidence psychiatric consults or services were provided.

A review of Resident #230's clinical record failed to evidence the development of a baseline care plan to address psychosocial needs and mood, including thoughts of self injury/suicide.

On 9/2/21, the comprehensive care plan documented in part, "FOCUS-Resident is at risk for a decline in mood related to medical condition and current living arrangements. INTERVENTIONS-Arrange for psych [psychiatric] consult follow up as indicated."

A review of the nursing progress notes documented in part the following:
- 8/24/21 at 1:11 PM, "Level of consciousness noted as oriented to person oriented to place oriented to time. Mood status is happy pleasant smiling. Behavioral problems are not noted."

- 8/25/21 at 4:27 PM, "Level of consciousness noted as oriented to person. Mood status is

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angry negative statements fidgety. Behavioral problems are not noted."

8/27/21 at 8:49 AM, "Level of consciousness noted as oriented to person oriented to place oriented to time. Mood status is depressed happy pleasant smiling negative statements flat affect. Behavioral problems are not noted."

A review of the social services progress note dated 8/27/21 at 2:54 PM, documented in part, "Resident answered yes to thoughts of hurting himself. Asked resident is [Sic.] he had any plans of hurting himself he stated he was in a bad mood the day of PHQ9 interview."

A facility hospital transfer form dated 8/31/21 at 2:58 AM, documented in part, "Suicide attempt. Reason for transfer: Resident was found with light cord wrapped around his neck and when asked what he was doing he stated, 'trying to f .....[expletive] hand (Sic. [hang]) myself'.

The hospital emergency department physician history and physical exam dated 8/31/21 at 3:55 AM, documented in part, "Chief complaint: Psychiatric evaluation. Context: Resident is an 85 year old male who presents from nursing home because of suicidal ideations. The patient apparently is upset with the nursing home and upset with his medical care to the point that he states he would like to be put out of his misery. He asked one of the nurses if they could shoot him. He also tried to wrap a small piece of string around his neck. The patient tells me that he would like to be put out of is misery. Review of Systems: Psychiatric/Behavioral: positive for suicidal ideas. Neuro/Psych: Normal affect and agitated mood. Patient is alert, and oriented to

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person place and circumstance.
Critical Care: Differential diagnosis considered includes: situational anxiety/frustration versus a true suicidal ideations."

A hospital emergency department nursing note dated 8/31/21, documented in part, "Disposition: Case discussed with patient, daughter and physician. Plan of Care: discharge with safety plan."

A nursing home nurses progress noted dated 8/31/21 at 4:24 PM, documented in part, "Patient returned from the hospital on stretcher accompanied by 2 EMT [emergency medical technicians], patient returned with no new order, all morning meds [medications] was administered at the hospital, new catheter and wound dress done while at the hospital. Vital signs: blood pressure 145/83, respirations 16, pulse 76, temperature 97.6. Patient continues to be monitored for suicidal idea. Patient was able to participate in Physical therapy activity. Currently in bed resting."

A review of Resident #230's medical record failed to evidence that a safety plan was initiated for the resident upon return to the facility.

On 10/20/21 at 4:05 PM, an interview was conducted with OSM (other staff member) #4, the social services manager. When asked about the discharge plan for Resident #230, OSM #4 stated, "We had a pre-discharge meeting. It was not a care plan meeting. The resident was to be discharged on Tuesday 9/7. The daughter decided to take the resident home on 9/3/21, a Friday at 6:42 PM.

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An interview was conducted on 10/21/21 at 2:46 PM with Resident #230's daughter. When asked about the discharge date for her father, Resident #230's daughter stated, "After his suicide attempt, I could not leave him in the facility over another weekend. I met with the social worker and she took notes on all kinds of scrap pieces of paper. I talked with the administrator about taking my dad home and he told me 'we really dropped the ball on this one including administration'. The administrator said they would release my dad with their wound vacuum since they had dropped the ball. I could not wait to get him out of there before something else happened to him."

An interview was conducted on 10/20/21 at 1:15 PM with ASM (administrative staff member) #2, the director of clinical services [director of nursing]. When asked what actions would be done if a resident answered yes to thoughts that they would be better off dead, or of hurting themselves in some way, ASM #2 stated, "We would remove everything out of room that they could do harm, give them plastic silverware, paper plates or Styrofoam containers for food. We would take away anything that could be wrapped around his neck. We would put them on 1:1. If situation escalated, we would send them out to the hospital. We would document behaviors and pass all this information on in report." When asked if she remembered the suicidal attempt by Resident #230, ASM #2 stated, "No, I was moving from another part of the state and don't remember being informed."

An interview was conducted on 10/20/21 at 2:55 PM, with OSM (other staff member) #4, the social services manager. When asked what process occurs when a resident answers yes to thoughts

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that they would be better off dead, or of hurting themselves in some way, OSM #4 stated, "I wasn't aware of the answer until 8/27. I would call the director of clinical services and alert them. I ask the resident if they have a plan in place and notify the nurse. We would not leave the resident alone and would pull any items from the room the resident could harm themselves with."

On 10/25/21 at 3:57 PM, another interview was conducted with OSM (other staff member) #4, the social services manager. When asked the about the process followed if a resident verbalized thoughts of self-harm, prior to education last week, OSM #4 stated, "Prior to education last week, I would just inform the MDS coordinator and the nursing director. Now we stay with the resident and do not leave them. Before last week, normally I would follow up immediately and leave a note immediately." When asked where this information was documented and evidenced, OSM #4 stated, "For Resident #230, I don't have any documentation or evidence."

An interview was conducted on 10/21/21 at 6:47 AM with LPN (licensed practical nurse) #8. When asked if she remembered Resident #230, she asked to pull up his picture and then LPN #8 stated, "Yes, I remember caring for him." When asked if she had been informed that he had verbalized thoughts of harm to himself, LPN #8 stated, "No, I never knew that he was a risk to himself and that there was behavior issues." When asked what actions would be taken if a resident verbalized thoughts of harm to himself, LPN #8 stated, "I would have them 1:1 and document it, inform the physician, nursing leaders, and family."

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An interview was conducted on 10/21/21 at 7:27 AM with LPN #5. When asked if she remembered Resident #230, LPN #5 stated, "Yes I remember the resident and there was an issue where they sent him out to the hospital because I think he had a cord tied around his neck. I do not remember that he was put on 1:1. Normally our protocol is to put them on 1:1." When asked what interventions were put in place upon his return from the hospital, LPN #5 stated, "I don't believe anything new was put in place."

An interview was conducted by phone on 10/21/21 at 8:48 AM with LPN #9, the nurse on duty 8/31/21, night shift with Resident #230. When asked to describe the situation, LPN #9 stated, "I found him [Resident #230] at about 3:00 AM. He knew what he was doing and he had the cord wrapped around his neck. I did my protocol. I had the CNA (certified nursing assistant) sit outside of his door and monitor him. I put him on frequent checks. Notified the nurse practitioner, the administrator and the nursing director. We were changing nursing directors I think at that time. I know the DON [director of nursing] and the administrator knew because they came in and talked with me the next day." When asked if she had been informed the resident had verbalized thoughts of harming himself, LPN #9 stated, "No, I knew nothing about that before this situation, this took me by surprise. I did not know he was at risk."

An interview was conducted on 10/21/21 at 10:20 AM with ASM #6, the nurse practitioner. When asked if she was informed that Resident #230 had verbalized thoughts of harming himself, ASM #6 stated, "No, I did not know beforehand that he had suicidal tendency. There would have been

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orders to have him taken to the hospital if needed and seen by psychiatry."

A second interview was conducted 10/21/21 at 12:11 PM, with Resident #230's daughter. When asked if her father had any history of self-harm or verbalizing thoughts of self-harm, the Resident #230's daughter stated, "No, he has never tried to harm himself. That morning (8/31/21), the facility had my phone number wrong and my nephew had to call me to inform me that had taken my dad to the emergency room. When I went into see him, my dad said, "Sis, I was in pain for two days and I couldn't sleep. So I see that cord and said I can wrap this cord around my neck and turn over in bed a few times it just might get tight enough. It's better than being here in this place."

An interview was conducted on 10/21/21 at 1:09 PM with ASM #1, the administrator. When asked what he remembered about Resident #230's suicide attempt, ASM #1 stated, "I would have to go back and look, but I remember being told that the cord was laying across his neck, not wrapped around his neck." When ASM #1 was informed of the interview conducted with the night nurse and that her recollection and the documentation in the medical record were consistent and documented, "Resident was found with light cord wrapped around his neck and when asked what he was doing he stated, 'trying to f ...[expletive] hand (Sic. [hang]) myself'." ASM #1 stated, "I don't remember that." When asked if any interventions were initiated upon Resident #230's return from the emergency department and if an investigation had been initiated, ASM #1 stated, "I don't think so."

A review of the facility's "Resident Expressing

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Suicidal Ideations" policy dated 8/2017, documented in part, "To ensure the safety of any resident that expresses the desire to harm themselves. The Director of Clinical Services and the Executive Director are to be notified immediately of any resident that expresses the desire to harm themselves. Once a resident expresses the desire to harm themselves, staff to do the following: staff to remain with resident until a physician or a qualified psychologist evaluates the resident and documents that the resident is not suicidal or at risk of harming self-OR until the resident is transferred to a higher level of care, the nurse to be notified immediately, the nurse to notify the physician and responsible party of the resident's condition, the nurse to notify the Director of Clinical Services and the Executive Director, the nurse to prepare the resident for transfer and ensure a safe transfer to the emergency room if ordered."

A review of the facility's "Mental Health Referrals" policy dated 11/2014, documented in part, "Mental Health referrals will be utilized by the facility when a resident's behavior and affect appears disturbed or indicates distress. Resident's behavior and affect are observed by nursing home staff members and documented in the resident's chart."

A list of any other residents who had verbalized self-injury was requested from ASM [administrative staff member) #1, the administrator, on 10/2/21 at approximately 1:01 p.m. On 10/21/21 at 2:15 p.m., ASM #1 provided a resident list based on MDS-Section D-Letter I "Thoughts that you would be better off dead, or of hurting yourself in some way"; that were coded as 'yes'. This list contained seven additional

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residents. The survey team reviewed the records of these additional seven residents, (Resident #'s 10, 50, 59, 20, 24, 61 and 13). The resident record review revealed five of the seven (Resident #'s 59, 20, 24, 61 and 13), failed to evidence any implementation of further assessments, safety interventions, and behavioral health services for these additional five residents with documented 'yes' answers to the MDS question about being better off dead or of hurting themselves. This resulted in a likely situation for serious psychosocial harm, serious injury, serious harm, serious impairment, or death to occur.

On 10/21/21 at 3:41 PM, the Long Term Care supervisor, was notified of the facility's failure to implement immediate further assessments, safety interventions, and behavioral health services for these additional five residents as documented above. The Long Term Care supervisor consulted with three additional Long Term Care supervisors and the Division director and the team was notified of immediate jeopardy findings. On 10/21/21 at 4:28 PM, the survey team met with the executive director, director of clinical services and the vice president of operations, and informed them of the concern for Immediate Jeopardy.

On 10/21/21, the facility submitted the following plan of correction that was accepted at approximately 8:05 p.m.

1. Resident #230 triggered for self-injury on the PHQ-9 completed on August 25, 2021. The resident was found with his call bell around his neck on 8/31/21 and was sent to the emergency

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room. The facility failed to implement behavioral health services for Residents #230, #61, #50, #59, #24, #10, #13, and #20. On October 21, 2021, it was identified residents #61, #50, #59, #24, #10, #13, and #20 triggered for self-injury on the PHQ-9. Resident #230 was discharged on 9/3/21. Residents #61, #50, #59, #24, #10, #13, and #20 had call bells removed from their room, plastic silverware implemented until assessed by a Registered Nurse on 10/21/21.

2. The Director of Nursing (DON) or designee will complete PHQ-9 for all residents with BIM score of 8 and above. Residents with a BIMS of 7 or below will have nursing and social services documentation reviewed for the last 30 days for thoughts of self-injury or other present symptoms. Residents identified with feelings of self-injury as recorded on PHQ-9 or through documentation review will have MD/NP/RP notification and appropriate interventions in place and plan of care updated. MD/NP will be consulted on appropriate immediate interventions until psych [psychiatric] services can be rendered in house or transferred to a higher level of care as appropriate. Plan of care will be updated by licensed nurse.

3. Regional Vice President of Operations/Regional Director of Clinical Services will re-educate Social Services Director, MDS Coordinators, and Nurse Management on policy and procedures related to completing PHQ-9 per the RAI Manual Guidelines and correctly identifying thoughts of self-injury and policy for addressing change in condition. Correctly identifying thoughts of self-injury include a resident verbalizing the following:
1. Feeling bad about yourself - or that you are a

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failure or have let yourself or your family down
2. Thoughts that you would be better off dead, or of hurting yourself in some way.
Addressing a change in condition is done by identifying a resident's change in their physical, mental, or psychosocial status.

DON [director of nursing] or designee will re-educate all staff on identifying changes in psychosocial behavior. Staff education to include identifying a resident expressing the desire to harm themselves and completing the following:
1. Staff to remain with resident until a physician or a qualified psychologist evaluates the resident and documents that the resident is not suicidal or at risk of harming self or until the resident is transferred to a higher level of care.
2. The nurse to be notified immediately
3. The nurse to notify the physician and responsible party of the resident's condition.
4. The nurse to notify the Director of Clinical Services and the Executive Director
5. The nurse to prepare the resident for transfer and ensure a safe transfer to the Emergency Room if ordered.

No staff will be allowed to work until education is completed.

IDT [interdisciplinary team] will review 24 hour report and nurse notes of residents triggering for self-injury and any other symptom presence during the morning clinical meeting to ensure appropriate interventions are in place, MD/NP/RP [medical doctor/nurse practitioner/ responsible party] notification and care plans reflect appropriate interventions. DON/designee to review completed PHQ-9's to identify residents who may have triggered for self-injury during

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morning clinical meeting Monday through Friday. Weekend staff identifying residents who express the desire to harm themselves will follow the suicidal ideation policy. This will be an ongoing intervention.

4. DON to report findings from QI [quality improvement] monitoring at the QI committee meeting monthly for 12 months for further compliance and/or revision.

5. Date of compliance 10/22/21 at 3:00pm.

On 10/23/21 from 8:00 AM-10:00 AM, the facility plan of correction was verified onsite by the following:
1. Review of the all resident's PHQ-9 and/or documentation of MD/NP/RP notification and appropriate interventions.
2. Review of all psychiatric evaluations of residents who were identified as wanting to harm themselves as coded on the PHQ-9.
3. Review of all resident care plans that required a revision/update regarding psychiatric services.
4. Review of all credible evidence for training provided, education content and staff sign in sheets for all shifts and staff.
5. Interviews, in-person and telephone, with numerous facility staff, including contract staff, from varying shifts and disciplines in regard to identifying changes in resident's psychosocial behavior or expressing the desire to harm themselves and the steps they need to follow:
a. Staff to remain with resident until a physician or a qualified psychologist evaluates the resident and documents that the resident is not suicidal or at risk of harming self or until the resident is transferred to a higher level of care.
b. The nurse to be notified immediately

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c. The nurse to notify the physician and responsible party of the resident's condition.
d. The nurse to notify the Director of Clinical Services and the Executive Director
e. The nurse to prepare the resident for transfer and ensure a safe transfer to the Emergency Room if ordered.

In addition to the seven resident's originally identified, the facility identified three additional residents as wanting to harm themselves. These residents were also included in the verification review. All ten resident were evaluated by psychiatric services and deemed safe before the immediate jeopardy abatement on 10/22/21 at 6:37 PM.

No further information was provided prior to exit.

2. The facility staff failed to assess and implement a plan of care for Resident #59 who stated he had thoughts that he would be better off dead, or of hurting himself in some way on a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/29/21. The facility staff failed to evidence that behavioral health services were offered to Resident #59 between 9/29/21 and 10/21/21.

Resident #59 was admitted to the facility on 1/29/21 with diagnoses that included but were not limited to: Diabetes mellitus (1), chronic obstructive pulmonary disease 'COPD' (2) and chronic respiratory failure. (3)

The most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 9/29/21, coded

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the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of MDS Section D-Mood-letter I: Thoughts that you would be better off dead, or of hurting yourself in some way coded the resident as "Yes" and frequency of symptoms coded the resident as "2-6 days."

A review of the comprehensive care plan dated 7/8/21, documented in part, "FOCUS-Resident has a decline in mood problem related to terminal prognosis. INTERVENTIONS-Behavioral health consults as needed. Seen by psych [psychiatric] services (initiated 10/22/21). Facility/hospice staff to provide emotional support as needed."

Review of the physician's orders failed to evidence any current order for Psychiatry as needed or Psychology as needed. A past order had a discontinuation date of 1/30/21.

A review of the social services progress note dated 9/29/21 at 11:07 AM, documented in part, "On PHQ9 resident answered yes to thoughts about being dead/harming self, he stated that he has no plan in place and the thoughts come and go."

There was no evidence in the medical record of additional monitoring or notification of nursing. There was no evidence of removing items from the resident's room or psychiatric consult for Resident #59, prior to identification of immediate jeopardy on 10/21/21, as documented above.

On 10/21/21 at 4:28 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services and ASM #3, the

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regional vice president of operations were informed of the Immediate Jeopardy findings at this time.

A review of the resident safety check form dated 10/21/21 3:00 PM through 10/21/21 6:45 PM documented every 15 minute checks.

On 10/21/21 at 5:10 PM an interview was conducted with Resident #59. When asked if he remembered being asked about thoughts of self-harm, Resident #59 stated, "Yes, I remember the conversation and remember saying that. Nothing else has been done, I have not talked with anyone."

A review of the nurse practitioner progress note dated 10/22/21 at 10:30 AM, documented in part, "Suicide screening: Psychiatric: Insight: good judgement. Mental status: confused and abnormal affect, hallucinations. Orientation: not oriented to time, place and person. Memory: recent memory abnormal and remote memory abnormal. Patient with no voiced suicidal ideations or thoughts per staff. Psych [psychiatric] to evaluate patient as well."

On 10/25/21 at 3:57 PM, an interview was conducted with OSM (other staff member) #4, the social services manager. When asked to provide any information regarding notification to the Director of Clinical Services regarding Resident #59's assessed thoughts of self-harm, OSM #4 stated, "I'm not sure, I will have to check and get back with you." When asked about the process staff follows if a resident verbalized thoughts of self-harm, prior to education last week, OSM #4 stated, "Prior to education last week, I would just inform the MDS coordinator and the nursing

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director. Now we stay with the resident and don't leave them. Before last week, normally I would follow up immediately and leave a note immediately."

On 10/25/21 at 4:06 PM, an interview was conducted with ASM (administrative staff member) #2, the director of clinical services [director of nursing]. When asked the process followed if the mood assessment identifies thoughts of self-harm, ASM #2 stated, "Normally the social services manager reports it to me prior to education last week." When asked what the revised process included, ASM #2 stated, "We assess the resident and put them on every 15 minute checks until the physician can see them. If suicidal, take call bell out of room and put them on 1:1. This process was started last week. We had someone in social services that was not reporting this information to us. That person is no longer here. Since, I have been here (8/26/21 as interim, 9/16/21 as permanent), I have never had anyone report a resident with thoughts of self-harm to me."

On 10/26/21 at 8:25 AM, OSM #4 provided email dated 9/29/21 at 8:05 AM to the ASM (administrative staff member) #2, the director of clinical services, which documented in part, "Resident #59 also answered yes to having thoughts about hurting himself or being better off dead but stated he had no plan in place. He seems very depressed now that he is in isolation, more so then before, seems to have a hard time understanding why he is in quarantine."

No further information was provided prior to exit.

References:

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(1) Diabetes mellitus inability of insulin to function normally in the body. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160.
(2) Chronic obstructive pulmonary disease 'COPD' (chronic non-reversible lung disease. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120.
(3) Chronic respiratory failure (chronic inability of the heart and lungs to maintain and adequate level of gas exchange. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 502.

3. The facility staff failed to assess and implement a plan of care for Resident #20 who stated he had thoughts that he would be better off dead, or of hurting himself in some way on a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/19/21. The facility staff failed to evidence that behavioral health services were offered to Resident #20 between 8/19/21 and 10/21/21.

Resident #20 was admitted to the facility on 3/30/21 with diagnoses that included but were not limited to: Diabetes mellitus (1), chronic kidney disease (decreased function of the kidneys frequently as a complication of diabetes) (2) and cerebrovascular accident (hemorrhage or blockage of the blood vessels of the brain leads to lack of oxygen and resulting symptoms) (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 8/19/21, coded Resident #20 as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score,

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indicating the resident was severely cognitively impaired. A review of MDS Section D-Mood-letter I: Thoughts that you would be better off dead, or of hurting yourself in some way coded Resident #20 he resident as "Yes" and frequency of symptoms coded the resident as "2-6 days".

A review of the comprehensive care plan dated 8/23/21, documented in part, "FOCUS-Potential for psychosocial well-being. INTERVENTIONS-Observe for psychosocial and mental status changes. Document and social work report as indicated. Provide emotional support and allow residents to express feelings, fears and concerns."

A review of the physician orders dated 3/16/21, documented in part "Psychiatry as needed. Psychology as needed."

A review of the MDS coordinator note dated 8/23/21 at 1:17 PM, documented in part, "MDS 8/13 Mood interviews. Mood is fluctuating daily. Recent SCIC (significant change in condition) due to coming off hospice."

There was no evidence in the medical record of additional monitoring or notification of nursing regarding Resident #20's 8/19/21, assessment for thoughts of being better off dead, or of hurting yourself in some way . There was no documented evidence of removing items from the resident's room or of psychiatric consult, prior to the identification of immediate jeopardy on 10/21/21, as documented above.

On 10/21/21 at 4:28 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services and ASM #3, the

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regional vice president of operations were informed of the Immediate Jeopardy findings at this time.

A review of the resident safety check form dated 10/21/21 11:00 PM through 10/22/21 11:45 AM documented every 15 minute checks.

On 10/21/21 at 5:00 PM, an interview was attempted with Resident #20, but was not completed.

A review of the nurse practitioner progress note dated 10/22/21 at 12:00 PM, documented in part, "Suicide screening: Psychiatric: Insight: poor insight. Mental status: lethargic, confused and abnormal affect, hallucinations. Orientation: not oriented to time, place and person. Memory: recent memory abnormal and remote memory abnormal. Patient does not answer questions or respond to provider, staff report no suicidal ideations or thoughts. Psych [psychiatric] to evaluate patient as well."

On 10/25/21 at 3:57 PM, an interview was conducted with OSM (other staff member) #4, the social services manager. OSM #4 was asked to provide any information regarding notification to the Director of Clinical Services for Resident #20's, 8/19/21, assessment documenting thoughts of being better off dead or hurting themselves. OSM #4 stated, "I'm not sure, I will have to check and get back with you." When asked about the process staff follows if a resident verbalized thoughts of self-harm, prior to education provided to staff last week, OSM #4 stated, "Prior to education last week, I would just inform the MDS coordinator and the nursing director. Now we stay with the resident and don't

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leave them. Before last week, normally I would follow up immediately and leave a note immediately."

On 10/25/21 at 4:06 PM, an interview was conducted with ASM (administrative staff member) #2, the director of clinical services. When asked about the process staff follows if the mood assessment identifies thoughts of self-harm, ASM #2 stated, "Normally the social services manager reports it to me prior to education last week." When asked what the revised process included, ASM #2 stated, "We assess the resident and put them on every 15 minute checks until physician can see them. If suicidal, take call bell out of room and put them on 1:1. This process was started last week. We had someone in social services that was not reporting this information to us. That person is no longer here. Since, I have been here (8/26/21 as interim, 9/16/21 as permanent), I have never had anyone report a resident with thoughts of self-harm to me."

An interview was conducted on 10/26/21 at 8:25 AM, with OSM #4, the social services manager. When asked how Resident #20 was scored on the mood assessment as her BIMS was 03, OSM #4 stated, "I don't know what she was asking to be honest with you. The other social worker was here then and I do not know how she determined the resident had harmful ideas for self."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160.

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(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 119.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 111.
4. The facility staff failed to assess and implement a plan of care for Resident #24 who stated he had thoughts that he would be better off dead, or of hurting himself in some way on a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/27/21. The facility staff failed to evidence that behavioral health services were provided to Resident #20 between 8/27/21 and 10/21/21.

Resident #24 was admitted to the facility on 3/29/20. Resident #24's diagnoses included but were not limited to diabetes and a history of stroke. Resident #24's quarterly minimum data set assessment with an assessment reference date of 8/27/21, coded the resident's cognitive skills for daily decision making as modified independence (some difficulty in new situations only).

Further review of Resident #24's 8/27/21 MDS assessment revealed section D, the PHQ-9 mood interview. This section revealed Resident #24 stated he had thoughts that he would be better off dead, or of hurting himself in some way two to six days during the 14 day look back period.

Review of Resident #24's clinical record, including August 2021 progress notes, assessments and physicians' notes, failed to reveal the resident was assessed/ monitored for the above statement. There was no evidence of removing items from the resident's room or

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psychiatric consult for Resident 24, prior to the identification of immediate jeopardy on 10/21/21, as documented above.

Resident #24 was not able to be interviewed during the survey.

The social services assistant who completed section D of Resident #24's 8/27/21 MDS assessment was no longer employed at the facility.

On 10/21/21 at 1:39 p.m., an interview was conducted with OSM (other staff member) #4 (the social services manager). OSM #4 stated that if a resident states that he or she has thoughts that he or she would be better off dead, or of hurting himself or herself while completing the mood interview then she asks if he or she has a plan in place, documents a note and notifies the floor nurse, unit manager or director of nursing.

On 10/25/21 at 3:56 p.m., another interview was conducted with OSM #4. OSM #4 stated the social services assistant who completed the mood interview for Resident #24's 8/27/21 MDS assessment was only employed at the facility for a few weeks. OSM #4 stated she was not aware Resident #24 stated he had thoughts that he would be better off dead or of hurting himself.

On 10/25/21 at 4:06 p.m., an interview as conducted with ASM (administrative staff member) #2 (the director of clinical services-director of nursing). ASM #2 stated if a resident states that he or she has thoughts that he or she would be better off dead then the resident should be placed on 15 minutes checks until evaluated by a physician. ASM #2 further stated that if a

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resident states that he or she is suicidal then the resident should be placed on one to one supervision until evaluated by the physician.

On 10/26/21 at 4:15 p.m., ASM #1 (the executive director) and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.
5. The facility staff failed to assess and implement safety/psychosocial interventions for Resident #61, who stated she had thoughts that he would be better off dead, or of hurting herself in some way on an admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/30/21. The facility staff failed to evidence that behavioral health services were offered to Resident #61 between 9/30/21 and 10/21/21.

Resident #61 was admitted to the facility on 9/24/21, and most recently readmitted on 9/27/21, with diagnoses including Alzheimer's disease and diabetes. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/30/21, Resident #61 was coded as being moderately cognitively impaired for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status).

A review of Resident #61's quarterly MDS with an ARD of 9/30/21 revealed she was coded as having answered yes to the question of having feelings that she would be better off dead or of hurting herself for two to six days during the look back period in section D200I. The assessment question was signed by OSM (other staff

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member) #4, the social services manager) on 9/30/21 at 4:51 p.m.

A review of Resident #61's physician's orders revealed the following orders, dated 9/24/21: "Psychology as needed ...Psychiatry as needed."

A review of Resident #61's clinical record revealed no evidence of staff assessment or interventions addressing Resident #61's psychosocial health, until 10/4/21, when OSM #4 wrote the following note: "10/4/21 12:32 p.m...Resident answered yes to having thoughts about wishing she was dead/harming herself. Stated she had no plan in place." Further review of the clinical record failed to reveal a safety plan was implemented and behavioral health assessment was completed and services provided prior to the identification of immediate jeopardy on 10/21/21.

On 10/21/21 at 1:39 p.m., an interview was conducted with OSM (other staff member) #4 (the social services manager). OSM #4 stated that if a resident states that he or she has thoughts that he or she would be better off dead, or of hurting himself or herself while completing the mood interview then she asks if he or she has a plan in place, documents a note and notifies the floor nurse, unit manager or director of nursing.

On 10/25/21 at 4:06 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of clinical services-director of nursing). ASM #2 stated if a resident states that he or she has thoughts that he or she would be better off dead then the resident should be placed on 15 minutes checks until evaluated by a physician. ASM #2 further stated that if a

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resident states that he or she is suicidal then the resident should be placed on one to one supervision until evaluated by the physician.

On 10/26/21 at 8:25 a.m., OSM #4 stated she could not find any evidence verifying that she had notified any other staff member of Resident #61's answer to question D200I documenting yes to having thoughts about wishing she was dead/harming herself.

On 10/26/21 at 3:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, and ASM #3, the regional vice president of operations, were informed of these concerns.

No further information was provided prior to exit.

6. The facility staff failed to assess and implement safety/psychosocial interventions for Resident #13, who stated they had thoughts they would be better off dead, or of hurting themselves in some way on a quarterly MDS (minimum data set) assessment on August 2, 2021. There was no evidence of removing items from the resident's room or that behavioral health services were provided to Resident #13 between 8/2/21 and 10/21/21.

Resident # 13 was admitted to the facility with diagnoses that included but were not limited to: traumatic brain injury [1], unspecified behavioral syndromes associated with physiological disturbances and physical factors, epilepsy [2] and muscle weakness.

Resident # 13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/03/2021,

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coded Resident # 13 as scoring a three [3] on the brief interview for mental status (BIMS) of a score of 0 - 15, three [3] - being severely impaired of cognition for making daily decisions. Resident # 13 was coded as requiring extensive assistance of one staff member for activities of daily living. Section D "Mood" area "D0200 Resident Mood Interview (PHQ-9)" coded Resident # 3 under "Symptom Presence" as "Yes" for "Thoughts that you would be better off dead, or of hurting yourself in some way." Under "Symptom Frequency" it documented "2-6 [two to six] days." Signed by RN [registered nurse] # 3, previous MDS supervisor, "August 2, 2021 at 12:52 p.m."

The POS [physician's order summary] dated October 2021 failed to evidence an order for behavioral health services.

Review of the facility's nursing notes dated 08/02/2021 through 10/21/2021 failed to evidence documentation of Resident # 13's statement of hurting themselves, monitoring of Resident # 13, notification to the physician and/or an assessment of Resident # 13's mental health.

Further review of Resident # 13's progress notes failed to evidence documentation from psychology or psychiatric services providers.

The comprehensive care plan for Resident # 13 dated 05/20/2021 with a revision date of 11/01/2021 failed to evidence documentation addressing Resident # 13 statement of hurting themselves.

On 10/21/21 at 1:39 p.m., an interview was conducted with OSM [other staff member #4, social services manager. OSM #4 stated that if a

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resident states that he or she has thoughts that he or she would be better off dead, or of hurting himself or herself while completing the mood interview then she asks if he or she has a plan in place, documents a note and notifies the floor nurse, unit manager or director of nursing.

On 10/25/2021 at 4:00 p.m., an interview was conducted with OSM [other staff member] # 4, social services manager. When asked if there was any follow-up to Resident # 13's statement of hurting themselves, if they were aware of Resident # 13 making that statement and how it was determined Resident # 13 indicate they wanted to hurt themselves with a BIMS of three, being severely impaired of cognition for making daily decisions, OSM # 4 stated they would look into it.

On 10/25/2021 at 4:06 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of clinical services. When asked to describe the process they follow when a resident indicate they want to harm/hurt themselves in some way ASM # 2 stated, "We put them on Q15 [every] 15 minutes checks and document it until the physician can assess the resident, if suicidal place them on one to one, remove the call bell cord and provide them with a tap bell."

On 10/26/2021 at 8:25 a.m., an interview was conducted with OSM [other staff member] # 4, social services manager in regard to questions on 10/25/2021 as stated above. OSM # 4 stated that there was no evidence of any follow-up or interventions related to Resident # 13's statement of thoughts of hurting themselves. In regard to determining how RN # 3 determined Resident #

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F 740	Continued From page 155 13 indicated that they wanted to hurt themselves OSM # 4 stated, "I don't know." On 10/26/2021 at 4:00 p.m., ASM [administrative staff member] # 1, executive director, ASM # 2, director of clinical services, ASM # 3, regional vice president of operations, were made aware of the above findings. No further information was provided prior to exit. References: [1] Happens when a bump, blow, jolt, or other head injury causes damage to the brain. Symptoms of a TBI may not appear until days or weeks following the injury. A concussion is the mildest type. It can cause a headache or neck pain, nausea, ringing in the ears, dizziness, and tiredness. People with a moderate or severe TBI may have those, plus other symptoms: A headache that gets worse or does not go away, repeated vomiting or nausea, Convulsions or seizures, Inability to awaken from sleep, Slurred speech, Weakness or numbness in the arms and legs, dilated eye pupils. This information was obtained from the website: https://medlineplus.gov/traumaticbraininjury.html [2] A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.	F 740		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		12/1/21

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F 755	Continued From page 156 §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 staff interview and clinical record review, it was determined that the facility staff failed to provide pharmacy services for two of 41 residents in the survey sample, Resident #24 and Resident #53.	F 755	1. The MD was notified of the medication omission for resident #24 Eliquis on 10/25/2021. The residents is receiving Eliquis as per MD order without any adverse effects. The MD was notified of the medication omission for resident #53	

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F 755	Continued From page 157 1. The facility staff failed to assure the medication Eliquis (1) was available for administration to Resident #24 on 7/5/21 and 7/29/21. 2. The facility staff failed to assure the medication Diazepam was acquired, and received for administration to Resident #53, per the physician order on 10/21/21 through 10/23/21. The findings include: Resident #24 was admitted to the facility on 3/29/20. Resident #24's diagnoses included but were not limited to diabetes, atrial fibrillation (1) and a history of stroke. Resident #24's quarterly minimum data set assessment with an assessment reference date of 8/27/21, coded the resident's cognitive skills for daily decision making as modified independence. Resident #24's comprehensive care plan dated 8/2/20 documented, "(Resident #24) has Peripheral Artery Disease. Give medications for improved blood flow or anticoagulants as ordered..." Review of Resident #24's clinical record revealed a physician's order dated 3/12/21 for Eliquis 2.5 mg (milligrams) - one tablet by mouth two times a day for peripheral vascular disease (2). Resident #24's July 2021 MAR (medication administration record) documented the order for Eliquis 2.5 mg-one tablet by mouth two times a day. On 7/5/21 at 5:00 p.m. and 7/29/21 at 5:00 p.m., the nurse did not document the medication as being administered. The MAR documented the code, "9=other/See Nurse Notes." A nurse's note dated	F 755	Diazepam on 10/25/202. The resident is receiving Diazepam as per MD order without any adverse effects. 2. Residents that reside in the facility have the potential to be affected. A quality review will be conducted by the Director of Clinical Services for missed medication administration over the past 2 weeks and Physician and RP's will be notified as indicated and follow up based on findings. 3.The Director of Nursing or designee will educate licensed nursing staff on following the six rights of medication administration, following MD orders for administering medications and the process for refilling prescriptions along with use of emergency medication supply. A) Unit Managers and or designee will conduct medication administration observations weekly x 4 weeks then monthly x 6 months to ensure medications are administered per physician order. B) A review of the missed medication administration report will be done during daily clinical meeting and variances will be addressed, and corrective action and or education will be provided. Provider will be notified when medications were not administered. This will continue for 6 months to ensure ongoing compliance. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations.	

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7/5/21 documented, "out of medication and was reordered." A nurse's note dated 7/29/21 documented, "not available."

On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses can fax medication refill requests to the pharmacy or request a refill directly through the computer system. LPN #1 stated if a medication is needed and not available then she calls the pharmacy or obtains the medication from the STAT box (a box containing various medications) if the medication is in the STAT box.

Review of the list for the STAT box in the facility during July 2021 failed to reveal Eliquis was contained in the box.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

The facility pharmacy policy titled, "Reordering, Changing and Discontinuing Orders" failed to specifically document steps to take if a medication is not available and not in the STAT box.

No further information was presented prior to exit.

References:

(1) "Apixaban (Eliquis) is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is

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not caused by heart valve disease." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613032.html

(2) Peripheral vascular disease is a condition of the blood vessels that supply the feet and legs. This information was obtained from the website: https://medlineplus.gov/ency/article/000170.htm
2. Resident #53 was admitted to the facility on 2/8/21 with diagnoses including cerebral palsy, hardening and disintegration of the spinal cord bones, quadriplegia and nerve pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/6/21, the resident was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). He was coded as receiving a medication to treat anxiety on all seven days of the look back period.

On 10/24/21 at 4:26 p.m., Resident #53 and his parents requested to meet with the survey team. Resident #53's mother reported concerns regarding Resident #53 not receiving his medications as ordered. She stated Resident #53 had not received Diazepam since Wednesday, 10/20/21. Resident #53 confirmed his mother's statement. He stated he had been "miserable" since that time.

A review of Resident #53's physician's orders revealed, in part, the following: "Diazepam Tablet 5 mg (milligrams. Give 2 tablets by mouth at bedtime...related to anxiety disorder."

A review of Resident #53's October 2021 MAR (medication administration record) revealed the

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number 9 in the square for the Diazepam administration on 10/21/21, 10/22/21, and 10/23/21. The legend for the October 2021 MAR documented: "9 =Other/See Nurse Note."

A review of Resident #53's progress notes revealed, in part:

"10/21/2021 11:23 p.m...Medication Administration Note Text: medication not available."

"10/22/2021 10:47 p.m...Medication Administration Note Text: medication not available."

"10/23/21 10:11 p.m...Medication Administration Note Text: medication not available."

Further review of Resident #53's progress notes revealed, in part, the following: "10/23/2021 18:00 (6:00 p.m.) Nursing Progress Note: Attempted calls to [ASM (administrative staff member) #8 (medical director and Resident #53's attending physician)] on numerous occasions to get Valium (Diazepam)...to be called to pharmacy for this resident. 1430 (2:30 p.m.), 1450 (2:50 p.m.), 1530 (3:30 p.m.), 1635 (4:35 p.m.) no answer, goes to voicemail that says that mailbox is full." The nurse who wrote this note was unavailable for interview at the time of the survey.

A review of Resident #53's comprehensive care plan dated 3/11/21 revealed, in part: "[Resident #53] uses anti-anxiety medications...Administer anti-anxiety medications as ordered by physician."

On 10/25/21 at 3:23 p.m., RN (registered nurse)

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#5 was interviewed. She stated she was taking care of Resident #53 that morning and that he is upset because he has not received his Diazepam the past few nights. She stated she had personally faxed the refill request to the NP (nurse practitioner), ASM (administrative staff member) #6, on Thursday, 10/21/21. She stated she had called ASM #6 and told her Resident #53 would soon be completely out of the Diazepam, and needed a refill. She stated because Diazepam is a controlled substance, a refill required the NP or physician to directly contact the pharmacy to authorize it. She stated she did not work between Thursday, 10/21/21 and that morning (10/25/21), she had not had the opportunity follow up on this refill. She stated when she arrived at work at 7:00 a.m. on 10/25/21, she discovered the medication had finally been re-ordered on 10/24/21, but still had not been delivered to the facility. RN #5 stated she had looked for, but had not been able to locate the refill requests she had faxed to ASM #6 on 10/21/21.

Review of the facility STAT (immediate) box revealed that Diazepam 5 mg was not available in the box for administration.

On 10/26/21 at 9:34 a.m., ASM #8, the medical director and Resident #53's attending physician, was interviewed. When asked the process for authorizing refills for controlled medications, he stated the facility nurses should communicate the refill needs a week before the medication runs out. He stated if he receives a request for a refill, he can send an electronic order directly to the pharmacy, or he can call the pharmacy to refill the medication. When asked what happens if the refill is urgently needed on a weekend, he stated

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the nurses at the facility have his phone number, as well as the phone numbers for both nurse practitioners, and they should call one of the providers. When asked if he was aware that facility staff had attempted to call him over the weekend, he stated he was not. He stated his voicemail had not been full over the weekend.

On 10/26/21 at 12:19 p.m., ASM #6, the nurse practitioner, was interviewed. She stated if a resident needs a refill for a controlled medication, the staff prints out the paper prescription for the provider to sign on their next visit to the facility. She stated if the refill is needed urgently, the staff may call her, and she can directly transmit an electronic refill request to the pharmacy. She stated she had not received any phone calls or faxes from facility nurses regarding Resident #53's Diazepam prescription.

On 10/26/21 at 3:42 p.m., ASM #2, the director of clinical services, was interviewed. She stated if a resident needs an urgent refill for a controlled substance, the nursing staff may all a provider and request the provider to transmit the refill request directly to the pharmacy. She stated she was not aware of any concerns regarding Resident #53's Diazepam.

On 10/26/21 at 3:50 p.m., ASM #1, the executive director, and ASM #2 were informed of these concerns. Additional evidence that Resident #53 had received the Diazepam as ordered was requested.

A review of the facility policy, "Medication Shortages/Unavailable Medications," failed to reveal any information related to the facility staff attempting unsuccessfully to reach the physician

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F 755	Continued From page 163 for a controlled substance refill while the provider states he/she was never contacted about the refill. No further information was provided prior to exit. REFERENCES (1) "Diazepam is used to relieve anxiety and to control agitation caused by alcohol withdrawal. It is also used along with other medications to control muscle spasms and spasticity caused by certain neurological disorders such as cerebral palsy (condition that causes difficulty with movement and balance), paraplegia (inability to move parts of the body), athetosis (abnormal muscle contractions), and stiff-man syndrome (a rare disorder with muscle rigidity and stiffness)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682047.html.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a resident was free from a significant medication error for one of 41 residents in the survey sample, Resident #24 The facility staff failed to administer the blood thinning medication Eliquis (1) to Resident #24 on 7/5/21 and 7/29/21.	F 760	1. The MD was notified of the medication omission for resident #24 Eliquis on 10/25/2021. The residents is receiving Eliquis as per MD order without any adverse effects. 2. Residents that reside in the facility have the potential to be affected. A quality review will be conducted by the Director of Clinical Services for residents with order	12/1/21

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F 760	Continued From page 164 The findings include: Resident #24 was admitted to the facility on 3/29/20. Resident #24's diagnoses included but were not limited to diabetes, atrial fibrillation (1) and a history of stroke. Resident #24's quarterly minimum data set assessment with an assessment reference date of 8/27/21, coded the resident's cognitive skills for daily decision making as modified independence. Resident #24's comprehensive care plan dated 8/2/20 documented, "(Resident #24) has Peripheral Artery Disease. Give medications for improved blood flow or anticoagulants as ordered..." Review of Resident #24's clinical record revealed a physician's order dated 3/12/21 for Eliquis 2.5 mg (milligrams) - one tablet by mouth two times a day for peripheral vascular disease (2). Resident #24's July 2021 MAR (medication administration record) documented the order for Eliquis 2.5 mg- one tablet by mouth two times a day. On 7/5/21 at 5:00 p.m. and 7/29/21 at 5:00 p.m., the nurse did not document the medication as being administered. The MAR documented the code, "9=other/See Nurse Notes." \ A nurse's note dated 7/5/21 documented, "out of medication and was reordered." A nurse's note dated 7/29/21 documented, "not available." On 10/20/21 at 1:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses can fax medication refill requests to the pharmacy or request a refill directly through the computer system. LPN #1	F 760	for blood thinning medications to ensure medication is being administered as per MD order. Any abnormal findings will be reported to the MD and follow up based on orders. 3.The Director of Nursing or designee will educate licensed nursing staff on following the six rights of medication administration, following MD orders for administering medications and the process for refilling prescriptions along with use of emergency medication supply. A) Unit Managers and or designee will conduct medication administration observations weekly x 4 weeks then monthly x 6 months to ensure medications are administered per physician order. B) A review of the missed medication administration report will be done during daily clinical meeting and variances will be addressed, and corrective action and or education will be provided. Provider will be notified when medications were not administered. This will continue for 6 months to ensure ongoing compliance 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. 12/01/2021	

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stated if a medication is needed and not available then she calls the pharmacy or obtains the medication from the STAT [immediate] box (a box containing various medications) if the medication is in the STAT box.

Review of the list for the STAT box in the facility during July 2021 failed to reveal Eliquis was contained in the box.

On 10/20/21 at 4:02 p.m., an interview was conducted with LPN #2. LPN #2 stated Eliquis is a blood thinning medication that is usually prescribed for atrial fibrillation. LPN #2 stated it is important to administer Eliquis as prescribed by the physician because a missed dose can cause a blood clot or put a resident at risk for a stroke.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

On 10/20/21 at 5:30 p.m., ASM #1 was asked to provide a policy regarding significant medication errors.

On 10/26/21 at 2:11 p.m., ASM #1 stated the facility did not have the requested policy.

The Eliquis manufacturer's website documented, "Do not stop taking ELIQUIS without talking to the doctor who prescribed it to you. For patients taking ELIQUIS for atrial fibrillation: stopping ELIQUIS increases your risk of having a stroke." This information was obtained from the website: https://www.eliquis.bmscustomerconnect.com/

No further information was presented prior to exit.

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F 760	Continued From page 166 References: (1) "Apixaban (Eliquis) is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613032.html (2) Peripheral vascular disease is a condition of the blood vessels that supply the feet and legs. This information was obtained from the website: https://medlineplus.gov/ency/article/000170.htm	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. 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 provide laboratory testing for one of 41 residents in the survey sample, Resident #26. The facility staff failed to provide laboratory testing ordered for Resident #26 on 9/30/20.	F 770	1. Physician notified and declined to have additional labs for resident #26. 2. Quality review completed for labs and diagnostics ordered since 10/20/21 to identify any other residents affected by this practice. Physician notification for	12/1/21

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F 770	Continued From page 167 The findings include: Resident #26 was admitted to the facility on 6/30/17, and most recently readmitted on 8/24/21, with diagnoses including diabetes, peripheral artery disease, and end stage kidney disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/23/21, Resident #26 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). The resident was coded as requiring the assistance of staff for bed mobility, dressing, toileting, personal hygiene, and bathing. He was coded as having received dialysis services during the look back period. A review of Resident #26's physician's orders revealed the following: "CBC (complete blood count) with diff (differentiation), BMP (basic metabolic panel), CRP (C-reactive protein), Ferritin (Iron level), D-dimer (clotting level), Fibrinogen (helps clotting) one time a day every Thursday for 14 days. Start date 9/23/21." Further review of Resident #26's September 2021 TARs (treatment administration records) and laboratory results revealed no results for the laboratory [lab] tests ordered for 9/30/21. A review of Resident #26's comprehensive care plan dated 7/27/20 revealed, in part: "Obtain and monitor lab/diagnostic work as ordered." On 10/20/21 at 1:44 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the information for lab (laboratory) tests that need to	F 770	other residents with this deficient practice. 3. Licensed staff re-education on obtaining labs and diagnostics per the physician order by the DON/designee. 4. The Administrator is responsible for maintaining compliance. The DON/designee will quality monitor labs and diagnostics 3 times weekly for 4 weeks and then monthly for 6 months. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021.	

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F 770	Continued From page 168 be done is kept in a book at the nurses' desk. LPN #1 stated the nurse who receives an order for a lab test fills out a request slip, and puts in the book. When the outside lab company staff arrive at the facility, they check the book and obtain blood specimens as ordered. She stated she is not sure why Resident #26's lab tests were not performed for 9/30/21, but she could not find any evidence that the tests were done. On 10/21/21 at 8:36 a.m., ASM (administrative staff member) #2, the director of clinical services, confirmed the lab tests had not been done for Resident #26 on 9/30/21. She stated the night shift nurse is responsible for double checking that all lab requests for a particular day are accurate and in the book for the outside lab company. ASM #2 stated she could not locate a lab test request sheet for Resident #26 for 9/30/21. On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. A review of the facility policy, "Laboratory, Diagnostic and X-ray," revealed, in part: "Obtain a physician's order for laboratory work, diagnostic testing, and X-ray. Complete the required requisition form (s). Schedule laboratory work...as indicated." No further information was provided prior to exit.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		12/1/21

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F 842	Continued From page 169 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 170 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure a complete and accurate medical record for two of forty-one residents in the survey sample, Resident #230 and Resident #2. 1. The facility failed to provide a complete and accurate medical record for Resident #230, for documentation on the TAR (treatment administration record) for the wound vacuum continuously running as ordered on 8/24/21 night	F 842	1. Resident #230 no longer at facility. Resident #2 pain level is documented prior to pain medication administration as of 11/20/2021. 2. Quality review of documentation records completed since 11/1/2021 to ensure records are complete and accurate. 3. Nursing staff re-educated on providing complete and accurate records on	

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F 842	Continued From page 171 shift and 8/30/21 day shift, and ostomy care every shift as ordered on 8/24/21, 8/25/21 and 8/26/21 as well as day shift on 8/30/21. 2. The facility failed to provide a complete and accurate medical record for the documentation of pain levels prior to the administration of pain medication on the MAR (medication administration record) for Resident #2. The findings include: 1. Resident #230 was admitted to the facility on 8/20/21 with diagnoses that included but were not limited to: Diabetes mellitus (inability of insulin to function normally in the body) (1), chronic obstructive pulmonary disease 'COPD' (chronic non-reversible lung disease) (2), end stage renal disease 'ESRD' (inability of the kidneys to excrete waste and to function in the maintenance of electrolyte balance in the body) (3) and abscess of testis and buttocks (accumulation of pus in the testis and buttocks) (4). The most recent MDS (minimum data set) assessment, a five day Medicare assessment with an ARD (assessment reference date) of 8/26/21, coded Resident #230 as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, locomotion, and dressing and bathing; total dependence for hygiene and supervision for eating. A review of MDS Section H- bowel and bladder coded the resident as having an ostomy for bowel and an indwelling catheter for bladder.	F 842	11/20/2021 by DON/designee 4. The Administrator is responsible for maintaining compliance. The DON/designee to quality monitor medication and treatment administration records weekly for 4 weeks and then monthly for 6 months to ensure compliance. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021.	

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A review of Resident #230's comprehensive care plan dated 9/2/21, the comprehensive care plan documents in part, "FOCUS-Resident has scrotal and right gluteal abscess. Decline in mobility and ADL (activities of daily living). INTERVENTIONS-Treatment per order. Toilet use: He is not toileted. He has a catheter and colostomy and is dependent on staff for care of these devices."

A review of the physician orders dated 8/20/21, documented in part, "Wound vacuum continuously running every shift. Colostomy care every shift and as needed.

A review of Resident #230's TAR (treatment administration record) failed to evidence documentation of wound vacuum continuously running every shift on 8/24/21 night shift and 8/30/21 day shift.

A review of Resident #230's TAR failed to evidence documentation of colostomy care every shift and as needed on the night shifts on: 8/24/21, 8/25/21 and 8/26/21 as well as day shift on 8/30/21.

An interview was conducted on 10/21/21 at 7:00 AM with LPN (licensed practical nurse) #8. When asked what blanks on the TAR indicates, LPN #8 stated, "Well, it could mean the treatment didn't happen, but it could also mean you didn't finish charting." When asked if she remembered providing care to Resident #230, LPN #8 stated, "Yes, I remember caring for him and I don't remember missing any treatments."

An interview was conducted on 10/26/21 at 9:46

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AM with LPN #10. When asked what blanks on the TAR indicates, LPN #10 stated, "Usually it means we didn't get it charted." When asked if he remembered caring for Resident #230, LPN #10 stated, "Yes, I do." When asked what the blanks on the TAR, shown to LPN #10 meant, LPN #10 stated, "I believe it is charting error."

A review of the facility's "Clinical/Medical Records" policy, dated 8/2017, documented in part, "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care."

On 10/26/21 at 3:52 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services and ASM #3 the regional vice president of operations were made aware of the concerns.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 498.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 4.

2. Resident #2 was admitted to the facility on

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4/15/21 with diagnoses that included but were not limited to: Diabetes mellitus (inability of insulin to function normally in the body) (1), chronic kidney disease (decreased function of the kidneys frequently as a complication of diabetes) (2) and right below the knee amputation 'RBKA' (surgical removal of right leg below the knee) (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 10/19/21, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for hygiene, supervision for bathing and dressing and independent for eating, bed mobility and transfers. Ambulation did not occur. A review of MDS Section H- bowel and bladder coded the resident as always continent for bowel and for bladder.

On 7/27/21 the comprehensive care plan documents in part, "FOCUS-Resident has history of chronic back pain. INTERVENTIONS-Meds [medications] per order."

A review of the physician orders dated 4/20/21, documented in part "Oxycodone (opioid analgesic) (4) tablet 5 milligram, give 1 tablet by mouth every 6 hours as needed for pain."

A review of Resident #2's MAR revealed the following:

The September 2021 MAR evidenced documentation of Oxycodone 5 milligram tablet administration for a documented pain level of '0'

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on 9/24/21 at 9:07 PM, 9/26/21 at 5:34 AM.

The October 2021 MAR evidenced documentation of Oxycodone 5 milligram tablet administration for the documented pain level of '0' on 10/2/21 4:12 AM, 10/3/21 9:01 PM, 10/7/21 at 10:08 PM, 10/15/21 at 11:51 PM, 10/16/21 at 5:52 AM, 10/17/21 at 12:05 AM, 10/18/21 at 5:55 AM, 10/19/21 at 8:44 PM, 10/20/21 at 6:08 AM and 10/21/21 at 12:18 AM.

An interview was conducted on 10/21/21 at 6:47 AM with LPN (licensed practical nurse) #8. When asked how pain level was determined, LPN #8 stated, "I ask them their pain level on a scale of 0-10, or their facial expressions." When ask to review the documentation of the MAR for Resident #2, LPN stated, "Yes that would be helpful." When asked why Oxycodone 5 milligram would be given for a pain level of 0, LPN #8 stated, "I would not give Oxycodone for a pain level of 0." When shown her documentation on the MAR, LPN #8 stated, "No, that's not right." LPN #8 pulled up her administration view and showed that on one section 0 = administration. "I was documenting that I administered the pain medication. His pain level was always a 6-7. It was never lower than a 6. I would never give Oxycodone, a narcotic, for a pain level of '0'." When asked if this documentation was accurate, since the '0' appeared next to pain level, LPN #8 stated, "No, this is not accurate documentation."

An interview was conducted on 10/21/21 at 7:27 AM with LPN #5, the director of clinical services. When asked about the wrong code being on the MAR for pain medication, LPN #5 stated, "The documentation is not accurate and doesn't tell the story."

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F 842	Continued From page 176 On 10/26/21 at 3:52 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services and ASM #3 the regional vice president of operations were made aware of the concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 119. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 29. (4) 2019 Lippincott Drug Guide for Nurses, Wolters Kluwer, page 283.	F 842		
F 886 SS=E	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:	F 886		12/1/21

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F 886	Continued From page 177 (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; (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	F 886		

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F 886	Continued From page 178 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 staff interview and facility document review, it was determined that the facility staff failed to evidence documentation that COVID-19 testing was completed for fourteen of 45 employee reviews. The facility staff failed to evidence documentation that COVID-19 testing was completed and the results of each staff test for multiple employees in September 2021 and October 2021. The findings include: Review of facility documentation revealed the facility began COVID-19 outbreak status on 8/26/21. Further review of facility documentation failed to reveal evidence that the facility staff tracked employee COVID-19 testing from 8/26/21 to the beginning of survey (10/19/21). Review of individual employee tests revealed the following: -For OSM #13 (temporary nurse aide) hired on 9/15/21, the facility staff failed to evidence documentation of completed testing for the weeks ending 10/9/21 and 10/16/21. -For CNA #14 hired on 9/17/21, the facility staff failed to evidence documentation of completed	F 886	1. Staff identified during survey have been tested for COVID per CMS guidance and testing is ongoing based on guidance. 2. Quality review of residents and staff to ensure that all tested per the Center for Medicare and Medicaid by DON/designee by 11/18/2021. 3. Staff re-educated on COVID-19 testing per the county transmission and outbreak testing by the DON/designee by 11/18/2021 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete weekly review of testing and random observation weekly for 4 weeks then monthly for 6 months to ensure compliance maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021	

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F 886	Continued From page 179	F 886		

testing for the weeks ending 9/25/21, 10/2/21 and 10/16/21.

-For RN #2 hired on 9/21/21, the facility staff failed to evidence documentation of completed testing for the week ending 10/2/21.

-For CNA #15 hired on 4/19/21, the facility staff failed to evidence documentation of completed testing for the week ending 9/18/21.

-For ASM #7 (nurse practitioner) hired on 8/31/20, the facility staff failed evidence documentation of completed testing for the weeks ending 9/18/21, 9/25/21, 10/2/21, 10/9/21 and 10/16/21.

-For CNA #1 hired on 8/25/21, the facility staff failed to evidence documentation of completed testing for the weeks ending 9/11/21 and 9/25/21.

-For OSM #21 (dietary supervisor) hired on 4/6/20, the facility staff failed to evidence documentation of completed testing for the weeks ending 9/11/21, 9/18/21, 9/25/21, 10/2/21 and 10/16/21.

-For OSM #9 (transportation/central supply) hired on 5/12/20, the facility staff failed to evidence documentation of completed testing for the weeks ending 10/2/21 and 10/16/21.

-For RN #4 hired on 9/14/21, the facility staff failed to evidence documentation of completed testing for the weeks ending 9/25/21, 10/9/21 and 10/16/21.

-For LPN #4 hired on 3/2/21, the facility staff failed to evidence documentation of completed testing for the week ending 10/9/21.

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-For CNA #22 hired on 7/1/21, the facility staff failed to evidence completed documentation of testing for the weeks ending 9/11/21, 9/18/21, 9/25/21, 10/2/21, 10/9/21 and 10/16/21.

-For CNA #9 hired on 8/2/21, the facility staff failed to evidence documentation of completed testing for the weeks ending 9/11/21, 9/18/21, 9/25/21, 10/2/21, 10/9/21 and 10/16/21.

-For CNA #23 hired on 8/11/21, the facility staff failed to evidence documentatiomn of completed testing for the weeks ending 9/11/21 and 9/18/21.

-For CNA #24, hired on 1/8/21, the facility staff failed to evidence documentation of completed testing for the week ending 9/18/21.

On 10/26/21 at 8:36 a.m., an interview was conducted with OSM #21. OSM #21 stated she is tested for COVID-19 every Tuesday and Thursday by different nurses.

On 10/26/21 at 8:49 a.m., an interview was conducted with CNA #9. CNA #9 stated she had been tested twice a week for COVID-19 by a nurses or someone who was trained.

On 10/26/21 at 8:51 a.m., an interview was conducted with #9. OSM #9 stated that prior to the survey, staff were completing their own testing. OSM #9 stated he only looked to see if the tests were positive, checked off the testing forms and gave the forms to ASM (administrative staff member) #1 (the executive director). When asked who was tracking employee testing to ensure required testing was being completed, OSM #9 stated he was not sure but now he is

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F 886	Continued From page 181 responsible and he has a tracking roster. On 10/26/21 at 8:57 a.m., an interview was conducted with ASM #2 (the director of clinical services and infection preventionist). ASM #2 stated in August 2021 when the first resident tested positive, she told ASM #1 all staff had to be tested and would need to be tested twice weekly. ASM #1 stated the facility was conducting broad based testing. ASM #1 stated all testing records were kept in a book in ASM #1's office. On 10/26/21 at 9:04 a.m., an interview was conducted with ASM #1. ASM #1 stated the testing records were kept in his office and he would go through the test results based on an employee roster. ASM #1 stated he had now learned the employee roster was not complete. On 10/26/21 at 4:15 p.m., ASM #2 was asked why there was no tracking for COVID-19 employee testing. ASM #2 shook her head. The facility COVID-19 pandemic plan documented, "Testing: 1. Centers will follow Federal and State regulations for testing of staff and residents...Documentation: Outbreak Investigation includes: -Date case was identified -Date all other residents and staff were tested -Date all residents and staff were retested -Results of all test -Outbreak Testing strategy used and rational (contact tracing or broad-based testing)..."	F 886		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System	F 919		12/1/21

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F 919	Continued From page 182 The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an operational call bell system for two of 41 residents in the survey sample, Residents #8 and #130. The findings include: 1. The facility staff failed to ensure Resident #8's call bell was operational since July 2021. Resident #8 was admitted to the facility on 8/13/20. Resident #8's diagnoses included but were not limited to major depressive disorder, diabetes and muscle weakness. Resident #8's annual minimum data set assessment with an assessment reference date of 8/2/21, coded the resident as being cognitively intact. Section G coded Resident #8 as requiring extensive assistance of two or more staff with bed mobility. On 10/19/21 at 10:09 a.m., Resident #8 was observed lying in bed. The resident's call bell was not operational. There was no light or sound signal when the call bell was pressed. An interview was conducted with Resident #8 at this time. Resident #8 stated that he sometimes uses his call bell but it hasn't worked.	F 919	1. Resident #8 and #130 call bells and/or ringing bell in reach and operational by the Licensed Practical Nurse on 10/20/2021. 2. Quality review completed by the Maintenance Director on 10/20/2021 to identify any other resident that could have been affected. 3. Staff re-education completed on 11/18/2021 by DON/designee on call bell system and that call bells that are not operational is placed in the maintenance log. 4. The Administrator is responsible for maintaining compliance. The DON/designee will complete quality monitoring of call bells and/or ringing bells in reach and operational, using daily round sheets and reviewing maintenance log 3 times per week to ensure compliance. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495315	A. BUILDING _____ B. WING _____	C 10/26/2021

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CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

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F 919	Continued From page 183	F 919		

On 10/19/21 at 11:39 a.m., an interview was conducted with OSM (other staff member) #1 (the maintenance director). OSM #1 stated Resident #8's call bell has not been operational since July 2021 but the resident did have a hand held ring bell. OSM #1 stated he can fix some call bell issues such as installing a new switch or new cord but some issues such as wiring have to be fixed by an outside company. OSM #1 stated he had notified the outside company regarding Resident #8's call bell but they had not recently been in the facility.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

The facility policy titled, "Call Bell System-Inoperable" documented, "Resident must have, at all times, a system to notify staff when assistance is needed. The call bell system is to be inspected on a regularly scheduled basis by Maintenance. If the Call Bell System is inoperable, in one room, one hall, or the entire unit, the following procedure must be followed:
Procedure:
-Maintenance, the Executive Director, and the Director of Clinical Services must be notified immediately if any call bell or the system is inoperable.
-Hand bells or tap type bells will be placed within reach of any resident affected by an inoperable call bell. Residents and staff will be educated on their usage.
-The Director of Maintenance and the Executive Director will focus on the repair of the inoperable call bell(s) which will be their priority until they are operable..."

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F 919	Continued From page 184 Note: The outside company came onsite to repair Resident #8's call bell during the survey. No further information was presented prior to exit. 2. The facility staff failed to ensure Resident #130's call bell was operational on 10/19/21. Resident #130 was admitted to the facility on 10/14/21. Resident #130's diagnoses included but were not limited to chronic kidney disease, diabetes and muscle weakness. Resident #130's admission minimum data set assessment with an assessment reference date of 10/21/21, coded the resident as being cognitively intact. On 10/19/21 at approximately 11:15 a.m., Resident #130 was observed in their room. The resident's call bell was tested and was not operational. There was no light or sound signal when the call bell was pressed. On 10/19/21 at 2:15 p.m., an interview was conducted with OSM (other staff member) #1 (the maintenance director). OSM #1 stated all call bells were checked by the maintenance department during the previous week and Resident #130's call bell was functioning. OSM #1 stated the switch attached to the bathroom call bell has to be pushed all the way up when turned off or the bedroom call bell will not signal. OSM #1 stated this can especially occur when the bathroom switch is worn and loose. On 10/19/21 at approximately 3:00 p.m., the above interview was verified and Resident #130's call bell was functional at this time.	F 919		

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F 919	Continued From page 185 On 10/19/21 at 4:07 p.m., OSM #1 stated he replaced the call bell switch in Resident #130's bathroom. On 10/10/21 at 12:32 p.m., an interview was conducted with Resident #130. When asked if she uses the call bell, Resident #130 stated, "I sure do." On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern. No further information was presented prior to exit.	F 919		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 947		12/1/21

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F 947	Continued From page 186 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure CNAs (certified nursing aides) completed required annual in-service trainings for two of three CNA record reviews, (CNA #5 and CNA #6). The facility staff failed to ensure CNA #5 completed annual abuse training and failed to ensure CNA #6 completed annual dementia or abuse training. The findings include: CNA #5 was hired on 8/6/13. Review of CNA #5's record failed to reveal evidence that the CNA had completed annual abuse training. CNA #6 was hired on 5/8/04. Review of CNA #6's record failed to reveal evidence that the CNA had completed annual dementia or annual abuse training. On 10/20/21 at 9:36 a.m., an interview was conducted with OSM (other staff member) #3 (the human resources coordinator). OSM #3 stated all training are completed through a computer program and the system prompts employees for trainings that must be completed. OSM #3 stated she thought abuse and dementia trainings must be done annually. OSM #3 stated she printed out each employee's trainings after she began employment on 5/31/21 or 6/1/21. OSM #3 stated she told employees they had to be caught up on their trainings by 9/30/21 and whoever was 30 days behind on trainings would be provided corrective action. OSM #3 stated she could not	F 947	1. CNA #5 and CNA #6 completed annual abuse training on 11/20/2021. CNA #6 completed annual dementia training per the policy on 11/20/2021. 2. Quality review of facility staff to ensure that annual abuse and dementia training completed per the policy. 3. Staff re-education on timely completion of annual required in-service by the DON/designee. 4. The Administrator is responsible for maintaining compliance. The DON/designee will complete quality monitoring monthly for 6 month to ensure compliance with staff required in-services. Follow-up based on findings and reported to the monthly QAPI meeting. Quality monitoring schedule modified based on findings. 5. 12/01/2021	

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F 947	Continued From page 187	F 947		

locate abuse training for CNA #5 or dementia or abuse training for CNA #6 who only works one or two days a month.

On 10/20/21 at 5:12 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of clinical services) were made aware of the above concern.

The facility policy titled, "In-Service Training-General" documented, "Employees will be provided in-service training on required topics on an annual basis...2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, and may include Company required in-service education topics. Each Care Center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly..."

No further information was presented prior to exit.