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	495389	A. BUILDING _____ B. WING _____	C 09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WINCHESTER, LLC	110 LAUCK DR WINCHESTER, VA 22603

(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 09/07/2021 through 09/09/2021. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of	E 036		10/14/21

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

Electronically Signed | 09/30/2021

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E 036	Continued From page 1 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	E 036	1. The facility has a documented Federal Emergency Plan (Fed EP) with a Training and Testing Program that meets the regulation, and will be reviewed and updated annually.	

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E 036	Continued From page 2 Facility staff failed to provide evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis. The findings include: On 09/09/2021 at 9:30 A.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence that the facility has a written training and testing program that meets the requirements of the regulation and failed to evidence documentation that the training and testing program had been reviewed and updated on, at least an annual basis. ASM # 1 stated, "We don't have the documentation." On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings. No further information was provided prior to exit.	E 036	2. There is only one required Fed EP, therefore no additional reviews were needed. 3. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- EP Training and Testing specific to properly maintaining documentation of the facility's Fed EP Training and Testing program, and will continue to monitor in accordance with the standard. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. 10/14/21	
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).	E 037		10/14/21

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E 037	Continued From page 3 *[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 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	E 037		

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E 037	Continued From page 4	E 037		

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 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

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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 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

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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 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

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E 037	Continued From page 7 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 09/09/2021 at 9:30 a.m., a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence 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, "We don't have the documentation." On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings. No further information was provided prior to exit.	E 037	1. The facility's Fed EP Training Program documentation will be properly maintained. 2. There is only one required Fed EP, therefore no additional reviews were needed. 3. The Executive Director educated the Maintenance Director and Director of Clinical Services on the importance of 42 CFR 483.73- EP Training Program specific to properly maintaining the facility's Fed EP Training Program documentation, and will continue to monitor in accordance with the standard. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. 10/14/21	

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/07/2021 through 09/09/2021. Four complaints (VA0051281- substantiated with deficiencies, VA00051554- unsubstantiated with no deficiencies, VA00050461- unsubstantiated with no deficiencies and VA00052257 - unsubstantiated with no 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 60 certified bed facility was 52 at the time of the survey. The survey sample consisted of 27 current resident reviews and eight closed record reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened	F 583		10/14/21

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mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview and facility document review it was determined that the facility staff failed to provide privacy for three of 35 residents in the survey sample, Resident #301, #33 and #47.

Resident #301's urinary catheter bag was visible with urine in the bag from the hallway while the resident was in bed and was not covered with a privacy cover; Resident #33's protected health information was left open on the medication cart in the hallway and was visible to staff and or others passing by, during the medication administration observation; and facility staff failed to provide personal privacy for Resident #47 while she was receiving personal care on 9/7/21.

The findings include:

1. On 9/7/2021 at approximately 12:47 p.m., an observation was made of Resident #301 in bed

1. Resident #301 had a dignity bag placed on catheter bag on 9/8/2021. Resident assignment sheet was turned over to protect resident information, and privacy curtain was pulled for other residents receiving care. Staff re-education started on 9/8/21 on the facilities policies and procedures on resident privacy including protection of health information, catheter care and providing privacy during cares.

2. Quality review completed and no other residents affected by catheter without privacy cover, health information being exposed and privacy curtains not being pulled during care on 9/9/2021

3. Staff re-education by the DON/designee completed on catheter care, HIPAA notice of privacy practices

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from the facility hallway. Resident #301 was observed lying in bed with a urinary catheter bag attached to the bedframe on the right side of the bed facing the hallway. Urine was observed in the catheter bag visible from the hallway.

Additional observations on 9/7/2021 at 2:18 p.m., and 9/7/2021 at 4:33 p.m. revealed the urinary catheter bag hanging on the right side of the bed facing the hallway with urine visible in the bag from the hallway.

On 9/8/2021 at 8:45 a.m., Resident #301 was observed in bed with a urinary catheter bag with a privacy cover hiding the contents of the bag from view.

Resident #301 was admitted to the facility with diagnoses that included but were not limited to malignant neoplasm of the bladder (1) and paraplegia (2). Resident #301's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/2/2021, coded Resident #301 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Section H documented Resident #301 having an indwelling catheter.

On 9/7/2021 at 4:33 p.m., an interview was conducted with Resident #301. Resident #301 stated that they were at the facility for therapy and short-term. Resident #301 stated that the nursing staff handled the urinary catheter bag and emptied it when needed.

The physician's orders for Resident #301 documented in part, "Flush suprapubic catheter

which include personal medical information protection and resident right to privacy by 10/8/2021

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, HIPAA information privacy and privacy during care 3 times weekly to ensure compliance maintained

5. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings.

6. 10/14/21

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(3) and Foley every 3 (three) hours with 50 ml (milliliter) of Normal Saline every 3 hours for mainance [sic]. Order Date: 08/28/2021." The orders further documented, "Foley and Suprapubic catheter care every shift. Order Date: 08/28/2021."

The progress notes for Resident #301 documented in part, "8/27/2021 21:33 (9:33 p.m.) [Resident #301] was admitted on 8/27/2021...Catheter is indwelling supra-pubic..."

The baseline care plan for Resident #301 dated 8/27/2021 documented in part, "Altered elimination...Catheter care per policy..."

On 9/8/2021 at approximately 1:54 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated that they placed urinary catheter bags on the bed frame and made sure the bag had a privacy cover on it. CNA #1 stated that some residents were admitted from the hospital with urinary catheter bags that did not have privacy covers on them and the nurses changed them after they were admitted to the ones with privacy covers. CNA #1 stated that they did this so everyone could not see the contents in the bag and that the urinary catheter bag with urine inside should not be visible from the hallway.

On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that residents should have dignity bags for urinary catheters so that the contents could not be seen. LPN #1 stated that they should not be able to see the urine from the hallway. When asked about Resident #301's urinary catheter bag on

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9/7/2021, LPN #1 stated that Resident #301 did not have a dignity bag but they had changed it to a dignity bag that morning so there would not be any further privacy concerns.

On 9/9/2021 at approximately 10:30 a.m., a request was made to ASM #1 for the facility policy for care of urinary catheter bags and privacy.

On 9/9/2021 at 3:48 p.m., ASM #1 provided via email, "Catheter Care, Urinary" dated 9/5/2017 which failed to evidence guidance on providing privacy for the urinary catheter bag contents. ASM #1 also provided the policy "Notice of Privacy Practice" dated 11/30/2014 which documented in part, "...The facility is responsible to: Maintain the privacy of the resident health information..." The facility policy "Resident and Patient Rights" dated 9/1/2017 documented in part, "...It is the policy of The Company that all employees will conduct themselves in a professional manner at all times, respecting the rights of each resident or patient to privacy, personal care, self-respect and confidentiality..."

On 9/8/2021 at approximately 5:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse were made aware of the findings.

No further information was provided prior to exit.

References:

1. Malignant neoplasm: refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. This

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information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm.

2. Paraplegia: is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. This information was obtained from the website: https://medlineplus.gov/paralysis.html

3. Suprapubic catheter: "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000145.htm.

2. On 9/7/2021 at approximately 4:55 p.m., an observation was made of LPN (licensed practical nurse) #3 administering medications at the facility. LPN #3 placed the medication cart in the hallway against the wall between the resident rooms. LPN #3 was observed preparing medications for administration to Resident #33. On 9/7/2021 at 5:07 p.m., LPN #3 entered Resident 33's room with the medications while leaving their laptop computer showing Resident #33's eMAR (electronic medication administration record) visible on the medication cart in the hallway. Another staff member was observed exiting Resident #33's room at that time, passing beside the medication cart. On 9/7/2021 at 5:11

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p.m., LPN #3 exited Resident #33's room to obtain another medication and proceeded to enter the room with the eMAR still visible on the computer screen. On 9/7/2021 at 5:12 p.m., LPN #3 exited Resident #33's room and returned to the medication cart.

Resident #33 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1) and dementia (2). Resident #33's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/6/2021, coded Resident #33 as scoring a 10 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 10- being moderately impaired for making daily decisions.

On 9/7/2021 at approximately 5:14 p.m., an interview was conducted with LPN #3. LPN #3 stated that they normally locked the computer screen on their computer before they left the cart to go into the residents room. LPN #3 stated that they had forgotten to lock the computer screen and left the eMAR in view by mistake.

On 9/8/2021 at approximately 5:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse were made aware of the findings.

No further information was provided prior to exit.

References:

1. Chronic obstructive pulmonary disease (COPD)
Disease that makes it difficult to breath that can

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lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. Dementia
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. Resident #47 was admitted to the facility on 5/20/21, and most recently readmitted on 8/14/21, with diagnoses including ESRD (end stage renal disease) (1), right and left above the knee amputations, and COPD (chronic obstructive pulmonary disease) (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/16/21, Resident #47 was coded as requiring the extensive assistance of one staff member for toileting.

On 9/7/21 at 2:32 p.m., Resident #47 was observed lying in her bed. The privacy curtain between her bed and the door was pulled 3/4 of the way down the bed. The other two privacy curtains were open, allowing Resident #47 to be observed by her roommate and the surveyor. Resident #47 was receiving assistance to pull up her underwear after using the bedpan, from OSM (other staff member) #2, an occupational therapy assistant.

Two subsequent attempts to interview Resident #47 were unsuccessful.

On 9/8/21 at 1:35 p.m., OSM #2 was interviewed. When asked if she remembered her work with

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Resident #47 the day before, she stated she did. OSM #2 stated she had transferred Resident #47 back to bed because the resident wanted to use the bedpan. When asked if she remembered who was able to see Resident #47 as she was toileting and re-dressing, OSM #2 stated, "You walked into the room as I was getting her pants back on." She stated when she first began working with Resident #47 yesterday, the roommate was not in the room. She stated she did not realize the roommate had entered the room. OSM #2 stated for the resident's personal privacy, she should have made sure all three privacy curtains were pulled, completely keeping Resident #47 out of anyone's view.

On 9/8/21 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse, were informed of these concerns.

No further information was provided prior to exit.

REFERENCES:
(1) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website https://medlineplus.gov/ency/article/000500.htm.

(2) "COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. COPD can cause coughing that produces large amounts of a slimy substance called mucus, wheezing, shortness of breath, chest tightness, and other symptoms." This

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F 583	Continued From page 17 information is taken from the website https://www.nhlbi.nih.gov/health-topics/copd.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	F 584		10/14/21

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F 584	Continued From page 18 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide a clean and homelike environment for 2 of 35 residents in the survey sample; Residents #9 and #37. Resident #9's right and Resident #37's wheelchairs were not maintained in a condition of good repair. Resident #9's right wheelchair arm was observed with cracks in the vinyl material, and exposed foam in the cracks. The findings include: 1. Resident #9 was admitted to the facility on 10/11/18 and had the diagnoses of but not limited to Parkinson's disease, chronic kidney disease, dysphagia, lymphedema, high blood pressure, depression, dementia, heart failure, and osteoarthritis. The annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 6/22/21 coded Resident #9 as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene and toileting; extensive assistance for dressing, transfers and bed mobility; as independent for eating; and as incontinent of bowel and bladder.	F 584	1. Resident #9 and #37 wheel chair repaired on 9/9/2021 by the Maintenance Director. 2. Quality review completed by the Maintenance Director on 9/9/2021 to identify any other resident that could have been affected. 3. Staff re-education completed on 10/8/2021 by DON/designee on completing the maintenance log for residents for resident equipment that require repair. 4. The Administrator is responsible for maintaining compliance. The DON/designee will complete quality monitoring using daily round sheets 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. 10/14/2021	

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On 09/07/21 5:22 PM during observations of Resident #9, the resident's right wheelchair arm was observed with cracks in the vinyl material, and exposed foam in the cracks.

On 9/8/21 at 2:06 PM an interview was conducted with CNA #1 (Certified Nursing Assistant). She stated that when a resident's wheelchair is torn and requires maintenance, it should be written in the maintenance log at the nurse's station. A review of the maintenance log revealed that the last entry was dated 9/2/21 and there were no entries for Resident #9's torn wheelchair arm.

On 9/8/21 at 4:18 PM an interview was conducted with OSM #4 (Other Staff Member) the Director of Maintenance. He stated that he was not aware of any issues with Resident #9's wheelchair arm rest and that it had not been documented in the log book. OSM #4 stated that the exposed foam absolutely cannot be cleaned and sanitized.

A review of the facility policy "Wheelchair Repairs - Non Electric Wheelchairs" documented, "Each resident requiring the use of a wheelchair will be provided the appropriate chair to maintain their highest level of functioning. All chairs will be maintained in safe operating condition."

On 9/8/21 at approximately 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the interim Administrator, ASM #2 the interim Director of Nursing (DON) and ASM #3 the regional nurse, were made aware of the findings. No further information was provided by the end of the survey.

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2. Resident #37 was admitted to the facility on 2/28/17 with the diagnoses of but not limited to stroke, dysphagia, diabetes, chronic obstructive pulmonary disease, atrial fibrillation, chronic kidney disease, heart attack, depression, peripheral vascular disease, pacemaker, alcohol abuse, insomnia, and dementia. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/21 coded the resident as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing and dressing; limited assistance for transfers, bed mobility, toileting and hygiene; as independent for eating; and as continent of bowel and bladder.

On 09/07/21 5:22 PM during observations of Resident #37, the resident's right wheelchair arm was observed with torn ripped vinyl, and exposed foam along the armrest. The top corners of the wheelchair backrest was also observed with torn vinyl and exposed foam.

On 9/8/21 at 2:06 PM an interview was conducted with CNA #1 (Certified Nursing Assistant). She stated that when a resident's wheelchair is torn and requires maintenance, it should be written in the maintenance log at the nurse's station. A review of the maintenance log revealed that the last entry was dated 9/2/21 and there were no entries for Resident #9's torn wheelchair arm.

On 9/8/21 at 4:18 PM an interview was conducted with OSM #4 (Other Staff Member) the Director of Maintenance. He stated that he was not aware of any current issues with Resident #37's wheelchair arm rest but that he has replaced it twice in the last 6 months, and most recently (approximately 3

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F 584	Continued From page 21 weeks ago) repaired the breaks on Resident #37's wheelchair. OSM #4 stated that Resident #37 "is hard on his wheelchair." He stated that the exposed foam absolutely cannot be cleaned and sanitized. On 9/8/21 at approximately 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the interim Administrator, ASM #2 the interim Director of Nursing (DON) and ASM #3 the regional nurse, were made aware of the findings. No further information was provided by the end of the survey.	F 584		
F 622 SS=E	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	F 622		10/14/21

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payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the 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)

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F 622	Continued From page 23 (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (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 and clinical record review it was determined that the facility staff failed ensure the required documentation and information was provided to the receiving provider, upon facility-initiated transfers for five of 35 residents in the survey sample. Residents #39, #18, #26, #13 and #32. The facility staff failed to evidence what if any required documentation was provided to the receiving facility for a facility-initiated transfers of Resident #39 on 8/2/2021, and Resident #18 on 6/18/2021. The staff failed to evidence the comprehensive care plan goals were provided to the receiving facility for a facility-initiated transfers	F 622	1. The facility was not able to provide documentation for Resident #39 and #18 for the facility initiated transfer, Facility unable to provide documentation for Resident #26, #13 and #32 for comprehensive care plan goals for the facility initiated transfer. 2. Quality review completed for facility initiated transfers completed on 10/4/2021 for all facility initiated transfers since 9/20/2021 to identify any other residents affected by the practice. Residents identified information sent to the receiving facility.	

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F 622	Continued From page 24 of Resident #26 on 7/22/21, Resident #13 on 5/10/2021 and 5/26/2021, and Resident #32 on 7/14/21. The findings include: 1. Resident #39 was admitted to the facility with diagnoses that included but were not limited to pneumonia (1) and end stage renal disease (2). Resident #39's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 8/11/2021, coded Resident #39 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired for making daily decisions. The progress notes for Resident #39 documented in part, "8/2/2021 09:12 (9:12 a.m.) Nursing progress note. NP (nurse practitioner) requests to send patient to [Name of hospital] ER (emergency room) for AMS (altered mental status), dusky color, facial swelling, and cough. Chest xray obtained yesterday showed CHF (congestive heart failure). Patient stated he was feeling too bad to go to dialysis today. BS (blood sugar) checked 152. Pt (patient) refused to eat breakfast. VS (vital signs) 119/79 (blood pressure), 97.8 (temperature), 92 (pulse), 93% RA (oxygen saturation on room air), 24 (respirations). Patient currently on Augmentin (antibiotic) for cough. Family notified." The clinical record failed to evidence documentation of information provided to the hospital on 8/2/2021. On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with LPN (licensed	F 622	3. Licensed staff re-education Transfer/discharge policy completed on 10/8/2021 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. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 10/14/2021.	

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practical nurse) #1. LPN #1 stated that when a resident was sent to the hospital they completed a transfer form, a SBAR (situation, background, assessment, response), contact the family, set up transport or called 911. LPN #1 stated that they sent the residents orders, a face sheet, the transfer form and the care plan if it coordinated with why they were going to the hospital. LPN #1 stated that they did not always send the care plan with the resident unless it applied to the reason they were being sent. LPN #1 stated that they documented this information in a progress note to evidence what was sent. LPN #1 stated that if there was no progress note or transfer form they could not evidence what information was provided to the receiving facility. LPN #1 stated that they had sent Resident #39 out to the emergency room on 8/2/2021 and thought they had completed a transfer form, SBAR and documented what was sent to the hospital but did not see it in the medical record.

On 9/9/2021 at approximately 10:30 a.m., a request was made to ASM #1 for the facility policy for transfers and discharges.

On 9/9/2021 at 3:48 p.m., ASM #1 provided via email, "Transfer/Discharge Notification & Right to Appeal" dated 3/26/2018, which documented in part, "...Information provided to the receiving provider must include but is not limited to: Contact information of the practitioner responsible for care of the resident; Resident representative information including contact information; Advance Directives; Special care instructions or precautions for ongoing care as indicated; Comprehensive care plan goals; All other necessary information, including copies of the resident's discharge summary and other

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documentation, as applicable to ensure safe and effective transition of care..."

On 9/8/2021 at approximately 5:02 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse was made aware of the findings.

No further information was provided prior to exit.

References:

1. Pneumonia: An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: <https://medlineplus.gov/pneumonia.html>

2. End-stage kidney disease: The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

2. Resident #18 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1) and dysphagia (2). Resident #18's most recent MDS (minimum data set) assessment, a significant change assessment with an ARD (assessment reference date) of 7/9/2021, coded Resident #18 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions.

The progress notes for Resident #18 documented in part, "6/18/2021 12:47 (12:47 p.m.) Nursing

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progress note. [Name of nurse practitioner] in to see resident with new orders to draw Amylase and Lipase (laboratory test) on next day lab [laboratory] r/t (related to) jaundice (3). RP (responsible party) aware."

The "Change in Condition" (SBAR) (situation, background, assessment, response)" for Resident #18 dated 6/18/2021 documented in part, "...critical total bilirubin of 13.1; Primary Care Clinician Notified: [Name of nurse practitioner], Date/Time notified: 06/18/2021 18:00 (6:00 p.m.); Recommendations of Primary Clinician: Send to ER (emergency room)..."

The physician orders for Resident #18 documented in part, "6/18/2021 17:59 (5:59 p.m.) send to ER for critical bilirubin/possible obstruction..."

The clinical record for Resident #18, failed to evidence documentation of what if any information that was provided to the hospital on 6/18/2021.

On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that when a resident was sent to the hospital they completed a transfer form, a SBAR (situation, background, assessment, response), contacted the family, set up transport or called 911. LPN #1 stated that they sent the residents orders, a face sheet, the transfer form and the care plan if it coordinated with why they were going to the hospital. LPN #1 stated that they did not always send the care plan with the resident unless it applied to the reason they were being sent. LPN #1 stated that they documented this information in a progress note to

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evidence what was sent. LPN #1 stated that if there was no progress note or transfer form they could not evidence what information was provided to the receiving facility.

On 9/8/2021 at approximately 5:02 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse was made aware of the findings.

No further information was provided prior to exit.

References:

1. Chronic obstructive pulmonary disease (COPD): Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. Dysphagia: A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

3. Jaundice: causes your skin and the whites of your eyes to turn yellow. Too much bilirubin causes jaundice. Bilirubin is a yellow chemical in hemoglobin, the substance that carries oxygen in your red blood cells. As red blood cells break down, your body builds new cells to replace them. The old ones are processed by the liver. If the liver cannot handle the blood cells as they break down, bilirubin builds up in the body and your skin may look yellow. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=jaundice&_ga=2.7899

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9444.126298920.1631308167-1838772440.1562936034

3. Resident #26 was admitted to the facility on 4/10/2020 with a recent readmission of 12/14/2020 with diagnoses that included but were not limited to: stroke (1), dysphagia (2), and sepsis (your body's overactive and extreme response to an infection) (3). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/4/2021, coded Resident #26 as scoring a "6" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving hospice care while a resident at the facility.

The nurse's note dated 7/22/2021 at 2:52 p.m. documented in part, "Upon starting my shift, it was reported to this nurse that resident was unresponsive and had been since about noon. It was reported also that resident had been running a fever of over 101 and that on call DR (doctor) and family had been notified. Dr... orders for 1 L (liter) of fluid to be run via IV (intravenously) and STAT (immediately) labs (laboratory tests) were drawn by day nurse...Lab results later arrived and... was notified. WBC (white blood cell) count very high and NP suggested calling the family to see if they wanted comfort care or for resident to be sent to the ER (emergency room). Family notified and requested resident to be sent to the ER for treatment. 911 called and took resident to the ER around 2230 (10:30 p.m.)."

Review of the clinical record failed to evidence a

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transfer form or documentation that the comprehensive care plan goals were sent with the resident and provided to the receiving hospital on 7/22/21.

On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN #1 stated that residents transferred to the hospital were sent with the physician orders, a face sheet, a transfer form and the care plan if it applied to the transfer. LPN #1 stated that they did not always send the care plan with the resident unless it applied to the reason they were being sent. LPN #1 stated that they documented this information in a progress note to evidence what was sent. LPN # 1 stated that if there was no progress note or transfer form they could not evidence what information was provided to the receiving facility.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse, were made aware of the above finding on 9/9/2021 at 11:14 a.m.

No further information was provided prior to exit.

References:
(1) Stroke: abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.
(2) Dysphagia: a condition in which swallowing is

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difficult or painful due to obstruction of the esophagus or muscular abnormalities of the esophagus or pharynx. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 178.
(3) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Sepsis&_ga=2.155403059.908502701.1629920181-1530802455.1629920181

4. Resident #13 was admitted to the facility on 2/10/2021 with a readmission on 6/1/2021, with diagnoses that included but were not limited to: dementia (1), high blood pressure, and kidney stones.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/30/2021 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident is capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living.

Review of the clinical record revealed the following:
A "Transfer Form" dated 5/10/2021, which documented, reason for transfer, "Unable to move from the neck down and stating she cannot see."
A "Transfer Form" dated 5/26/2021, which documented, reason for transfer, "Severe RLQ (right lower quadrant) pain."
Further review of the clinical record failed to

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evidence any nurse's notes addressing the transfers of Resident #13 5/10/2021 and 5/26/2021, as documented above.

Further review of the clinical record failed to evidence documentation that the comprehensive care plan goals were sent to the hospital with the resident upon transfer on 5/10/2021 and 5/26/2021.

On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN #1 stated that residents transferred to the hospital were sent with the physician orders, a face sheet, a transfer form and the care plan if it applied to the transfer. LPN #1 stated that they did not always send the care plan with the resident unless it applied to the reason they were being sent. LPN #1 stated that they documented this information in a progress note to evidence what was sent. LPN # 1 stated that if there was no progress note or transfer form they could not evidence what information was provided to the receiving facility.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse, were made aware of the above finding on 9/9/2021 at 11:14 a.m.

No further information was provided prior to exit.

(1) Dementia: a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

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5. Resident # 32 was admitted to the facility with diagnoses included but were not limited to: fractured clavicle [bone that connects the shoulder to the breastplate], and low blood pressure. Resident # 32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/04/2021, coded Resident # 32 as scoring a seven [7] on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions.

The nurse's note for Resident # 32 dated 07/14/2021 at 4:34 p.m., documented, "Nurse received X-ray results which showed displaced right clavicle fracture. Np [nurse practitioner] notified with orders to send to ER [emergency room] for further eval [evaluation]. RP [responsible party] made aware."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 32 failed to evidence that the comprehensive care plan goals were sent to the receiving facility at the time of Resident # 32's resident-initiated transfer on 07/14/2021.

On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN # 1 stated that residents transferred to the hospital were sent with the physician orders, a face sheet, a transfer form and the care plan if it applied to the transfer. LPN # 1 stated that they did not always send the care plan with the resident unless it applied to the reason they were being sent. LPN # 1 stated that they documented this information in a progress note to evidence what was sent. LPN # 1 stated

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F 622	Continued From page 34 that if there was no progress note or transfer form they could not evidence what information was provided to the receiving facility. On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings. No further information was provided prior to exit.	F 622		
F 623 SS=D	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. (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	F 623		10/14/21

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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, 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

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F 623	Continued From page 36 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 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 and clinical record review, it was determined that the facility staff failed to ensure written notification was provided to the ombudsman, the resident and the resident's representative (RP) for a facility/resident-initiated transfer for one of 35 residents in the survey sample, Residents #32.	F 623	1. On 10/4/2021 written notification was sent to RR and Ombudsman for resident #32 and 14. 2. Quality review completed on transfer/discharges on 10/4/2021 for all facility initiated transfers since 9/20/2021. Residents identified information sent to	

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F 623	Continued From page 37 The facility staff failed to evidence that the ombudsman was notified and Resident # 14 and resident's representative were provided written notification of a resident-initiated transfer on 07/14/2021 for Resident # 32. The findings included: Resident # 32 was admitted to the facility with diagnoses included but were not limited to: fractured clavicle [bone that connects the shoulder to the breastplate], and low blood pressure. Resident # 32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/04/2021, coded Resident # 32 as scoring a seven [7] on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions. The nurse's note for Resident # 32 dated 07/14/2021 at 4:34 p.m., documented, "Nurse received X-ray results which showed displaced right clavicle fracture. Np [nurse practitioner] notified with orders to send to ER [emergency room] for further eval [evaluation]. RP [responsible party made aware." Review of the clinical record and the EHR (electronic health record) for Resident # 32 failed to evidence notification to the ombudsman and that a written notification was provided to the resident and resident's representative for Resident # 32's facility-initiated transfer on 07/14/2021. On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with ASM [administrative	F 623	RR and Ombudsman. 3. Licensed nurse re-educated on issuing transfer notices and Social Services re-educated on notification of RR and Ombudsman on 10/8/2021 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. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 10/14/2021.	

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F 623	Continued From page 38 staff member] # 1, the administrator. When asked about the documentation for the ombudsman notification and the written notification to Resident # 23 and Resident # 32's representative regarding the facility-initiated transfer on 07/14/2021, ASM # 1 stated that they were not completed because the staff knew the resident was being sent out and that they did not see a need for it. On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings. No further information was provided prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		10/14/21

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F 625	Continued From page 39 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a transfer to the hospital for one of 35 residents in the survey sample, Residents # 32. The facility staff failed to provide Resident #32 and or the resident's representative with a copy of the bed hold policy prior to and or at the time of transfer to the hospital on 07/14/2021. The findings included: Resident # 32 was admitted to the facility with diagnoses included but were not limited to: fractured clavicle [bone that connects the shoulder to the breastplate], and low blood pressure. Resident # 32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/04/2021, coded Resident # 32 as scoring a seven [7] on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions.	F 625	1. Facility unable to provide documentation of behold issued for resident #32/RR. 2. Quality review completed on bed hold documentation 10/4/2021 for all facility initiated discharges since 9/20/2021.Residents identified bed hold issues to resident/RR 3. Licensed staff re-educated on Bed Hold policy 10/8/2021 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. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 10/14/2021	

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The nurse's note for Resident # 32 dated 07/14/2021 at 4:34 p.m., documented, "Nurse received X-ray results which showed displaced right clavicle fracture. Np [nurse practitioner] notified with orders to send to ER [emergency room] for further eval [evaluation]. RP [responsible party] made aware."

Review of the clinical record and the EHR (electronic health record) for Resident # 32 failed to evidence documentation the a bed hold policy was provided to Resident # 32 or Resident # 32's responsible party in regard to the transfer to the hospital on 07/14/2021.

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On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with ASM [administrative staff member] # 1, the administrator. When asked about documentation evidencing the bed hold policy was provided to Resident # 32 or Resident # 32's responsible party prior to and or at the time of transfer to the hospital on 07/14/2021, ASM # 1 stated that it wasn't [provided] because the staff knew the resident was being sent out and that they did not see a need for it.

The facility's policy "Bed Hold" documented in part, "At the time of transfer to the hospital or therapeutic leave, the center will provide a copy of notification of bed hold.

On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

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F 625	Continued From page 41 No further information was provided prior to exit.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure an accurate MDS (minimum data set) assessment for two of 35 residents in the survey sample; Residents #37 and #52. 1. The 8/10/21 quarterly MDS assessment for Resident #37 was not completed accurately regarding the coding of Section J1800 falls. The clinical record documented Resident #37 was found on the floor by staff on 6/8/21, and Section J1800 of the 8/10/21, quarterly MDS assessment coded the resident as having "0" falls, since admission/entry or reentry or the prior assessment. 2. The facility staff failed to accurately code Resident # 52's discharge status to community on the discharge MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/2021. Instead, the resident's discharge was coded as "Acute hospital." The findings include: 1. Resident #37 was admitted to the facility on 2/28/17 with the diagnoses of but not limited to stroke, dysphagia, diabetes, chronic obstructive	F 641	1. Resident #37 MDS corrected for section J1800 and resident #52 MDS corrected for section A2100 on 9/10/2021. 2. Quality review of MDS section J1800 and section A2100 on 10/4/2021 for MDS submitted since 9/20/21. MDS identified with coding errors will be corrected. 3. Re-education with MDS coordinators on coding accuracy by Region MDS/designee by 10/8/2021 4. The Administrator is responsible for maintaining compliance. DON/designee will complete quality monitor for 10% of submitted MDS section J1800 and A2100 weekly to ensure compliance. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality monitoring schedule. 5. 10/14/2021.	10/14/21

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pulmonary disease, atrial fibrillation, chronic kidney disease, heart attack, depression, peripheral vascular disease, pacemaker, alcohol abuse, insomnia, and dementia.

The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/21 coded Resident #37 as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing and dressing; limited assistance for transfers, bed mobility, toileting and hygiene; independent for eating; and as continent of bowel and bladder.

A review of the clinical record revealed a "Change in Condition" assessment dated 6/8/21 that documented, "Found sitting on floor in room between w/c (wheelchair) and bed. States he was trying to get into w/c. Pants noted soaked with urine...No injuries noted. VSS (vital signs stable)."

A review of the clinical record revealed a nurse's note dated 6/10/21 that documented, "S/p (status post) fall with no acute changes noted. Up to his wheelchair propel self up and down the hallways. Denied pain or discomfort. No concerns voiced this shift."

Further review of the above quarterly MDS revealed that it was not accurately completed for Section J1800 "Has the resident had any falls since admission/entry or reentry or the prior assessment..." This question was coded as "0" (Code 0 for No and 1 for Yes).

On 9/8/21 at 3:58 PM an interview was conducted with LPN #5 (Licensed Practical Nurse), the MDS nurse. She stated that it should be coded but

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was going to review it and see what happened with the coding. When asked if there was any policy or procedure she follows to complete the MDS, LPN #5 stated that she was sure there was one somewhere. She did not identify the RAI manual.

A review of the facility policy "MDS" did not address the accuracy of an MDS.

On 9/8/21 at approximately 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing (DON) and ASM #3 the regional nurse, were made aware of the findings. No further information was provided by the end of the survey.

2. Resident # 52 was admitted to the facility with diagnoses that included but were not limited to: high blood pressure, history of falling, and depression.

Resident # 81's MDS (minimum data set) assessment, a discharge assessment with an ARD (assessment reference date) of 07/22/2021, coded Resident # 52 as "03 (three) - Acute hospital" under section "A2100 Discharge Status."

The facility's "Progress Notes" dated 07/20/2021 documented in part, "This SSD [social services department] spoke with resident about upcoming discharge. Resident states that she is ready to go home and feels that she and husband have developed a plan for safety when they discharge home. Resident will discharge home of 07/22/2021 with referral for home health to [Name of Home Health Agency]."

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F 641	Continued From page 44 On 09/08/2021 at 3:58 p.m., an interview was conducted with LPN #5 (Licensed Practical Nurse), the MDS nurse. She stated that it [A2100 Discharge Status on the MDS assessment] was coded in error. It should have been coded as a discharge to community. When asked if there was any policy or procedure she follows to complete the MDS assessments, LPN #5 stated that she was sure there was one somewhere. She did not identify the RAI manual. On 10/10/19 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing and ASM # 3, regional nurse were made aware of the findings. No further information was provided prior to exit.	F 641		
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	F 656		10/14/21

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F 656	Continued From page 45 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 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 observations, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for 10 of 35 residents in the survey sample, Resident's # 3, # 16, # 32, # 36, #26, # 44, #40, # 30, # 15 and # 25. The findings include: 1. The facility staff failed to develop a comprehensive care plan to address Resident # 3's pain.	F 656	1. Care plan developed for pain for resident #3, care plan implemented for non-pharmacology intervention for resident #16, care plan implemented for fall mats for resident #32, care plan developed for #36 use of oxygen, care plan developed for hospice for resident #26, care plan developed for fluid restrictions for resident #44, care plan implemented for resident #40 care of pressure ulcer, care plan developed for comprehensive plan of care for resident #30 and #25, care plan implemented for resting (L) hand splint for resident #15.	

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F 656	Continued From page 46 Resident # 3 was admitted to the facility with diagnoses that include but not limited to: spinal stenosis [3] and osteoarthritis. Resident # 3's most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 06/10/2021, coded Resident # 3 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 3 as having frequent pain at a level of 4 [four] on a pain scale of zero to ten, with ten being the worse pain. The physician's order for Resident # 3 documented in part, "Percocet [1] [Oxycodone-Acetaminophen] 5-325MG [milligram]. Give 1 [one] tablet by mouth every 12 hours as needed for pain. Order Date: 7/12/2021." "Acetaminophen [2] Tablet 325MG. Give 2 tablet by mouth every 4 [four] hours as needed for pain. Order Date: 6/4/2021." Review of the comprehensive care plan dated 06/09/2021 for Resident # 3 failed to evidence a care plan to address pain. On 09/08/2021 at 3:58 p.m., an interview was conducted with LPN #5 (Licensed Practical Nurse), the MDS nurse. LPN #5 stated that the purpose of the care plan was to direct resident care and set goals for resident care. When asked about a care plan to address Resident # 3's assessed pain, and prescribed pain medications, LPN #5 stated that the resident should have had a care plan developed by now.	F 656	2. Quality review of care plan to ensure care plan development for pain, use of oxygen, hospice, fluid restriction, comprehensive plans of care for new admissions since 8/1/2021. Implementation of plan of care for non-pharmacological interventions for pain, pressure ulcer care, splints by 10/8/2021. 3. Licensed Nurse and Interdisciplinary team re-educated on care plan development and implementation pain, non-pharmacological interventions, fall interventions, hospice, fluid restriction, and splints by DON/designee on 10/8/2021 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete the care plan quality monitor for development and implementation of residents with hospice, pain, non-pharmacological interventions, fall intervention, pressure ulcer care, fluid restrictions, and splints weekly to ensure compliance. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 10/14/2021.	

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She stated that it [comprehensive care plan] could be an issue if someone who did not know the resident was assigned to care for the resident and there was no care plan to direct the resident's care. She stated that she was the only MDS nurse and was trying to do all the MDS work by herself and was behind on getting things done. When asked if there was any policy or procedure she follows regarding developing care plans she stated that she was sure there was one somewhere. She did not identify the RAI manual.

On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Oxycodone [Percocet] is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

[2] Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

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2. The facility staff failed to implement the comprehensive care plan for the use of non-pharmacological interventions prior to the administration of as needed [prn] pain medication to Resident #16.

Resident # 16 was admitted to the facility with diagnoses that included but were not limited to: spinal stenosis [1], back and left hip pain. Resident # 16's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/30/2021, coded Resident # 16 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. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 16 as having frequent moderate pain.

The physician's order for Resident # 16 documented in part, "Percocet [2] [Oxycodone-Acetaminophen] 5-325MG [milligram]. Give 5 [five] mg by mouth every 8 [eight] hours as needed for pain. Order Date: 2/12/2020."

Resident # 16's eMAR [electronic medication administration record] dated August 2021 documented the above physician's order. The eMAR failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Percocet to Resident #16 on: 08/02/2021 at 8:29 a.m., with pain level of six, on 08/11/2021 at 10:30 a.m. with pain level of ten, on 08/14/2021 at 7:45 p.m. with pain level of seven, on 08/16/2021 at 9:03 a.m. with pain level of five, and on 08/31/2021 at 12:07 a.m. with pain level of seven.

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Further review of the August 20212 eMAR failed to evidence the location of Resident # 16's pain on: 08/02/2021 at 8:29 a.m., with pain level of six, 08/14/2021 at 7:45 p.m. with pain level of seven, 08/18/2021 with pain level of seven, and on 08/31/2021 at 12:07 a.m. with pain level of seven.

Resident # 16's eMAR [electronic medication administration record] dated September 2021 documented the above physician's order for Percocet. The eMAR failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of Percocet on: 09/01/2021 at 8:54 a.m. with pain level of five and on 09/02/2021 at 8:48 p.m. with pain level of nine.

The comprehensive care plan for Resident # 16 with a revision date of 01/18/2021 documented in part, "Focus: [Resident # 16] has potential for pain r/t Chronic Physical Disability, GERD, Osteoarthritis, Neuropathy, Gout. Revision on 01/18/2021." Under "Interventions" it documented in part, "Use non pharmacological interventions per protocol. Date Initiated: 03/05/2020."

On 09/07/2021 at approximately 3:25 p.m., an interview was conducted with Resident # 16. When asked if the nurse's attempt non-pharmacological interventions before administering the as needed pain medications, Resident # 16 stated, "Sometimes."

On 09/09/2021 at approximately 9:05 a.m., an interview was conducted with LPN [licensed practical nurse] # 4. After reviewing the eMARs for the dates and times listed above and Resident # 16's comprehensive care plan, LPN # 4 was

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asked if the care plan was being implemented for the use of non-pharmacological interventions before administering the prn pain medications. LPN # 4 stated no. When asked to describe the purpose of the care plan, LPN # 4 stated, "So we know how to care for their individual needs."

On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

[2] Oxycodone [Percocet] is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

3. The facility staff failed to implement the comprehensive care plan for the use of fall mats for Resident #32.

Resident # 32 was admitted to the facility with diagnoses included but were not limited to: fractured clavicle [bone that connects the shoulder to the breastplate], muscle weakness and low blood pressure. Resident # 32's most recent MDS (minimum data set), a quarterly

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assessment with an ARD (assessment reference date) of 08/04/2021, coded Resident # 32 as scoring a seven [7] on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions.

On 09/07/2021 at 5:00 p.m., an observation of Resident # 32's room revealed Resident # 32 lying in bed. Further observation failed to evidence fall mats on the floor on the right or left side of the bed.

On 09/08/2021 at 2:25 a.m., an observation of Resident # 32's room revealed Resident # 32 lying in bed. Further observation failed to evidence fall mats on the floor on the right or left side of the bed.

On 09/08/2021 at 2:25 p.m., an observation of Resident # 32's room revealed Resident # 32 lying in bed. Further observation failed to evidence fall mats on the floor on the right or left side of the bed.

On 09/09/2021 at 8:20 a.m., an observation of Resident # 32's room revealed Resident # 32 lying in bed. Further observation failed to evidence fall mats on the floor on the right or left side of the bed.

The comprehensive care plan for Resident # 32 dated 05/28/2021 documented in part, "Focus: [Resident # 32] has had an actual fall with major injury r/t [related to] poor communication/comprehension, unsteady gait, weakness and debility." Under "Interventions" it documented in part, "Bilateral floor mats at bedside. Date Initiated: 05/28/2021."

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On 09/09/2021 at 8:05 a.m., an interview and observation of Resident #32 was conducted with LPN [licensed practical nurse] # 3. LPN #3 observed Resident # 32 in bed without fall mats on the left or right side of the bed. After reviewing Resident # 32's comprehensive care plan, LPN # 3 stated that there were no fall mats alongside Resident # 32's bed. When asked if the care plan was being implemented, LPN # 3 stated no.

On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

No further information was provided prior to exit.

4. The facility staff failed to develop a comprehensive care plan to address Resident # 36's use of oxygen.

Resident # 36 was admitted to the facility with diagnoses that include but not limited to: respiratory failure and chronic obstructive pulmonary disease [1]. Resident # 36's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 08/17/2021, coded Resident # 36 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 36 as receiving oxygen therapy.

On 09/07/2021 at 2:44 p.m., an observation of Resident # 36 revealed they were receiving

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oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator flow meter revealed the oxygen flow rate at two liters per minute.

On 09/08/2021 at 9:15 a.m., an observation of Resident # 36 revealed they were receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator flow meter revealed the oxygen flow rate at two liters per minute.

The physician's order for Resident # 36 dated 08/24/2021 documented, "Respiratory: Oxygen - Continuous 2L NC [two liters per minute nasal cannula]. Order Date: 08/24/2021."

Review of the comprehensive care plan for Resident # 36 dated 09/07/2021 failed to evidence a care plan to address Resident # 36's use of oxygen.

On 09/08/2021 at 3:58 p.m., an interview was conducted with LPN #5 (Licensed Practical Nurse), the MDS nurse. She stated that the purpose of the care plan was to direct resident care and set goals for resident care. When asked about Resident # 36's care plan for oxygen, LPN #5 stated that the resident should have had a care plan developed by now. She stated that it could be an issue if someone who did not know the resident was assigned to care for the resident and there was no care plan to direct the resident's care. She stated that she was the only MDS nurse and was trying to do all the MDS work by herself and was behind on getting things done.

On 09/09/2021 at 11:30 a.m., ASM

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[administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.
5. The facility staff failed to develop a care plan to address the needs of a resident receiving hospice care for Resident #26.

Resident #26 was admitted to the facility on 4/10/2020 with a recent readmission of 12/14/2020 with diagnoses that included but were not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1), dysphagia (a condition in which swallowing is difficult or painful due to obstruction of the esophagus or muscular abnormalities of the esophagus or pharynx) (2), and sepsis (your body's overactive and extreme response to an infection) (3).

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/4/2021, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as

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being dependent upon one or more staff members for most of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving hospice care while a resident at the facility.

The physician order dated 7/26/2021, documented, "Resident to be under the care of (Name of Hospice Company)."

The comprehensive care plan, dated 4/30/2020, failed to evidence a care plan to address hospice care for Resident #26.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/9/2021 at 8:48 a.m. When asked the purpose of the care plan, ASM #2 stated it's to direct the staff to provide the care for each resident. When asked if a resident receiving hospice care, should have a care plan to address the hospice services and care, ASM #2 stated, yes, it should be care planned.

ASM (administrative staff member) #1, the administrator; ASM #2 the director of nursing and ASM #3, the regional nurse, were made aware of the above concerns on 9/8/2021 at 5:10 p.m.

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 114.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 178.

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(3) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Sepsis&_ga=2.155403059.908502701.1629920181-1530802455.1629920181

6. The facility staff failed to develop a care plan to address Resident #44's physician ordered fluid restriction.

Resident #44 was admitted to the facility on 12/14/2020 with diagnoses that included but were not limited to: congestive heart failure (CHF - abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (1), COPD (chronic obstructive pulmonary disease -general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) and dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation. (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/15/2021, coded the resident as scoring an "8" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living except eating which she was coded as independent after set up assistance was provided.

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The physician order dated, 4/8/2021, documented in part, "1500 ml (milliliters) fluid restriction 260 ml per meal and 240 ml every shift for CHF."

The comprehensive care plan dated, 7/18/2021, documented in part, "Focus: (Resident #44) has congestive heart failure." The "Interventions" documented in part, "Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of Congestive Heart Failure, dependent edema of legs and feet, periorbital edema, SOB (shortness of breath) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation." The care plan further documented, dated, 2/3/2021, "Focus: The resident has potential for fluid deficit r/t (related to) diuretic use." The "Interventions" documented in part, "Monitor and document intake and output as per facility policy." The care plan did not address the need for Resident #44 to be on a fluid restriction.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/9/2021 at 8:48 a.m. When asked if a physician prescribes a fluid restriction for a resident should that be addressed on the care plan, ASM #2 stated, "Absolutely."

The facility policy, "Fluid Restrictions" documented in part, "The Care Planning Team will discuss the restriction, and they will be included in the Care Plan."

ASM #1, the administrator, ASM #2 and ASM #3, the regional nurse, were made aware of the

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above concern on 9/8/2021 at 5:10 p.m.

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 138.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

7. The facility staff failed to implement Resident #40's care plan for care of a pressure injury.

Resident #40 was admitted to the facility on 6/28/2017 with a recent readmission on 12/15/2020, with diagnoses that included but were not limited to: dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.)(1), diabetes, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2), schizophrenia (any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response) (3), and high blood pressure.

The most recent MDS (minimum data set), a quarterly assessment, with an assessment reference date of 8/11/2021 coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating she was capable

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of making daily cognitive decisions. Resident #40 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was coded as independent after set up assistance was provided. In Section M - Skin Conditions, Resident #40 was coded as having a Stage III pressure injury.

[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. Stage III - 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.] (4).

The comprehensive care plan dated 12/10/2018, documented in part, "Focus: (Resident #40) has potential for impairment to skin integrity r/t (related to) fragile skin, incontinence, infection, diabetes, impaired mobility." The "Interventions" documented in part, "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and

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symptoms) of infection, maceration etc. to MD (medical doctor)."

The nurse's note dated, 1/2/2021 at 12:10 p.m. documented, "New order for tx (treatment) to coccyx pressure injury noted possible stage 2."

The "Change in Condition" form dated 1/2/2021 documented a check mark next to, "Pressure ulcer/Pressure injury." Further review of the form failed to evidence documentation of measurements of the pressure injury area or any description of the area.

Further review of the clinical record failed to evidence documented measurements of the wound on or around 1/2/2021. The first documented measurements of the wound was on 2/1/2021 on the "Weekly Wound Report: Pressure Injury." The form documented the resident's name, "visualized stage - 3, Measurements - 2x1x0.2 (2 centimeters [cm] in length, by 1 cm in width by 0.5 cm in depth), Location - sacrum."

An interview was conducted with LPN (licensed practical nurse) #6 on 9/8/2021 at 3:28 p.m. LPN #6 is the nurse who wrote the note of 1/2/2021. When asked if she was trained in wound care, LPN #6 stated she is trained in the basic dressing changes. When asked if she can stage a pressure injury, LPN #6 stated, "Technically no, I need more training." LPN #6 was asked to explain what actions she took on 1/2/2021. LPN #6 stated when she found the area, she notified the doctor and management. She stated she told the ADON (assistant director of nursing). [ADON no longer employed at facility]. LPN #6 stated she implemented the new orders from the physician.

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When asked if she measured the wound, LPN #6 stated she did not. When asked if she should have measured the wound, LPN #6 stated, she should have measured the wound. When asked if the care plan was implemented if it documents to monitor/document location, size and treatment of skin injury, LPN #6 stated no.

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse, were made aware of the above findings on 6/9/2021 at 11:14 a.m.

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 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.
(4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

8. The facility staff failed to develop a comprehensive care plan for Resident #30.

Resident #30 was admitted to the facility on 7/30/21 and had the diagnoses of but not limited to cervical cancer, morbid obesity, diabetes, congestive heart failure, chronic kidney disease, lymphedema, high blood pressure, stroke, heart attack, peripheral vascular disease. The

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Admission MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 8/5/21 coded the resident as cognitively intact in ability to make daily life decisions. Resident #30 was coded as requiring extensive care for bathing; limited assistance for transfers, toileting and hygiene; supervision for bed mobility; independent for eating; and as continent of bowel and bladder.

This MDS assessment was coded in Section VO200C2 "Signature of Person Completing Care Plan Decision and Date Signed" of Section V - Care Area Assessment (CAA) Summary, was dated 8/12/21.

A review of the RAI manual (Resident Assessment Instrument) dated October 2019 documented on page 2-16 the following in the table: "Care Plan Completion Date (Item V0200C2) No Later Than, CAA(s) Completion Date + [plus] 7 calendar days."

This indicates that the comprehensive care plan should have been completed by 8/19/21.

A review of the care plan revealed that a comprehensive care plan was never completed as of 9/8/21. The only care plan areas that were developed for the resident were Activities (dated 8/6/21), Urinary tract infection (dated 8/5/21), and Mood (dated 8/16/21).

Section V of the MDS documented the following areas as triggered to be care planned: Visual Function, ADL (activities of daily living) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Activities, Falls,

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Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcer, Pain.

None of the above areas other than Activities had been care planned.

On 9/8/21 at 3:58 PM an interview was conducted with LPN #5 (Licensed Practical Nurse), the MDS nurse. She stated that the purpose of the care plan was to direct resident care and set goals for resident care. She stated that Resident #30 should have had a comprehensive care plan developed by now. She stated that it could be an issue if someone who did not know the resident was assigned to care for the resident and there was no care plan to direct the resident's care. LPN #5 stated that she was the only MDS nurse and was trying to do all the MDS work by herself and was behind on getting things done. When asked if there was any policy or procedure she follows regarding developing care plans, LPN #5 stated that she was sure there was one somewhere. She did not identify the RAI manual.

A review of the facility policy "Plans of Care" documented, "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements....Develop and implement an Individualized 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, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as

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determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s) within seven (7) days after completion of the comprehensive assessment (MDS)."

On 9/8/21 at approximately 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing (DON) and ASM #3 the regional nurse, were made aware of the findings. ASM #1 stated that there had been a lot of staffing changes and the MDS nurse had been pulled to work on the unit for a period of time.

No further information was provided by the end of the survey. No further information was provided by the end of the survey.

9. The staff failed to implement Resident #15's comprehensive care plan to apply Resident #15's physician ordered resting left hand splint on 9/7/21 and 9/8/21.

Resident #15 was admitted to the facility on 8/1/13, and most recently readmitted to the facility on 1/13/17, with diagnoses including cerebral palsy (1) and psychotic disorder (2). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/6/21, Resident #15 was coded as severely cognitively impaired for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). She was coded as requiring extensive assistance of staff for all activities of daily living. She was coded as having functional limitations for range of motion

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on both left and right upper extremities.

On the following dates and times, Resident #15 was observed sitting in a wheelchair in her room. During all observations she was not wearing a hand splint on her left hand: 9/7/21 at 12:36 p.m. and 1:59 p.m.; 9/8/21 at 8:46 a.m. and 10:42 a.m.

A review of Resident #15's comprehensive care plan, dated 11/12/18, updated on 5/5/21, revealed, in part: "[Resident #15] has an ADL (activities of daily living) self-care performance deficit requiring extensive assist r/t Activity Intolerance, Cerebral Palsy, Fatigue, Limited Mobility...Hand splint as ordered."

A review of Resident #15's clinical record revealed the following physician order dated 3/17/21: "Pt (patient) to wear L (left) resting hand splint during the day, donned after breakfast and doffed before bed for pain management. Complete daily skin checks for s/s (signs/symptoms) skin breakdown."

On 9/8/21 at 1:54 p.m., CNA (certified nursing assistant) #1 was interviewed. When asked how she knows what sorts of special devices a resident might need to wear, CAN #1 stated, "It's usually on the chart. Or the nurse tells me." She stated she was not aware that Resident #15 needed a left hand splint. When asked if she can see a resident's care plan, CNA #1 stated she can only see what comes up on the tablet for her to chart.

On 9/8/21 at 2:27 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the therapist usually informs the nursing staff of any devices needed to be worn by residents. She

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stated there is also usually an order. When asked if she was aware of any orders for Resident #15 for a left hand splint, LPN #1 stated she was not. When asked the purpose of a care plan, she stated the care plan is special for each resident. LPN #1 stated the care plan lets the staff know how to provide the right care for each person. When asked how she makes sure the care plan for each resident is being followed, LPN #1 stated, "I know the residents well. I know how they like things."

On 9/8/21 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse, were informed of these concerns.

No further information was provided prior to exit.

REFERENCES:
(1) "Cerebral palsy is a group of disorders that affect a person's ability to move and to maintain balance and posture." This information is taken from the website https://medlineplus.gov/cerebralpalsy.html.

(2) "Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there." This information is taken from the website https://medlineplus.gov/psychoticdisorders.html.

10. The facility staff failed to develop a

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comprehensive care plan for Resident #25, who was admitted to the facility on 7/29/2021.

Resident #25 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (1), diabetes (2) and heart failure (3).

Resident #25's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/4/2021, coded Resident #25 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section G coded Resident #25 requiring extensive assistance of two or more staff for bed mobility and transfers and total assistance of two or more persons for toileting. Section H coded Resident #25 having an indwelling catheter and always incontinent of bowel. Section J coded Resident #25 having pain occasionally. Section M coded Resident #25 being at risk of developing pressure ulcers/injuries. Section N coded Resident #25 receiving antianxiety, antidepressant and diuretic medications during the observation period. Section O coded Resident #25 receiving dialysis. Section V documented care area assessment triggers in the area of visual function, ADL (activities of daily living) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid maintenance, Pressure ulcer and Psychotropic drug use. Section V of the assessment was signed by the facility staff on 8/6/2021.

On 9/7/2021 at approximately 12:52 p.m., an interview was conducted of Resident #25 in their

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room. Resident #25 was observed in a wheelchair beside their bed. Resident #25 stated that they went to dialysis three days a week and had an access in their chest for dialysis. Resident #25 stated that they had recently had their right leg amputated (removed) and was there for therapy. Resident #25 stated that they had a history of eye problems and needed to see the eye doctor because they were not in the building when the optometrist had visited recently. Resident #25 also stated that they were working with therapy to get assessed for a prosthetic leg. Resident #25 stated that they had talked with the physical therapist but had not participated in a care plan meeting.

The comprehensive care plan for Resident #25 dated 9/7/2021 documented a care plan for activities by the community life director, a care plan for code status by the social worker and a care plan for dialysis three times a week by nursing. The comprehensive care plan failed to evidence documentation for the additional care areas triggered from the comprehensive assessment including visual function, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid maintenance, Pressure ulcer and Psychotropic drug use.

On 9/8/2021 at 3:58 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #5, the MDS nurse. LPN #5 stated that the purpose of the care plan was to direct resident care and set goals for resident care. LPN #5 stated that a resident admitted on 7/29/2021 should have had a comprehensive care plan developed by now. LPN #5 stated that it could be

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an issue if someone who did not know the resident was assigned to care for them and there was no care plan to direct the resident's care. LPN #5 stated that they were the only MDS nurse and was trying to do all of the MDS work by themselves and was behind on getting things done. When asked if there was any policy or procedure they followed regarding developing care plans she stated that she was sure there was one somewhere. LPN #5 did not identify the RAI (resident assessment instrument) manual.

On 9/9/2021 at 8:10 a.m., an interview was conducted with RN (registered nurse) #1, unit manager. RN #1 stated that the baseline care plan was developed by the admitting nurse or the unit manager and placed in a book kept at the nurse's station. RN #1 stated that there were not sure who developed the comprehensive care plan, that they only did the baseline care plan on admission.

On 9/9/2021 at 8:48 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the purpose of the care plan was to direct the care the staff provide to residents.

On 9/9/2021 at approximately 10:30 a.m., a request was made to ASM #1 for the facility policy for developing the comprehensive care plan.

On 9/9/2021 at approximately 8:45 a.m., ASM #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

References:

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F 656	Continued From page 70 1. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . 2. Diabetes mellitus: A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 3. Congestive heart failure: A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html	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.	F 657		10/14/21

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F 657	Continued From page 71 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to review and revise the comprehensive care plan for one of 35 residents in the survey sample; Resident #9. The facility staff failed to review and revise Resident #9's comprehensive care plan was to include and address the use of side rails. The findings include: Resident #9 was admitted to the facility on 10/11/18, with the diagnoses of but not limited to Parkinson's disease, chronic kidney disease, dysphagia, lymphedema, high blood pressure,	F 657	1. Comprehensive care plan updated on 9/10/2021 for use of side rails. 2. Quality review of residents with side rail completed 9/10/2021 and no other findings identified. 3. Licensed staff re-education on review and revising plan of care for use of side rails by 10/8/2021 by DON/designee 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete quality monitor for care plan revisions/review for residents with physician order for use of side rails weekly to ensure compliance. Follow up based on findings and reported	

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F 657	Continued From page 72 depression, dementia, heart failure, and osteoarthritis. The annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 6/22/21 coded Resident #9 as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene and toileting; extensive assistance for dressing, transfers and bed mobility; independent for eating; and as incontinent of bowel and bladder. On 09/07/21 5:22 PM during observations of Resident #9, the resident was observed in bed eating her dinner meal, and the half-length upper side rails on Resident #9's bed were up. A review of the clinical record revealed a "Side Rail Evaluation" dated 7/7/21. This assessment documented, "Resident use the rails for assist. Risk and benefit explained and measurements completed." A review of Resident #9's comprehensive care plan failed to reveal any evidence that the resident was care planned for the use of side rails. On 9/8/21 at 3:58 PM an interview was conducted with LPN #5 (Licensed Practical Nurse), the MDS nurse. She stated that the purpose of the care plan was to direct resident care and set goals for resident care. LPN #5 stated that the use of side rails should be care planned. She stated that any nurse or the DON (Director of Nursing) can review and revise a care plan. When asked if there was any policy or procedure she follows regarding reviewing and revising care plans she stated that she was sure there was one somewhere. She did not identify the RAI manual.	F 657	to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 10/14/2021	

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F 657	Continued From page 73 A review of the facility policy "Plans of Care" documented, "Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being." On 9/8/21 at approximately 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the interim Administrator, ASM #2 the interim Director of Nursing (DON) and ASM #3 the regional nurse, were made aware of the findings. No further information was provided by the end of the survey.	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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure professional standards for the administration of pain medications for one of 35 residents in the survey sample, Resident # 3.	F 658	1. The pain medication for resident #3 was clarified on 9/10/2021. 2. Quality review of residents with pain medication to ensure physician ordered pain medication clarified when should be administered.	10/14/21

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F 658	Continued From page 74 The facility staff failed to clarify physician orders for two prescribed as needed pain medications, Percocet and acetaminophen, to determine when and which medication should be administered. The findings include: Resident # 3 was admitted to the facility with diagnoses that include but not limited to: spinal stenosis [3] and osteoarthritis Resident # 3's most recent MDS (minimum data set), an admission assessment with an ARID (assessment reference date) of 06/10/2021, coded Resident # 3 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 3 as having frequent pain at a level of 4 [four] on a pain scale of zero to ten, with ten being the worse pain. The physician's order for Resident # 3 documented in part the following: "Percocet [Oxycodone-Acetaminophen] 5-325MG [milligram]. Give 1 [one] tablet by mouth every 12 hours as needed for pain. Oder Date: 7/12/2021." "Acetaminophen Tablet 325MG. Give 2 tablet by mouth every 4 [four] hours as needed for pain. Oder Date: 6/4/2021." Resident # 3's ear [electronic medication administration record] dated August 2021 documented the above physician's order for acetaminophen and Percocet. Further review of the eMAR documented the administration of acetaminophen on 08/14/2021 at 6:20 a.m. with	F 658	3. Licensed staff re-education on professional standards including clarification of pain medication to be administered by DON/designee on 10/8/2021. 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete pain medication quality monitor weekly 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. 10/14/2021	

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pain level of six, Percocet on 08/14/2021 at 12:04 a.m. with pain level of seven and Percocet at 5:40 p.m. with pain level of six, acetaminophen on 08/16/2021 at 8:53 a.m. with pain level of two and Percocet at 1:30 p.m. for pain level of three, acetaminophen on 80/26/2021 at 10:36 a.m. with pain level of two and Percocet at 12:30 a.m. with pain level of seven, and Percocet at 9:16 p.m. with pain level of one.

Resident # 3's eMAR [electronic medication administration record] dated September 2021 documented the above physician's orders for Percocet and acetaminophen. Further review of the eMAR documented the administration of acetaminophen on 09/03/2021 at11:25 p.m. with pain level of seven and Percocet at 2:41 p.m. with pain level of eight.

On 09/09/2021 at 9:05 a.m., an interview was conducted with LPN [licensed practical nurse] # 4 regarding Resident # 3's prescribed as needed pain medication. LPN #4 reviewed the physician's orders for Resident # 3's as needed pain medications of acetaminophen and Percocet and the August and September eMARs. After completing the review, LPN # 4 was asked how staff determine which and when to administer each as needed pain medication to Resident # 3. LPN # 4 stated, "[Resident # 3] requests which one she wants." When asked if this was the correct way to administer Resident # 3's as needed pain medications, LPN # 4 stated no. LPN # 4 stated, "There are no parameters to tell me which pain medication to administer." When asked to describe the procedure that should be followed when they have two as needed pain medications without parameters LPN # 4 stated, "Call the physician and get clarification."

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On 9/7/2021 at 5:47 p.m., ASM [administrative staff member] #1, administrator, stated that the facility used their policies and procedures and Lippincott as their standard of practice.

According to "Lippincott Manual of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Oxycodone [percocet] is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

[2] Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches,

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F 658	Continued From page 77 and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html. [3] A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.	F 658		
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 observation, staff interview and facility document review, it was determined the facility staff failed to ensure physician ordered fluid restrictions were implemented and monitored per physicians orders for one of 35 residents in the survey sample, Resident # 44. The facility staff failed to ensure the amount of fluid Resident #44 received was monitored and	F 684	1. Resident #44 fluid restriction monitored per the physician order. 2. Quality review of residents on physician ordered fluid restrictions to ensure fluid restriction being monitored on 10/4/2021. Resident identified will have fluid monitored per the physician order.	10/14/21

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F 684	Continued From page 78 within the physician prescribed fluid restriction amount of 1500 ml (milliliters). The findings include: Resident #44 was admitted to the facility on 12/14/2020 with diagnoses that included but were not limited to: congestive heart failure (CHF - abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (1), COPD (chronic obstructive pulmonary disease -general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) and dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation. (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/15/2021, coded the resident as scoring an "8" on the BIMS (brief interview for mental status) score, indicating Resident #44 was moderately impaired to moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living except eating, which she was independent after set up assistance was provided. The physician order dated, 4/8/2021, documented in part, "1500 ml (milliliters) fluid restriction 260 ml per meal and 240 ml every shift for CHF." Review of the meal tickets for 9/8/2021, one full day for Resident #44 was conducted. The meal ticket documented the three meals. For	F 684	3. Licensed nurse re-education on fluid restriction and monitoring by DON/designee on 10/8/2021. 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete quality monitor for residents on physician ordered fluid restrictions weekly to maintain compliance. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 10/14/2021	

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breakfast, the resident received 8 ounces (equals 237 ml) of whole milk. The lunch meal documented, 4 oz. (ounces) of water and 4 oz. of iced tea (237 ml). The dinner meal documented 4 oz. (ounces) of water and 4 oz. of iced tea (237 ml).

Review of the POC (point of care) documentation, recorded by the staff after meal intake, for August 2021 and September 2021, revealed no documentation of fluid intake for Resident #44.

The medication administration record (MAR) for August 2021 was reviewed. The MAR documented the above physician order for 1500 ml (milliliters) fluid restriction. Of 93 possible entries for fluid consumption, there were only 82 documented entries. There was no total of liquids consumed for the day documented. On 8/15/2021 and 8/28/2021 for the day shift, a "N/A" (not applicable) was documented. On 8/18/2021 the total documented as consumed was 1640 ml. On 8/20/21 the total documented as consumed was 1700 ml. On 8/25/2021 the total documented as consumed was 2980 ml. The totals for the rest of the days in August 2021, documented 240 ml to 1240 ml.

The MAR for September 2021 was reviewed. The MAR documented the above physician order for 1500 ml (milliliters) fluid restriction. There was no total of liquids consumed for the day documented. On 9/6/2021 for the night shift "N/A" was documented. The totals for the day documented 480 ml to 1240 ml.

The nurse's note dated, 8/26/2021 at 1:06 p.m. documented in part, "Resident with new order for chest x-ray for increased sob (shortness of

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breath) two views. Bumex (4), changed to two times a day.

The comprehensive care plan dated, 7/18/2021, documented in part, "Focus: (Resident #44) has congestive heart failure." The "Interventions" documented in part, "Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of Congestive Heart Failure, dependent edema of legs and feet, periorbital edema, SOB (shortness of breath) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation." The care plan further documented, dated, 2/3/2021, "Focus: The resident has potential for fluid deficit r/t (related to) diuretic use." The "Interventions" documented in part, "Monitor and document intake and output as per facility policy."

An interview was conducted with LPN (licensed practical nurse) #1, on 9/8/2021 at 2:27 p.m. When asked how staff know how much fluid to give a resident on physician ordered fluid restrictions, LPN #1 stated the amount comes with the physician order. When asked where the total amount of fluids given for the day is documented, LPN #1 stated it's on the MAR or TAR (treatment administration record). When asked who monitors the fluid restriction, LPN #1 stated it (MAR or TAR) should have a place to put it in each shift. The CNA (certified nursing assistant) document fluids given. When a resident is on a fluid restriction, you normally know how much they had. The CNAs are with them more that we are. When asked why it is important to know the total amount of fluids given

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at the end of each day, LPN #1 stated it's to see if they went over their fluid restriction. When asked whose responsibility is it to monitor a fluid restriction, LPN #1 stated each nurse each shift should monitor it. They (the resident) has a specific number per shift they are allow, if they go over it they could go over it for the whole day."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/9/2021 at 8:48 a.m. When asked who is responsible for monitoring that a resident is maintaining their fluid restriction, ASM #2 stated it should be on the intake record. Would expect the nurse to record all the resident receives on their shift. It's up to the nurse to coordinate with the aide to document what intake the resident has had for their shift. Someone should be monitoring it. ASM #2 was informed of the above concern and shown the above documents.

The facility policy, "Fluid Restrictions" documented in part, "Policy: Residents receive adequate fluid intake within the limitations determined by the attending physician. Procedure: A written order will be obtained from the attending physician. The resident will have fluid restrictions calculated so that he/she can have intake on each shift based on resident preferences. In calculating intake per shift, keep in mind fluid required for resident to take medications and desired at mealtimes. Caregivers will be notified on limitations. Dietary will be notified that resident is on restricted fluids and fluids on the resident's tray will be calculated according to overall restrictions. The dietician will determine d the amount of fluid to be given with each meal. The amount of fluid per meal is

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F 684	Continued From page 82 translated into allowed beverages and entered on the tray cared for reach meal. The Care Planning Team will discuss the restrictions, and they will be included in the Care Plan. The dietician documents the allowed fluids in the medication record and provides a written breakdown of fluids to the nursing staff. Resident education will be provided on established limits and importance of adherence to the restrictions. The Attending physician will be notified of resident non-compliance." ASM #1, the administrator, ASM #2, and ASM #3, the regional nurse, were made aware of the above findings on 9/9/2021 at 11:14 a.m. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (4) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=Bumex&_ga=2.204964112.1680204588.1631291755-1055126650.1631291755.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		10/14/21

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F 686	Continued From page 83 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services consistent with professional standards of practice, to promote healing of a pressure injury for one of 35 residents in the survey sample, Resident #40. The facility staff failed to conduct a thorough initial assessment to include measurements of Resident #40's pressure injury upon discovery on 1/2/21, and failed to ensure ongoing assessments including measurements and staging until 2/1/2021. The findings include: Resident #40 was admitted to the facility on 6/28/2017 with a recent readmission on 12/15/2020, with diagnoses that included but were not limited to: dementia (a progressive state of mental decline, especially memory function	F 686	1. Resident #40 pressure ulcer re-assessed by the wound physician on 9/10/2021. Wound continue to be monitored weekly by licensed nurses. 2. Quality review of residents with pressure ulcers to ensure assessment and ongoing monitoring to include measurements and staging by 9/10/2021. 3. Licensed nurse re-educated on skin and wound guidelines and pressure injury record by DON/designee by 10/8/2021 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete pressure ulcer quality monitor for residents with pressure injuries weekly to ensure compliance maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings.	

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and judgement, often accompanied by disorientation.)(1), diabetes, COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2), schizophrenia (any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response) (3), and high blood pressure.

The most recent MDS (minimum data set), a quarterly assessment, with an assessment reference date of 8/11/2021 coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was independent after set up assistance was provided. In Section M - Skin Conditions, the resident was coded as having a Stage III pressure injury. (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. Stage III - 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

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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.)(4).

A physician order dated 12/15/2020 documented, "Greers Goo three times a day to buttock."

Review of the December 2020 TAR (treatment administration record) for Resident #40 documented the physician ordered Greers Goo was administered every day in December after the medication was ordered.

The last Braden Scale (a scale to determine the likeness of developing a pressure injury) was dated 12/22/2020. The Braden Scale documented the resident was at "low risk" for developing a pressure injury.

The "Weekly Skin Integrity Review" dated 12/24/2020 documented in part, "Skin intact."

A nurse's note dated, 1/2/2021 at 12:10 p.m. documented, "New order for tx (treatment) to coccyx pressure injury noted possible stage 2."

The "Change in Condition" form dated 1/2/2021 documented a check mark next to, "Pressure ulcer/Pressure injury." Further review of the form failed to evidence documentation of the measurements of the area or any description of the area.

A physician order dated 1/3/2021, documented, "Desitin Paste; apply to wound on buttock twice a day, day and evening shift." Review of the

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January 2021, TAR for Resident #40 documented the physician ordered Desitin Paste was applied as ordered the entire month.

Further review of the clinical record failed to evidence documentation of measurements of the wound on or around 1/2/2021. The first documentation of the wound was on 2/1/2021 on the "Weekly Wound Report: Pressure Injury." The form documented the resident's name, visualized stage - 3, Measurements - 2x1x0.2 (2 centimeters [cm] in length, by 1 cm in width by 0.5 cm in depth), Location - sacrum."

The nurse's notes dated 1/6/2021 at 9:36 p.m. documented in part, "CNA (certified nursing assistant) reported to this nurse that she went in to resident's room to offer pericare since resident had not rung bell all shift to have brief changed (per resident's usual routine) and resident refused to allow CNA to check her brief or do pericare. Resident insisted she was dry and accused CNA of 'caller her a liar."

The nurse's note dated 1/7/2021 at 12:09 p.m. documented, "Pt (patient) is refusing to be changed at this time." The nurse's note dated 1/10/2021 at 2:48 p.m. documented, "Pt refused CNAs to change her, pt states she is dry."

The nurse's note dated 1/14/2021 at 12:59 p.m. documented, "Patient refused shower and lunch, unable to redirect the pt. Educated pt. on importance of eating and taking a shower. Pt continues to refuse."

The nurse's note dated 1/21/2021 at 11:33 a.m. documented, "Pt refusing to have CNA change her at this time. Pt will not allow even be checked

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and stated to this write, 'I done (sic) even feel let I know if I'm wet."

The comprehensive care plan dated 12/10/2018, documented in part, "Focus: (Resident #40) has potential for impairment to skin integrity r/t (related to) fragile skin, incontinence, infection, diabetes, impaired mobility." The "Interventions" documented in part, "Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (medical doctor)." The care plan, dated 2/3/2021, documented in part, "(Resident #40) has a pressure injury on sacrum r/t hx (history of) ulcers, immobility, B&B (bowel and bladder) incontinence, refusal to be turned and repositioned, declining to get OOB (out of bed)." The "Interventions" documented in part, "Assess/record/ monitor wound healing per protocol. Resident refused to have air mattress placed on bed."

On 9/7/2021 at 5:47 p.m., ASM [administrative staff member] #1, administrator, stated that the facility used their policies and procedures and Lippincott as their standard of practice.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/8/2021 at 1:37 p.m. The above documents were reviewed with ASM #2. When asked at what stage was the wound found at, ASM #2 stated it was found as a stage III on wound documents of 2/1/2021. When asked if a nurse finds something, such as a "possible stage II" pressure injury what is the process, ASM #2 stated the nurse should do a skin assessment, measure the wound, stage the wound or have

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someone look at it if they are not proficient in it, assess the wound is it a pressure injury or excoriation. They need to find out what it is and notify the doctor to get treatment orders.

Observation was made of the wound on 9/8/2021 at 11:31 a.m. accompanied by LPN (licensed practical nurse) #4. The wound was cleansed with wound cleanser. LPN #4 measured the wound. The length was 3.5 cm (centimeters), the width was 2.0 cm, and the depth was 1.0 cm. LPN #4 stated the wound had 100% granulation tissue.

An interview was conducted with LPN (licensed practical nurse) #6 on 9/8/2021 at 3:28 p.m. LPN #6 is the nurse who wrote the note of 1/2/2021. When asked if she was trained in wound care, LPN #6 stated she is trained in the basic dressing changes. When asked if she can stage a pressure injury, LPN #6 stated, "Technically no, I need more training." LPN #6 was asked to explain what actions she took on 1/2/2021. LPN #6 stated when she found the area, she notified the doctor and management. She stated she had told the ADON (assistant director of nursing). [ADON no longer employed at facility]. LPN #6 stated she implemented the new orders from the physician. When asked if she measured the wound, LPN #6 stated she did not. When asked if she should have measured the wound, LPN #6 stated, she should have measured the wound.

The facility policy, "Pressure Injury Record" documented, "Policy: To document the presence of skin impairment/new skin impairment related to pressure when first observed and weekly thereafter until the site is resolved. One site will be recorded per page. Procedure: 1. Residents

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will have a Pressure Injury Record completed for each skin impairment that is related to pressure. 2. Mark the pressure area on the body description identifying the site. 3. Enter the date. 4. Enter the stage of the pressure injury. 5. Enter the size of the pressure in jury - length x width x depth in centimeters. 6. Enter tissue type and color. 7. Enter the wound edges and drainage. 8. Enter the peri-wound information. 9. Licensed nurse to sigh the appropriate area."

The Pressure Ulcer Treatment Quick Reference Guide by NPUAP states on page 8 concerning pressure ulcer assessment, "Assess and accurately document physical characteristics such as location, Category/Stage, size, tissue type (s), wound bed and periwound condition, wound edges, sinus tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization." Page 10 of this reference states, "Re-evaluate the pressure ulcer, the plan of care, and the individual if the pressure ulcer does not show progress toward healing within 2 weeks (or as expected given the individual's overall condition and ability to heal)..." This information was obtained from: National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel. Pressure Ulcer Prevention and Treatment: Clinical Practice Guideline. Washington, DC: National Pressure Ulcer Advisory Panel, Second edition published 2014.

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse, were made aware of the above findings on 6/9/2021 at 11:14 a.m.

No further information was provided prior to exit.

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F 686	Continued From page 90 References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. (4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		10/14/21

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F 688	Continued From page 91 Based on observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to provide appropriate services, and equipment, to maintain or improve mobility per the physicians order for one of 35 residents in the survey sample, Resident #15. The staff failed to apply Resident #15's physician ordered resting left hand splint on 9/7/21 and 9/8/21. The findings include: Resident #15 was admitted to the facility on 8/1/13, and most recently readmitted to the facility on 1/13/17, with diagnoses including cerebral palsy (1) and psychotic disorder (2). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/6/21, Resident #15 was coded as being severely cognitively impaired for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). She was coded as requiring extensive assistance of staff for all activities of daily living. She was coded as having functional limitations for range of motion on both left and right upper extremities. On the following dates and times, 9/7/21 at 12:36 p.m. and 1:59 p.m.; 9/8/21 at 8:46 a.m. and 10:42 a.m., Resident #15 was observed sitting in a wheelchair in her room. During all observations Resident #15 was not wearing a hand splint on her left hand. A review of Resident #15's clinical record revealed the following physician order dated 3/17/21: "Pt (patient) to wear L (left) resting hand splint during the day, donned after breakfast and	F 688	1. Resident #15 splint applied per the physician order on 9/10/2021. 2. Quality review of residents with equipment to maintain or improve mobility completed on 9/10/2021. Resident identified will have re-evaluation by therapy. 3. Licensed nurse re-educated on Contracture prevention by DON/designee by 10/8/2021. 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete quality monitor on equipment to improve mobility 3 times weekly 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. 10/14/2021	

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doffed before bed for pain management. Complete daily skin checks for s/s (signs/symptoms) skin breakdown."

A review of Resident #15's comprehensive care plan, dated 11/12/18 and updated 5/5/21, revealed, in part: "[Resident #15] has an ADL (activities of daily living) self-care performance deficit requiring extensive assist r/t Activity Intolerance, Cerebral Palsy, Fatigue, Limited Mobility...Hand splint as ordered."

On 9/8/21 at 1:54 p.m., CNA (certified nursing assistant) #1 was interviewed. When asked how she knows what sorts of special devices a resident might need to wear, CNA #1 stated, "It's usually on the chart. Or the nurse tells me." She stated she was not aware that Resident #15 needed a left hand splint.

On 9/8/21 at 2:27 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the therapist usually informs the nursing staff of any devices needed to be worn by residents. She stated there is also usually an order. When asked if she was aware of any orders for Resident #15 for a left hand splint, she stated she was not.

On 9/8/21 at 4:05 p.m., LPN #1 stated she had checked Resident #15's orders. She stated the computer software had not flagged the order as something that needed to be signed off by the nursing staff, so she was not aware of the order. She stated she would make a change in the electronic medical record to correct this error.

On 9/8/21 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional

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F 688	Continued From page 93 nurse, were informed of these concerns. A review of the facility policy, "Contractures, Prevention" revealed, in part: "Some residents may have braces or splints to prevent or help release contractures - be sure to follow the physician's order regarding the schedule of when to put these on and when to remove them." No further information was provided prior to exit. REFERENCES: (1) "Cerebral palsy is a group of disorders that affect a person's ability to move and to maintain balance and posture." This information is taken from the website https://medlineplus.gov/cerebralpalsy.html. (2) "Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. Two of the main symptoms are delusions and hallucinations. Delusions are false beliefs, such as thinking that someone is plotting against you or that the TV is sending you secret messages. Hallucinations are false perceptions, such as hearing, seeing, or feeling something that is not there." This information is taken from the website https://medlineplus.gov/psychoticdisorders.html.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/14/21

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F 689	Continued From page 94 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, it was determined that facility staff failed to the implement assistive device safety measures to ensure an environment free of accident hazards for one of 35 residents in the survey sample, Resident #32. The facility staff failed to implement Resident #32's fall mat on 9/07/21, 9/08/21, and the morning of 9/09/21, per the comprehensive plan of care. The findings include: Resident # 32 was admitted to the facility with diagnoses included but were not limited to: fractured clavicle [bone that connects the shoulder to the breastplate], low blood pressure, muscle weakness and low blood pressure. Resident # 32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/04/2021, coded Resident # 32 as scoring a seven [7] on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions. On 09/07/2021 at 5:00 p.m., an observation of Resident # 32's room revealed Resident # 32 lying in bed. Further observation failed to evidence fall mats on the floor on the right or left side of the bed.	F 689	1. Resident # 32 fall mat implemented per the plan of care on 9/9/2021. 2. Quality review of residents with fall preventatives to ensure fall preventions implemented per the plan of care on 9/10/2021. No other residents identified. 3. Licensed nurses re-educated on the fall prevention guideline by DON/designee on 10/4/2021 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete fall prevention quality monitor weekly 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. 10/14/2021.	

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On 09/08/2021 at 2:25 a.m., an observation of Resident # 32's room revealed Resident # 32 lying in bed. Further observation failed to evidence fall mats on the floor on the right or left side of the bed.

On 09/08/2021 at 2:25 p.m., an observation of Resident # 32's room revealed Resident # 32 lying in bed. Further observation failed to evidence fall mats on the floor on the right or left side of the bed.

On 09/09/2021 at 8:20 a.m., an observation of Resident # 32's room revealed Resident # 32 lying in bed. Further observation failed to evidence fall mats on the floor on the right or left side of the bed.

The comprehensive care plan for Resident # 32 dated 05/28/2021 documented in part, "Focus: [Resident # 32] has had an actual fall with major injury r/t [related to] poor communication/comprehension, unsteady gait, weakness and debility." Under "Interventions" was documented in part, "Bilateral floor mats at bedside. Date Initiated: 05/28/2021."
On 09/09/2021 at 8:05 a.m., an interview was conducted with LPN [licensed practical nurse] # 3. After observing Resident # 32's room and reviewing Resident # 32's comprehensive care plan LPN # 3 acknowledged that there were no fall mats alongside Resident # 32's bed.

On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

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F 689	Continued From page 96 No further information was provided prior to exit.	F 689		
F 697 SS=E	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, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for three of 35 residents in the survey sample, Residents # 201, # 3, and # 16. The facility staff failed to assess and document the location of pain and failed to attempt and or provide non-pharmacological interventions prior to the administration of a prn [as needed] pain medications to Resident #201, #3 and Resident #16, on multiple occasions during August and September 2021. The findings include: 1. Resident # 201 was admitted to the facility with diagnoses that included but were not limited to: osteoarthritis [1], and chronic pain. Resident # 201's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 08/30/2021, coded Resident # 201 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.	F 697	1. Resident #3 and #16 non-pharmacological interventions being attempted prior to administering pain medication. Resident #201 no longer at the facility. 2. Quality review of residents with PRN pain medications to ensure non-pharmacological interventions being attempted prior to medication administration on 10/4/2021. 3. Licensed nurses re-educated on pain management and attempting and documenting non-pharmacological intervention prior to administering PRN medications by DON/designee on 10/8/2021. 4. The Administrator is responsible for maintaining compliance. DON/designee will complete PRN pain medication quality monitor 3 times per week to ensure compliance. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule	10/14/21

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F 697	Continued From page 97 Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 201 as having pain at a level of [seven] on a pain scale of zero to ten, with ten being the worse pain. The physician's order for Resident # 201 documented in part, Norco Tablet 7.5-325 MG [milligram] (Hydrocodone-Acetaminophen) *Controlled Drug* Give 2 tablet by mouth every 4 [four] hours as needed for Pain." Resident # 201's eMAR [electronic medication administration record] dated August 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions attempted and or provided prior to the administration of Norco on: 08/25/2021 at 1:50 a.m., with pain level of 10, at 6:24 a.m. with pain level of eight, at 10:21 a.m. with pain level of nine, at 2:59 p.m. with pain level of eight and at 8:25 p.m. with pain level of six, on 08/26/2021 at 12:35 a.m. with pain level of ten, at 9:23 a.m. with pain level of nine, on 08/27/2021 at 3:55 a.m. with pain level of ten, 08/28/2021 at 12:30 a.m. with pain level of nine, at 7:44 a.m. with pain level of ten, at 4:00 p.m. with pain level of eight, 08/29/2021 at 2:05 a.m. with pain level of six, at 2:36 p.m. with pain level of seven, on 08/30/2021 at 7:05 with pain level of eight, at 9:05 p.m. with pain level of six and on 08/31/2021 at 7:21 a.m. with pain level of seven and at 2:39 p.m. with pain level of seven. Further review of the August 2021 eMAR failed to evidence the location of Resident # 201's pain on 08/25/2021 at 8:25 p.m. with pain level of six, on 08/26/2021 at 12:35 a.m. with pain level of ten, on 08/28/2021 at 12:30 a.m., at 4:00 p.m. with pain	F 697	modified based on findings. 5. 10/14/2021.	

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level of eight, 08/29/2021 at 2:05 a.m. with pain level of six, on 08/30/2021 at 7:05 with pain level of eight, at 9:05 p.m. with pain level of six and on 08/31/2021 at 7:21 a.m. with pain level of seven and at 2:39 p.m. with pain level of seven.

Resident # 201's eMAR [electronic medication administration record] dated September 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of Norco on: 09/01/2021 at 10:07 a.m. with pain level of seven, at 6:48 p.m. with pain level of seven, at 11:50 p.m. with pain level of eight, on 09/02/2021 at 1:08 a.m. with pain level of seven, at 11:26 a.m. with pain level of seven, at 3:32 p.m. with pain level of six and at 8:08 p.m. with pain level of seven, on 09/03/2021 at 1:08 a.m. with pain level of nine, at 8:13 a.m. with pain level of eight, at 7:49 p.m. with pain level of seven, on 09/04/2021 at 12:37 a.m. with pain level of seven, at 7:10 a.m. with pain level of eight, at 11:22 a.m. with pain level of seven, on 09/05/2021 at 7:07 a.m. with pain level of six, at 12:23 with pain level of seven, at 5:35 p.m. with pain level of six, at 11:53 p.m. with pain level of seven, on 09/06/2021 at 6:57 p.m. with pain level of seven, and on 09/07/2021 at 8:06 a.m.

Further review of the September 2021 eMAR failed to evidence the location of Resident # 201's pain on: 09/01/2021 at 10:07 a.m. with pain level of seven, at 6:48 p.m. with pain level of seven at 11:50 p.m. with pain level of eight, on 09/02/2021 at 11:26 a.m. with pain level of seven, at 3:32 p.m. with pain level of six and at 8:08 p.m. with pain level of seven, on 09/04/2021 at 12:37 a.m. with pain level of seven, on 09/05/2021 at 7:07

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a.m. with pain level of six, at 12:23 with pain level of seven, at 5:35 p.m. with pain level of six, at 11:53 p.m. with pain level of seven, on 09/06/2021 at 6:57 p.m. with pain level of seven, 09/07/2021 at 8:06 a.m. with pain level of seven and on 09/08/2021 at 2:10 a.m. with pain level of eight and at 7:16 a.m. with pain level of eight.

Review of the facility's "Progress Notes" for Resident # 201 dated 08/24/2021 through 09/08/2021 failed to evidence documentation of non-pharmacological interventions prior to the administration of Norco and failed to document the location Of Resident # 201's pain as stated above.

The comprehensive care plan for Resident # 201 dated 09/01/2021 documented in part, "Focus" [Resident # 201] has acute/chronic pain r/t Diabetic neuropathy, osteomyelitis, surgical wound, severe PAD, Date Initiated: 09/01/2021." Under "Interventions": it documented, "Monitor/document for side effects of pain medication. Date Initiated: 09/01/2021; Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Date Initiated: 09/01/2021."

On 09/07/2021 at approximately 3:00 p.m., an interview was conducted with Resident # 201. When asked if the nurse's attempt non-pharmacological interventions before administering the as needed pain medications Resident # 201 stated, "No."

On 9/7/2021 at 5:47 p.m., ASM [administrative staff member] #1, administrator, stated that the facility used their policies and procedures and Lippincott as their standard of practice.

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On 09/09/2021 at approximately 9:05 a.m., an interview was conducted with LPN [licensed practical nurse] # 4, regarding the procedure nursing staff follows when administering a prn pain medication. LPN #4 stated, "the resident should be assessed for pain by determining a pain level on a scale of zero to 10, with ten being the worst pain, if the resident is able to communicate, determine the location of the resident's pain, try non-pharmacological strategies such as repositioning or relaxation to alleviate their pain. If it doesn't help check the physician's orders for what medication is prescribed, and administer the medication." When asked if the pain assessment including the location of the resident's pain and attempted non-pharmacological strategies are documented and where staff document this information, LPN # 4 stated that they are documented in the nurse's notes. LPN # 4 was then asked to review the eMAR and nurse's notes for the dates listed above for the administration of Resident # 201's prn Norco. LPN # 4 stated that there was no documented evidence of the location of Resident # 201's pain or the attempts of non-pharmacological strategies on the dates listed above.

The facility's policy "Pain Management Guideline" documented in part, "Treatment: Develop patient centered interventions (pharmacologic and non-pharmacologic) to manage pain."

On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

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No further information was provided prior to exit.

References:
[1] Norco [Hydrocodone] is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone.
The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website:
https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm.

[2] The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website:
https://medlineplus.gov/osteoarthritis.html.

2. Resident # 3 was admitted to the facility with diagnoses that include but not limited to: spinal stenosis [3] and osteoarthritis. Resident # 3's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/10/2021, coded Resident # 3 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 3 as having frequent pain at a level of 4 [four] on a pain scale of zero to ten, with ten being the worse pain.

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The physician's order for Resident # 3 documented in part,
- "Percocet [Oxycodone-Acetaminophen] 5-325MG [milligram]. Give 1 [one] tablet by mouth every 12 hours as needed for pain. Order Date: 7/12/2021."

- "Acetaminophen Tablet 325MG. Give 2 tablet by mouth every 4 [four] hours as needed for pain. Order Date: 6/4/2021."

Resident # 3's eMAR [electronic medication administration record] dated August 2021 documented the physician's order for Percocet as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions attempted or provided prior to the administration of Percocet on: 08/01/2021 at 10:46 p.m. with pain level of eight, 08/04/2021 at 2:43 a.m. with pain level of eight and at 3:44 p.m. with pain level of five, 08 05/2021 at 8:20 a.m. with pain level of eight, 08/11/2021 at 11:03 a.m. with pain level of ten and at 11:59 p.m. with pain level of eight, 08/14/2021 at 12:04 a.m. with pain level of seven and at 5:40 p.m. with pain level of six, 08/16/2021 at 1:31 p.m. with pain level of three, 08/18/2021 at 12:22 a.m. with pain level of five, 08/23/2021 at 8:31 a.m. with pain level of four, 08/24/2021 at 8:54 a.m. with pain level of four and at 9:26 p.m. with pain level of two, 08/26/2021 at 12:30 a.m. with pain level of seven and at 2:16 with pain level of one, 08/28/2021 at 10:11 a.m. with pain level of eight, 08/30/2021 at 1:21 p.m. with pain level of one, 08/31/2021 at 2:26 a.m. with pain level of six and at 2:26 p.m. with pain level of ten.

Further review of the August 2021 eMAR for the administration of Percocet, failed to evidence the

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location of Resident # 3's pain on: 08 05/2021 at 8:20 a.m. with pain level of eight, 08/11/2021 at 11:03 a.m. with pain level of ten and at 11:59 p.m. with pain level of eight, 08/14/2021 at 12:04 a.m. with pain level of seven and at 5:40 p.m. with pain level of six, 08/16/2021 at 1:31 p.m. with pain level of three, 826/2021 at 2:16 with pain level of one, 08/30/2021 at 1:21 p.m. with pain level of one, 08/31/2021 at 2:26 p.m. with pain level of ten.

Resident # 3's eMAR [electronic medication administration record] dated August 2021 documented the physician's order for Acetaminophen as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions attempted or provided prior to the administration of Acetaminophen on: 08/14/2021 at 6:20 a.m. with pain level of six, 08/16/2021 at 8:53 a.m. with pain level of two and on 08/26/2021 at 10:36 a.m. with pain level of two.
Further review of the August 2021 eMAR for the administration of Acetaminophen, failed to evidence the location of Resident # 3's pain on: 08/14/2021 at 6:20 a.m. with pain level of six, 08/16/2021 at 8:53 a.m. with pain level of two.

Resident # 3's eMAR [electronic medication administration record] dated September 2021 documented the physician's order for Percocet as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions attempted or provided prior to the administration of Percocet on: 09/01/2021 at 9:17 p.m. with pain level of seven, 09/02/2021 at 5:26 with pain level of seven, 09/03/2021 at 2:41 p.m. with pain level of eight, 09/04/2021 at 3:46 a.m. with pain level of seven and at 5:19 p.m. with pain

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level of six, 09/05/2021 at 4:46 p.m. with pain level of seven, 09/07/2021 at 12:51 a.m. with pain level of six and at 12:22 p.m. with pain level of eight and on 09/08/2021 at 12:56 a.m. with pain level of eight.

Further review of the August 2021 eMAR for the administration of Percocet, failed to evidence the location of Resident # 3's pain on: 09/02/2021 at 5:26 with pain level of seven, 09/04/2021 at 3:46 a.m. with pain level of seven and at 5:19 p.m. with pain level of six, 09/05/2021 at 4:46 p.m. with pain level of seven, 09/07/2021 at 12:51 a.m. with pain level of six and at 12:22 p.m. with pain level of eight.

Resident # 3's eMAR [electronic medication administration record] dated September 2021 documented the physician's order for Acetaminophen as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of Acetaminophen and the location of Resident # 3's pain on: 09/03/2021 at:25 p.m. with pain level of seven.

Review of the facility's "Progress Notes" for Resident # 3 dated 08/01/2021 through 09/08/2021 failed to evidence documentation of non-pharmacological interventions attempted and or provided prior to the administration of Percocet and acetaminophen and failed to document the location of Resident # 3's pain as stated above.

On 09/07/2021 at approximately 2:26 p.m., an interview was conducted with Resident # 3. When asked if the nurse's attempt non-pharmacological interventions before administering the prn pain medications Resident

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3 stated, "No."

On 09/09/2021 at approximately 9:05 a.m., an interview was conducted with LPN [licensed practical nurse] # 4, regarding the procedure nursing staff follows when administering a prn pain medication. LPN #4 stated, "the resident should be assessed for pain by determining a pain level on a scale of zero to 10, with ten being the worst pain, if the resident is able to communicate, determine the location of the resident's pain, try non-pharmacological strategies such as repositioning or relaxation to alleviate their pain. If it doesn't help check the physician's orders for what medication is prescribed, and administer the medication." When asked if the pain assessment including the location of the resident's pain and attempted non-pharmacological strategies and where staff document this information, LPN # 4 stated that they are documented in the nurse's notes. LPN #4 was then asked to review the eMAR and nurse's notes for the dates listed above for the administration of Resident # 3's prn Percocet and acetaminophen. LPN # 4 stated that there was no documented evidence of the location of Resident # 3's pain or the attempts of non-pharmacological strategies on the dates listed above.

On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings.

No further information was provided prior to exit.

References:

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[1] Oxycodone [Percocet] is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

[2] Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.

[3] A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.

3. Resident # 16 was admitted to the facility with diagnoses that included but were not limited to: spinal stenosis [2], back and left hip pain. Resident # 16's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/30/2021, coded Resident # 16 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. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 16 as having frequent moderate pain.

The physician's order for Resident # 16

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documented in part, "Percocet [Oxycodone-Acetaminophen] 5-325MG [milligram]. Give 5 [five] mg by mouth every 8 [eight] hours as needed for pain. Order Date: 2/12/2020."

Resident # 16's eMAR [electronic medication administration record] dated August 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions attempted and or offered prior to the administration of Percocet on: 08/02/2021 at 8:29 a.m., with pain level of six, on 08/11/2021 at 10:30 a.m. with pain level of ten, on 08/14/2021 at 7:45 p.m. with pain level of seven, on 08/16/2021 at 9:03 a.m. with pain level of five, on 08/31/2021 at 12:07 a.m. with pain level of seven.

Further review of the August 20212 eMAR failed to evidence the location of Resident # 16's pain on: 08/02/2021 at 8:29 a.m., with pain level of six, 08/14/2021 at 7:45 p.m. with pain level of seven, 08/18/2021 with pain level of seven, and on 08/31/2021 at 12:07 a.m. with pain level of seven.

Resident # 16's eMAR [electronic medication administration record] dated September 2021 documented the physician's order as stated above. The eMAR failed to evidence documentation of non-pharmacological interventions attempted and or offered prior to the administration of Percocet on: 09/01/2021 at 8:54 a.m. with pain level of five and on 09/02/2021 at 8:48 p.m. with pain level of nine.

The comprehensive care plan for Resident # 16 with a revision date of 01/18/2021 documented in part, "Focus: [Resident # 16] has potential for

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pain r/t Chronic Physical Disability, GERD, Osteoarthritis, Neuropathy, Gout. Revision on 01/18/2021." Under "Interventions" it documented in part, "Use non pharmacological interventions per protocol. Date Initiated: 03/05/2020"

On 09/07/2021 at approximately 3:25 p.m., an interview was conducted with Resident # 16. When asked if the nurse's attempt non-pharmacological interventions before administering the prn pain medications Resident # 16 stated, "Sometimes."

On 9/7/2021 at 5:47 p.m., ASM [administrative staff member] #1, administrator, stated that the facility used their policies and procedures and Lippincott as their standard of practice.

On 09/09/2021 at approximately 9:05 a.m., an interview was conducted with LPN [licensed practical nurse] # 4, regarding the procedure nursing staff follows when administering a prn pain medications. LPN #4 stated, "the resident should be assessed for pain by determining a pain level on a scale of zero to 10, with ten being the worst pain, if the resident is able to communicate, determine the location of the resident's pain, try non-pharmacological strategies such as repositioning or relaxation to alleviate their pain. If it doesn't help check the physician's orders for what medication is prescribed, and administer the medication." When asked if the pain assessment including the location of the resident's pain and attempted non-pharmacological strategies are documented and where staff document this information, LPN # 4 stated that they are documented in the nurse's notes. LPN #4 was then asked to review the

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F 697	Continued From page 109 eMAR and nurse's notes for the date's list above for the administration of Resident # 16's prn Percocet. LPN # 4 stated that there was no documented evidence of the location of Resident # 61's pain or the attempts of non-pharmacological strategies on the dates listed above. On 09/09/2021 at 11:30 a.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, and ASM # 3, regional nurse, were made aware of the above findings. No further information was provided prior to exit. References: [1] Oxycodone [Percocet] is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. [2] A narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of the openings (called neural foramina) where spinal nerves leave the spinal column. This information was obtained from the website: https://medlineplus.gov/ency/article/000441.htm.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following	F 700		10/14/21

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elements.

§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview and facility document review it was determined facility staff failed to obtain informed consent for the use of bed rails for one of 35 residents in the survey sample, Resident #301.

The facility staff failed to obtain an informed consent prior to the use of bed rails for Resident #301.

The findings include:

On 9/7/2021 at approximately 12:47 p.m., an observation was made of Resident #301 in bed. Resident #301 was observed lying in bed with an upper side rail in place and up on the right side of the bed.

Additional observations on 9/7/2021 at 2:18 p.m., and 9/7/2021 at 4:33 p.m. revealed Resident #301 in bed with the upper side rail in place and

1. Resident #301 informed consent obtained for use of side rails on 9/10/2021.

2. Quality review of residents with side rails to ensure evaluation completed for use of side rails, informed consent obtained, measurements, risk and benefits completed on 9/9/2021.

3. Licensed nurse re-educated on Side rail policy on 10/8/2021 by DON/designee.

4. The Administrator is responsible for maintaining compliance. The DON/designee to complete quality monitor of residents with side rails weekly to ensure compliance maintained. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on

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F 700	Continued From page 111 up on the right side of the bed. Resident #301 was admitted to the facility with diagnoses that included but were not limited to malignant neoplasm of the bladder (1) and paraplegia (2). Resident #301's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/2/2021, coded Resident #301 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Section G coded Resident #301 requiring extensive assistance of one staff member for bed mobility, dressing and personal hygiene. On 9/7/2021 at 4:33 p.m., an interview was conducted with Resident #301. Resident #301 stated that they were at the facility for therapy and short-term. Resident #301 stated that they used the bed rail at times to hold onto when staff were providing care. The baseline care plan for Resident #301 dated 8/27/2021 failed to evidence documentation of the use of bed rails. The "Side Rail Evaluation" dated 8/28/2021 for Resident #301 documented in part, "...Side rails recommended; Per surgeon, resident is not allowed to transfer or use his abdominal muscles. Abd (abdominal) binder in place. Assist x 1 (one person) with rolling to either side per PT (physical therapy). PT also recommends side rails on both sides..." On 9/8/2021 at approximately 9:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the signed	F 700	findings. 5. 10/14/2021.	

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F 700	Continued From page 112	F 700		

consent for use of bed rails for Resident #301.

On 9/8/2021 at approximately 1:00 p.m., ASM #1 provided the document, "Side Rail Evaluation" which failed to evidence an informed consent for the use of bed rails for Resident #301.

On 9/8/2021 at approximately 1:30 p.m., a second request was made to ASM #1 for the consent for use for bed rails for Resident #301.

On 9/8/2021 at approximately 2:27 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that they performed a side rail assessment on each resident prior to the use of bed rails. LPN #1 stated that they spoke with the resident or the responsible party and explained the risks and benefits of using bed rails prior to using them. LPN #1 stated that a consent was obtained and documented in the medical record for the use of bed rails. LPN #1 stated that they could get a verbal consent from the responsible party but they documented it on the paper form and had two staff witness the document.

On 9/9/2021 at approximately 10:30 a.m., a request was made to ASM #1 for the facility policy for bed rails.

On 9/9/2021 at 3:48 p.m., ASM #1 provided via email, "Side Rail/Bed Rail" dated 4/19/2018 which documented in part, "The Center will attempt alternative interventions, and document in the medical record, prior to the use of side rail/bed rail...3. Obtain consent from the resident and/or resident representative..."

On 9/8/2021 at approximately 5:02 p.m., ASM

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F 700	Continued From page 113 (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse were made aware of the findings. No further information was provided prior to exit. References: 1. Malignant neoplasm: The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. 2. Paraplegia: Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. This information was obtained from the website: https://medlineplus.gov/paralysis.html 3. Suprapubic catheter: "A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly." This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000145.htm.	F 700		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		10/14/21

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F 726	Continued From page 114 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure that two of 2 nurse aid records reviewed had received required annual competencies, (CNA [certified nursing assistant] #1 and CNA #2).	F 726	1. CNA #1 and CNA #2 will receive annual competency evaluations and annual training as required. 2. A review of employee files will be completed by the Human Resource	

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F 726	Continued From page 115 CNA #1 was hired 9/12/1988 and CNA #2 hired 7/16/2019, and neither CNA had annual training and competency evaluations completed. The findings include: Upon entrance on 9/8/21 at approximately 11:45 AM, an Entrance Conference form was provided to the interim Administrator (ASM #1 - Administrative Staff Member). One document on this form was a request for a list of all current CNA (Certified Nursing Assistant) staff who had been employed at the facility for longer than one year. The list provided contained 2 CNA's that had been employed longer than a year and was still employed at the facility (CNA #1 was hired 9/12/1988 and CNA #2 hired 7/16/2019). A request was made for both CNA's #1 and #2 annual training and competency evaluations. On 9/09/21 at 9:51 AM, in an interview with ASM #1, he stated that there were no competencies "because of COVID" and that "there was not an HR (Human Resources) person for 4 months." A review of the facility policy "Employee Job Performance Evaluations" documented, "It is the policy of The Company to evaluate each employee's job performance on a continual and ongoing basis. Employees will receive an evaluation of their performance prior to the completion of their Introductory Period and annually thereafter." On 9/9/21 at approximately 11:10 AM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the interim Administrator, ASM #2 the interim Director of Nursing (DON) and ASM #3	F 726	Coordinator/designee to ensure annual competency evaluations and required annual trainings are complete. 3. Regional Vice President of Operations will educate Human Resource Coordinator (HRC) and Executive Director (ED) on completing annual competency evaluations and annual training on employees. The HRC and ED will audit employee files monthly for three months to ensure training and evaluations are complete. 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. 10/14/21	

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F 726	Continued From page 116 the regional nurse, were made aware of the findings. No further information was provided by the end of the survey.	F 726		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure 8 consecutive hours of RN (Registered Nurse) coverage for the facility on August 13, 14, and 15, 2021. The findings include: Upon entrance on 9/8/21 at approximately 11:45 AM, an Entrance Conference form was provided to the interim Administrator (ASM #1 - Administrative Staff Member). One document on this form was a request for the as-worked schedule for the last 30 days.	F 727	1. No residents were affected. The facility has 8hrs of RN staffing daily as required. 2. The Director of Clinical Services or designee will review the last 30 days of as worked schedules to ensure compliance with required 8hr RN staffing. Follow up based on findings. 3. The Workforce Manager and the Director of clinical services will be educated on the requirements for daily registered nurse coverage by the Regional Director of Clinical Services. The clinical team will review staffing coverage weekly for 8 weeks to ensure	10/14/21

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F 727	Continued From page 117 A review of the as-worked schedule for a 30 day period of August 9, 2021 through September 8, 2021 revealed that there was no RN coverage on Friday 8/13/21, Saturday 8/14/21, and Sunday 8/15/21. On 9/9/21 at 8:52 AM an interview was conducted with OSM #5 (Other Staff Member) the staffing coordinator. When asked if she knew what the requirement was for RN coverage, OSM #5 stated she did not other than that there needed to be one in the building every day. When asked about RN coverage for the three above dates, OSM #5 stated, "We did not have an RN at that time. I tried calling agencies for RN's and no one had any available." On 9/9/21 at 3:48 PM via email, ASM #1 (Administrative Staff Member) the Administrator, documented that there were no policies for RN coverage, that the facility follows the regulations. On 9/8/21 at approximately 5:00 PM at the end-of-day meeting, ASM #1, ASM #2 the Director of Nursing (DON) and ASM #3 the regional nurse, were made aware of the findings. ASM #1 stated that it was correct that there was no RN coverage for the above dates. No further information was provided by the end of the survey.	F 727	requirements are meet. 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. 10/14/21	
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.	F 732		10/14/21

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F 732	Continued From page 118 (ii) The current date. (iii) The total number and the actual hours worked 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, staff interview, and facility document review, it was determined that the facility staff failed to post a daily nurse staff posting that was complete and accurate from 8/7/12 through 9/8/21.	F 732	1. The daily staff posting is posted correctly to include the census number daily. 2. No residents were affected.	

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F 732	Continued From page 119 The findings include: A review of the staff posting form revealed the form contained a row for each shift - day, evening and night shifts. For each shift, was a line with the word "census" under it, on which the facility was to document the resident census for that shift. On 9/7/21 at approximately 11:45 AM, upon entrance to the facility, the daily nurse posting was observed. The census data for each shift was not documented. On 9/8/21 at approximately 7:45 AM, upon entrance to the facility, the daily nurse posting was observed. The date posted was 8/8/21 (August, not September) and also did not contain any census data for each shift. At this time, the Administrator, (ASM [administrative staff member] #1), walked by and a copy of the daily census sheet was requested. He looked up at it and stated, "That should have today's date on it." ASM #1 stated the facility was working on providing the daily posting for the last 30 days. A review of the daily nursing staff posting form for 8/7/21 through 9/8/21 was reviewed. All dates except 9/8/21 did not contain the census data. The one for 9/8/21 was not the same one observed at 7:45 AM on entrance, which did not contain census data. The copy that was provided of the 9/8/21 staff posting did have the census data documented. On 9/8/21 at 9:24 AM an interview was conducted with OSM #5 (Other Staff Member) the staffing coordinator. She stated that she accidentally wrote August 8 on the staffing posting for 9/8/21.	F 732	3. Workforce Manager will be educated on importance of a complete and accurate daily staff posting to include addition of census number by the Executive Director/designee. 4. Executive Director/designee will review daily staff posting daily for 5 days and weekly x 4 weeks to ensure accurate postings are completed. Results of the review will be reviewed by the Quality Assurance Performance Improvement Committee for review, analysis, and further recommendations. 5. 10/14/21	

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F 732	Continued From page 120 OSM #5 stated that she originally posted it between 6:30 AM and 7:00 AM, but that she had to make changes that she became aware of after it was posted, which included census data. She stated that she did not know until today (9/8/21) that census data had to be documented on it as well. She stated, "I am new at this. I taught myself everything. I did not realize the census column was there. I started June 16 (2021). The day I started, the person who was going to train me quit 2 days later." When asked if it should be complete and accurate for each shift, she stated, "I believed it to be complete and accurate." On 9/9/21 the facility was provided with a list of policies requested by and to be emailed to the survey team. The policy provided via email on 9/9/21 at 3:48 PM for staff posting was a copy of a blank form of the staff posting, on which was documented, "Post beginning of each shift in a prominent place that is readily accessible to residents and visitors. Daily posting of this information is required for nursing homes participating in Medicare and Medicaid...." On 9/8/21 at approximately 5:00 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the interim Administrator, ASM #2 the interim Director of Nursing (DON) and ASM #3 the regional nurse, were made aware of the findings. No further information was provided by the end of the survey.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		10/14/21

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F 755	Continued From page 121 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 observation, staff interview, facility document review and in the course of a complaint investigation, it was determined facility staff failed to remove and discard of expired medications in one of one facility medications rooms and failed to provide pharmacy services for one of 35 residents in the survey sample, Resident # 101.	F 755	1. The vitamin mineral eye drops were discarded from the medication room immediately. Resident #101 does not reside in the facility any longer. The medication room was checked to ensure expired medications had been removed. 2. The medication room was checked to ensure expired medications had been	

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F 755	Continued From page 122 1. Expired Preservision eye vitamin mineral supplement soft gels with an expiration date of July 2021 were available for resident administration in the one facility medication room. 2. The facility staff failed to ensure Resident #101's physician ordered medication, Meropenem 500 mg (milligrams) every 8 hours for pneumonia for 10 days, was available and administered intravenously as prescribed on 1/11/2021 at 10:00 p.m. The findings include: 1. On 9/7/2021 at approximately 4:49 p.m., an inspection of the facility medication room was conducted with LPN (licensed practical nurse) #3. An unopened bottle of 120 preservision eye vitamin mineral supplements was observed on the bottom shelf stored with other house stock medications. The date "2021-07" was observed on the box. On 9/7/2021 at approximately 4:55 p.m., an interview was conducted with LPN #3. When asked what the date on the box of Preservision eye vitamin mineral supplements meant, LPN #3 stated that it meant they expired July of 2021 and should not have been on the shelf. LPN #3 stated that the medication was available for use and removed the box from the shelf. LPN #3 placed the medication in a pharmacy bag and stated that it would be returned to the pharmacy. LPN #3 stated that they checked the dates on the medications when they removed them from the medication room but the medication should have been found during routine checks by staff and pharmacy.	F 755	removed. Resident #101 did not have any negative effects for not having his medication available from the pharmacy. 3. The Director of Clinical Services (DCS) or designee will educate the licensed nursing staff on medication administration and storage to include expired medications and administering medications per doctor's orders. The DCS or designee will complete random medication administration observations to ensure compliance weekly for 8 weeks. The DCS or designee will complete random medication room audits weekly to ensure no expired medications are identified weekly for 8 weeks. 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. 10/14/21	

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F 755	Continued From page 123 On 9/9/2021 at approximately 10:30 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for disposal of expired medications. On 9/9/2021 at 3:48 p.m., ASM #1 provided via email, "Disposal/Destruction of Expired or Discontinued Medication" dated 12/01/07 which documented in part, "...Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction..." On 9/8/2021 at approximately 5:02 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse was made aware of the findings. No further information was provided prior to exit. 2. Resident #101 was admitted to the facility on 1/11/2021 with a readmission on 1/26/2021, with diagnoses that included but were not limited to: COVID, pneumonia (An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia) (1), high blood pressure, history of breast cancer, anemia	F 755		

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F 755	Continued From page 124	F 755		

(condition in which the hemoglobin content of the blood is below normal limits) (2), depression and pancreatitis (inflammation of the pancreas) (3).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/1/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living except eating in which she was coded ad being independent after set up assistance was provided.

A physician order dated, 1/11/2021, documented, "Meropenem Solution Reconstituted (used to treat skin and abdominal infections caused by bacteria and meningitis) (4) 500 mg (milligrams); use 500 mg intravenously every 8 hours for pneumonia for 10 days."

The MAR (medication administration record) for January 2021, documented the above order. On 1/11/2021 at 10:00 p.m. a "9" was documented in the block for administration. The Code at the bottom of the MAR indicated a "9" is "other/see nurse's notes."

The nurse's note dated, 1/11/2021 at 10:00 p.m. documented, "Hasn't arrived from pharmacy."

An interview was conducted with LPN (licensed practical nurse) #1 on 9/8/2021 at 2:27 p.m. When asked how the medications arrive at the facility for a new admission, LPN #1 stated they go by the discharge summary, verify the orders with the physician and then fax them to the

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F 755	Continued From page 125	F 755		

pharmacy. If we get the orders in by 2:00 p.m. the medications will come on the 8:00 - 9:00 p.m. run. Some medications can be pulled from the Stat box. Some medications don't come until the next day. Especially those that are once a day medications.

The nurse's that signed the MAR that the resident did not receive her medications were no longer employed at the facility and unavailable for interview.

The MARs were reviewed with ASM #2, the director of nursing, who was not at the facility at the time of this resident's admission, on 9/9/2021 at approximately 10:00 a.m. ASM #2 stated she could not tell why the medications were not given as there is no documentation but the medication were not given for whatever reason. ASM #2 stated the nurses are not filling out the notes in the computer related to not giving a medication.

No other information was provided.

Complaint Deficiency

References:
(1) This information was obtained from the following website: https://search.cdc.gov/search/index.html?query=COVID+-+19+definition&sitelimit=&utf8=%E2%9C%93&affiliate=cdc-main#content
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 432.
(4) This information was obtained from the

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F 755	Continued From page 126 following website: https://medlineplus.gov/druginfo/meds/a696038.html	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that the facility staff failed to secure medications properly on one of three facility medication carts, the medication cart on the Blue unit.	F 761	1. Medication carts are locked for safe storage of medications 2. All residents have the potential to be affected.	10/14/21

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F 761	Continued From page 127 The facility staff failed to lock the medication cart on the Blue unit when the cart was out of the line of sight of the nurse. The findings include: On 9/7/2021 at approximately 4:55 p.m., an observation was made of LPN (licensed practical nurse) #3 administering medications at the facility. LPN #3 placed the medication cart in the hallway against the wall between the resident rooms. LPN #3 was observed preparing medications, including two bottles containing eye drops to administer to a resident. On 9/7/2021 at 5:07 p.m., LPN #3 entered the residents room with the medications while leaving one bottle of eye drops on top of the medication cart. Another staff member was observed exiting the residents room at that time, passing beside the medication cart. On 9/7/2021 at 5:11 p.m., LPN #3 exited the residents room to obtain the bottle with the eye drops from the top of the medication cart and placed the other bottle of eye drops on the top of the medication cart. On 9/7/2021 at 5:12 p.m., LPN #3 exited Resident #33's room and returned to the medication cart. On 9/7/2021 at approximately 5:14 p.m., an interview was conducted with LPN #3. LPN #3 stated that they normally locked all medications in the cart when they left the cart unattended but did not have enough hands to hold everything and had left one bottle on top of the cart until they administered the first eye drop. LPN #3 stated that leaving the medication on top of the cart was not secured because anyone passing by could pick it up.	F 761	3. The DCS/designee will educate licensed nurses on proper medication storage to include locking of medications carts. The DCS or designee will audit each medication cart to ensure it is secured daily x 5 days and weekly x 8 weeks and monthly thereafter. 4. The DCS/designee will report results of audits to the quality assurance performance improvement committee monthly for 3 months or committee determines substantial compliance has been met. 5. 10/14/21.	

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F 761	Continued From page 128	F 761		

On 9/9/2021 at approximately 10:30 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for securing medications.

On 9/9/2021 at 3:48 p.m., ASM #1 provided via email, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" dated 12/1/07 which documented in part, "...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors..."

On 9/8/2021 at approximately 5:02 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse were made aware of the findings.

No further information was provided prior to exit.

References:

1. Chronic obstructive pulmonary disease (COPD)
Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. Dementia
A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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F 804	Continued From page 129	F 804		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and in the course of a complaint investigation, it was determined the facility staff failed to serve food at temperatures that were palatable for meal enjoyment during the evening meal. The findings include: Observation was made of the kitchen during the evening meal tray line on 9/7/2021 at 4:45 p.m. The following foods were at the documented temperatures that were obtained by facility staff using a facility thermometer: Potato wedges - 181.1 degrees Mixed Vegetables - 202.6 Corn flake chicken - 157.4 Ground chicken - 181.1 Puree chicken - 199 Mashed potatoes - 201.2 Puree vegetables - 194 Baked chicken for renal diets - 171.5 Chicken gravy - 188 Cheese Ravioli - 171.3	F 804	1. In-service education provided by the District Manager or Designee on following policies and procedures for meal distribution and ensuring palatability of food. 2. Dietary Manager or Designee will complete one test tray per day for one week followed by three test trays per week for one month. 3. The Dietary Manager and District Manager are responsible for maintaining compliance. 4. Follow up based on findings and reported to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 10/14/2021.	10/14/21

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F 804	Continued From page 130	F 804		

Mechanical renal chicken - 182.3
Coffee was taken from under the steam table and placed on individual trays. The coffee was not temped prior to being placed on the trays.

A test tray was prepared at the end of the tray line. The fourth hall cart was observed. All trays were distributed. At 5:50 p.m., the test tray was taken to the dining room where the temperatures were taken and food tasted by OSM (other staff member) # 6, the dietary manager in training, and two surveyors. The food tasted good. The potato wedges were tasted and found to be cold. The temperature of the wedges was obtained by OSM #6, and was 119 at the time. OSM #6 stated it tasted like cold french fries. The coffee temperature was tested by OSM #6 and read 109 degrees. The coffee was tasted and was not warm.

The facility policy, "Food: Quality and Palatability" documented in part ,"Policy Statement: It is the center policy that, food is prepared by methods that conserve nutritive value, flavor and appearance. Food is palatable, attractive and served at the proper temperatures." The facility policy, "Food Preparation" documented in part, "The Dining Services Director/Cook will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees and/or less that 135 degrees, or per state regulation...All foods will be held at appropriate temperatures, greater than 135 degrees F (Fahrenheit) for hot holding, and less that 41 degrees F for cold food holding. Temperature for TCS (temperature control safety) foods will be recorded at time of service, and monitored periodically during meal service periods."

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F 804	Continued From page 131 ASM (administrative staff member) #1, the administrator, ASM #2 the director of nursing and ASM #3, the regional nurse, were made aware of the above concerns on 9/8/2021 at 5:10 p.m. No further information was obtained prior to exit.	F 804		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain the dumpster area in a sanitary manner. The findings include: Observation was made of the dumpster area on 9/8/2021 at 4:46 p.m. accompanied by OSM (other staff member) #6, the dietary manager in training. Around the dumpster were seven piles of used gloves. It could not be determined if it was one or two gloves on each pile. When asked whose responsibility it was for keeping the dumpster area clean, OSM #6 stated it's both dietary and housekeeping. The director of environmental services, OSM #7, was not available for interview. An interview was conducted with OSM #4 on 9/9/2021 at 10:34 a.m. When asked whose responsibility it was to keep the dumpster area clean, OSM #4 stated, he checks it every	F 814	1. The dumpster area was cleaned of debris immediately upon findings. 2. No residents have the potential to be affected. The dumpster area remains free of debris. 3. The ED/designee will educate staff on proper storage of refuse at the dumpster area. ED/designee will audit the dumpster area to be free from debris weekly x 8 weeks to ensure compliance. 4. The ED/designee will report results of audits to the quality assurance performance improvement committee monthly for 3 months or committee determines substantial compliance has been met. 5. 10/14/21	10/14/21

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F 814	Continued From page 132 morning. Putting on gloves and picking up trash and mostly gloves. He stated, (name of OSM #7) the director of housekeeping, checks in in the evenings before she leaves. OSM #4 stated the dumpster had been emptied yesterday (9/8/2021) around noon. The facility policy, "Dispose of Garbage and Refuse," documented in part, "Policy Statement: All garbage and refuse will be collected and disposed of in a safe and efficient manner. Procedures: 1. The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish and other debris." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3 the regional nurse, were made aware of the above concern on 9/8/2021 at 5:10 p.m. No further information was obtained prior to exit.	F 814		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (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.	F 842		10/14/21

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ENVOY OF WINCHESTER, LLC	110 LAUCK DR WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 133	F 842		

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

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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F 842	Continued From page 134 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 and clinical record review, and during the course of a complaint investigation, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 35 residents in the survey sample, Resident # 101. Resident #101's January MAR (medication administration record) documented "see nurses note" on 1/27/21 and 1/28/21, beside the physician ordered medication Flovent. Review of the January 2021, nurses notes for Resident #101 failed to evidence any documentation related to the use of the Flovent. The findings include: Resident #101 was admitted to the facility on 1/11/2021 with a readmission on 1/26/2021, with diagnoses that included but were not limited to: COVID, pneumonia (An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia) (1), high blood	F 842	1. Resident #101 does not reside in the center any longer. Medications are given as prescribed. 2. Current residents have the potential to be affected. Admissions, readmissions and residents with new medications audited to ensure medications are being delivered by the pharmacy and administered as ordered. 3. The DCS/designee will educate licensed staff on accurately documenting medication availability and notifying the physician of any variances. The DCS/designee will review new admissions, readmissions and new medication order documentation 5 days/week x 4 weeks, then weekly for 8 weeks to ensure compliance. 4. The DCS will report results of the audits to the quality assurance performance	

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pressure, history of breast cancer, anemia (condition in which the hemoglobin content of the blood is below normal limits) (2), depression and pancreatitis (inflammation of the pancreas) (3).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/1/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living except eating in which she was independent after set up assistance was provided.

The physician order dated 1/26/2021 documented, "Flovent HFA Aerosol (used to prevent difficulty breathing, chest tightness, wheezing, and coughing caused by asthma in adults and children.) (4) 220 MG/ACT - 2 puffs inhale orally two times a day related to acute respiratory distress syndrome."

The January 2021 MAR (medication administration record) documented the above order for Flovent. The MAR documented for 1/27/2021 and 1/28/2021 - "see nurse's note." Review of the nurse's notes failed to evidence any documentation related to the use of the Flovent.

The nurse's that signed off the above medications were no longer employed at the facility and were unavailable for interview.

An interview was conducted with LPN (licensed practical nurse) #1 on 9/8/2021 at 2:27 p.m.

improvement committee monthly for 3 months or committee determines substantial compliance has been met.

5. 10/14/21

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When asked how the medications arrive at the facility for a new admission, LPN #1 stated they go by the discharge summary, verify the orders with the physician and then fax them to the pharmacy. If we get the orders in by 2:00 p.m. the medications will come on the 8:00 - 9:00 p.m. run. Some medications can be pulled from the Stat box. Some medications don't come until the next day. Especially those that are once a day medications.

The MARs were reviewed with ASM #2, the director of nursing, who was not at the facility at the time of this resident's admission, on 9/9/2021 at approximately 10:00 a.m. ASM #2 stated she could not tell why the medications were not given as there is no documentation but the medication were not given for whatever reason. ASM #2 stated the nurses are not filling out the notes in the computer related to not giving a medication.

Complaint Deficiency

References:
(1) This information was obtained from the following website: https://search.cdc.gov/search/index.html?query=COVID+-+19+definition&sitelimit=&utf8=%E2%9C%93&affiliate=cdc-main#content
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 432.
(4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601056.html

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F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; 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 maintain an effective Quality Assurance program. The findings include: On 09/09/2021 at approximately 11:00 a.m., a review of the facility's "QAPI [quality assurance performance improving] Meeting" sign-in sheets" dated January 2021 through March 2021 failed to evidence the signature of the facility's medical director. On 09/09/2021 at approximately 11:28 a.m., an interview was conducted with ASM [administrative staff member] # 1, administrator, regarding the missing signature of the medical director for the date listed above. When asked about the missing signature of the facility's medical director ASM # 1 stated that they did not have any evidence that they had attended. No further information was provided by the end of the survey.	F 867	1. The Medical Director will attend QAPI meetings at least quarterly and a signature will be obtained. 2. No residents had the potential to be affected. 3. Regional Vice President of Operations will educate QAPI committee on having the Medical Director attend QAPI at least quarterly. RVPO will audit QAPI minutes quarterly for 2 quarters to ensure compliance. 4. The ED will report results of the audits to the quality assurance performance improvement committee quarterly for 2 quarters or until committee determines substantial compliance has been met. 5. 10/14/21	10/14/21
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		10/14/21

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The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 139 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete infection control program as evidenced by missing infection control surveillance for April, May and June 2021. The findings include: On 09/09/2021 at approximately 10:00 a.m., a review of the facility's infection control surveillance for the past six months was conducted. Review of the surveillance records failed to evidence infection control surveillance for	F 880	1. Missing Infection Control Surveillance logs recreated using the lab findings for April, May June. 2. No other residents affected for the this practice 3. Infection Control nurse re-educated on Infection Control Surveillance and tracking and trending by DON/designee by 10/8/2021 4. The Administrator is responsible for	

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F 880	Continued From page 140 April, May and June 2021. On 09/09/2021 at approximately 10:33 a.m., an interview was conducted with ASM [administrative staff member] # 1, administrator. When asked about the missing surveillance ASM # 1 stated, "We don't have a full six months of surveillance, we're unable to locate them." When asked who was responsible for infection control ASM # 1 stated that it was [ASM # 2], director of nursing who started at the facility on 09/02/2021. On 09/09/2021 at 12:58 p.m. an interview was conducted with ASM # 3, regional nurse. When asked to describe the procedure for maintaining the infection control surveillance ASM # 3 stated, "They are all kept together for the year in a binder." When asked why it was important to maintain the surveillance records ASM # 3 stated, "To track and trend infections and tract the use of antibiotics for overuse."' The facility's policy "Surveillance for Infections" documented in part, "Policy Interpretation and Implementation. 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections." Under "Gathering Surveillance Data" it documented in part, "1. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The Infection Control Committee and/or QAPI [quality insurance performance improvement] Committee may be involved in interpretation of the data." Under "Data Collection and Recording" it documented in part, "4. For targeted surveillance	F 880	maintaining compliance. DON/designee will completed weekly quality monitor to ensure compliance maintained. 5. 10/14/2021	

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F 880	Continued From page 141 using facility-created tools, follow these guidelines: a. DAILY (as indicated): Record detailed information about the resident and infection on an individual infection report form. b. MONTHLY: Collect information from individual resident infection reports and enter line listing of infections by resident for the entire month. c. MONTHLY: Summarize monthly data for each nursing unit by site and pathogen. d. MONTHLY/QUARTERLY: Identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording month to month and observing trends. e. MONTHLY/QUARTERLY: Compare incidents of current infections to previous data to identify trends and patterns. Use average infection rate over a previous time period as a baseline. Compare subsequent rates to the average rate to identify possible increases in infection rates." No further information was provided prior to exit.	F 880		