STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	C 12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 Prepardedness survey was conducted on 12/07/21 through 12/10/21 and 12/13/21 through 12/14/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		1/27/22

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

Electronically Signed | 01/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 006	Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an up dated risk assessment and reviewed annually and as needed.	E 006	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported	

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E 006	Continued From page 2 The findings included: During the Emergency Preparedness review on 12/08/21 at 10:00 A.M. with the Administrator and the Maintenance Director, they were asked for documentation that the facility had updated the Emergency Preparedness Risk Assessment. A review of the Emergency Preparedness Risk assessment indicated the Assessment had not been review or updated since 2019. During an interview with the administrator on 12/08/21 at 10:10 a.m. he stated that, he had only been at the facility for three months.	E 006	conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. E006 1. The facility has updated the facility risk assessment and completed an annual review. 2. Current residents in the center have the potential to be affected. 3. The Maintenance Director was educated by the Administrator/designee on updating the facility risk assessment and completion of an annual review of the facility risk assessment. 4. The Administrator/designee will review the facility risk assessment monthly to ensure that the risk assessment is current and has been reviewed annually. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Maintenance Director are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	
E 007	EP Program Patient Population	E 007		1/27/22

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E 007 SS=C	Continued From page 3 CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an Emergency	E 007	E007 1. The facility has documented identified	

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E 007	Continued From page 4 Preparedness Plan that included the facility's patient population. The findings included: During the Emergency Preparedness Plan review on 12/08/21 at 10:00 A.M. with the Administrator and the Maintenance Director, the administrator was asked for facility's Emergency Preparedness patient population that would be at risk during an emergency. During an interview on 12/08/21 at 10:12 A.M. the administrator stated the Emergency Preparedness plan did not include strategies nor identify resident at risk during an emergency event.	E 007	population at risk in the Emergency Preparedness Plan. 2. Current residents have the potential to be affected. 3. The Maintenance Director will be educated by the Administrator/designee on inclusion of identified population at risk in the Emergency Preparedness Plan. 4. The Administrator/designee will complete a random monthly review of the Emergency Preparedness Plan to ensure that there is documentation of the facility□s identified population at risk. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Maintenance Director are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		1/27/22

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E 013	Continued From page 5	E 013		

be reviewed and updated at least every 2 years.

*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.

*Additional Requirements for PACE and ESRD Facilities:

*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.

*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section,

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E 013	Continued From page 6 and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an Emergency Preparedness Plan that included the facility's communication plan was reviewed and updated on an annual basis. The findings included: During the Emergency Preparedness Plan review on 12/08/21 at 10:00 A.M. with the Administrator and the Maintenance Director, the administrator was asked for facility's Risk Assessment and Communication Plan policies and procedures updates and reviews. During an interview on 12/08/21 at 10:20 a.m. the administrator stated the facility's Emergency Preparedness Plan did not include policy and procedures reviews and updates on an annual basis for communication and risk assessment.	E 013	E013 1. The facility has reviewed and updated the Emergency Preparedness policies and procedures for a communication plan. 2. Current residents in the center have the potential to be affected. 3. The Maintenance Director will be educated by the Administrator/designee on review and updating of the Emergency Preparedness Plan on an annual basis. 4. The Administrator will complete a random monthly review of the Emergency Preparedness Plan to ensure that the policies and procedures for communication are reviewed and updated annually. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Maintenance Director are responsible for implementation of the plan of correction 6. Date of completion 1.27.2022	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)	E 015		1/27/22

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E 015	Continued From page 7 §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		

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E 015	Continued From page 8 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: The facility staff failed to have policies and procedures for the provision of sewage and waste disposal. The findings included: During the Emergency Preparedness review on 12/08/21 at 10:21 A.M. with the Administrator and the Maintenance Director, the administrator was asked for policies and procedures to provide for sewage and waste disposal. During an interview with the administrator on 10:24 A.M. he stated, the facility did not have provisions for sewage and waste disposal in the Emergency Preparedness Plan.	E 015	E015 1. The facility has an emergency preparedness plan to address sewage and waste disposal. 2. Current residents have the potential to be affected. 3. The Maintenance Director will be educated by the Administrator/designee on annual review of sewage and waste disposal policies and procedures in the Emergency Preparedness Plan 4. The Maintenance Director/designee will complete a random monthly review to ensure that Emergency Preparedness policies and procedures to address sewage and waste disposal are reviewed and updated annually. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The	

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E 015	Continued From page 9	E 015	Administrator/Maintenance Director are responsible for implementation n of the plan of correction. 6. Date if completion 1.27.2022	
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other	E 025		1/27/22

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E 025	Continued From page 10 [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an Emergency. The findings included: During the Emergency Preparedness Plan review on 12/08/21 at 10:30 A.M. with the Administrator and the Maintenance Director, the administrator was asked for documentation that the facility had arrangements with other facilities to receive patients during an emergency event. During an interview with the administrator on 12/08/21 at 10:34 A.M. he stated, the facility was recently sold and all agreements and arrangements with other facilities had not been completed.	E 025	E025 1. The facility has arrangements and/or agreements with other facilities to receive patients during an emergency event. 2. Current residents in the center have the potential to be affected. 3. The Maintenance Director has been educated by the Administrator/designee on documentation of facility arrangements and/or agreements with other facilities to receive patients during an emergency event. 4. The Administrator/designee will complete a random monthly review to ensure that emergency Preparedness policies and procedures to address arrangements and/or agreements with other facilities to receive patient during an emergency event are updated and reviewed annually. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will	

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E 025	Continued From page 11	E 025	be conducted on a random basis. The Administrator/Maintenance Director are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an Emergency Preparedness Plan that included the facility's updated communication plan. The findings included: During the Emergency Preparedness Plan review on 12/08/21 at 10:45 A.M. with the Administrator and the Maintenance Director, the administrator was asked for the facility's updated communication plan. During an interview on 12/08/21 at 10: 48 a.m. with the administrator, he stated, the Emergency Preparedness Communication Plan had not been up dated. The Communication Plan was	E 029	E029 1. The facility has reviewed and updated the Emergency Preparedness policies and procedures for a communication plan. 2. Current residents have the potential to be affected. 3. The Maintenance Director will be educated by the Administrator/designee on reviewing and updating of the Emergency Preparedness Plan. 4. The Administrator/designee will complete a random monthly review of the Emergency Preparedness Plan to ensure that the policies and procedures for communication are reviewed. 5. The results of the review will be	1/27/22

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	495108	A. BUILDING _____ B. WING _____	C 12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 029	Continued From page 12 observed to have been last updated in the year 2019.	E 029	discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Maintenance Director are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the	E 030		1/27/22

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E 030	Continued From page 13	E 030		

following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [hospitals and CAHs].
(v) Volunteers.

*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Next of kin, guardian, or custodian.
(iv) Other RNHCIs.
(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Volunteers.

*[For Hospices at §418.113(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Hospice employees.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Other hospices.

*[For HHAs at §484.102(c):] The communication

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E 030	Continued From page 14 plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an Emergency Preparedness Plan that included the facility's contact information in the communication plan. The findings included: During the Emergency Preparedness Plan review on 12/08/21 at 10:50 A.M. with the Administrator and the Maintenance Director, the administrator was asked for facility's contact information. A review of documentation presented from the communication plan did not include the facility's contact information. During an interview with the administrator on 12/08/21 at 10:53 a.m., he stated, the communication plan had not been updated to include facility contact information.	E 030	E030 1. The facility Emergency Preparedness Plan has been revised to include facility contact information from the communication plan. 2. Current residents in the center have the potential to be affected. 3. The Maintenance Director has been educated by the Administrator/designee on inclusion of facility contact information in the Emergency Preparedness Plan. 4. The Administrator/designee will complete a random monthly review of the Emergency Preparedness Plan to ensure that the plan includes facility contact information. 5. The results of the review will be discussed at the monthly QAPI meeting.	

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E 030	Continued From page 15	E 030	Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Maintenance Director are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	
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	E 036		1/27/22

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E 036	Continued From page 16 section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have an Emergency Preparedness Plan that included training and testing as well as updated on an annual basis.	E 036	E036 1. The facility has a training and testing program for Emergency Preparedness.	

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E 036	Continued From page 17 The findings included: During the Emergency Preparedness Plan review on 12/08/21 at 11:02 A.M. with the Administrator and the Maintenance Director, the administrator was asked for documentation of the facility's training and testing program. During an interview on 12/08/21 at 11:07 a.m. with the administrator, he stated, the facility did not have a training and testing program.	E 036	2. Current residents in the center have the potential to be affected. 3. Facility staff will be educated by the Maintenance Department/designee on the Emergency Preparedness Plan. 4. The Administrator /designee will complete a random monthly review to ensure that staff are trained and tested on the Emergency Preparedness Plan. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Maintenance Director are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E 039		1/27/22

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(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or

(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.

(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]

(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not

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accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community

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based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

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E 039	Continued From page 21 (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional	E 039		

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E 039	Continued From page 22 exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 23 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

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a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group

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discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.
(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

*[RNCHIs at §403.748]:
(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated,

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E 039	Continued From page 26 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation that an annual Emergency Preparedness full scale community based exercise had conducted. The findings included: During the Emergency Preparedness Plan review on 12/08/21 at 11:22 A.M. with the Administrator and the Maintenance Director, the administrator was asked for documentation of the facility's full scale community based exercise. During an interview with the administrator on 12/08/21 at 11:26 a.m., he stated, the facility had not conducted an Emergency Preparedness full scale exercise since July 10, 2020.	E 039	E039 1. The facility will complete a community-based tabletop exercise for emergency preparedness. 2. Current residents in the center have the potential to be affected. 3. The Maintenance Director will be educated by the Administrator/designee on completion of a community-based tabletop exercise on an annual basis. 4. The Administrator/designee will review documentation of a completed annual community-based tabletop exercise. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be conducted on a random basis. The Administrator/Maintenance Director are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/07/21 through 12/14/21. Significant corrections are required for	F 000		

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F 000	Continued From page 27 compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey: VA00048975-Substantiated, no deficiencies, VA00050216-Substantiated with deficiencies, VA00052395-Substantiated, no deficiencies, VA00052667-Substantiated, no deficiencies, VA00053527-Unsubstantiated, lack of sufficient evidence and VA00053730, Substantiated, no deficiencies. The census in this 180 certified bed facility was 166 at the time of the survey. The survey sample consisted of 58 residents: 47 current Resident reviews and 11 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		1/27/22

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F 550	Continued From page 28 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility staff failed to provide care and services to one resident (Resident #28) during wound care treatment to promote dignity and respect and failed to remind and assist 3 Residents (#146, #132 and #103) to vote in the November 2021 general election in the survey sample of 58 residents. The findings included: 1.Resident #28 was originally admitted to the facility on 06/29/15 and re-admitted on 04/06/21 with diagnoses which included hyperlipidemia, ischemic cardiomyopathy, a fib, hypertensive, dementia, pressure ulcer of right heel, insomnia, and muscle weakness. Resident received wound	F 550	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550	

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F 550	Continued From page 29 treatment on 12/08/21 from Licence Practical Nurse (LPN) LPN #11. Resident #28 was assessed having a Basis Interview of Mental Status (BIMS) score of (7) seven. A Quarterly Minimum Data Set (MDS) dated 09/17/21 indicated this resident had ADL (activities of daily living) deficits in self care, physical mobility, and maintaining adequate nutritional status. A revised care plan dated 10/23/21 indicated: Potential for skin impairment and or pressure ulcer: Goal: Resident will have no evidence of skin impairment; interventions- keep skin clean and dry. Moisture barrier cream as needed for protection of skin. A physician order dated 10/23/21 indicated: Current Treatment Plan - Skin prep. On 12/08/21 at 1:15 P.M. LPN #11 was observed to provided wound care to the right heel of Resident #28. After removal of old dressing and applying the new wound care per physician's orders, LPN #11 was observed to date the new wound dressing by writing on the right top ankle of Resident #28. Following the wound dressing disposal and washing of hands, LPN #11 asked how she had performed. LPN #11 was reminded that she wrote the date of the dressing change on the resident. LPN #11 stated, yes I did. I should not have done that. 2. The facility staff failed to remind and assist Resident #146, to vote in the November 2021 general election.	F 550	1. Resident #28 is receiving care and services during wound care treatment to promote dignity and respect. Residents #146 and #103 will be offered assistance with voting during election times. Resident #132 discharged from the facility. 2. Residents with wounds have the potential to be affected. Residents wishing to vote in future elections have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on provision of wound care treatment in a manner which promotes dignity and respect. The Discharge Planning Department will be educated by the Administrator/designee on reminding residents of upcoming elections during Resident Council meetings and offering needed assistance with voting. 4. The Unit Managers/designees will complete a random weekly review of wound care treatments to ensure that dignity and respect is maintained. The Administrator/designee will complete a random monthly review of Resident Council minutes to ensure that residents were reminded of upcoming elections and offers of assistance in voting were made. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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Resident #146 was originally admitted to the facility 7/12/18. The current diagnoses included; stroke, diabetes and coronary artery disease.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/15/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #146's cognitive abilities for daily decision making were intact.

On 12/7/21 at approximately 4:00 p.m., an interview was conducted with the Resident Council group. During this interview Resident #146 stated she didn't get to vote in the November 2021 election and it was her desire to vote. The resident stated no one talked about the upcoming election or asked if she wanted or needed assistance to obtain an absentee ballot.

3. The facility staff failed to remind and assist Resident #132, to vote in the November 2021 general election.

Resident #132 was originally admitted to the facility 12/22/16 and readmitted 4/4/18 after an acute care hospital stay. The current diagnoses included; a-fibrillation, diabetes and coronary artery disease.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/14/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #132's cognitive abilities for

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daily decision making were intact.

On 12/7/21 at approximately 4:00 p.m., an interview was conducted with the Resident Council group. During this interview Resident #132 stated she didn't get to vote in the November 2021 election and she has always voted. The resident stated no one talked about the upcoming election or asked if she wanted or needed assistance to participate in the November 2021 election.

4. The facility staff failed to remind and assist Resident #103, to vote in the November 2021 general election.

Resident #103 was originally admitted to the facility 12/27/16 and readmitted 08/07/20 after an acute care hospital stay. The current diagnoses included; right lung cancer with metastases, prostatic hyperplasia and COPD.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/7/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #103's cognitive abilities for daily decision making were intact.

On 12/7/21 at approximately 4:00 p.m., an interview was conducted with the Resident Council group. During this interview Resident #146 stated he didn't get to vote in the November 2021 election and he would have liked to vote. The resident stated no one talked about the upcoming election or asked if he desired an absentee ballot.

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F 550	Continued From page 32 On 12/9/21 at approximately 3:10 p.m., an interview was conducted with the Discharge Planner. The Discharge Planner stated it is her duty to manage all voting activities but she aware it included talking with the residents and assisting those not registered or in need of obtaining application and absentee ballots. The Discharge Planner stated she assisted all ballots addressed to residents to ensure they were received and returned to the local registration office. The Discharge Planner stated going forward she would ensure all activities related to voting are carried out. On 12/14/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. No additional information was offered.	F 550		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		1/27/22

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F 578	Continued From page 33 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews and facility documentation review, the facility staff failed to ensure residents were afforded the opportunity to formulate advance directives, and the advance directive was maintained in the clinical record, readily accessible to the direct care staff to convey upon transfer to the emergency medical personnel and/or the hospital for 5 of 58 residents (123, 55, 77, 146 and 170), in the survey sample	F 578	F578 1. Residents #123, 55, 77, and 146 have been afforded the opportunity to formulate advance directives. Resident #170 discharged from the facility. 2. Current residents have the potential to be affected. 3. The Admissions Department will be educated by the Director of Nursing/designee on offering information regarding Advance Directives and	

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F 578	Continued From page 34 The findings include: 1. Resident #123 was originally admitted to the facility 9/28/21 and readmitted 11/5/21 after an acute care hospital stay. The current diagnoses included; diabetes, heart failure, renal insufficiency and status post left great toe amputation. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/4/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #123's cognitive abilities for daily decision making were severely impaired. A review of the Resident #123's clinical record didn't reveal a written Advance Directive which would have included what to do if the resident becomes incapacitated, a designated health care surrogate, medical/surgical treatments, feeding restrictions, organ donation, autopsy request or other but; a scanned DO NOT RESUSCITATE (DNR) form dated 9/9/21, was in noticed in miscellaneous records. This form read as follows; I, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify: The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signatures of the physician and patient were on the document.)	F 578	requesting a copy of Advance Directives if the resident has Advance Directives. Nurses will be educated by the Director of Nursing/designee on ensuring that Advance Directives are included in the medical record and are easily available to the direct care staff to convey upon transfer to the hospital. In addition, Direct care staff will be educated by the Director of Nursing/designee on including a copy of the Advance Directive when sending a resident to the hospital. 4. The Unit Managers/designees will complete a random weekly review of Advance Directives to ensure that the resident was offered information if desired and that a copy is easily available in the medical record. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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The Physician's Order Summary revealed an order written 11/25/21 for DNR. It read verified from medical records only. There was no evidence of a discussion with the resident and/or responsible party neither was there evidence the NP provided information to the resident and/or responsible party regarding his right to refuse medical or surgical treatment or to formulate an advance directive.

The clinical record further evidenced a nurse's note dated 10/14/21 at 2:36 p.m., which read; per nurse KB copies of the Medication Administration Record/Treatment Administration Record and the bed hold policy were faxed to the hospital. There was no evidence the DNR form or an advance directive was conveyed to the hospital along with the other documents.

An interview was conducted with the Unit Manager UM) for Resident #123's unit on 12/9/21 at approximately 4:40 p.m., she wasn't sure where to locate an advance directive for she had only been the UM for five days but she was aware of how important such a document would be to the direct care staff during a life threatening emergency.

An interview was conducted with the Admission's Director on 12/9/21 at approximately 4:50 p.m. The Admission's Director stated if the documents are sent from the hospital with other medical records she makes them available to nursing but it is nursing responsible to discuss advance directives with the resident and/or their responsible party.

On 12/14/21 at approximately 5:30 p.m., the

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above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated they be putting together a training plan relating to Advance Directives.

2. Resident #55 was originally admitted to the facility 10/14/21 and readmitted 11/16/21 after an acute care hospital stay. The current diagnoses included; diabetes, a stroke with left hemiparesis and Methicillin Susceptible Staphylococcus Aureus (MSSA) related to a left arm abscess.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/18/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #55's cognitive abilities for daily decision making were intact

A review of the Resident #55's clinical record didn't reveal a written Advance Directive which would have included what to do if the resident becomes incapacitated, a designated health care surrogate, medical/surgical treatments, feeding restrictions, organ donation, autopsy request or other but; a scanned document dated 10/07/21 from the Palliative Medicine team read; Advance Directives:
The Palliative Care Interdisciplinary Team has updated the Navigator with Health Care Agent and any associated documents. Medical Power of Attorney, Living Will, Physician orders for life-sustaining treatment form (POLST). There is no POLST form on file for this patient. No Advance Directive, Surrogate Decision Maker, son (name) awaiting contact.

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The Physician's Order Summary revealed an order written 11/17/21 for FULL CODE. There was no evidence information was provided to the resident and/or responsible party regarding his right to refuse medical or surgical treatment or to formulate an advance directive and the person-centered care plan didn't contain information on advance directives.

The clinical record further evidenced a nurse's note dated 12/11/21 at 10:36 p.m., which read; Writer spoke with 5 east nurse to get an update on the resident. The nurse stated the resident was having an esophagogastroduodenoscopy (EGD) procedure completed and afterwards he would be admitted for bleeding. The progress note further stated the Family was notified and the Care plan goals and bed hold policy was faxed over to hospital. There was no evidence advance directives were conveyed to the hospital along with the above documents.

An interview was conducted with the Unit Manager UM) for Resident #55's unit on 12/9/21 at approximately 4:40 p.m., she wasn't sure where to locate an advance directive for she had only been the UM for five days but she was aware of how important such a document would be to the direct care staff during a life threatening emergency.

An interview was conducted with the Admission's Director on 12/9/21 at approximately 4:50 p.m. The Admission's Director stated if the documents are sent from the hospital with other medical records she makes them available to nursing but it is nursing responsible to discuss advance

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directives with the resident and/or their responsible party.

On 12/14/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated they be putting together a training plan relating to Advance Directives.

3. The facility staff failed to provide Resident #77 with the opportunity to formulate an advance directive.

Resident #77 was admitted to the facility on 10/06/21 with diagnoses which included; kidney failure, COPD, depression, and diabetes.

A Quarterly Minimum Data Set (MDS) dated 10/26/21 assessed this resident as having a Basic Interview for Mental Status (BIMS) score of 9. Resident #77 was coded as having Activities of Daily Living (ADL's) deficits in mobility, and at risk for falls.

A revised care plan dated 11/22/21 indicated: Focus: Nutrition Risk r/t Recent hospitalization, chewing/swallowing difficulty with mechanically altered diet in place.

A review of the clinical records did not indicate Resident #77 was provided with the opportunity to develop an advance directive. During an interview on 12/08/21 at 3:00 P.M. with the Director of Nursing (DON) she was asked if Resident #77 had an advance directive. The DON stated no, Resident #77 had not formulated an advance directive.

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4. The facility staff failed to provide Resident #146 with the opportunity to formulate an advance directive.

Resident #146 was admitted to the facility on 07/12/18 with diagnoses which included cerebral ischemic, diabetes, heart disease, dysphagia, bipolar II, Parkinson's Disease, and depression.

A Quarterly MDS dated 11/15/21 assessed resident as having a BIMS score of 15. Resident #146 was coded as having ADL deficits with balance, and limited physical mobility.

A revised care plan dated 09/22/21 indicated: Focus: Resident is/has potential to be physically aggressive r/t irritability and anger issues.

A review of the clinical records did not indicate Resident #146 was provided with the opportunity to develop an advance directive. During an interview on 12/08/21 at 3:10 P.M. with the Director of Nursing (DON) she was asked if Resident #77 had an advance directive. The DON stated no, Resident #146 had not formulated an advance directive.

5. The facility staff failed to ensure that Resident #170's Advanced Directive/DNR was sent upon transfer/discharge to the hospital on 10/17/21. Resident #170 was originally admitted to the facility on 12/13/17. Diagnosis for Resident #170 included but not limited to Type II Diabetes and Chronic Diastolic Congestive Heart Failure.

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 07/22/21 coded the resident on the Brief Interview for

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Mental Status (BIMS) a 13 of 15 indicating no cognitive impairment.

Review of Resident #170's Order Summary for October 2021 revealed the following order: Do not resuscitate (DNR) effective as of 05/24/21.

On 10/17/21 at approximately 3:22 p.m., an eINTERACT change in condition document was completed by License Practical Nurse (LPN) #2. The document revealed the following information: send Resident #170 to the hospital due to being unresponsive, experiencing shortness of breath, labored or rapid breathing and oxygen saturation at 83% on room air.

The clinical record did not show evidence that Resident #170's Advanced Directive/Do Not Resuscitate (DNR) was sent with him when transferred to the hospital.

A nurse's note entered by LPN #2 on 10/17/21 (3-11) shift at approximately 9:45 p.m., revealed the following: (name of hospital) Emergency Department (ER) physician called and spoke with LPN #2. The physician requested for Resident #170's DNR form to be faxed to the ER department. The note further revealed that Resident #170's DNR form was faxed to the hospital as requested by the ER physician.

An interview was conducted with LPN #2 on 12/10/21 at approximately 11:11 a.m., who stated, "I was not assigned to Resident #170 but did assist with his transfer to the hospital on 10/17/21." When asked if the Resident's Advance Directive or DNR form was sent with the resident when he was transferred to the hospital

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F 578	Continued From page 41 on 10/17/21, she replied, "No, the DNR form was sent later after being requested by the ER physician." A debriefing was conducted with the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. The DON said the expectation is for the resident's Advance Directive/DNR form to be sent with the resident when is transferred to the hospital. The facility's policy titled Advance Directive with an effective date 03/24/20. 1. A copy of the Center's policies governing the implementation of self-determination of rights is present upon admission by the Admission Office and the Notification/Acknowledgement Form verifying all communication regarding advance directives is to be placed in the Medical Record at the time of admission. 2. Upon admission a licensed nurse must immediately review the advance medical directive documents provided. If the Living Will specifies or declares the withholding of Cardiopulmonary resuscitation (CPR) or specifies that they do not want to be resuscitated, a license nurse must immediately notify the attending physician an secure a valid DNR.	F 578		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		1/27/22

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

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

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F 580	Continued From page 43 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on complaint investigation, staff interviews, facility document review, and clinical record review, the facility staff failed to notify the physician and resident's representative of missed laboratory services for 3 residents (Resident #13, Resident #17 and Resident #170), and they failed to notify one representative of a change in condition for one resident (Resident #167), a closed record resident in the survey sample of 58 residents. The findings included: 1. The facility staff failed to notify the physician and resident representative of missed blood work ordered on 11/01/21 for Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) for Resident #13. Resident #13 was originally admitted the nursing facility on 07/27/21. Diagnosis for Resident #13 included but not limited to Type II Diabetes and long term use of anticoagulants (blood thinner). The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/21 coded the resident on the Brief Interview for Mental Status (BIMS) a 03 of 15 indicating severe cognitive impairment. Resident #13 was coded total dependence of one with bathing, extensive assistance of one with transfer, dressing, hygiene, bed mobility and toilet use and supervision with setup with eating for Activities of	F 580	F580 1. The physician and resident representative for residents #13 and 17 were notified of the missed lab work. Residents #170 and 167 have discharged from the facility. 2. Current residents have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on documentation of physician and resident representative notification of missed lab work and resident change of condition. 4. The Unit Managers/designees will complete a weekly review of physician and resident representative notification of missed lab work and resident change of condition. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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Daily Living (ADL) care.

Review of Resident #13's clinical record revealed the following order dated 11/01/21: labs for CBC and BMP every Tuesday for 3 weeks.

During the review of Resident #13's clinical record on 12/08/21 did not reveal lab results for CBC and BMP for 11/02/21 or 11/16/21. On the same day, the Director of Nursing stated she was not able to locate in the clinical record lab results for the CBC or BMP for the two dates mentioned above.

A debriefing was conducted with the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. The DON was asked if the physician and the resident's representative should have been notified of the missed labs for CBC and BMP, the DON stated, "Yes."

2. The facility staff failed to notify the physician and resident representative of missed blood work ordered on 11/24/21 for Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) for Resident #17. Resident #17 was admitted the nursing facility on 09/03/21. Diagnosis for Resident #17 included but not limited to Type II Diabetes, Cardiac Arrest and Pulmonary Embolism (blood clot in the lungs).

The most recent Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 09/10/21 coded the resident on the Brief Interview for Mental Status (BIMS) a 15 of 15 indicating no cognitive

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impairment. Resident #17 was coded supervision with limited assistance of one with transfer, dressing, hygiene, bed mobility and toilet use and supervision with eating and bathing Activities of Daily Living (ADL) care.

Review of Resident #17's clinical record revealed the following order dated 11/24/21: labs for CBC with diff and BMP to be drawn on 11/26/21.

During the review of Resident #17's clinical record on 12/08/21 did not reveal lab results for CBC with diff and BMP. On the same day, the Director of Nursing stated she was not able to locate in the clinical record lab results for the CBC with diff and BMP for 11/26/21.

A debriefing was conducted with the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. The DON was asked if the physician and the resident's representative should have been notified of the missed labs for CBC with diff and BMP, the DON stated, "Yes."

Definitions:
-CBC is a blood test that measures the number and types of cells in your blood. This helps doctor's check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders (https://medlineplus.gov/bloodcounttests.html).

-BMP is a test that measures eight different substances in your blood. It provides important information about your body's chemical balance

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and metabolism. Metabolism is the process of how the body uses food and energy. A BMP includes tests for the following: Glucose, a type of sugar and your body's main source of energy (https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp).

-Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI (http://www.webmd.com/a-to-z-guides/urine-culture).

-Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-culture).

- Urinary Tract Infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney (http://www.cdc.gov/HAI/ca_uti/uti.html).

3. The facility staff failed to notify the physician and resident representative of missed lab work for UA/C&S ordered on 10/13/21 for Resident #170. Resident #170 was admitted the nursing facility on 09/03/21. Diagnosis for Resident #170 included but not limited to Hematuria (blood in the

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urine) and Urinary Tract Infection (UTI).

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 07/22/21 coded the resident on the Brief Interview for Mental Status (BIMS) a 13 of 15 indicating no cognitive impairment. Resident #170 was coded total dependence of two with dressing, total dependence of one with bathing and toilet use, supervision with one assist with hygiene with Activities of Daily Living (ADL) care. The MDS coded the resident as always incontinent of bladder and bowel.

Review of Resident #170's clinical record revealed the following order dated 10/13/21: obtain labs for UA with C&S for hematuria.

During the review of Resident #170's clinical record on 12/09/21 did not reveal lab results for UA with C&S. On the same day, the Regional Director of Clinical Services stated she was not able to locate in the clinical record lab results for the UA with C&S.

A debriefing was conducted with the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. The DON was asked if the physician and the resident's representative should have been notified of the missed UA with C&S, the DON stated, "Yes."

4. The facility staff failed to notify the Resident Representative of an open area found on Resident #167's chest. Resident #167 was originally admitted to the facility 06/15/21 and discharged on 06/26/21 to an acute care hospital.

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The current diagnoses included; Cerebral Infarction and Aphasia.

The discharge, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/26/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for short term memory problems as well as moderately impaired for daily decision making. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance with bed mobility and eating. Requires total dependence with transfers, locomotion on the unit, dressing, toilet use and personal hygiene. Requiring total care with bathing.

A review of the TAR (Treatment Authorization Record) reads: dressing changes to chest daily, clean with dermal wound cleanser apply Xeroform and cover with dry dressing every day shift for chest abrasion -Order Date 06/22/2021 5:14 PM -D/C (discontinue) Date 06/26/2021 12:04 PM. (Resident received wound care treatment as ordered).

A review of the weekly skin assessment dated 6/12/21 reveal that Resident #167's skin is intact.

A review of the weekly skin assessment dated 6/12/21 reveal that Resident #167 has an abrasion on his chest. Measuring 7.4 cm (Length) x 7.0 cm (Width). Note reads: Pt. (Patient) has open area to chest, appears to be from him rubbing on his chest with his hand. MD notified. Date acquired: 6/20/21.

A review of progress notes dated 6/20/2021 at 22:14 (10:14 PM) Reads: Open area to pt.

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(patient) chest noted, appears to be a stage 2 from pt. rubbing his hand repeatedly across his chest. Area was cleaned and dried and dressing placed over area. Note placed in communication book asking provider to assess and give treatment order. Pt. wife notified.

On 12/10/21 at approximately, 3:00 PM an interview was conducted with the DON (Director of Nursing) concerning Resident #167. She stated, "The nurse documented that she notified the family but she didn't. She said she got busy and forgot to call the RP (Responsible Party).

A copy of an Employee Corrective Action was received from the DON concerning LPN #4 dated 7/01/21. It reads: A resident was found with a wound, you charted that the family was updated. Family was in for a visit, noticed the wound and was upset that nobody had notified them. When speaking to you about the documentation you stated that you meant to update the family but did not.

On 12/14/21 at approximately 10:35 AM an interview was conducted with LPN #4 concerning Resident #167 concerning an area found on his chest. She stated, "He was anxious when he came from the hospital. I worked the 3-11 shift. He kept rubbing his hand across his chest a lot. The doctor was notified and a treatment was put in for it. It looked pink like the top layer of skin came off. I asked her to assess the area to make sure we were providing the correct treatment. I found the area. He didn't come in with it. The family was notified the following day but I didn't personally notify them. I found it late at night. I was going to notify her but it was late and I forgot to go back and change my note. I think I said that

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F 580	Continued From page 50 provider and RP were notified. But I only notified the provider by putting a note in the communication book. I should have gone back and fixed my note. On 12/14/2021 at approximately 3:10 PM, the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 580		
F 584 SS=E	COMPLAINT DEFICIENCY 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;	F 584		1/27/22

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F 584	Continued From page 51 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interviews the facility staff failed to provide reasonable care for the protection of residents' property from loss and to return laundry in a timely manner for 3 of 58 residents (Resident #50, Resident #90 and Resident #138) in the survey sample. The findings included; 1.The facility staff failed to return Residents laundry in a timely manner and protect Resident's laundry from loss. Resident #50 was originally admitted to the facility 05/14/2021 and readmitted 06/28/2021 after an acute care hospital stay. The current diagnoses included; Non-displaced Fracture and Obesity. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date	F 584	F584 1. Residents #50 and 138 are being reimbursed for lost laundry. Resident #90 has discharged from the facility pending replacement of missing laundry. 2. Current residents have the potential to be affected. 3. Nursing staff will be educated by the Director of Nursing/designee on identifying clothing prior to sending to laundry. In addition, Laundry staff will be educated by the Administrator/designee on protecting resident clothing from loss. 4. The Administrator/designee will interview 5 residents weekly who has their laundry done at the facility to ensure clothing has been returned from laundry. 5. The results of the review will be discussed at the monthly QAPI meeting.	

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F 584	Continued From page 52 (ARD) of 10/11/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #50 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring supervision of one person assistance with bed mobility, transfers and toilet use. Resident is independent with no set-up help or assistance with walking in the room or corridor. Independent with locomotion on and off the unit. Requires extensive assistance of one person with dressing. Requires independence set-up help only with eating. The care plan dated 6/02/21 reads: The resident has an ADL self-care performance deficit r/t Limited Mobility, Limited ROM, Musculoskeletal impairment, fractures. Goal: The resident will improve current level of function in ADLs through the review date. Interventions: Assist with all ADL's as needed. On 12/08/21 at approximately 11:55 AM during the initial tour an interview was conducted with Resident #50 concerning personal belongings. She stated," My laundry has been in the laundry for over two months. They say the laundry is behind and the washer stays broken. I had to go out and buy clothes because I didn't have any. I'm missing 6 pairs of sweats, 5 T- shirts and underwear. I did get a pair of sweats back yesterday (12/07/21). I gave the receipt to the administrator yesterday. My name is written in my clothes." On 12/09/21 at approximately, 12:54 PM an interview was conducted with the administrator concerning missing personal belongings for	F 584	Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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Resident #50. He stated, "I just received this receipt from her on yesterday for lost clothing. I will reimburse her $56.24."

Received an invoice from the facility administrator on 12/09/21 at 4:00 PM. It reads: Please send payment of $58.24 to Resident #50 for reimbursement of missing clothing.

2. The facility staff failed to return Residents laundry in a timely manner and protect Resident's laundry from loss. Resident #90 was originally admitted to the facility on 08/08/2016 and readmitted on 11/02/2021 after an acute care hospital stay. The resident has been discharged multiple times from the facility to the community. The current diagnoses included; Fracture of unspecified part, History of falling and an unstageable ulcer of the left heel.

The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/04/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #90 cognitive abilities for daily decision making were intact.

In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. Requires one person assist with locomotion on and off the unit and with eating. Requiring total dependence of one person with bathing.

The care plan dated 11/15/21 reads: Focus-The resident has an ADL self-care performance deficit r/t Activity Intolerance. Goals: The resident will

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improve current level of function in ADLs through the review date. Interventions: Staff to assist with ADL's (Activity of Daily Living) as needed. Provide sponge bath when a full bath or shower cannot be tolerated.

On 12/08/21 at approximately 5:36 PM an interview was conducted with Resident #90 concerning missing clothing. He stated, "I had three shirts, three pair pants washed 4 four weeks ago on a Wednesday and I haven't gotten them back. I told everybody. They said they'd call. My name was written in these clothes."

3. The facility staff failed to return Residents laundry in a timely manner and protect Resident's laundry from loss. Resident #138 was originally admitted to the facility 02/07/2021 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Chronic Pain Syndrome and Pain Unspecified.

The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #138 cognitive abilities for daily decision making were intact.

In section "G"(Physical functioning) the resident was coded as independent set-up help only with transfers, walking in the room, locomotion on and off the unit, eating and bathing. Requiring supervision after set-up help only with dressing and personal hygiene. Requiring supervision one person physical assistance with toileting.
On 12/08/21 at approximately 3:37 PM an

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interview was conducted with Resident #138 concerning missing laundry. She stated, "I'm missing pieces of laundry (Clothing). Several shirts and pants. I notified the administrator. I gave him a copy of my receipts in early November."

On 12/09/21 at approximately 4:00 PM the facility administrator presented the surveyor with a handwritten list of missing clothing that he received from the resident. The administrator also presented surveyor with an invoice dated 12/09/21 reading: Please send payment of $97.48 to Resident #138 for reimbursement of missing clothes.

On 12/13/21 at approximately 1:00 PM an interview was conducted with Laundry Aide (OSM/Other Staff Member) #3 concerning missed clothing on the above residents. She stated, "I talked to him (Resident #90). I've been looking for his clothes and nothing is back there anymore. I was down and washer and dryer and worked by myself for two weeks. Today I found a white shirt and PJ's (Pajama Bottoms) He said he didn't want us to do his laundry anymore." I pulled Resident #138's clothes, washed and dried them separately. I haven't seen any of her items." "The other attendant has her (Resident #50).

Surveyor asked to speak with the other attendant in question but was not able to speak with her.

On 12/14/2021 at approximately 3:10 PM, the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility record review, the facility staff failed to recognize, assess and intervene (to follow physician orders for obtaining daily weights and act upon the spouse's concerns regarding edema to the resident's legs) on behalf of a resident presenting with an acute change in condition for 1 of 58 residents in the survey sample (Resident #123). The findings included: Resident #123 was originally admitted to the facility 9/28/21 and readmitted 11/5/21 after an acute care hospital stay. The current diagnoses included; diabetes, heart failure, renal insufficiency and status post left great toe amputation. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/4/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #123's cognitive abilities for daily decision making were severely impaired. In	F 684	F684 1. Resident #123 is being weighed daily as ordered and are acting on the spouse□s concerns. 2. Residents with orders for daily weights and spousal concerns have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on documentation of daily weights as ordered and following physician orders for notification of weight gain. In addition, nurses will also be educated on acting upon spousal concerns. 4. The Unit Managers/designees will complete a weekly review of daily weights and follow-up of spousal concerns. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	1/27/22

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

The Physician's Order Summary (POS) revealed an order dated 11/8/21 for daily weights related to congestive heart failure every day shift related to acute diastolic congestive heart failure with a discontinue order for 12/2/21, a new weight order for 12/02/2021 which read daily weights related to congestive heart failure every day shift. The 12/2/21 order was discontinued on 12/10/21 when a new order was received for daily weights related to congestive heart failure one time a day related to acute diastolic congestive heart failure. Notify the Physician/Nurse Practitioner of a weight gain of 2 pounds in one day or 5 pounds in one week. The POS also had an order for Basic Metabolic Panel (BMP) every Monday.

The resident's diet order dated 11/5/21 read, Heart Healthy Diabetic diet, Level 7 - Regular texture, Regular Liquids consistency.

The current care plan had a problem dated 11/5/21 which read; The resident has Congestive Heart Failure. The goal read; The resident will have clear lung sounds, heart rate and rhythm within normal limits through the review date and the resident will be free of peripheral edema through the review date. The interventions included; encourage proper/ordered diet. Give cardiac medications as ordered. Monitor for edema. Oxygen at 2 liters per minute via nasal

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cannula. Vital signs as ordered. Report abnormal findings as needed. Weights as ordered.

An interview was conducted with Resident #2's spouse on 12/7/21 at approximately 2:35 p.m. The spouse stated there was concern with the meals the resident receives because of the disease processes of diabetes and heart failure. The spouse stated the resident currently had great edema to the legs and there was facial edema and she thought the resident was receiving Bumex (a diuretic) daily, was to be weighed daily and should be receiving a low carbohydrate (carb) and low salt diet because of his medical conditions.

On 12/7/21 at approximately 2:38 p.m., Resident #92 stated there was tightness of his chest and he was short of breath.

On 12/7/21 at approximately 2:45 p.m., an observation was made of the resident legs; the left was with plus 4 swelling and the right with plus 3 swelling. Both legs presented tight and shiny. Review of the oxygen concentrator revealed the resident was receiving 2 liters of oxygen at that time.

Review of the clinical record revealed the Bumex was discontinued during the resident's last hospitalization but the order for a daily weight was active. The Medication Administration Record (MAR) had an order beginning 11/9/21 for daily weights. The weight obtained ranged from 236.6 to 222.8 then to 229.1, with no documented notification to the responsible party or practitioner. From 12/1/21 through 12/9/21 no weights were documented. On 12/10/21 a weight of 199.1, was obtained and a new order was given for daily

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weight on 12/10/21. No weight was obtained on 12/11/21, the 12/12/21 weight was 228 (there was no documentation the practitioner or family was notified of the 29 pound weight gain), the 12/13/21 weight was documented as not applicable, and the 12/14/21 weight was recorded as 228.1.

All recorded weights after administration of the diuretic on 12/9/21 were greater than the pre-diuretic weight of 199.1, with no notifications documented.

On 12/9/21 at approximately 4:40 p.m., an interview was conducted with the Unit Manager (UM) for the Unit Resident #123 resided on. The above information was shared with the UM and she stated an assessment would be made of the resident's status and the practitioner would be made know if there were negative findings.

On 12/10/21 at approximately 11:40 a.m., the UM stated a significant change in condition was documented 12/9/21 on behalf of Resident #123 for the resident presented with new or worsening edema. The UM stated a one time dose of Lasix was administered 12/9/21, a venous Doppler examination to bilateral lower extremities was ordered and the resident was followed-up by the in house provider that day.

The Nurse Practitioner's documentation revealed the following; Chief Complaint/ Nature of Presenting Problem: left lower extremity swelling, congestive heart failure and shining bilateral lower extremities, the resident had chronic congestive heart failure; start Bumex 2 milligrams daily and obtain a BMP & Complete Blood Count (CBC) with differential on 12/13/21.

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F 684	Continued From page 60 On 12/14/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Corporate Consultant stated when the weights indicated a discrepancy another weight should have been obtained and the practitioner should have been notified of the edema had it been observed. No additional information was offered. Heart failure signs and symptoms may include: Shortness of breath with activity or when lying down, fatigue and weakness, swelling in the legs, ankles and feet, rapid or irregular heartbeat, swelling of the belly area (abdomen), very rapid weight gain from fluid buildup ... (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142). The above information was obtained 12/17/21.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		1/27/22

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F 686	Continued From page 61 by: Based on observations, resident interviews, staff interviews, clinical record reviews, and review of facility documents, the facility staff failed to provide necessary care and service to prevent deterioration for 1 of 58 resident's (Resident #92) who had stage IV pressure ulcer to the coccyx. The coccyx pressure ulcer on admission to the facility measured length 9.96 centimeters by width 3.89 centimeters by depth 0.30 centimeters and on 12/2/21 the coccyx pressure ulcer measured 16.00 centimeters by 7.66 centimeters by 2.0 centimeters with a tunneling at six o'clock measuring 5.50 centimeters, and it presented malodorous with heavy drainage which constituted harm. For 2 of 11 residents with facility acquired pressure ulcers in a survey sample of 58 residents, the facility staff failed to initially identify them prior to an advanced stage. Resident #65's right lateral ankle pressure ulcer was initially identified by the facility staff as a stage III with 40% granulation tissue and 60% slough/eschar. For Resident #90, the facility staff initially identified a left heel pressure ulcer as unstageable on 12/7/21, which constituted harm. The findings included: 1. Resident #92 was originally admitted to the facility 11/1/21 after an acute care hospital stay and has never been discharged from the facility. The current diagnoses included; neurofibromatosis, neurosarcoidosis, diabetes and a neurogenic bladder with a right urethral stone. The admission Minimum Data Set (MDS)	F 686	F686 1. Resident #65 has developed no new wounds. Residents #90 and 92 have discharged from the facility. 2. Current residents and residents with wounds have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on completion of weekly skin evaluation, identification of pressure ulcers, prevention and treatment of pressure ulcers, and documentation of pressure ulcers. In addition, CNAs will be educated on completion of a clinical alert to notify nursing of concerns about the resident□s skin. 4. The Unit Managers/designees will complete a weekly review of weekly skin evaluations and pressure ulcer identification, prevention, and treatment. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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assessment with an assessment reference date (ARD) of 11/7/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #92's cognitive abilities for daily decision making were intact.

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

On 12/7/21 at approximately 3:45 p.m., an interview was conducted with Resident #92. The resident stated the wound care Nurse Practitioner (NP) was disappointed with the condition of the coccyx pressure ulcer because it showed significant deterioration during the 12/2/21 assessment but it was worse on 12/7/21, even with the ordered change in the treatment on 12/2/21. The resident also stated the wound care NP instructed him on 12/2/21 to ensure the staff repositioned him frequently and provided incontinence care timely to prevent further wound deterioration. The resident further stated the suprapubic catheter eliminated most moisture but as a result of anal cancer he was unaware of when or if he had a bowel movement. The resident also stated he is able to assist the staff when he is positioned and can hold on to the bed rail while care is rendered.

Review of the Braden Scale for Predicting Pressure Sore Risk revealed the resident had a potential for pressure ulcer development

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secondary to sensory loss, for he was unable to feel pain or discomfort in 1 to 2 extremities, chairfastness; for his ability to walk was severely limited or non-existent, unable to bear weight and/or must be assisted into a chair or wheelchair, limitations in mobility; makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently and friction and shear; requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. The resident score 15 on the Braden Predictor which classified him as At Risk. A moderate risk was 13-14, high risk 10-21 and a very high risk was 9 or below.

Review of Resident #92's current care plan dated 11/16/21 read; the resident has pressure ulcers (Coccyx, heels) or potential for pressure ulcer development related to decreased functional mobility. The goal read; the resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date. The interventions included; monitor nutritional status. Provide supplements as ordered, monitor intake and record and position resident as needed.

The clinical record revealed Resident #92 had no weekly skin assessments or wound care evaluation between 11/9/21 and 11/24/21, recommendation offered by the wound care NP were not instituted from 11/4/21 through 12/2/21 and there was no evidence the the facility staff informed the NP of the not carrying out the recommendation, and wound care treatments were not documented as completed on the Treatment Administration Record for the following

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days; 11/2/21, 11/3/21, 11/21/21, 11/23/21, 12/3/21 and 12/8/21 and a Certified Nursing Assistant was given the responsibility to round with the wound care NP and write verbal orders to be transcribed into nurse documentation and recommendations for orders to treat wounds. The wound care NP Wound Tissue Analytics document of the coccyx pressure ulcer recommended a Specialty bed, ensure compliance with turning and elevate the legs regularly.

Observations were make of the Resident #92 in bed 12/7/21 at approximately 3:45 p.m., 12/8/21 at approximately 11:55 a.m., 12/9/21 at approximately 1:35 p.m., 12/10/21 at approximately 2:40 p.m. and 12/13/21 at approximately 5:15 p.m. During each of the observations the resident's legs were not elevated as recommended.

Review of the Clinical Record revealed the following documentation:
The nurse's weekly skin evaluation dated 11/1/21 listed a stage IV sacral pressure ulcer present on admission to the facility without measurements or description.

A Wound Tissue Analytics document dated 11/2/21, which stated Resident #92 was admitted to the facility with a stage IV coccyx pressure ulcer measuring length 9.96 centimeters by width 3.89 centimeters by depth 0.30 centimeters and presented with 20 percent granulation tissue and 80 percent eschar, no odor and moderate serosanguious drainage. The treatment was cleanse with normal saline and Medihoney and silicone dressing. Specialty bed, ensure compliance with turning and elevate the legs

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regularly.

The weekly skin evaluation dated 11/8/21 listed the coccyx pressure ulcer and referred the reader to the wound care NP notes. There wasn't a wound care NP note until 11/9/21.

A Wound Tissue Analytics document dated 11/9/21, revealed the coccyx pressure ulcer had stalled. It measured 7.51 centimeters by 9.43 centimeters by depth 0.20 centimeters and presented with 50% granulation tissue and 50% eschar, no odor and moderate serosanguious drainage. The treatment was cleanse with Dakins and Dakins moist to dry and silicone dressing. Specialty bed, ensure compliance with turning and elevate the legs regularly.

There was no further weekly skin evaluations between 11/8/21 and 11/19/21.

There was no weekly wound assessments between 11/9/21 and 11/24/21.

The weekly skin evaluation dated 11/19/21 listed the coccyx pressure ulcer and referred the reader to the wound care NP notes. There wasn't a new wound care NP note until 11/24/21.

A Wound Tissue Analytics document dated 11/24/21, revealed the coccyx pressure ulcer was worsening. It measured 15.23 centimeters by 7.79 centimeters by depth 0.30 centimeters and presented with 30% granulation tissue and 70% eschar, no odor and moderate serosanguious drainage. The treatment remained cleanse with Dakins and Dakins moist to dry and a silicone dressing. Specialty bed, ensure compliance with turning and elevate the legs regularly.

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The weekly skin evaluation dated 11/27/21, listed the coccyx pressure ulcer and referred the reader to the wound care NP notes.

A Wound Tissue Analytics document dated 12/2/21, revealed the coccyx pressure ulcer was worsening. It measured 16.00 centimeters by 7.66 centimeters by depth 2.00 centimeters, and a tunneling at six o'clock measuring 5.50 centimeters and the coccyx pressure ulcer presented with 30% granulation tissue and 70% eschar, malodorous, and with heavy serosanguious drainage. The treatment remained cleanse with Dakins and Santyl and a super- absorbent dressing. Specialty bed, ensure compliance with turning and elevate the legs regularly.

A Wound assessment dated 12/8/21, revealed the coccyx pressure ulcer was worsening. It measured 16.16 centimeters by 7.71 centimeters by depth 2.00 centimeters, and a tunneling at six o'clock measuring 5.50 centimeters and the coccyx pressure ulcer presented with 10% granulation tissue and 90% eschar, malodorous, and with heavy purulent drainage. The treatment remained cleanse with Dakins and Santyl and a super-absorbent dressing.

An amended note written by the wound care NP dated 12/8/21 read; discussed possible debridement of the sacral wound as well as needing to send the resident out to have surgical debridement done. This was tried by me (NP) on Tuesday but the eschar was too adherent to the wound bed. Will look at attempting debridement when rounding on 12/14/21 if the eschar is loosen enough by the Santyl.

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The next weekly skin evaluation was dated 12/12/21, and listed the coccyx pressure ulcer and referred the reader to the wound care NP notes.

Review of the Treatment Administration Record revealed the following orders for the coccyx pressure ulcer:
11/1/21 - 11/2/21;cleanse sacral area with dermal wound cleanser, pat dry. Apply hydrogel and cover with a dry dressing daily and as needed if soiled, every day shift. This order was discontinued 11/2/21.

11/2/21 - 11/3/21; there were no treatment orders for the coccyx or sacral pressure ulcer.

11/4/21 - 11/24/21; cleanse coccyx with dermal wound cleanser, apply honey fiber and cover with a silicone dressing daily, every day shift. This order was discontinued 11/24/21. The wound care NP recommendations dated 11/9/21 read; cleanse the coccyx with Dakin's and use of Dakin's moist-to-dry dressings was never instituted.

11/24/21 - 12/2/21; cleanse coccyx with dermal wound cleanser, apply honey fiber and cover with a silicone dressing every two days, day shift. This order was discontinued 12/2/21. The wound care NP recommendations dated 11/24/21 read; cleanse the coccyx with Dakin's and use of Dakin's moist-to-dry dressings was never instituted.

12/2/21- 12/10/21; cleanse the coccyx with Dakin's solution, apply Santyl ointment, cover with a super-absorbent dressing every day shift. This

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order was discontinued 12/10/21.

12/10/21 - current ; cleanse the coccyx with dermal wound cleanser, pack with Dakin's soaked gauze, cover with an ABD pad and secure with tape.

On 12/10/21 at approximately 2:40 p.m., an observation was made of Resident #92's coccyx pressure ulcer during wound care performed by Licensed Practical Nurse (LPN) #14 assisted by LPN #15. LPN #14 removed a old dressing fully saturated with dark green foul smelling drainage. The odor was so overwhelming it permeated the room and hallway outside the door. The coccyx wound presented as a butterfly shape covering greater than 50% of both sides of the coccyx. The tissue was totally black and green and leathery with a red outline of the entire wound. Above the coccyx are was a deep tunneling area with a flap of skin in the very center and a large amount of dark green drainage flowed from it. LPN #14 cleaned the dark leathery portion of the wound with Dakin's solution, applied Santyl ointment and two thick foam dressing which covered the leathery portion of the wound but barely the tunneled area. The tunneled area wasn't cleaned, neither was Santyl or other treatment applied inside the tunneled wound.

After wound care on 12/10/21 at approximately 2:55 p.m., an interview was conducted with LPN #14. LPN #14 stated this was the first time she had provided the coccyx wound care for Resident #92 therefore; she was unable to provide any information on the wound's prior state. LPN #14 stated she didn't see the tunneling area above the dark leathery tissue and she didn't think about where the large amount of

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drainage had come from. LPN #14 did acknowledge the foul odor of the wound.

An interview was also conducted with LPN #15 on 12/10/21 at approximately 3:00 p.m. LPN #15 stated she was the fulltime day shift nurse for Resident #92 and she completed the coccyx wound care regularly. LPN #15 stated the wound presented with more drainage than she had seen before and she stated the odor was more offensive. LPN #15 stated she wasn't aware of the tunneling area above the dark leathery tissue and she had never performed a treatment to the tunneling area.

An interview was also conducted with the Unit Manager on 12/10/21 at approximately 3:05 p.m. The Unit Manager stated she had been working in the position for five days and she had not had the opportunity to observed Resident #92's coccyx pressure ulcer or read information provided by the wound care NP but she would notify the NP of the state of the coccyx pressure ulcer. The Unit Manager also stated LPN #6 had previously provided oversight to the unit and she may have some additional information regarding Resident #92's coccyx pressure ulcer.

An interview was conducted with LPN #6 on 12/10/21 at approximately 3:25 p.m. LPN #6 stated sometimes she assisted the wound care NP with rounds and other times other nurses or a Certified Nursing Assistant (CNA) rounded with the NP. LPN #6 stated during the rounds the NP gives verbal orders and they are written down and passed on to the nurses on the unit for documentation purposes and even when the CNA rounded with the NP that was the procedure and they simple destroy the notes after they are

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recorded the information in the clinical record. LPN #6 also stated most of the time when treatment orders are changed it can take up to two days to get the newly ordered products in the facility to begin use.

On 12/13/21 at approximately 12:15 p.m., an interview was conducted with CNA #4. CNA #4 stated she worked frequently with Resident #92 and the resident always had a good attitude, was compliant with care, remained positioned when positioned although he favored the sitting position because he enjoyed watching sports on television and using his phone. CNA #4 stated the resident was incontinent of bowels and required staff to provide incontinence care for bowel movements.

On 12/13/21 at approximately 12:20 p.m., an interview was conducted with CNA #5. CNA #5 stated she had worked a few times with Resident #92 while orientating to the position. She stated she had assisted to provide care for the resident that morning and found him to be very pleasant, and attempted to assisted with his care as much as he was capable.

On 12/14/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

*Dakin solution is a strong topical antiseptic widely used to clean infected wounds, ulcers, and burns.[6] Full strength Dakin's solution is usually diluted in water, depending on its intended use. A 0.5% solution of hypochlorite (containing approximately 5000 ppm free chlorine) is used for

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disinfecting areas contaminated with bodily fluids, including large blood spills (after the area has been cleaned with a detergent). Dilute Dakin's solution (0.05% to 0.025%) can be used to irrigate, cleanse, or as a component in wet-to-dry dressings to treat or prevent skin and soft tissue infections (https://www.ncbi.nlm.nih.gov/books/NBK507916/) This information was obtained 12/17/21.

The information below was obtained on 12/17/21 from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/pressure_ulcer_prevention/webinars/webinar6_pu_woundassesst.pdf

*Eschar. Cornified or dried out dead tissue.

*Tunneling. Tracts extending out from the wound.

*A Stage IV Pressure Ulcer: Definition o Full thickness tissue loss with exposed bone, tendon, or muscle - Slough or eschar may be present.
o Often include undermining and tunneling Description o The depth of a stage IV pressure ulcer varies by anatomical location. - The bridge of the nose, ear, occiput, and malleolus do not have "adipose" subcutaneous tissue and stage IV ulcers can be shallow.
o Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule), making osteomyelitis or osteitis likely to occur.
o Exposed bone/tendon is visible or directly palpable.

*An Unstageable Pressure ulcer: Definition o Full thickness tissue loss in which actual depth of the

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ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.
Description o Until enough slough and/or eschar is removed to expose the base of the wound, the true depth cannot be determined but it will be either a Stage III or IV.
o Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.
2. The facility staff failed to identify Resident #65's right lateral ankle pressure ulcer prior to it being found at an advanced stage resulting in harm. The pressure injury was found as a stage III with 40% granulation tissue and 60% slough/eschar.

Resident #65 was originally admitted to the facility on 06/23/21. Diagnosis for Resident #65 included but are not limited to Quadriplegia (paralysis of all four limbs), morbid (severe) obesity, Cerebral Infarction (stroke). Resident #65's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date of 10/22/21 coded Resident #65 a 06 out of a possible score of 15 indicating severe cognitive impairment.

The MDS coded Resident #65 requiring total dependence of two with bathing, bed mobility, toilet use, hygiene and dressing, extensive assistance of one with transfer and eating for Activities of Daily Living care. Under section G0400 - Functional Limitation in Range of Motion (ROM) coded Resident #65 with impairment on both sides to her upper and lower extremity. Resident #65 was coded as having no mood, rejection of care or behavioral problems.

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The MDS with an ARD of 10/22/21 under section "M" (Skin Condition - M0100) was coded for the using a Formal Assessment Instrument/tool (e.g., Braden, Norton or other) for the determination of Pressure Ulcer Risk. Under section (M0150) for Risk of Pressure Ulcers coded Resident #65 at risk for developing pressure ulcers and under section (M1200) for skin and treatments was coded for having pressure reducing device bed, turning/repositioning program and pressure ulcer care.

Resident #65's care plan with a created date of 06/23/21 identified the resident with the potential for skin impairment and actual skin impairment to the left heel, left outer ankle, right lateral foot and left buttocks. The goal set for the resident by the staff was that the resident will have no evidence of skin impairment through next review date. Some of the interventions/approaches the staff would use to accomplish this goal is to keep skin clean and dry, lotion dry skin, moisture barrier cream as needed for protection of skin and weekly skin assessment.

Resident #65's care plan with a revision date of 11/16/21 identified the resident with another pressure ulcer located to the right outer ankle. Some of the interventions/approaches the staff would use to accomplish this goal is for Healing Partners to provide skin/wound care as needed, turn and reposition, wedge foam, air loss mattress and wound care as ordered.

A Braden Risk Assessment Report was completed on 10/20/21; resident scored a 10 indicating high risk for the development of pressure ulcers. Sensory perception is the ability

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to respond meaningfully to pressure-related discomfort. Resident #65 is very limited with sensory perception and only responds to painful stimuli and cannot communicate discomfort except by moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. Activity (degree of physical activity) is chair fast, Mobility is completely immobile (does not make even slight changes in body or extremity position without assistance) and Friction & Shear with a problem requiring moderate to maximum assistance in moving, frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.

Review of Resident #65's bi-weekly skin assessments were reviewed from 06/23/21 through 11/02/21 with no skin issues to the right lateral ankle until identified at an advance stage (stage III) by the Wound Specialist (NP) on 11/02/21.

The Wound Care Specialist/Nurse Practitioner documented the following on a Tissue Analytics Form:
-11/02/21 at 9:11 a.m., a new Stage III pressure ulcer was identified to right lateral ankle measuring 1.75 cm x 2.03 cm with 40% granulation tissue and 60% slough/eschar (dead) tissue with a moderate amount of serosanquinous drainage with unattached edges. The stage III pressure ulcer was documented as facility acquired. A treatment started to apply Honey Fiber to wound bed and wrap with kling/kerlix daily.

-11/11/21 -stage III pressure ulcer to right lateral

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ankle measuring 1.91 cm x 1.94 cm with 10% granulation tissue and 90% slough/eschar with scant amount of serosanquinous drainage. Wound status documented as improving. A new treatment was started for Betadine three times daily, wrap with kling/kerlix.

- 11/23/21 - Stage III pressure ulcer to right lateral ankle measuring 3.29 cm x 3.33 cm with 100% slough/eschar with scant amount of serosanquinous drainage with attached edges. Wound status documented as stable. Recommendation: offloading heels wearing foot protectors and frequently positioning. Ensure compliance with turning protocol, elevate legs regularly, wedge/foam cushion for offloading and specialty bed. Offloading heels by wearing foot protectors and frequent positioning. Dressing is Betadine with Kling/Kerlix.

-11/30/21 - Stage III pressure ulcer to right lateral ankle measuring 3.05 cm x 2.65 cm with 40% granulation and 60% slough/eschar with moderate amount of serosanquinous drainage and bleeding also present from wound bed with unattached edges. Wound status documented as worsening. Recommendation: offloading heels wearing foot protectors and frequently positioning. Ensure compliance with turning protocol, elevate legs regularly, wedge/foam cushion for offloading and specialty bed. Treatment changed to Honey fiber - apply to wound bed daily and wrap with kling/kerlix.

-12/14/21 - Stage III pressure ulcer to right lateral ankle measuring 3.68 cm x 2.88 cm with moderate amount of sersanquinous drainage and bleeding also present from wound bed with unattached edges. Wound status documented as

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worsening but without odor. Recommendation: offloading heels wearing foot protectors and frequently positioning. Ensure compliance with turning protocol, elevate legs regularly, wedge/foam cushion for offloading and specialty bed. Treatment changed to Collagen Ag daily.

The current treatment as of 12/09/21 is to cleanse right lateral ankle with normal saline, pat dry, apply medihoney, cover with gauze and wrap with kerlix.

On 12/09/21 at approximately 12:20 p.m., wound care observation was conducted with License Practical Nurse (LPN) #1. Resident #65 was lying in bed, positioned on her right side lying on an alternating low air loss pressure mattress. LPN #1 perform wound care with the assistance of another nurse. Prior to starting wound care to the Resident #65, LPN #1 washed her hands x 31 seconds, used hand sanitizer and donned a new pair of gloves. The LPN removed the dressing from the resident's right lateral ankle wound with a large amount of sersanquinous drainage present on dressing removed. The right lateral ankle wound bed noted with red granulation and yellow tissue present; no odor present. LPN #1 removed her gloves, applied hand sanitizer then applied a new pair of gloves. The wound was cleansed with normal saline in a circular motion x 2, gloves removed, hand sanitizer applied, new gloves applied, Manuk-ahd honey coated dressing applied to wound bed, covered with gauze and wrapped with kling.

A phone interview was conducted with the Wound Specialist/Nurse Practitioner (NP) on 12/10/21 at approximately 1:16 p.m. When asked if the staff had informed her prior to performing wound care

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to Resident #65 on 11/02/21 that the resident had a stage III to her right lateral ankle, she replied, "No." The NP stated, "While providing routine wound care with the assistance of a nurse on 11/02/21, I observed a new stage III pressure ulcer to the right lateral ankle." The NP said the wound had been there then for a while due to the fact that the wound bed had some granulation tissue present as well as slough and eschar.

Review of Resident #65's clinical record revealed a weekly skin evaluation entered by LPN #1 on 11/02/21 at approximately 3:03 p.m. The document included the following: wound to right outer ankle.

An interview was conducted with LPN #1 on 12/13/21 at approximately 10:14 a.m. When asked if she identified the pressure ulcer on Resident #65 on 11/02/21, she replied, "It was found on 11/02/21 by the NP." She said the NP need assistance with positioning Resident #65 and while positioning the resident, the NP found the pressure ulcer to the resident's right outer ankle. LPN stated, "I do the resident's wounds often and to be perfectly honest, I never say the wound the right outer ankle until it was identified by the NP on 11/02/21."

A debriefing was conducted with the Administrator, Director of Nursing and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. When asked, "At what stage do you expect for the nurses to first identify a pressure ulcer" she replied, "They should be found when there is a difference in the color of their skin; at a stage I."

Definitions

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*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 (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

* Stage 3 Pressure Injury: Full-thickness skin loss - Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages).

*Low air loss mattress is an alternating pressure mattress systems are designed to heal and prevent bedsores (http://www.medicalairmattress.com/deluxe.html).

*MANUK-Ahd is a honey impregnated super absorbent gelling fiber dressing that maintains a balanced moist environment conducive to wound healing. Dressing properties cause honey to gel with wound fluid and allows for easy removal. Benefits from using Manuk-ahd honey gel include

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the following: easily conforms to any wound type, gels with exudate, high strength and integrity, super absorbent for moderate to heavy exuding wounds, high sugar levels in the honey results in osmotic pressure, promoting autolytic debridement
and wound odor reduction
(https://www.woundsource.com/product/manukahd-lite).

3.The facility staff failed to ensure the necessary treatment, care and services were provided to prevent development of a pressure ulcer that was initially identified at an advanced stage, resulting in harm. Resident #90 was originally admitted to the facility on 08/08/2016 and readmitted on 11/02/2021 after an acute care hospital stay. The resident has been discharged multiple times from the facility to the community.

The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/04/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #90 cognitive abilities for daily decision making were intact.

In section"G"(Physical functioning) of the admission MDS, the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. Requires one person assist with locomotion on and off the unit and with eating. Requiring total dependence of one person with bathing.

The admission MDS in section "M" (Skin Conditions) M0100 Determination of Pressure

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Ulcer/Injury Risk: Section A reads: Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. =Yes. Section B reads: Formal assessment instrument/tool (e.g., Braden, Norton, or other) = Yes. Section C reads: Clinical assessment= Yes. M0150 Risk of Pressure Ulcers/Injuries. Is this resident at risk of developing pressure ulcers/injuries? =Yes. M0210. Unhealed Pressure Ulcers/Injuries. Does this resident have one or more unhealed pressure ulcers/injuries stage 1 or higher? = Yes.
M0300 (Current number of unhealed pressure ulcers at each stage.
G. unstageable deep tissue: Suspected deep tissue injury. Number of unstageable pressure ulcers suspected with deep tissue injury: 1.
Number of unstageables present on admission: 1
M01030-Number of venous and arterial ulcers: 1
M1040-Other ulcers, wounds and skin problems: None
M1200-Skin and Ulcer Treatments: Pressure reducing device for chair, Pressure reducing device for bed, Pressure ulcer care and application of dressings to feet.
The MDS above only list Skin problems before the new unstageable ulcer on the left heel was identified.

Braden Scale for Predicting Pressure Ulcers dated 11/02/16. Score is 16.
SCORING: AT RISK 15-18. MODERATE RISK 13-14. HIGH RISK 10-12. VERY HIGH RISK 9 or below.

The care plan dated 11/15/21 reads: Focus-The resident has an ADL self-care performance deficit r/t Activity Intolerance. Goals: The resident will improve current level of function in ADLs through

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the review date. Interventions: Staff to assist with ADL's (Activity of Daily Living) as needed. Provide sponge bath when a full bath or shower cannot be tolerated. A review of the MDS and Care Plan reveal no refusals for bed baths or bathing

The Self Care assessment dated on 11/03/21 indicated that the Resident was dependent on staff to put on and take off footwear. The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

The care plan dated 11/15/21 reads:
Focus-Actual skin impairment r/t limited mobility, muscle weakness, and DM (Diabetes Mellitus) II, admitted with surgical incision to Right hip with staples, skin tears to Right lower leg, and Right Forearm, and skin breakdown to Right lateral ankle and Right buttock. Goals: Resident will have no evidence of skin impairment through next review. Keep skin clean and dry. Lotion to dry skin. Moisture barrier cream as needed for protection of skin. Pericare with incontinence episodes. Pressure reduction mattress. Treatments to all areas as ordered. Notify MD as needed. Weekly Skin Assessment.

A review of the ADL (Activity of Daily Living) sheet note dated 12/13/21 reads: Resident prefers bed baths and is scheduled for baths/showers on Tuesday, Thursday and Saturday. The ADL sheets indicated that he took bed baths. There was no documentation to indicate that feet and legs were excluded during from bathing during bed baths. On 12/06-12/07/21, the resident took a bed bath and, according to facility documentation there was no indication of staff identifying a new unstageable ulcer to Resident's left ankle.

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A review of the CNA skin observations dated 12/04/21-12/07/21 was checked off showing none of the above were observed (scratches,red areas, discolorations and open areas) no check marks were placed.

The Admissions Summary Note dated 11/02/21 at 16:42 (4:42 PM) reads: The Resident arrived from Hospital. The reason for the admission per the resident/POA (Power of Attorney) is UTI (Urinary Tract Infection)/ Dehydration.

The Admissions note dated 11/2/2021 at 23:14 (3:14 AM) reads:
Patient has a pressure area to sacrum. Open area also noted to Right outer ankle. Patient denies pain to either area. Patient able to make needs known. Chief Complaint: Comprehensive skin and wound evaluation for readmission to facility for DTI (Deep Tissue Injury) to sacrum, arterial ulcer to right lateral ankle. Patient has edema of bilateral lower extremities. There was no documentation about a left heel ulcer.

A review of the Skin/Wound assessment note dated on 12/07/21 reveal that Resident #90 has a new unstageable ulcer to the left heel identified during the Comprehensive skin and wound evaluation by OSM (Other Staff Member)/Wound Care Nurse Practitioner #9. Wound plan of care reads: Recommend elevating patient's feet every couple hours and wearing compression stockings to decrease edema . Recommend frequent position changes to decrease pressure on sacrum. With a new unstageable found on left heel recommend patient not use his foot to propel himself around in his wheelchair as it is putting too much pressure on his foot.

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The POS (Physicians Order Summary) reads: Left Heel: Cleanse with NACL (Normal Saline) apply honey fiber and wrap with Kerlix every day shift Order date: 12/07/2021 Start date: 12/08/2021.

A review of the TAR (Treatment Administration Record) show that Resident #90 received his wound care treatments to his left heel once identified.

A review of progress note dated 12/9/2021 at 10:43 AM., reveal that wife was notified and asked about bringing resident in more clothing and slippers to help relieve pressure off heel when in w/c (wheel chair). Also confirmed that she updated about new wound to heel with her stating she was aware. Family member stated that she will bring him clothes and slippers as soon as she can because she has been sick herself.

A review of progress notes dated 12/09/21 at 11:25 AM., reads: Spoke with Resident about using footrests on his WC (Wheel Chair) to aid in healing of his foot wounds and prevent further wounds. Therapy Director has educated him on avoiding crossing of his legs when he is sitting. He agreed that he will utilize the footrests and will allow staff to place pillows under his legs to elevate his feet when in bed. Advised to eat well and drink well and he stated that he does both.

A review of progress notes dated 12/13/21 at 4:52 PM reads:
Pt is suggested to float his heels while in bed which he did for 3 hours and requested me to take off pillows because he was uncomfortable. I

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did remove the pillows. Pt is in the bed now and call button with in reach.

Weekly Skin Evaluation:
11/09/21 with a lock date of 11/14/21. Did not identify an unstageable wound to left ankle.
11/19/21 with a lock date of 11/19/21. Did not identify an unstageable wound to left ankle.
11/29/21 with a lock date of 11/29/21. Did not identify an unstageable wound to left ankle.
12/06/21 with a lock date of 12/13/21-left heel pressure unstageable (no notation in nurse's note that physician was made aware of this new area on 12/6/21).
12/13/21 (Weekly skin evaluation) with a lock date of 12/13/21 read: Left Heel Pressure Ulcer.

On 12/08/21 at 5:40 PM during the initial visit buy this surveyor, Resident #90 was observed sitting in his wheel chair. No footrest were attached. Resident voiced that he prefers bed baths over showers.

An interview was conducted on 12/09/21 at approximately 5:10 PM with LPN (Licensed Practical Nurse) #6 concerning Resident #90. She stated, "The area on Resident #90's left heel is due to him digging his heels on the floor while propelling in the wheel chair. The area is blackened and swollen. We're floating his heels, providing foot pedals to his wheel chair and encouraging resident to wheel with his hands. We've asked his wife to bring in slippers."

On 12/09/21 at approximately 8:40 PM., an interview was conducted with OSM (Other Staff Member/Wound Care Nurse Practitioner) #9 over the telephone concerning the new unstageable ulcer found on Resident #90's left ankle. She

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stated, "I went to do my wound assessment on resident (12/7/21), I just happen to look at the right ankle when he told me 'my heel (Left Heel) hurts', that's when I saw it. It is currently unstageable with loose skin and black Skin. He has an arterial wound on his right ankle hard to heal. I recommend something on wheel chair so he won't propel himself around. I talked to him on Tuesday (12/07/21) about not putting pressure on his heel." The Wound Care Nurse Practicioner stated she was not made aware of the left heel by the nursing staff prior to her assessment.

On 12/10/21 at approximately 9:15 AM, wound care observation was made with LPN (Licensed Practical Nurse) #7. The newly unstageable area on the left heel appeared to be blackened with eschar, large serosanguous drainage was noted. no odor was present. Resident tolerated wound care without difficulty. Wound care was conducted per wound care orders.

On 12/10/21 at approximately 1:15 PM an interview was conducted with PA/OSM #4 (Physician Associates) concerning Resident #90 concerning his newly found unstageable on his left ankle. She stated, "I was told through the nursing staff that he will walk in the wheel chair with heel toe push. OSM #9 had observed him on his heel. He need to keep his feet elevated. Normally the CNA's (Certified Nurses Assistants) will dress the patients."

On 12/10/21 at approximately 1:30 PM an interview was conducted with CNA #3. She stated, "I've worked with him twice. He was already dressed and bathed this morning. Normally when he's in bed he keeps his feet propped up. Whenever we see a new area we let

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F 686	Continued From page 86 the nurse know and we chart it in the kiosk. The nurses and CNA's do skin assessments together. After the shower we chart if there are any open areas. It's been a couple of weeks ago since I took care of him. Showers are given twice a week. Bed baths are given everyday." The facility's policy, "Pressure Ulcer Monitoring and Documentation" Dated: 11/01/2019. Reads: All Pressure Ulcers will be monitored. Procedure: 1. A licensed nurse will assess patients for the presence of pressure ulcers/injuries; if a pressure ulcer/injury is present, the nurse will evaluate for complications. 2. Provide pain management prior to pressure ulcer/injury treatment as indicated. 3.The Skin Wound Evaluation will be completed weekly by a licensed nurse for any patient with pressure ulcers/injuries. 4. There will be a Wound Evaluation for each site. On 12/14/2021 at approximately 3:10 PM, the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 686		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		1/27/22

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F 690	Continued From page 87 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility's documentation, the facility staff failed to provide the necessary care and services to 1 of 58 residents (Resident #170) for the prevention and complication of a Urinary Tract Infection (UTI) and sepsis. The facility staff failed to notify the physician or Physician Assistant (PA) when orders were given for a UA with C&S, and that they were never obtained, over five days. The resident became unresponsive, with oxygen saturation levels of 83% (normal=95-100%), and was transferred via 911 (emergent) to the local	F 690	F690 1. Resident #170 discharged from the facility. 2. Residents with orders for UA C&S have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on obtaining UA C&S, physician notification of results, and physician notification if the UA C&S cannot be obtained in a timely manner. In addition, nurses will be educated to enter	

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F 690	Continued From page 88 hospital and admitted on 10/17/21 with a diagnosis of severe sepsis, hypothermia at 88 degrees, complicated UTI and Acute Kidney Injury (AKI); which constitutes harm. The findings included: Resident #170 was originally admitted the nursing facility on 12/13/17. The resident was discharged to the local hospital on 10/17/21 and did not return to the nursing facility. Diagnoses for Resident #170 included but not limited to Hematuria (blood in the urine) and Urinary Tract Infection (UTI). The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 07/22/21 coded the resident on the Brief Interview for Mental Status (BIMS) a 13 of 15 indicating no cognitive impairment. Resident #170 was coded total dependence of two with dressing, total dependence of one with bathing and toilet use, extensive assistance of two with bed mobility and supervision with one assist with hygiene for Activities of Daily Living (ADL). Under section H - (Bladder and Bowel) was coded for always incontinent of bladder and bowel. The care plan with a created date on 05/11/18 and a revision date of 10/17/21 identified Resident #170 at risk for UTI related to has history of UTI's. The goal set for the resident by the staff was that the resident's UTI will resolve without complications by the review date. One of the interventions/approaches the staff would use to accomplish this goal is monitor/document/report to MD as needed for signs and symptoms of UTI: frequency urgency,	F 690	the UA C&S order into the electronic medical record without a stop date to ensure that the order is visible until obtained and discontinued. 4. Unit Managers/designees will complete a weekly review of ordered UA C&S to ensure that the specimen was obtained, the physician notified of the results, or the physician notified if the UA C&S could not be obtained as ordered. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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malaise, foul smelling urine, dysuria, fever, nausea and vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status and behavioral changes.

On 10/11/21, Physician Assistant (PA) progress revealed the following information: "Resident #170 is being seen today possible UTI symptoms per nursing staff. Per nursing, there are concerns that the resident may have a UTI and states his catheter was recently removed by urology. Resident was recently sent to the Emergency Room (ER) for hematuria and treated for UTI." Under general information revealed the following: incontinent of bowel and bladder, penile discharge present and with no visible hematuria in his brief. The PA wrote to obtain UA with C&S if symptoms develop.

On 10/13/21, PA progress note dated 10/13/21 revealed the following information: "Resident #170 is being seen today for evaluation of hematuria and confusion per nursing staff. Resident has a significant history of recurring UTI's and recently had catheter removed per urology order." Under general information revealed the following: report hematuria with confusion; change from baseline. The PA wrote an order for UA with C&S and to continue monitoring and supportive care.

During the review of Resident #170's clinical record did not reveal lab results for UA with C&S after being ordered on 10/13/21.

On 12/09/21 at approximately 5:29 p.m., an interview was conducted with the Regional Director of Clinical Services. The Regional Director said if the nurse was not able to obtain

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the urine specimen as ordered by the physician, PA or Nurse Practitioner (NP) then the nurse should have communicated to oncoming shift that Resident #170 still needed to have urine obtain for a UA with C&S. She said if the nurses were still not able to obtain the urine then the physician, PA or NP should have been notified and to possibly get an order for a straight Cath to obtain the urine sample. She said the nurse's should have been monitoring the resident for s/s of UTI and a change in condition and to notify the physician, NP or PA right away if such symptoms occurred and to document in the information in the resident's clinical record.

On 12/09/21 at approximately 5:40 p.m., an interview was conducted with the Medical Director. He said if the nurses were not able to obtain the labs as ordered for UA with C&S, myself the NP or PA should have been notified. The Medical Director was informed by the surveyor that the resident was having signs of UTI to include confusion and hematuria. He stated, "If the resident was having signs of UTI and the staff were not able to obtain the labs as ordered, an order would have been given to straight Cath to obtain the urine specimen. He said the resident could have been treated prophylactically with antibiotics until the C&S was received.

License Practical Nurse (LPN) #9 documented in the resident's nurses note on 10/13/21 at approximately 3:13 p.m., that the resident was informed several times during the shift a urine sample has been ordered. The resident replied several times "I don't have to go yet. The urine sample was not collected on the 7-3 shift." The nurses note did not indicate the NP/PA or

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physician were made aware the UA with C&S was not obtained as ordered.

An interview was conducted with the LPN #9 on 12/10/21 at approximately 11:17 a.m. The LPN stated, "The 11-7 shift reported off to me that Resident #170 need a UA with C&S. The nurse said she was not able to obtain the urine specimen so it was passed on the oncoming nurse for the 3-11 shift on 10/13/21."

On 12/10/21 at approximately 11:25 a.m., a phone interview was conducted with LPN #10. The LPN was assigned to provide care and services to Resident #170 on 10/13/21 (3-11 shift). The LPN stated, "I don't recall ever being told in report that Resident #170 need a urine sample but I know for sure, "I did not obtain a urine specimen from Resident #170."

Review of Resident #170's clinical record revealed the following documentation entered on 10/17/21 at approximately 3:22 p.m. Resident #170 noted with altered mental status, unresponsiveness with oxygen saturation at 83% on room air. A new order was obtained to send to the ER for evaluation and treatment. Resident #170 was admitted to the hospital and placed in Intensive Care Unit (ICU), the resident did not return to the nursing facility.

Review of the hospital records revealed the following: Resident #170 presented in the Emergency Room (ER) on 10/17/21 from (name of nursing facility) for further evaluation due to Altered Mental Status (AMS). The 911 transport revealed the following: "Resident #170 was transferred from (name of nursing home) where he was found unresponsive and hypoxic. The

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resident was placed on non-breather mask and transported to the ER." On the evaluation work-up at (name of hospital), in the ER Resident #170 was awake but sluggish and continues on non-breather mask. Upon arrival to the hospital, the ER records indicated Resident #170's body temperature @ 88 degrees F (hypothermia - low body temperature) with a Bair Hugger and warming lights. The white blood count was 16,000, urinalysis with large leukocyte esterase, positive nitrites and WBC too numerous to count with 4+ bacteria. The ER records indicated the resident was admitted to Intensive Care Unit (ICU). Intravenous Fluids (IV), IV antibiotic (Vancomycin and Aztreonam) was started. The resident was diagnosis but not limited to severe sepsis, complicated UTI, Acute Kidney Injury (AKI), hypothermia and Acute Metabolic Encephalopathy.

A debriefing was conducted with the Administrator, Director of Nursing and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m., Resident #170's issues was presented again. The facility did not present any further information about the findings.

Definitions

-Urinary tract infection occurs when there is compromise of host defense mechanisms and a virulent microbe adheres, multiplies, and persists in a portion of the urinary tract. Most commonly, UTI is caused by bacteria, but fungi and viruses are possible. Urine culture and sensitivity are the gold standards for diagnosis of bacterial UTI (https://www.ncbi.nlm.nih.gov).

-Sepsis is a serious medical condition. It's caused

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by an overwhelming immune response to infection. The body releases immune chemicals into the blood to combat the infection. Those chemicals trigger widespread inflammation, which leads to blood clots and leaky blood vessels. As a result, blood flow is impaired, and that deprives organs of nutrients and oxygen and leads to organ damage. In severe cases, one or more organs fail. In the worst cases, blood pressure drops, the heart weakens, and the patient spirals toward septic shock (https://www.nigms.nih.gov/education/Documents/Sepsis.pdf).

-Severe sepsis symptoms may include but not limited to organ failure, such as kidney (renal dysfunction resulting in less urine) low platelet count and change in mental status, pain in the lower abdomen and blood in the urine. Systolic pressure is equal to or less than 100 millimeters of mercury (mmhg) and abnormal white blood cell count (either too high or too low). In some cases, sepsis may turn into septic shock, which is a drastic drop in blood pressure that can increase the risk of death. Signs of septic shock include but not limited to: needing medication to maintain systolic blood pressure equal to or greater than 64 mmHG and high levels of lactic acid in your blood, which means your cells aren't using oxygen in the right way. To prevent urosepsis, get treated as soon as possible. The longer you delay treating UTI, the more likely to develop urosepsis, septic shock, renal failure and death (https://webmd.com).

-Acute Kidney Injury occurs when your kidneys suddenly become unable to filter waste products from your blood. When your kidneys lose their filtering ability, dangerous levels of wastes may

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accumulate, and your blood's chemical makeup may get out of balance. Acute kidney failure - also called acute renal failure or acute kidney injury - develops rapidly, usually in less than a few days (https://www.mayoclinic.org/diseases-conditions/kidney-failure/symptoms-causes).

-Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI (http://www.webmd.com/a-to-z-guides/urine-culture).

-Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-culture).

-Bair hugger system is a temperature management system used in a hospital or survey center to maintain a patient's core body temperature (https://www.bairhugger.com).

-Hypothermia is a medical emergency that occurs when your body loses heat faster than can produce heat, causing a dangerously low body temperature. Normal body temperature is around 98.6. Hypothermia occurs as your body

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F 690	Continued From page 95 temperature falls below 95 degrees Fahrenheit (https://www.mayoclinic.org). -Oxygen saturation levels are considered normal between 95-100%. Levels that fall to 88% or lower, seek immediate attention (medlineplus.gov).	F 690		
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 observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to treat, monitor and manage pain for 1 of 58 residents (Resident #138), in the survey sample. The findings included: Resident #138 was originally admitted to the facility 02/07/2021 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Chronic Pain Syndrome and Pain Unspecified. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #138 cognitive abilities for	F 697	F697 1. Resident #138 is receiving effective pain management. 2. Current residents with orders for a pain management program have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on ensuring that ordered pain medication is available through refill request or new written prescription and physician notification if medication is not available or is ineffective. 4. Unit Managers/designees will complete a weekly review of pain management to ensure that the pain management is administered and effective. 5. The results of the review will be discussed at the monthly QAPI meeting.	1/27/22

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F 697	Continued From page 96 daily decision making were intact. In section "G"(Physical functioning) the resident was coded as independent set-up help only with transfers, walking in the room, locomotion on and off the unit, eating and bathing. Requiring supervision after set-up help only with dressing and personal hygiene. Requiring supervision one person physical assistance with toileting. In section "J" J0100 (Pain Management, dated 11/12/21) the resident was coded as Received scheduled pain medication regimen? Yes. Received PRN pain medications or was offered and declined? No. Received non-medication intervention for pain? No. J0200. Should Pain Assessment Interview be conducted? Yes. J0300. Pain Presence. Ask resident: "Have you had pain or hurting at any time in the last 5 days?" Yes. J0400. Pain Frequency. Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?" Almost constantly. J0500. Pain Effect on Function. Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?" Yes. The care plan dated 11/12/21 reads: Focus: Pain. Goal: Resident will have no/decreased complaints of pain through next review. Interventions: Attempt non-pharmacological interventions as needed. Interventions utilized before use of PRN pain medication (reposition, dim lights, locate to calm environment, diversional activities). Medicate as ordered. Notify MD for pain not relieved with medication or with new complaints of pain. Premedicate in anticipation of painful procedures. The POS (Physician Order Summary) reads:	F 697	Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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All Narcotic Pain medication Refills to come from Doctor's office every shift for Pain Management. Active 08/24/2021.

TiZANidine HCl Capsule 6 MG Give 1 capsule by mouth three times a day for back spasms per Pain management center Phone Active 11/18/2021.

Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain Verbal Active 02/07/2021.

Tylenol with Codeine #4 Tablet 300-60 MG (Acetaminophen-Codeine) Give 1 tablet by mouth three times a day for back pain per doctor pain management center Verbal Active 03/04/2021.

The MAR (Medication Administration Record) reads:

All Narcotic Pain medication Refills to come from Doctor's office every shift for (Evening and Night) Pain Management -Order Date 08/24/2021 1337. Initialed by staff from 12/01/21-12/14/21.

TiZANidine HCl Capsule 6 MG Give 1 capsule by mouth three times a day for back spasms per Pain management center -Order Date 11/18/2021 1336
Tylenol with Codeine #4 Tablet 300-60 MG (Acetaminophen Codeine) Give 1 tablet by mouth three times a day for back pain per Doctors pain management center -Order Date 03/04/2021 0857 (8:57 AM).

According to the MAR 5 doses of Tylenol with Codeine #4 Tablets 300-60 MG were not administered. The chart code indicating 9 was

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written = Other/See Progress Notes. Missed doses on the following days: 12/13/21 missed doses at 1300 (1:00 PM) and 1700 (5:00 PM) and on 12/14/21 missed doses at 0900 (9:00 AM), 1300 (1:00 PM) and 1700 (5:00 PM).

Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain -Order Date 02/07/2021 0954 (9:54 AM).

No doses of as needed Tylenol 325 MG was given per MAR.

Percocet Tablet 5-325 MG (oxyCODONE-Acetaminophen) Give 1 tablet by mouth every 8 hours for pain for 2 Days DC when Tylenol #3 arrives -Order Date 12/14/2021 1054 (10:54 AM) -D/C Date 12/15/2021 0045 (12:45 AM).

The First dose of Percocet Tablet 5-325 MG (oxyCODONE-Acetaminophen) Give 1 tablet by mouth one time only for pain for 1 Day -Order Date 12/14/2021 9:15 AM. Was administered at 10:20 AM.

The Second dose of Percocet 5-325 MG was administered on 12/14/21 at 4:00 PM.
A review of nursing notes reveal the following on 12/13/2021 at 14:32 (2:32 PM) concerning Resident #138's pain medication. Called patients MD, it was on automated message so left the message regarding her being positive of COVID and a request to refill her (acetaminophen-codeine). Per LPN #7.

On 12/08/21 at approximately 3:44 PM a telephone interview was conducted with Resident #138 concerning her pain medication. I didn't

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receive Tylenol # 4 from a nurse.

On 12/14/21 at 8:28 AM a follow up phone call was made to resident #138. She states she's having pain in her lower back. When asked to rate her pain level she stated. I'm an 8 out of 10. I've been out of Tylenol #4 since Yesterday. A review of the MAR (Medication Administration Record) reveal that resident did not receive her scheduled Tylenol #4 at 1300 (1:00 PM) and 1700 (5:00 PM).

On 12/14/21 at approximately 9:05 AM surveyor spoke to the DON (Director of Nursing) concerning Resident not receiving her pain medications. She was asked to contact the said surveyor after investigating the pain medication concerns.

On 12/14/21 at 9:10 AM an interview was conducted with LPN #7 (via telephone/LPN #7 states she's not working today) concerning Resident #138's Tylenol #4. She stated, "She gets that from her pain doctor. We don't order for her. I tried calling him. There was an automatic voice message. The resident told me to call the office. I told LPN #6 (Unit Manager) about it. She's aware. I haven't given any replacements for her. She said that she was fine. I had no idea that I had to order it. That doctor will send the medication. I asked her if she wanted a Tylenol. She wasn't in any pain yesterday."

On 12/14/21 at 9:50 AM., an interview was conducted with the DON concerning Resident #138. She stated, "She is out of the medication but the nurse at the pain office said her physician did not sign the script. The physician was out and didn't sign her script. It did not fax to pharmacy but faxing it this morning. She received Percocet

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this morning. The surveyor asked, what she received on yesterday as a substitute for her Tylenol #4. She stated, "I think she has a prn (as needed) order for Tylenol but did not receive it. It was ordered this morning. Someone should have followed up but the nurse said she received the script and sent to it to Pharma script on yesterday but the physician didn't sign it. When medications run low we would fax the script to the pharmacy. When running low, renew the medication. The pain doctor is notified. I would have had the nurse follow up. I did call Pharma script to add it to the Omnicell (Drug Dispensing System).

On 12/14/21 at approximately 12:30 PM a telephone interview was conducted with The Pharmacist at Pharmascript (OSM #1/Director of Quality and Pharmacist). Concerning Resident #138. She stated, "Currently, Omnicell now list Tylenol#4. This was added as of today. The request is to add Tylenol #4 to their Omnicell which was added today 12/14/21. The original script is from October 22, 2021. We had a prescription on file based on the dispensing timeline we dispensed on 12/01/21 for 30 tablets a 10 day supply. The next was refilled on 12/14/21 today. There was quantity remaining. Meaning they could have called to request another supply. We need an original valid prescription on file. Set up to dispense 30 tablets at a time. 12/01/21 should have been active only a 10 day supply, if they needed more there was quantity remaining to get more from us. They should order more. Let me call you back. The next fill after 12/01/21 is today."

12/14/21 at approximately, 12:45 PM a phone call was make to LPN #6 concerning Resident #138.

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She stated, "She follows pain management our NP (Nurse Practitioner) don't do anything here for narcotics. We have to actually call the doctor's office, then he faxes the script into pharmacy. Normally we do 3-5 days because pharmacy won't refill if over 5 days. I told her (LPN #7) to call the doctor's office. I didn't know anything until the evening. The said surveyor asked LPN #6 if the facility's Omnicell had Tylenol #4 available. She stated, "No it doesn't. If we had known that the NP could supply it we would have her pain medication if I had an order for it. The NP had to issue a verbal order on the phone to pharmacy so they could issue a code. The Doctor's office had the script because we called. He wasn't available to sign off until today. Every week I will personally look at her supply and reorder it (Tylenol #4) as it goes. We will stock it in our Omnicell."

On 12/14/21 at approximately 1:05 PM a returned phone call was received from the Pharmacist (OSM #1). She stated, "We did have a prescription on file that could have been refilled on 12/01/21. We didn't have a refill request until today. We had a valid prescription on file. They could have called us or went through point click care. We will sit up refresher courses for them so they could know how to request from us."
On 12/14/21 at approximately 3:00 PM a phone call was received from Resident #138. She stated," they gave me pain medications this morning and they said my pain medication is not in. My pain still an 8 out of 10. The Percocet brought my pain down to a 5. I was hurting bad. I take Tylenol 4 plus Terzanidine together. I don't know how often I'm supposed to take the Percocet."

No policies were available per facility staff.

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F 697	Continued From page 102 On 12/14/2021 at approximately 3:10 PM, the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Corporate Consultant stated," We thought we had to obtain a new prescription."	F 697		
F 755 SS=E	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 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	F 755		1/27/22

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F 755	Continued From page 103 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility staff failed to procure narcotics timely for one resident (Resident #138) in a survey sample of 58 residents. The findings included: Resident #138 was originally admitted to the facility 02/07/2021 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Chronic Pain Syndrome and Pain Unspecified. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #138 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as independent set-up help only with transfers, walking in the room, locomotion on and off the unit, eating and bathing. Requiring supervision after set-up help only with dressing and personal hygiene. Requiring supervision one person physical assistance with toileting. In section "J" J0100 (Pain Management, dated 11/12/21) the resident was coded as Received scheduled pain medication regimen? Yes. Received PRN pain medications or was offered and declined? No. Received non-medication intervention for pain? No.	F 755	F755 1. Resident #138 is receiving effective pain management. 2. Residents with orders for a pain management program have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on ensuring that ordered pain medication is available through refill request or new written prescription and physician notification if medication is not available or is ineffective. 4. Unit Managers/designees will complete a weekly review of pain management to ensure that the pain management is administered and effective. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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J0200. Should Pain Assessment Interview be conducted? Yes.
J0300. Pain Presence. Ask resident: "Have you had pain or hurting at any time in the last 5 days?" Yes.

J0400. Pain Frequency. Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?" Almost constantly.
J0500. Pain Effect on Function. Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?" Yes.

The care plan dated 11/12/21 reads: Focus: Pain. Goal: Resident will have no/decreased complaints of pain through next review. Interventions: Attempt non-pharmacological interventions as needed. Interventions utilized before use of PRN pain medication (reposition, dim lights, locate to calm environment, diversional activities). Medicate as ordered. Notify MD for pain not relieved with medication or with new complaints of pain. Premedicate in anticipation of painful procedures.

The POS (Physician Order Summary) reads:

All Narcotic Pain medication Refills to come from Doctor's office every shift for Pain Management. Active 08/24/2021.

TiZANidine HCl Capsule 6 MG Give 1 capsule by mouth three times a day for back spasms per Pain management center Phone Active 11/18/2021.
Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain Verbal Active 02/07/2021.

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Tylenol with Codeine #4 Tablet 300-60 MG (Acetaminophen-Codeine) Give 1 tablet by mouth three times a day for back pain per doctor pain management center Verbal Active 03/04/2021.

The MAR (Medication Administration Record) reads:
All Narcotic Pain medication Refills to come from Doctor's office every shift for (Evening and Night) Pain Management -Order Date 08/24/2021 1337. Initialed by staff from 12/01/21-12/14/21.

TiZANidine HCl Capsule 6 MG Give 1 capsule by mouth three times a day for back spasms per Pain management center -Order Date11/18/2021 1336 (1:36 PM).

Tylenol with Codeine #4 Tablet 300-60 MG (Acetaminophen Codeine) Give 1 tablet by mouth three times a day for back pain per Doctors pain management center -Order Date 03/04/2021 8:57 AM).

According to the MAR 5 doses of Tylenol with Codeine #4 Tablets 300-60 MG were not administered. The chart code indicating 9 was written = Other/See Progress Notes. Missed doses on the following days: 12/13/21 missed doses at 1300 (1:00 PM) and 1700 (5:00 PM) and on 12/14/21 missed doses at 0900 (9:00 AM), 1300 (1:00 PM) and 1700 (5:00 PM).

Tylenol Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain -Order Date 02/07/2021 0954 (9:54 AM).

No doses of as needed Tylenol 325 MG was given per the MAR.

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Percocet Tablet 5-325 MG (oxyCODONE-Acetaminophen) Give 1 tablet by mouth every 8 hours for pain for 2 Days DC when Tylenol #3 arrives -Order Date 12/14/2021 1054 (10:54 AM) -D/C Date 12/15/2021 0045 (12:45 AM).

The First dose of Percocet Tablet 5-325 MG (oxyCODONE-Acetaminophen) Give 1 tablet by mouth one time only for pain for 1 Day -Order Date 12/14/2021 9:15 AM. Was administered at 10:20 AM.

The Second dose of Percocet 5-325 MG was administered on 12/14/21 at 4:00 PM.

A review of nursing notes reveal the following on 12/13/2021 at 14:32 (2:32 PM) concerning Resident #138's pain medication. Called patients MD (Medical Doctor), it was on automated message so left the message regarding her being positive of COVID and a request to refill her (acetaminophen-codeine). Per LPN #7.

On 12/08/21 at approximately 3:44 PM a telephone interview was conducted with Resident #138 concerning her pain medication. I didn't receive Tylenol #4 from a nurse.

On 12/14/21 at 8:28 AM a follow up phone call was made to resident #138. She states she's having pain in her lower back. When asked to rate her pain level she stated. I'm an 8 out of 10. I've been out of Tylenol #4 since Yesterday. A review of the MAR (Medication Administration Record) reveal that resident did not receive her scheduled Tylenol #4 at 1300 (1:00 PM) and 1700 (5:00 PM).

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On 12/14/21 at approximately 9:05 AM surveyor spoke to the DON (Director of Nursing) concerning Resident not receiving her pain medications. She was asked to contact the said surveyor after investigating the pain medication concerns.

On 12/14/21 at 9:10 AM an interview was conducted with LPN #7 (via telephone/LPN #7 states she's not working today) concerning Resident #138's Tylenol #4. She stated, "She gets that from her pain doctor. We don't order for her. I tried calling him. There was an automatic voice message. The resident told me to call the office. I told LPN #6 (Unit Manager) about it. She's aware. I haven't given any replacements for her. She said that she was fine. I had no idea that I had to order it. That doctor will send the medication. I asked her if she wanted a Tylenol. She wasn't in any pain yesterday."

On 12/14/21 at 9:50 AM., an interview was conducted with the DON concerning Resident #138. She stated, "She is out of the medication but the nurse at the pain office said her physician did not sign the script. The physician was out and didn't sign her script. It did not fax to pharmacy but faxing it this morning. She received Percocet this morning. The surveyor asked, what she received on yesterday as a substitute for her Tylenol #4. She stated, "I think she has a prn (as needed) order for Tylenol but did not receive it. It was ordered this morning. Someone should have followed up but the nurse said she received the script and sent to it to Pharma script on yesterday but the physician didn't sign it. When medications run low we would fax the script to the pharmacy. When running low, renew the medication. The pain doctor is notified. I would

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have had the nurse follow up. I did call Pharma script to add it to the Omnicell (Drug Dispensing System).

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12/01/21 should have been active only a 10 day supply, if they needed more there was quantity remaining to get more from us. They should order more. Let me call you back. The next fill after 12/01/21 is today."

12/14/21 at approximately, 12:45 PM a phone call was make to LPN #6 concerning Resident #138. She stated, "She follows pain management our NP (Nurse Practitioner) don't do anything here for narcotics. We have to actually call the doctor's office, then he faxes the script into pharmacy. Normally we do 3-5 days because pharmacy won't refill if over 5 days. I told her (LPN #7) to call the doctor's office. I didn't know anything until the evening. The said surveyor asked LPN #6 if the facility's Omnicell had Tylenol #4 available.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 109 She stated, "No it doesn't. If we had known that the NP could supply it we would have her pain medication if I had an order for it. The NP had to issue a verbal order on the phone to pharmacy so they could issue a code. The Doctor's office had the script because we called. He wasn't available to sign off until today. Every week I will personally look at her supply and reorder it (Tylenol #4) as it goes. We will stock it in our Omnicell. On 12/14/21 at approximately 1:05 PM a returned phone call was received from the Pharmacist (OSM #1). She stated, "We did have a prescription on file that could have been refilled on 12/01/21. We didn't have a refill request until today. We had a valid prescription on file. They could have called us or went through point click care. We will sit up refresher courses for them so they could know how to request from us." On 12/14/21 at approximately 3:00 PM a phone call was received from Resident #138. She stated," they gave me pain medications this morning and they said my pain medication is not in. My pain still an 8 out of 10. The Percocet brought my pain down to a 5. I was hurting bad. I take Tylenol #4 plus Terzanidine together. I don't know how often I'm supposed to take the Percocet." No policies were available per facility staff. On 12/14/2021 at approximately 3:10 PM, the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Corporate Consultant stated," We thought we had to obtain a new prescription."	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		1/27/22

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F 760	Continued From page 110 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, and staff interviews, the facility staff failed to ensure the resident was free from significant medication error (the staff failed to administer the intravenous (IV) antibiotic (Cefazolin 2 grams IV every 8 hours) as ordered from 11/16/21 through 12/2/21 for 1 of 58 residents (#55), in the survey sample The findings include: Resident #55 was originally admitted to the facility 10/14/21 and readmitted 11/16/21 after an acute care hospital stay. The current diagnoses included; diabetes, a stroke with left hemiparesis and Methicillin Susceptible Staphylococcus Aureus (MSSA) related to a left arm abscess. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/18/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #55's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of one person with bed mobility, transfers, dressing, eating, toileting, and personal hygiene and limited assistance of one person with walking and	F 760	F760 1. Resident #55 has completed the ordered IV antibiotics. Residents followed by Infectious Disease in the hospital are receiving care and services as ordered by Infectious Disease. 2. Residents admitted with Infectious Disease orders have the potential to be affected. 3. Clinical Nurses will be educated by the Director of Nursing/designee on transcription of physician orders on new admissions/readmissions from the hospital discharge orders. 3. Unit Managers/designees will complete a weekly review of admitted residents to ensure that Infectious Disease orders are included in the facility orders. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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F 760	Continued From page 111	F 760		

locomotion.

An interview was conducted with Resident #55 on 12/8/21 at approximately 12:15 p.m. Resident #55 stated one day he woke up one day with a painful left upper arm, draining from a hole in it and he had no idea how it occurred. The resident stated he was hospitalized and received surgery related to the left upper arm and after leaving the hospital and returning to the rehabilitation facility, he was to receive IV antibiotics but he didn't start receiving them until last Friday, 12/3/21.

A review of the Resident #55's discharge records from the local hospital to the rehabilitation facility included the following orders written on a document from the Infectious Disease practitioner's office; Cefazolin 2 grams IV every 8 hours. Stop date-12/11/21. Indication- High grade MSSA Bacteremia. Peripherally inserted central catheter (PICC) line care per protocol (10 milliliters (ml) flush with normal saline pre and post infusion. 3 ml heparin flush (10 units/ml) post infusion or every 24 hours). Discontinue PICC line after completion of antibiotic. If the patient has a port -use 5 ml (100 units/ml) heparin. Port care per protocol.
The following blood test were requested; Complete Blood Count (CBC) with differential, Comprehensive Metabolic Panel (CMP), Erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) every week while on the IV antibiotic. Lab results to be faxed to (number). Follow-up in Infectious Disease office 12/2/21 at 1440. Office address.

The Physician's Order Summary for November 2021, didn't reveal the above orders and there

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was no evidence the resident received the ordered antibiotic.

The Physician's Order Summary had an ordered dated 12/2/21 to start the following order on 12/3/21; ceFAZolin Sodium-Dextrose Solution 2-4 GM/100ML- % Use 2 gram intravenously every 8 hours for MSSA bacteremia for 28 Days. Another physician's order dated 12/2/21 read; CBC with differential, CMP, ESR, CRP one time a day every Friday.

The clinical record provided no evidence regarding the IV antibiotic administration or information informing the resident/responsible party or Practitioner of the delay in beginning the IV therapy.

A review of miscellaneous documents revealed an appointment with the Infectious Disease practitioner dated 12/2/21. The document revealed the visit was related to the infection of the left humerus; hospital stay 11/9/21 through 11/16/21, IV Cefazolin day 19, End of the IV therapy will be 12/11/21. A large left upper extremity abscess, unclear how he obtained wounds to the left arm, unless due to pressure measuring 27 by 7 by 3.8 centimeters and mixed attenuation with fluid, gas and enhancing periphery, no destructive lesion of bone, no definite joint involvement. Bacteremia of the left upper arm likely to the abscess. The progress note further read; the resident unfortunately has not been on IV Cefazolin since discharged from the hospital at which time he was on day 4 of a planned 28 day. The Practitioner further stated

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F 760	Continued From page 113 the rehabilitation facility was contacted and the nurse confirmed the resident had not been on antibiotic since admission to the facility. The progress note further read; a follow-up call was made to the Case Manager at the hospital who stated the order was indeed entered and confirmed the order was the rehabilitation facility had received the order. The Practitioner's decided to restart the antibiotic therapy and provided the order to the rehabilitation facility. An interview was conducted with the Director of Nursing on 12/8/21 at approximately 2:20 p.m. The Director of Nursing stated the primary admission orders didn't include the IV therapy orders and the Admission Director failed to provide the document from the ID office with the IV information to the admitting nurse therefore; it was omitted. The Director of Nursing provided a document dated 12/3/21, acknowledging the medication error. A plan wasn't developed to help prevent further admission medication errors. On 12/14/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. No additional information was offered.	F 760		
F 770 SS=E	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 770		1/27/22

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F 770	Continued From page 114 (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and the facility's policy, the facility staff failed to follow physician orders for laboratory services for 3 out of 58 residents (Resident #13, Resident #17 and Resident #170) in the survey sample. The findings included: 1. The facility staff failed to obtain Resident #13's blood work ordered on 11/01/21 for Complete Blood Count (CBC) and Basic Metabolic Panel (BMP). Resident #13 was originally admitted the nursing facility on 07/27/21. Diagnosis for Resident #13 included but not limited to Type II Diabetes and long term use of anticoagulants (blood thinner). The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/21 coded the resident on the Brief Interview for Mental Status (BIMS) a 03 of 15 indicating severe cognitive impairment. Resident #13 was coded total dependence of one with bathing, extensive assistance of one with transfer, dressing, hygiene, bed mobility and toilet use and supervision with setup with eating for Activities of Daily Living (ADL) care. Review of Resident #13's clinical record revealed the following order dated 11/01/21: labs for CBC and BMP every Tuesday for 3 weeks.	F 770	F770 1. Residents #13 and 17 are receiving laboratory services as ordered. 2. Current residents with orders for laboratory services have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on obtaining laboratory services as ordered, reporting results to the physician, and physician and responsible representative notification if the lab test cannot be obtained. 4. Unit Managers/designees will review ordered labs on a weekly basis. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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During the review of Resident #13's clinical record on 12/08/21 did not reveal lab results for CBC and BMP for 11/02/21 or 11/16/21. On the same day, the Director of Nursing stated she was not able to locate in the clinical record lab results for the CBC or BMP for 11/02/21 or 11/16/21.

A debriefing was conducted with the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. The above findings were presented again; no further information was provided prior to exit.

2. The facility staff failed to obtain Resident #17's blood work ordered on 11/24/21 for CBC and BMP. Resident #17 was admitted the nursing facility on 09/03/21. Diagnosis for Resident #17 included but not limited to Type II Diabetes, Cardiac Arrest and Pulmonary Embolism (blood clot in the lungs).

The most recent Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 09/10/21 coded the resident on the Brief Interview for Mental Status (BIMS) a 15 of 15 indicating no cognitive impairment. Resident #17 was coded supervision with limited assistance of one with transfer, dressing, hygiene, bed mobility and toilet use and supervision with eating and bathing Activities of Daily Living (ADL) care.

Review of Resident #17's clinical record revealed the following order dated 11/24/21: labs for CBC with diff and BMP to be drawn on 11/26/21.

During the review of Resident #17's clinical

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F 770	Continued From page 116	F 770		

record on 12/08/21 did not reveal lab results for CBC with diff and BMP. On the same day, the Director of Nursing stated she was not able to locate in the clinical record lab results for the CBC with diff and BMP.

A debriefing was conducted with the Administrator, Director of Nursing and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. The above findings were presented again; no further information was provided prior to exit.

3. The facility staff failed to obtain lab work for UA with C&S ordered on 10/13/21. Resident #170 was admitted the nursing facility on 09/03/21. Diagnosis for Resident #170 included but not limited to Hematuria (blood in the urine) and Urinary Tract Infection (UTI).

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 07/22/21 coded the resident on the Brief Interview for Mental Status (BIMS) a 13 of 15 indicating no cognitive impairment. Resident #170 was coded total dependence of two with dressing, total dependence of one with bathing and toilet use, supervision with one assist with hygiene with Activities of Daily Living (ADL) care. The MDS coded the resident as always incontinent of bladder and bowel.

Review of Resident #170's clinical record revealed the following order dated 10/13/21: obtain labs for UA with C&S for hematuria.

During the review of Resident #170's clinical

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record on 12/09/21 did not reveal lab results for UA & C/S. On the same day, the Regional Director of Clinical Services stated she was not able to locate in the clinical record lab results for the UA with C&S. The Regional Director said the physician and responsible party should have been notified of the missed UA with C&S.

A debriefing was conducted with the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. The DON was asked if the physician and the resident's representative should have been notified of the missed UA with C&S, the DON stated, "Yes."

The facility's policy titled: Laboratory/Diagnostic Testing with an effective date of 11/01/19.
Policy: Laboratory, radiology and other diagnostic services are provided to the Center by way of written contractual agreements. The contracted service vendor is to provide services to the Center that ensure safe and effective patient testing and timely delivery of laboratory, radiology and other diagnostics testing results.

-Procedure:
1. A licensed nurse will obtain laboratory, radiology, or other diagnostic services to meet the needs of its patients as ordered the physician or physician extender.
2. A license nurse will monitor and track all physician or physician extender ordered laboratory, radiology, and other diagnostic tests; ensure that tests are complete as ordered and communicate results to the physician in a timely manner.

Definitions:

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1. CBC is a blood test that measures the number and types of cells in your blood. This helps doctor's check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders (https://medlineplus.gov/bloodcounttests.html).

2. BMP is a test that measures eight different substances in your blood. It provides important information about your body's chemical balance and metabolism. Metabolism is the process of how the body uses food and energy. A BMP includes tests for the following: Glucose, a type of sugar and your body's main source of energy (https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp).

3. Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI (http://www.webmd.com/a-to-z-guides/urine-culture).

4. Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-culture).

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F 770	Continued From page 119 5. Urinary Tract Infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney (http://www.cdc.gov/HAI/ca_uti/uti.html).	F 770		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		1/27/22

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F 791	Continued From page 120 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and clinical record review, the facility staff failed to promptly provide 1 out of 58 resident's (Resident #27) the services needed to meet their dental needs after knowing about broken dentures. The findings included: Resident #27 was originally admitted the nursing facility on 07/10/18. Diagnosis for Resident #27 included but not limited to Gastro-Esophageal Reflex Disease (GERD) and Iron Deficiency Anemia. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 09/16/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15, which indicated no cognitive impairment for daily decision-making. The MDS coded Resident #27 supervision with eating. A significant change MDS was completed on 02/05/21. Under section L0200 (Dental) was coded for no natural teeth or tooth fragment(s)	F 791	F791 1. Resident #27□s dentures are being repaired. 2. Current residents with dentures have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on communication of dental needs when dentures are broken. 4. The Unit Managers/designees will review dental needs for broken dentures on a weekly basis to ensure that the needs are met in a timely manner. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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(edentulous).

Review of Resident 27's Admission Assessment/Screening document dated 07/10/18 documented the following under mouth: gums are pink/moist with upper and lower dentures present.

The care plan with a revision date of 02/22/21 identified Resident #27 has the potential for oral health problems related to (r/t) edentulous. The goal set for the resident by the staff will be free of infection, pain or bleeding in the oral cavity by the review date of 12/15/21. Some of the interventions/approaches the staff would use to accomplish this goal is to coordinate arrangements for dental care, transportation as needed and diet as ordered; consult with dietitian and change if chewing/swallowing problems are noted.

An interview was conducted with Resident #27 on 12/07/21 at approximately 12:33 p.m. Resident #27 said her dentures (full and lower) were in a denture cup on the overbed table when the Certified Nursing Assistant (CNA) accidently bumped into my overbed table causing my denture cup to fall off the table breaking my bottom denture in half. Observed on the overbed table was a denture cup with upper denture only. She said the nurse spoke with me (not sure of her name) but was informed that I could not get my dentures right now due to issues with transportation.

An interview was conducted with CNA #1 on 12/09/21 at approximately 5:45 p.m. She said about a week ago, Resident #27's dentures were on her overbed table. She stated, "I'm not really sure what happened but the denture cup

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F 791	Continued From page 122	F 791		

containing both Resident's 27's upper and lower dentures fell off the table breaking the lower denture in half." When asked, what happen to the broken lower dentures, she replied, I placed them back in the denture cup and reported the incident to License Practical Nurse (LPN) #4.

On 12/10/21, the Administrator provided a nurse's note entered on 12/10/21 at 2:32 p.m., that read: Resident #27 will go to affordable dentures on 12/14/21 at 7:30 a.m.

A debriefing was conducted with the Administrator, Director of Nursing and Regional Director of Clinical Services on 12/14/21 at approximately 12:35 p.m. The facility did not present any further information about the findings.

The facility's policy titled Dental Service Needs (effective date 11/01/19).
Policy: In the event of a patient is in need of routine or emergency dental services, a licensed nurse will initiate and coordinate the necessary care.

Procedure read in part:
1. Nursing will notify the attending physician and secure a consult recommendation.
6. In the event of a patient's dentures are lost or damaged the nursing will promptly, within three days, refer the patient for dental services. If the referral does not occur within three (3) days, nursing will provide documentation of what has been done to ensure that the resident can still eat/drink adequately while awaiting dental services and will describe the reasons of the delay.
8. In the event any patient's dentures are lost or damaged by the staff during or as a direct results

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F 791	Continued From page 123 of providing a direct care service the patient will not be charged for replacement or repairs.	F 791		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview, and clinical record review, the facility staff failed to accommodate the resident's foods preferences to meet nutritional needs for 1 of 58 residents (Resident #123), in the survey sample. The findings included: Resident #123 was originally admitted to the facility 9/28/21 and readmitted 11/5/21 after an acute care hospital stay. The current diagnoses included; diabetes, heart failure, , renal insufficiency and status post left great toe amputation. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/4/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This	F 806	F806 1. Resident #123 is receiving foods to meet his preferences and to meet his nutritional needs. 2. Current residents have the potential to be affected. 3. Dietary Services will be educated by the Dietary Manager/designee to assess resident food preferences and nutritional needs. Nursing will be educated on communication of resident preferences for food. 4. The Unit Managers/Designees will complete j5 resident interviews weekly to ensure that food preferences are identified. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will	1/27/22

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F 806	Continued From page 124	F 806		

indicated Resident #123's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with transfers, extensive assistance of one person with bed mobility, dressing, and toileting, limited assistance of one person with walking and locomotion, supervision of one person after set-up with eating and personal hygiene.

The resident's diet order dated 11/5/21 read, Heart Healthy Diabetic diet, Level 7 - Regular texture, Regular Liquids consistency.

The current care plan had a problem dated 11/29/21 which read; Nutrition Risk related to a recent hospitalization, diagnosis diabetes, heart failure, and a surgical wound with need for a therapeutic diet. The goal read; The resident will maintain adequate nutritional status as evidenced by no significant weight change by next review. The interventions included; provide and serve diet as ordered. Monitor intake and record every meal. Weekly weights.

An interview was conducted with Resident #2's spouse on 12/7/21 at approximately 2:35 p.m. The spouse stated there was concern with the meals the resident receives related to his disease processes of diabetes and heart failure. The spouse stated the resident currently had great edema to the legs he should be receiving a low carbohydrate (carb) low salt diet because of his medical conditions. The spouse further stated the resident receives too many carbs and his meals often are the same as the roommate's

be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction.
6. Date of completion 1.27.2022

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meal. The stated spouse also stated the lunch meal served that day was Salisbury steak with gravy (there is too much gravy served) rice and corn (too many carbs) and a roll (another high carb food). The spouse stated the resident is served green vegetables (low carbs) about twice weekly.

On 12/7/21 at approximately 2:45 p.m., an observation was made of the resident legs; the left was with plus 4 swelling and the right with plus 3 swelling. Both legs appeared tight and were shiny.

On 12/8/21 at approximately 2:00 p.m., an interview was conducted with the District Dining Services Manager (DDSM) regarding responsibilities for obtaining resident likes/dislikes, preferences, substitutions, and variation between the regular diet and specialty diet for Resident #123. The DDSM stated it is the Culinary Services Manager's (CSM) responsible to obtain the above information from the resident and/or resident representative with in twenty-four hours of admission but; the resident was missed because of the weekend admission. The DDSM stated the the CSM had received disciplinary action regarding the oversight and an interview had been conducted and the dietary card updated with likes/dislikes and preferences.

On 12/14/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

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F 842	Continued From page 126	F 842		
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. §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,	F 842		1/27/22

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F 842	Continued From page 127 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, review of facility documents and during the course of a complaint investigation, the facility's staff failed to accurately document in one residents medical record for 1 of 58 residents (Resident #167), a closed record, in the survey sample. The findings included:	F 842	F842 1. Resident #167 discharged from the facility. 2. Current residents have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on accurate documentation of resident representative	

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F 842	Continued From page 128 Resident #167 was originally admitted to the facility 06/15/21 and discharged on 06/26/21 to an acute care hospital. The current diagnoses included; Cerebral Infarction and Aphasia. The discharge, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/26/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for short term memory problems as well as moderately impaired for daily decision making. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance with bed mobility and eating. Requires total dependence with transfers, locomotion on the unit, dressing, toilet use and personal hygiene. Requiring total care with bathing. A review of the weekly skin assessment dated 6/12/21 reveal that Resident #167's skin is intact. A review of the weekly skin assessment dated 6/12/21 reveal that Resident #167 has an abrasion on his chest. Measuring 7.4 cm (Length) x 7.0 cm (Width). Note reads: Pt. (Patient) has open area to chest, appears to be from him rubbing on his chest with his hand. MD (Medical Doctor) notified. Date acquired: 6/20/21. A review of progress notes dated 6/20/2021 at 22:14 (10:14 PM) Reads: Open area to pt (patient) chest noted, appears to be a stage 2 from pt rubbing his hand repeatedly across his chest. Area was cleaned and dried and dressing placed over area. Note placed in communication book asking provider to assess and give	F 842	notification in the medical record. 4. The Unit Managers/designees will review documentation of resident representative notification in the medical record to ensure accurate documentation during clinical review 5x weekly. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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F 842	Continued From page 129	F 842		

treatment order. Pt wife notified.

On 12/10/21 at approximately, 3:00 PM an interview was conducted with the DON (Director of Nursing) concerning documentation on Resident # 167. She stated, "The nurse documented that she notified the family but she didn't. She said she got busy and forgot to call the RP (Responsible Party).

A copy of an Employee Corrective Action was received from the DON concerning LPN #4 dated 7/01/21. It reads: A resident was found with a wound, you charted that the family was updated. Family was in for a visit, noticed the wound and was upset that nobody had notified them. When speaking to you about the documentation you stated that you meant to update the family but did not.

On 12/14/21 at approximately 10:35 AM an interview was conducted with LPN #4 concerning Resident #167 medical record and an area found on his chest. She stated, "He was anxious when he came from the hospital. I work the 3-11 shift. He kept rubbing his hand across his chest a lot. The doctor was notified and a treatment was put in for it. It looked pink like top layer of skin came off. I asked her to assess to make sure we were providing the correct treatment. I found the area. He didn't come in with it. The family was notified the following day but I didn't personally notify them. I found it late at night. I was going to notify her but it was late and I forgot to go back and change my note. I think I said that provider and RP were notified. But I only notified provider by putting a note in the communication book. I should have gone back and fixed my note.

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F 842	Continued From page 130 On 12/14/2021 at approximately 3:10 PM, the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 842		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		1/27/22

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F 883	Continued From page 131 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide documentation in the resident's clinical record of the influenza vaccine administration or the refusal of or medical contraindications to vaccines for 2 of 58 residents (Resident #129 and 112), in the survey sample. The findings included: 1. Resident #129 was originally admitted to the facility 11/11/21 and was discharged home 12/9/21. The current diagnoses included; COPD, hypertension, coronary, artery disease and a	F 883	F883 1. Residents #129 and 112 have received the flu vaccine. 2. Current residents have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on offer of influenza vaccine, administration, refusal, or medical contraindications with documentation in the medical record. 4. The Unit Managers/designees will review documentation of the influenza vaccine on a weekly basis.	

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F 883	Continued From page 132 major depression disorder. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #129's cognitive abilities for daily decision making were moderately impaired. An interview was conducted with Resident #129 on 12/8/21 at approximately 11:25 a.m. The resident stated she would be discharged home on 12/9/21 after 5:00 p.m. The resident further stated she had asked for the influenza vaccine but hadn't received it and she really desired to have it prior to going home. Resident #129 stated she had been hospitalized prior to coming to the rehabilitation center for falling multiple times and shortness of breath after not having her inhalers for several days. Review of Resident #129's 11/11/21 hospital discharge summary revealed the resident requested the influenza vaccine prior to the discharge to the rehabilitation facility but there was no documentation that the hospital staff administered it prior to her leaving the hospital. Review of the resident 11/17/21 admission MDS assessment revealed at O0250A that the resident didn't receive the influenza vaccine in this facility for this year's Influenza vaccination season because at O0250C read; the influenza vaccine was received outside facility. The clinical record revealed the resident's last influenza immunization was administered 10/5/2020. An interview was conducted with the	F 883	5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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MDS Coordinator on 12/13/21 at approximately 3:00 p.m. The MDS Coordinator stated she thought the resident received the influenza vaccine at the hospital because of the resident's request for it but she saw no documentation to support her thoughts and they hadn't been successful in getting additional documentation from the hospital.

An interview was also conducted with the Admission's Director on 12/13/21 at approximately 3:10 p.m. The Admission's Director stated it is her responsibility to obtain COVID-19 vaccination and testing status prior to admissions to the facility but not influenza and pneumococcal immunization status.

An interview was conducted with the Director of Nursing on 12/13/21 at approximately 3:34 p.m. The Director of Nursing stated vaccination options begin at the time of admissions and if a resident decides they would like an influenza immunization nursing provides the education, obtains consents, the order and administer the vaccine. The Director of Nursing further stated the influenza vaccine is readily available and are offered to all.

On 12/14/21 at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Corporate Consultant stated Resident #129 was not administer the influenza vaccinated while she was in the facility.
2. The facility staff failed to ensure Resident #112 was given the opportunity to receive her influenza vaccination. Resident #112 was originally admitted to the nursing facility on 02/06/20. Diagnosis for Resident #112 included

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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but not limited to Palliative Care.

The most Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/07/21 on Resident #112's Brief Interview for Mental Status (BIMS) scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions.

The MDS coded Resident #112 under section "O" Special Treatments and Programs (O0300) section (A) asked if the resident receive the influenza vaccine in this facility for this year's influenza vaccination season; was coded "No."

Review of Resident #112's immunization record did not display the influenza vaccine was either offered or declined.

Review of Resident #112 Order Summary Report revealed the following order: Flu vaccine annually as indicated starting on 09/22/20.

An interview was conducted with the Infection Preventionist (IP) on 12/13/21 at approximately 02/18/21 at approximately 2:15 p.m. When asked if Resident #112 was offered the influenza vaccine, she replied, "No, it was missed."

On 12/14/21, the facility provided an updated immunization report with the following: Resident #112 was given the influenza vaccination on 12/13/21 at 11:00 a.m.

The Administrator, Director of Nursing and Regional Director of Clinical Services were informed of the finding during a briefing on 12/14/21 at approximately 12:35 p.m. The facility

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did not present any further information about the findings.

The facility's policy titled Influenza and Pneumococcal Vaccinations.
-Policy: Vaccination against influenza will be offered to Center patients and staff annually.

Admission Physician Orders must be provided for every patient at the time of admission or readmission to activate a medical plan of care.

Procedure - read in part:
1a. An effective influenza vaccine program offers a two-fold defense against influenza in a nursing center. It can prevent an outbreak in inducing resistance of the group to spread of influenza and to reduce the impact of an outbreak when it does occur.
1c. Influenza vaccine should be given annually. According to the CDC, the timing flu is unpredictable and can vary from season to season. The optimal time to administer influenza vaccine is in the late September or early October of each year. The flu vaccine can be given after the flu season.

Definitions
Palliative Care is treatment of the discomfort, symptoms, and stress of serious illness. Palliative care provides relief from symptoms including pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, problems with sleep, and many other symptoms. It can also help you deal with the side effects of the medical treatments you're receiving. Perhaps most important, palliative care can help improve your quality of life and provide help to your family as well

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F 883	Continued From page 136 (https://www.ninr.nih.gov/newsandinformation/what-is-palliative-care).	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;	F 886		1/27/22

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F 886	Continued From page 137 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation, the facility staff failed to provide evidence of the facility's COVID-19 recommended frequency of twice a week staff testing to include agency employees based on the level of community transmission. The findings included: An interview was conducted with the Infection Preventionist (IP) and Director of Nursing (DON)	F 886	F886 1. The facility staff are documenting frequency of twice a week staff testing for Covid-19 to include agency employees. 2. Current residents have the potential to be affected. 3. The Infection Preventionist and Unit Managers will be educated by the Director of Nursing/designee on documentation of staff testing according to the level of	

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F 886	Continued From page 138 on 12/09/21 at approximately 3:30 p.m. The DON said, there's no COVID-19 cases in the building. The DON stated, "Vaccinated staff does not require testing but all unvaccinated staff are to be tested twice a week based on the community transmission. When asked if the facility has agency staffing in the building, the DON replied, "Yes." When asked if they have their vaccination status, the DON replied, "No, it's been requested from the agency but have not yet been received." The (IP) and DON were asked to provide the last 2 weeks of the as-worked schedule to include all agency staffing and to provide a copy of their vaccination status or their twice a week COVID-19 testing. On 12/10/21 at approximately 10:35 a.m., and again at 4:10 p.m., an interview was conducted with the IP. She (IP) said she was still working on gathering the information that was requested on 12/09/21 at approximately 3:30 p.m. An interview was conducted with the IP on 12/13/21 at approximately 3:05 p.m. She (IP) stated, "I do not have evidence that any of the agency staffing COVID-19 vaccination status nor do I have documentation that they are being tested twice a week." When asked, who is responsible of the twice a week testing, she replied, "Me, but I have never tested the agency staff." The IP provided the as-worked schedule for the past 2 weeks but not provide evidence of their vaccination status or that they were tested twice a week based on the community transmission. On 12/13/21 at approximately 3:10 p.m., an interview was conducted with all the agency staff on the (3-11 shift) who were able to provide	F 886	community transmission, to include agency staff. 4. The DON/ADON/designee will complete a weekly review of documentation of staff testing. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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evidence of their vaccination status via presenting their vaccination card.

Review of the as-worked schedule revealed the number of agency staff working in the facility without having their COVID-19 vaccination status or the required COVID-19 twice a week testing based on the level of community transmission on the following days: 12/12/21 @ 7, 12/11/21 @ 11, 12/10/21 @ 18, 12/09/21 @ 10, 12/08/21 @, 12/07/21 @ 7, 12/06/21 @ 11, 12/05/21 @ 10, 12/04/21 @ 6, 12/03/21 @ 10, 12/02/21 @ 13, 12/01/21 @ 13, 11/30/21 @ 11 and 11/29/21 @ 14 agency staff working.

On 12/13/21 at approximately 3:40 p.m., Corporate provided a letter that was dated for 11/30/21 that included but not limited to the following information: "Per CMS regulation, we continue to conduct routine testing of all unvaccinated employees based on your center's level of community transmission. Unfortunately, at this time, all counties in which our centers reside are either in substantial community transmission (orange) or high community transmission (red), which both require routine twice a week."

The Administrator, Director of Nursing and Regional Director of Clinical Services were informed of the finding during a briefing on 12/14/21 at approximately 12:35 p.m. The facility did not present any further information about the findings.

The facility policy titled COVID-19 Testing, effective date of 09/21/21.
Policy: COVID-19 testing will be performed by trained personnel following CMS

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F 886	Continued From page 140 recommendations for testing. Procedure: a. Routine testing is not recommended for fully vaccinated employees. (Fully vaccinated refers to greater or equal to 2 weeks following receipt of the second dose in a 2-dose series, or greater than or equal to 2 weeks following receipt of one dose of a single-dose vaccine, there is currently no post-vaccination time limited on fully vaccinated status). b. Unvaccinated employees are to be routinely tested based on the center's county level of community transmission.	F 886		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident,	F 887		1/27/22

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resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC]
and
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National

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F 887	Continued From page 142 Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide documentation in the resident's clinical record of the COVID-19 vaccine administration or the refusal of or medical contraindications to vaccines for 1 of 58 residents (Resident #129), in the survey sample. The findings included: Resident #129 was originally admitted to the facility 11/11/21 and was discharged home 12/9/21. The current diagnoses included; COPD, hypertension, coronary, artery disease and a major depression disorder. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/17/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #129's cognitive abilities for daily decision making were moderately impaired. An interview was conducted with Resident #129 on 12/8/21 at approximately 11:25 a.m. The resident stated she would be discharged home on 12/9/21 after 5:00 p.m. The resident further stated she had asked for the COVID-19 vaccine but hadn't received it and she really desired to have it prior to going home. Resident #129 stated she had been hospitalized prior to coming to the rehabilitation center for falling multiple times and shortness of breath after not having her inhalers for several days.	F 887	F887 1. Resident #129 has received the first dose of the Covid-19 vaccine. 2. Current unvaccinated residents have the potential to be affected. 3. Nurses will be educated by the Director of Nursing/designee on documentation of administration of the Covid-19 vaccine or the refusal of, or medical contraindications. 4. The Unit Managers/designees will complete a weekly monitor of documentation of the Covid-19 vaccine. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. 6. Date of completion 1.27.2022	

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Review of Resident #129's 11/11/21 hospital discharge summary revealed the resident requested the COVID-19 vaccine prior to the discharge to the rehabilitation facility but there was no documentation the hospital staff administered it prior to her leaving the hospital.

The clinical record revealed no COVID-19 immunization information therefore; an interview was conducted with the MDS Coordinator on 12/13/21 at approximately 3:00 p.m. The MDS Coordinator stated she thought the resident received the COVID-19 vaccine at the hospital because of the resident's request for it but she saw no documentation to support her thoughts and they hadn't successful in get additional documentation from the hospital.
An interview was also conducted with the Admission's Director on 12/13/21 at approximately 3:10 p.m. The Admission's Director stated it is her responsibility to obtain COVID-19 vaccination and testing status prior to admissions to the facility but she failed to gain the vaccination status for Resident #129.

An interview was conducted with the Director of Nursing on 12/13/21 at approximately 3:34 p.m. The Director of Nursing stated vaccination options begin at the time of admissions and if a resident decides they would like an immunization nursing provides the education, obtains consents, the order and administer the vaccine. The Director of Nursing stated they keep a record of resident's requesting the COVID-19 vaccine because they are unable to obtain it until ten residents are to be vaccinated.

On 12/14/21 at approximately 5:30 p.m., the above findings were shared with the

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F 887	Continued From page 144 Administrator, Director of Nursing and Corporate Consultant. The Corporate Consultant stated the facility has two vaccination clinic each month and Resident #129 was vaccinated while she was in the facility and or arrangements were made on her behalf to receive the COVID-19 vaccine in the community.	F 887		