STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495305	A. BUILDING _____ B. WING _____	C 10/28/2021

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COLISEUM NURSING AND REHABILITATION CENTER	305 MARCELLA ROAD HAMPTON, VA 23666

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E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Recertification on 10/26/21 to 10/29/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/26/21 through 10/29/21 Survey Census: 126 Sample Size: 28 Supplemental Residents: 0 Intake ID VA00052484 was unsubstaniated, however an incidental finding was issued at F684 related to the intake.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		12/10/21

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

Electronically Signed | 11/24/2021

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F 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the 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, interview, and facility policy review, the facility failed to ensure residents were treated with respect and dignity for three of 28 residents reviewed for respect and dignity (Resident (R) 36, R77, and R119).	F 550	1. For Resident 119 the catheter drainage bag was immediately covered. Social worker interviewed Residents 77, 119 and 36- they did not express any concerns/complaints in regards to the manner in which they were fed by staff members.	

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F 550	Continued From page 2 Findings include: 1. During dining observation on 10/26/21 at 12:27 PM, R77 was sitting at the table in the dining room and Certified Nursing Assistant (CNA) 2 walked over to the resident and fed her two spoonfuls of food, while standing at the table next to R77. During an interview on 10/26/21 at 12:34 PM, CNA2 confirmed she assisted R77 with eating while standing beside the resident. 2. Observations on 10/26/21 at 9:34 AM, 10/27/21 at 8:31 AM, and 10/27/21 at 2:14 PM revealed R119 lying in bed supine (on his back) with his urinary catheter bag hanging from the left side of his bed uncovered and exposed to the view of his roommate and others that may enter his room. During an observation on 10/27/21 at 8:31 AM, Nursing Assistant (NA)2 was standing to the right of R119, feeding the resident breakfast at this time. During an interview on 10/27/21 at 8:31 AM, NA2 revealed she was R119's regular NA and she always left the urinary catheter bag uncovered and did not know if there was a cover for the urinary catheter bag. Additionally, NA2 stated she always stands when feeding R119. Review of R119's "Face Sheet" located in the Electronic Medical Record (EMR) under the "Resident Info" tab, revealed an admission date of 05/11/21 with diagnoses including neuromuscular dysfunction of the bladder and quadriplegia.	F 550	2. Residents with a catheter were assessed to ensure the catheter bag was covered any variance noted were corrected. All residents were observed over several days and meals to ensure dignity was maintained while feeding residents. 3. ADON/Designee in-serviced staff on residents' rights- this shall include but not limited to the right to privacy in regards to concealing the catheter bag from other residents and visitors and treatment with respect in regards to sitting while feeding a resident 4. Director of Nursing or designee will conduct observations/interviews weekly for 6 weeks to include 20% of residents to ensure they are treated with respect and dignity. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly.	

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F 550	Continued From page 3	F 550		

Review of R119's "Minimum Data Set" (MDS) located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 08/16/21 revealed the presence of an indwelling urinary catheter.

During an interview on 10/27/21 at 2:14 PM, Licensed Practical Nurse (LPN) 3 stated the urinary catheter bag should be always covered for infection control and dignity purposes.

During an interview on 10/28/21 at 3:26 PM, the Director of Nursing (DON) stated, "The catheter bags that we use has a cover over them so there is no extra bag that we put it in." The DON further stated if a resident comes to the facility with a catheter bag without a cover, she expects the catheter bag to be change to the type of catheter bag that is used at the facility in order to "provide a level of dignity." The DON further confirmed R119 did not have a catheter bag with a cover.

Review of the facility's policy titled, "10 Helpful Meal Pass Guidelines for CNA Staff" reviewed and approved 06/23/10, indicated, "While providing resident assistance with feeding, CNA staff should be in a seated position next to the resident."

Review of the facility's policy titled, "Catheter Care, Indwelling" reviewed and approved 07/06/12, indicated, " Maintain catheter tubing above level of drainage and prevent tension. The drainage bag should be kept off the floor and below bladder, covered with a drainage bag cover."

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F 550	Continued From page 4	F 550		

3. Review of R36's "Face Sheet" found in R36's Electronic Medical Record (EMR) under the "Admission" tab revealed the resident was admitted to the facility on 03/10/20 and had diagnoses of muscle weakness (generalized), sepsis, and unspecified age-related cataract.

Review of R36's Quarterly "MDS" with an ARD of 08/25/21, found in R36's EMR under the "MDS" tab revealed the resident had a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident was severely impaired in cognition. The MDS indicated R36 had no limitations in range of motion (ROM) to the upper and lower extremities on both sides and was totally dependent on staff for eating.

Review of R36's comprehensive "Care Plan," effective 01/29/21, found in R36's EMR under the "Care Plan" tab indicated, the resident had the potential for health and safety concerns related to ADL (activities of daily living) needs and mobility status." The care plan also indicated the intervention to "provide feeding and setup assistance when the resident was unable to perform independently."

Observation of R36 in the resident's room, on 10/26/21 at 12:39 PM, revealed Nurse Aide (NA) 1 took the lunch tray off the meal cart in the hallway, placed it on the bedside table, removed the lids off the food then lowered the bed. Continued observation revealed NA1 stated the resident's name a couple of times then fed her a couple of bites of pureed food with a spoon while standing on the left side of the bed. Further observation revealed NA1 exited R36's room then went to the nurse's station.

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F 550	Continued From page 5 Interview on 10/26/21 at 1:15 PM with NA1 confirmed she was standing while feeding R36 a couple bites of food and that she was trying to get R36 ready to feed herself because some days she had to feed R36. NA1 stated that if she fed her the entire meal then she would sit next to her as she fed her. Interview on 10/28/21 at 9:03 AM with LPN10 revealed that when feeding a resident, the staff should be sitting down next to the resident because the resident could choke, and it could be a dignity issue. Interview on 10/29/21 at 4:13 PM with Social Worker (SW) 2 revealed that she had not received any complaints from residents on how they are fed but she wouldn't want the staff to stand over her for she considered it a dignity issue.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to 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.	F 584		12/10/21

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F 584	Continued From page 6 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of maintenance records, and review of facility policy, the facility failed to ensure maintenance services to maintain clean and orderly environment for residents' rooms on three of three units in the facility. Findings include: The following observations were made during an environmental tour with the Maintenance Director (MD) on 10/29/21 that began at 10:11 AM and concluded at 11:00 AM:	F 584	1. Maintenance repairs were completed on the following: room 109-bathroom door stained, room 112 and 321 heat/ac unit firmly fixed to the wall, room 131 wall repair under the sink, room 329 and 407 the call light reaffixed to base, room 404 ac resealed and affixed to the wall, and room 424-night stand was replaced. 2. All resident rooms were evaluated for maintenance needs using a comprehensive checklist tool to evaluate needs for a safe clean homelike environment. Any variance will be	

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F 584	Continued From page 7 1. In Room (RM) 109 the bathroom door was observed to have a large amount of white substance along the bottom on the inside of the door. The MD identified the substance as being material used to fill holes and was unaware aware of why there was no further repair such as painting the door. 2. In RM 112 the heating/air conditioning unit was attached only on the top corner and was hanging crooked off the wall. The base cove molding was observed to be coming away from wall and there was crumbling plaster underneath the heating/air conditioning unit. 3. In RM 131 the wall under the bathroom sink had large chunks of plaster falling off the wall with pieces of the plaster laying on the floor under the sink. In this same room there was peeling paint and plaster around the air conditioner under the window by B bed. 4. In RM 321 the heating air-conditioned under the window by B bed was not firmly attached to the wall. 5. In RM 329 and RM 407 the resident call light box was dislodged from the wall. The box and wires were noted to be hanging out of the wall. The MD stated he has snapped a couple of these call light boxes back in place in other resident rooms, but they continue to become dislodged when the staff or the residents pull on the call light cord. 6. In RM 404 the seal around the air-conditioner on the wall under the window by B bed was broken. The heating/air-conditioner was dislodged and not firmly attached to the wall. 7. In RM 424 the nightstand located beside the first bed by the door was observed with the top surface of the nightstand peeling off. The side of the second and third drawers were also noted	F 584	corrected. 3. Administrator/designee in-serviced staff on the process of reporting maintenance needs to include but not limited to writing maintenance needs in the log book, maintenance to review log books and sign off when item completed. Room assessments will be completed monthly or as needed to determine any maintenance needs. 4. Administrator/designee will audit 25% of rooms weekly for six weeks to ensure rooms provide a clean safe homelike environment. Administrator/designee will audit the maintenance log books weekly for six weeks to ensure maintenance needs are written in the log book and completed timely. Administrator will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	

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F 584	Continued From page 8 with large pieces of peeling surfaces hanging off of them. The MD verified the above findings and confirmed these areas needed repair. He indicated there are maintenance binders on each unit where the staff are required to post any maintenance needs. Review of the binders on the 100 Hall, 300 Hall and 400 Hall binders revealed they were silent to the areas identified during the tour. The MD indicated he had only been employed at the facility for one week and is aware there are maintenance concerns that need to be addressed in the facility, he will be setting up a plan to conduct routine room observations to ensure concerns are identified and repairs done as needed but that has not been done yet. During an interview with the Administrator on 10/29/21 at 3:33 PM she indicated the facility has been without maintenance staff since April 2021. She indicated if they had major issues while they were without a MD, they were required to call cooperate maintenance to fix what was needed. The Administrator indicated the new MD was hired one week ago and will working to set up a system to ensure all maintenance concerns are identified and corrected. The Administrator confirmed the identified concerns noted from the tour with the MD will need to be addressed. Review of the facility's policy titled, "Quality-of-Life" indicated the facility would provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior environment.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		12/10/21

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F 677	Continued From page 9 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and policy review, the facility failed to provide documented evidence assistance with activities of daily living (ADLs) was given to three of four residents reviewed for ADLs (Residents (R)20, R32, and R95) out of a total sample of 28 residents. Specifically, there was no documented evidence residents received showers/tub baths in accordance with the bath schedule and their needs. All three residents resided on the Hampton unit. Findings include: Review of the paper "Tub or Shower Bath" policy dated 03/01/15 revealed "Residents should receive a tub or shower bath at least twice weekly. The purpose was "To provide cleanliness and comfort to the resident. To assist the resident in bathing. To prevent body odors. To stimulate circulation and provide a mild form of exercise. To observe the resident's skin condition. To alleviate skin conditions." 1. Review of the "Face Sheet" undated, in the electronic medical record (EMR) under the admission tab, revealed R20 was admitted to the facility on 02/17/95. Diagnoses included intellectual disability, epilepsy, aphasia (loss of ability to understand or express speech), and seizure disorder.	F 677	1. Resident 20, 32 and 95 were provided showers. 2. The shower records for all residents have been reviewed for the past week to ensure the medical records reflect residents were offered showers twice weekly. Any variances identified will be corrected. Residents who refuse showers or have preferences regarding their shower will be accommodated to the extent possible and preferences will be care planned. Nursing staff will be responsible for documenting showers or refusals and alternate received at least twice weekly. 3. The Director of Nursing /designee in-serviced the CNA□s on the importance of ensuring residents are offered a shower at least twice weekly including accurate documentation that showers are provided/refused. The charge nurse/designee will review the daily ADL documentation at the end of each shift for 2 weeks to ensure the records accurately reflect showers provided/refused. 4. The Director of Nursing /designee will review 20% of resident□s shower logs weekly for six weeks. The review will ensure ongoing compliance with offering/providing showers twice weekly and accurate documentation. The Director of Nursing/Designee will identify any	

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F 677	Continued From page 10	F 677		

Review of the Annual "Minimum Data Set" (MDS), with an Assessment Reference Date (ARD) of 08/03/21, in the electronic medical record (EMR) under the "MDS" tab, revealed the resident had no speech during the assessment period, she was rarely understood, rarely understood others, and was highly impaired in vision. A Brief Interview for Mental Status (BIMS) test was not completed. R20 had both short term and long-term memory problems and was severely impaired in decision making. R20 was dependent on one to two persons for ADLs including hygiene and baths.

Review of the "Care Plan" dated 08/13/20, in the EMR under the care plan tab revealed R20 was totally dependent on staff for bathing. The goal was for the resident to be bathed/showered by staff. Interventions included "Tub or Shower two times weekly."

Review of the "Care Plan" dated 08/13/21, in the EMR under the care plan tab revealed the resident required total care with ADLs. One of the interventions was to, "Keep hair clean and tidy."

Review of the paper undated shower schedule, in the ADL book, revealed R20 was scheduled for showers twice a week.

Review of the paper "ADL Verification Worksheet" for showers, from 08/30/21 - 10/28/21 and printed by the facility, revealed R20 was documented to have received one shower/tub bath during this two-month period, provided on 09/15/21. One refusal was documented on 10/13/21.

Observations on 10/26/21 9:05 AM and 11:30 AM and on 10/27/21 at 8:39 AM, revealed R20's hair

patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.

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F 677	Continued From page 11	F 677		

was greasy. During each observation, she was lying in bed.

During an interview on 10/27/21 at 9:46 AM, family member (F)20 stated R20's hair was greasy at times and R20's hair did not get washed often enough.

During an interview on 10/27/21 at 4:38 PM, Licensed Practical Nurse (LPN)7 stated residents should receive two shower/baths per week. He stated Certified Nurse Aides (CNAs) documented the provision of showers/baths in the computer. He verified not all residents received showers/baths as scheduled twice a week. He stated, when he worked, he went and asked residents who were scheduled for showers if they wanted their scheduled shower. He stated he made sure the specific residents who stated they wanted their showers, received them.

During an interview on 10/28/21 at 10:25 AM, CNA3 stated residents were scheduled for showers according to their room number and were supposed to receive two showers per week. CNA3 stated if there were not enough CNAs on the Hampton Unit, she was not able to get showers completed. She stated, "At times I do not give baths/showers that are scheduled."

During an interview on 10/29/21 at 7:58 AM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed together. They explained the coding on the computerized shower/tub bath records and stated "Yes" meant a shower/tub bath was given. The ADON stated families had expressed some concerns related to the provision of showers/tub baths. They stated if a shower/tub bath could not be provided, a bed

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bath was given instead.

During an interview on 10/29/21 at 2:29 PM, the Administrator stated she was not sure if R20 refused showers. The Administrator stated she expected staff to document a refusal if a resident refused their scheduled shower. The Administrator stated residents should receive two showers weekly. The Administrator reviewed the paper "ADL Verification Worksheet" for showers from 08/30/21 - 10/28/21 and verified one "Yes" response was documented on the report indicating one shower was provided.

2. Review of the "Face Sheet" undated, in the EMR under the admission tab, revealed R32 was admitted to the facility on 07/07/20; diagnoses included dementia with behavioral disturbance, anxiety disorder, overactive bladder and history of urinary tract infections.

Review of the "MDS" with an ARD of 05/19/21, in the EMR under the assessment tab, revealed R32 was unable to complete the BIMS test. R32 was impaired in long- and short-term memory and had moderately impaired decision making. Although R32 exhibited some behaviors, R32 was not identified as rejecting care. R32 required physical help from one staff for bathing.

Review of the "Care Plan" dated 05/24/21, in the EMR under the care plan tab, revealed the potential problem of health and safety concerns related to ADL needs and mobility status. Interventions included in pertinent part assisting the resident with bathing as needed.

Review of the paper undated shower schedule, in the ADL book, revealed R32 was scheduled for

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showers twice a week.

Review of the paper "ADL Verification Worksheet" for showers, from 08/30/21 - 10/28/21 revealed it was documented R32 received six showers in this two-month period (on 09/02/21, 09/16/21, 09/29/21, 10/04/21, 10/14/21, and on 10/18/21).

During an observation on 10/27/21 at 8:28 AM, R32's hair was greasy and hanging straight down next to her face; she was sitting in her wheelchair in her room. On 10/28/21 at 9:33 AM, R32's hair was hanging straight down and was greasy looking; she was up in her wheelchair in her room. On 10/28/21 at 12:15 PM R32 was wheeling herself into the hallway; her hair was greasy.

During an interview on 10/28/21 at 1:29 PM, family member (F)32 recalled an incident and stated R32 was incontinent of urine and when he took her to see an ophthalmologist. F32 stated upon arriving to the appointment, he discovered R32 reeked of urine. F32 stated, "It looks like she has not been bathed at times." F32 stated R32's hair was oily, and the family brought this up to administrative staff. F32 stated he had purchased waterless shampoo and had washed R32's hair when he visited because her hair was "that oily and soiled."

During an interview on 10/29/21 at 2:29 PM, the Administrator stated she attended a care plan meeting with F32. The Administrator stated F32 expressed concerns with R32 being wet from urine when he took R32 to an appointment. The Administrator stated she was not aware of concerns about the resident not receiving showers or her hair not getting washed. The

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Administrator reviewed the paper "ADL Verification Worksheet" for showers from 08/30/21 - 10/28/21 and verified six "Yes" responses were documented on the report indicating six showers were provided in the past two months.

3. Review of the "Face Sheet" undated, in the EMR under the admission tab, revealed R95 was admitted to the facility on 09/25/19. Diagnoses included in pertinent part muscle weakness, difficulty walking, atherosclerotic heart disease, chronic obstructive pulmonary disease and schizophrenia.

Review of the Significant Change "MDS" with an ARD of 10/02/21, in the EMR under the MDS tab, revealed it was very important to R95 to choose between a tub bath, shower, bed bath or sponge bath. The resident was moderately impaired (moderate impairment equals a score of 8 - 12) in cognition with a BIMS of 10 out of a total of 15. R95 exhibited no behavior; he required extensive assistance of one person for dressing and bathing.

Review of the "Care Plan" dated 10/10/19, in the EMR under the care plan tab, revealed R95 had "the potential for health and safety concerns related to ADL needs and mobility status." Interventions in pertinent part included to assist R95 with bathing as needed.

Review of the paper undated shower schedule, in the ADL book, revealed R 95 was scheduled for showers twice a week.

Review of the paper "ADL Verification Worksheet" for showers, from 08/28/21 - 10/28/21, revealed

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F 677	Continued From page 15 during this two-month period it was documented R95 received showers six times (on 9/10/21, 9/14/21, 9/17/21, 9/28/21, 10/5/21, 10/12/21). During an interview with the resident on 10/26/21 at 12:02 PM, R95 stated he received a shower about once every two weeks. R95's hair was observed to be hanging down and was greasy during the interview. The resident's hair remained the same throughout the survey with additional observations on 10/28/21 at 9:35 AM when he was wheeling himself down the hall in his wheelchair. R95 was participating in an activity in the dining room on 10/28/21 at 4:18 PM and during the group interview on 10/27/21 at 10:37 AM. Based on the paper "ADL Verification Worksheet" for showers, from 08/28/21 - 10/28/21, as of 10/28/21, R95's last shower was documented 16 days earlier on 10/12/21. During an interview on 10/29/21 at 2:29 PM, the Administrator reviewed the paper "ADL Verification Worksheet" for showers from 08/28/21 - 10/28/21 and verified six "Yes" responses were documented on the report indicating six showers were provided in the past two months.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		12/10/21

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F 684	Continued From page 16 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and policy review, the facility failed to ensure one of two residents reviewed for hospitalizations (Resident (R)112), out of a total sample of 28 residents, received timely adequate nursing care and services in accordance with physician's orders. The condition of R112's post-surgical ankle wound deteriorated, and an order was received from the physician to send the resident to the hospital emergency department. There was a delay of approximately 12 hours in sending the resident to the hospital; R112's wound was significantly infected when he arrived at the hospital and a two-week hospital stay to treat the ankle/wound was required before R112 could return to the facility to continue rehabilitation for the right ankle fracture. Findings include: Review of the "Face Sheet" dated 10/07/21, in the electronic medical record (EMR) under the admission tab, revealed R112 was originally admitted to the facility on 05/25/21. Diagnoses included in pertinent part: nondisplaced comminuted fracture (bone broken into two or more pieces) of the shaft of the right fibula (break in the bone that stabilizes and supports your ankle and lower leg muscle), infection to internal fixation site, osteomyelitis of right tibia (larger of the two bones in the lower leg or the shin bone) and fibula, infection following procedure at surgical site, type two diabetes with diabetic neuropathy, and congestive heart failure (CHF). Review of the paper hospital "Discharge	F 684	1. Resident 112 was transferred to the hospital on 6/19/2021. 2. All residents transferred to the transport in the last 30 days will be reviewed to ensure the residents were transported timely and if not, the provider was notified. 3. ADON/designee in-serviced staff on the process of adequate nursing care and services in accordance with physician orders. 4. Director of Nursing or designee will audit residents with physician orders for transport to the hospital weekly for six weeks to ensure resident has been transported in accordance with physician order. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly.	

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Summary" dated 05/25/21, provided by the facility, revealed the resident was hospitalized prior to his original admission to the nursing home with an ankle fracture bimalleolar (in addition to one of the malleoli being fractured, the ligaments on the inside (medial) side of the ankle are injured, making the ankle unstable), closed right. The ankle fracture was surgically repaired with an open reduction internal fixation (ORIF) procedure. The resident was to receive weekly dressing changes to the right lower extremity surgical site or as needed for soiling and saturation. The resident was to be non-weightbearing to the right lower extremity with a CAM walker boot (controlled ankle motion walking boot) in place.

Review of the "Minimum Data Set" (MDS) with an assessment reference date (ARD) of 05/31/21, in the EMR under the MDS tab, revealed R112 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (score of 13 - 15 equals cognitively intact). R112 required extensive assistance of one staff for bed mobility, dressing, and toilet use, R112 did not walk during the assessment period.

Review of the paper "Clinical Notes Report" for 06/16/21 - 06/18/21, provided by the facility revealed on 06/18/21 at 12:12 PM a nurse documented, "Call placed to [name of orthopedic office], office never picked up the phone will try again later." On 06/18/21 at 12:49 PM the nurse documented "Spoke with resident wife this morning made aware of status of wounds and attempts to call [name of orthopedic office] and attempts to call [facility name] ortho office. Also noted today right medial malleolus wound larger and with more drainage than previous dressing change, resident also aware. NP (nurse

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practitioner) [name] aware." On 06/18/21 at 8:46 PM the nurse documented, "Spoke with [name of orthopedic office] r/t (related to) new wound on right shin and decline of wound to the right medial malleolus, state since resident is unable to be seen if [sic] the office today that the provider would like resident to go to [facility name] ED (emergency department). Resident made aware and wife made aware. NP [name] made aware." On 06/19/21 at 8:17 AM the nurse documented, "Called several times for transport. Wife/social worker made aware not picked up this time. Resident up in w/c (wheelchair) alert and orient able to make needs known. No distressed noted by resident." On 06/19/21 at 2:49 PM the nurse documented, " Sitting up in bed. Call bell within reach. Denies pain. No signs of distress ... to be picked up via stretcher by 0830 (8:30 AM)."

During an interview on 10/26/21 at 2:30 PM, R112 stated he fell down the stairs at home and broke his ankle in two places and tore some ligaments. He stated, in the hospital, a rod and screws were placed on both sides to hold the ankle in place. R112 stated he came to the facility for rehabilitation of his ankle with an anticipated stay of two and a half months. R112 stated on 06/17/21 he first noted the ankle wound did not, "look right" and he told the wound nurse changing the bandage he wanted to go to the emergency room (ER). R112 stated he did not have much pain; however, indicated he had reduced sensation to his feet due to neuropathy. R112 stated on 06/18/21, he expressed concern again and the nurse told him she would send him to the ER that day. R112 stated, "Transportation did not come; I called my wife on Saturday (06/19/21)." R112 stated his wife was upset and stated if no one came to pick him up she was going to come

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to the facility and call 911(emergency services). R112 stated the facility then arranged transportation and he left the facility on 06/19/21 at about 9:00 AM. R112 stated the wound was in poor condition when he arrived at the hospital on 06/19/21 and the surgeon informed him if he had waited any longer to come to the hospital, his foot would have required amputation. R112 stated he remained in the hospital for two weeks; the wound was infected, he was administered intravenous antibiotics, and the wound required continual debriding, all the way to the bone, hardware was removed, and a wound vac was initiated.

Review of the paper hospital "History and Physical" dated 06/21/21, provided by the facility, revealed, "Patient was called to the emergency room for possible I & D (process to drain abscesses) due to infected wound and hospitalist was called to admit by orthopedics team ...Delayed wound healing, concerns of wound infection. Post ORIF right ankle in May 2021 ... [Resident's name] ... has the following co-morbidities: HTN (hypertension), diabetes and CHF. Therefore, he will need to be admitted to the general medical floor as an inpatient, for a minimum of 2 midnights to reduce the risk of developing severe sepsis and progression to septic shock and/or death if not treated in a hospital setting."

During an interview on 10/27/21 at 4:11 PM, the Wound Care Nurse (WCN) stated R112 came into the facility following surgery to his right ankle. The WCN stated she called the orthopedic physician about R112's inner ankle, but the orthopedic physician did not answer the call (documented on 06/18/21). The WCN stated, on

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06/18/21, she spoke to the resident's wife and made her aware of the status of the wound; the right malleolus wound was larger and there was more drainage. The WCN stated the Nurse Practitioner was notified. The WCN stated R112 went to the hospital on 06/19/21. The WCN stated staff called several times for transportation on 06/18/21; however, no one came and picked up R112 on 06/18/21. The WCN stated a different ambulance company was called on Saturday morning and they came and picked up R112 and transported him to the hospital. The WCN stated, if an ambulance service was not able to pick up a resident, then staff should call a different company for transport. It was standard protocol to call another ambulance company.

During an interview on 10/29/21 at 9:03 AM, Licensed Practical Nurse (LPN)4 stated she worked on the morning of 06/19/21 and sent R112 to the hospital. LPN4 stated R112 had asked to go to the ED, tried to go the night before, but it did not work out. LPN4 stated R112 was at the point on 06/19/21 where he was going to call 911 or his wife was going to. LPN4 stated she was not sure what happened with the transportation on 06/18/21, but R112 was very upset. LPN4 stated she was not sure if the transportation was supposed to be non-emergent transport. LPN4 stated the order was for R112 to go to a specific hospital because that is where his orthopedic physician was located. LPN4 stated if 911 was called there was no guarantee R112 would go to the hospital where his orthopedic surgeon was located. LPN4 stated according to her note written on 06/19/21, R112 was not in pain or in distress on the morning of 06/19/21.

On 10/29/21 at 8:05 AM, the Director of Nursing

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(DON) and Assistant Director of Nursing (ADON) were interviewed together. They stated transportation should have been set up for R112 to get him to the ED per the physician's order. However, if the resident was not in immediate distress, he could not be transported via 911. In the case of R112, staff could have tried calling a different ambulance company when the first one did not come and get him on 06/18/21. They stated if 911 was called, R112 would be transported to the closest hospital which was not the one in which his orthopedic physician was located. The DON stated, had she been notified, she would have gotten involved and made some calls. The DON stated she was not notified at the time of the incident of the failure of the ambulance transport company to come and pick up R112.

During an interview on 10/29/21 at 12:49 PM, the Administrator stated the facility had other means to get R112 to the ED on 06/18/21. She stated in the past the facility had utilized cabs to get residents to the hospital depending on the care they needed. The Administrator stated, for transportation calls that were not emergent, transportation companies did not always give time frames when they would arrive. The Administrator stated if a resident needed to be seen and the transportation had not arrived, nurses should use their judgement about whether to call 911. The Administrator stated nursing staff could have notified her or the DON if they were not getting a response regarding transportation from the ambulance company. The Administrator stated the DON or herself could look at other options. She stated there was also the possibility the family could take a resident to the ED.

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F 684	Continued From page 22 During the resident interview on 10/26/21 at 2:30 PM, R112 was observed to be wearing a CAM boot on his right foot with a dressing in place underneath the boot. On 10/28/21 at 9:05 AM, R112's wound care to the right ankle was observed. Physician's orders were followed, technique was appropriate, and no concerns were noted. The right ankle wounds had dated and labeled dressings on both medial and lateral areas with dates of 10/27/21 reflecting daily dressing changes occurring per the physician's order. There was no drainage from either wound, both wounds were healing and per R112, he stated the wounds were healing, and way better than they were previously. Review of the paper "Resident Change in Condition" policy dated 3/13/17 revealed "Residents are assessed when there is a change in condition and assessment documented in the medical record. The attending physician and the resident representative are notified of change in condition."	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		12/10/21

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F 688	Continued From page 23 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to provide services to ensure two (Residents (R)63 and R4) of four residents reviewed for limited of Motion (ROM) and mobility, maintained or improved function unless reduced ROM/mobility was unavoidable based on the resident's clinical condition. Findings include: 1. Review of the "Face Sheet" in the Electronic Health Record (EMR) for R4 revealed an admission date of 07/02/19 with a current diagnosis of arthritis. Review of the "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 07/19/21 revealed a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition. The "MDS" indicated R4 had functional limitation in ROM to her upper extremities to include her shoulder, elbow, wrist, and hand with impairment of both sides. Review of the "Comprehensive Care Plan," located in the EMR under the "Care Plan" tab revealed R4 had the potential for health and safety concerns related to activities of daily living (ADLs) needs. Interventions were noted to daily clean and dry R4 left and right hand and apply left and right palm protectors daily after AM ADLs	F 688	1. Resident 63 was placed on restorative plan including ROM and ambulation on 10/28/2021. Resident 4 had palm protectors applied per care plan to prevent a decline in ROM/mobility. 2. All residents identified with limited ROM and mobility were reviewed to ensure appropriate services were provided to maintain and/or improve function. 3. ADON/designee in-serviced staff on ROM/mobility to include but not limited to importance of maintaining mobility, policy of nursing rehabilitation restorative care program 4. Director of Nursing or designee will audit 10 residents weekly for the next six weeks to ensure residents with limited ROM and mobility received appropriate service to maintain and/or improve function. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	

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care and apply left and right palm protectors at PM after ADLs.

Observations of R4 on 10/26/21 at 11:33 AM revealed she was in bed and her hands were observed to be contracted with her fingers clenched tightly to the middle of her hands. She was not able to spread her fingers out upon request. There were no splint devices or palm protectors observed in the right or left hand.

Observation on 10/27/21 at 8:44 AM and 3:18 PM and again on 10/28/21 at 9:48 AM while R4 was in bed revealed her hands were contracted with her fingers clenched tightly to the middle of her hands. She was not able to spread her fingers out upon request. There were no splint devices or palm protectors noted in her right or left hand.

Interview with Certified Nurse Aide (CNA)1 on 10/28/21 at 2:03 PM during an observation of R4 verified R4 did not have splints devices or palm protectors to her left or right hand in place. She verified the resident should always have cloth protectors in both hands except when she is eating.

Interview with Licensed Practical Nurse (LPN)7 on 10/28/21 at 2:07 PM verified splints or palm protectors were not in place in R4 left or right hand and indicated they should have been placed in her hands after lunch.

Interview with CNA4 on 10/28/21 at 2:15 PM the CNA verified R4 did not have splints or palm protectors in her left or right hand and stated palm protectors should have been placed in both her hands after she fed herself lunch. CNA4 obtained two palm protectors from R4's

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nightstand and applied them to her left and right hand.

This information was shared with Registered Nurse (RN) Corporate and the Director of Nursing (DON) on 10/28/21 at 4:18 PM and no additional information was provided regarding the lack of palm protectors that were care planned to be in in R4' left and right hands during the observations on 10/26, 10/27 and 10/28/21.

2. Review of the "Face Sheet" located in the EMR revealed R63 was admitted to the facility on 09/10/21 with a diagnosis of peripheral vascular disease, diabetes and right below the knee amputation.

During an interview with R63 on 10/26/21 at 9:50 AM he stated he would like to continue to receive the therapy he was receiving after he returned to the facility from having a right below the knee amputation. He stated he stopped receiving therapy a few weeks ago and was not sure why.

Review of the most recent "MDS" with an ARD of 09/10/21 revealed a BIMS score of 15 which indicated intact cognition. The "MDS" revealed R63 received Occupational Therapy for four days out of the last seven days for 180 minutes and received Physical Therapy for four days out of the last seven days for 147 min. The "MDS" revealed R63 required extensive assistance of two staff for bed mobility and transfers from the bed to the wheelchair.

Review of the "Person-centered Comprehensive Care Plan" in the EMR under the "Care Plan" tab related to ADLS for R63 revealed he had the potential for health and safety concerns related to

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ADLs needs and mobility status. Interventions include for staff to provide transfer assistance when transferring to and from different surfaces and to use a sit to stand lift attended by at least one staff. The care plan included to provide assistance with dressing and or managing clothing during dressing. The care plan was silent to any current therapy or restorative programs R63 was participating in.

Review of the "Clinical Notes" located in the EMR under the "Notes" tab revealed R63 received a Medicare Non-Coverage letter on 09/21/21 indicating his last covered day of skilled care would be on 09/23/21. R63 signed the letter and requested an appeal of the decision and on 09/22/21 a notice was received indicating R63 had won the appeal and would continue with skilled services. On 09/28/21 the clinical notes revealed R63 received a Medicare Non-Coverage letter on 09/28/21 indicating his last covered day of skilled care would be on 09/30/21 and R63 appealed the decision. The appeal to continue services was denied and the clinical notes revealed R63 was being prepared to be discharged to home with his son.

Interview with Occupational Therapist (OT) on 10/28/21 at 2:39 PM revealed when a resident is discharged from therapy and remaining in the facility, they will often be placed on a functional maintenance restorative program in which they would receive specific exercises to prevent physical decline. She stated R63 was scheduled to go home on 10/01/21 when his therapy services were cut. OT stated at the time R63 was discharged from therapy services he was performing a scoot pivot transfer. She stated his last day of therapy services was noted to be

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10/07/21. She stated if insurance denied services, they would at least place a resident on a functional maintenance restorative program, but he was scheduled to go home, and she was not aware if once the decision was made for R63 to remain in the facility for a longer period of time if the MDS staff had identified the need for him to be placed on a functional maintenance restorative program.

Interview with MDS Coordinator 1 and MDS Coordinator 2 on 10/28/21 at 2:59 PM revealed R63's therapy services were discontinued on 10/07/21 and Social Worker (SW) 1 and 2 had worked with the family for discharged plans. MDS Coordinator 1 indicated the discharge plans for R63 changed and the family decided he would be staying at the facility until he got stronger.

Interview with SW2 on 10/28/21 at 3:15 PM revealed when R63 was readmitted to the facility on 09/10/21 he was placed on therapy and then was denied therapy services and therapy services ceased on 10/07/21 and the resident had not received any services since 10/07/21. She indicated once therapy services were discontinued it would be the therapy staff that would recommend a resident for the functional maintenance restorative program but verified R63 was not currently receiving those services.

Interview with Registered Nurse (RN) Cooperate on 10/28/21 at 3:43 PM regarding the lack of follow through on recommending R63 for a functional maintenance restorative program once his therapy was discontinued. She stated it sounds like he got lost in the confusion regarding being discharged to home verses remaining in the facility. She confirmed R63 should have been

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referred to receive functional maintenance restorative services. She stated the facility staff should have been having weekly meetings where they talked about therapy needs and planned discharges if R63 was waiting to go home he should have been picked up for the functional maintenance restorative program until he was discharged.

A follow up interview with OT on 10/28/21 4:09 PM revealed the therapy department had conducted a therapy screening on R63 and they would be starting him with the functional maintenance restorative program. She stated he would be receiving strengthening and ROM services. She verified based on the screening conducted R63 had not experienced any declines since he was discharged from therapy services. She stated R63 would begin to receive maintenance restorative therapy services on 10/29/21.

Further review of the updated care plan dated 10/28/21 on 10/29/21 at 9:08 AM provide by the OT revealed effective 10/28/21 R63 was receiving active ROM to include upper extremity and lower extremity strengthening and wheelchair propulsion using bilateral upper extremities and left lower extremity to propel his wheelchair. The care plan was updated to include the restorative nursing program to include measurable goals and objectives to ensure R63 maintains the ability to propel his wheelchair and develop no new contractures.

Review of the facility policy titled, "Nursing Rehabilitation/Restorative Care Program," dated 05/21/21, revealed all residents should receive, as part of their plan of care, services and

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F 688	Continued From page 29 interventions which promote or assist the resident to attain his or her maximum functional ability.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of facility policy, the facility failed to ensure one (Resident (R) 83) of four residents reviewed for nutrition maintained to the extent possible, acceptable parameters of nutritional status and did not experience a significant weight loss. Findings include:	F 692	1. Resident 83 was evaluated by the dietician with recommendation initiated and continue to monitor weekly weights to maintain resident nutritional status to the extent possible. 2. All Residents weights were reviewed for significant weight loss with nutrition maintained to the extent possible, acceptable parameters of nutritional status and did not experience significant	12/10/21

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F 692	Continued From page 30 Review R83's "Face Sheet" located in the Electronic Medical Record (EMR) revealed he was admitted to the facility on 03/03/21 with a diagnosis of glaucoma, blindness of the right eye, low vision in left eye and Vitamin D deficiency. Review of the admission "Minimum Data Set" (MDS) in the EMR under the "MDS" tab with an assessment reference date (ARD) of 03/09/21 revealed R83 was able to understand and to be understood and his vision was noted to be highly impaired. R83's Brief Interview for Mental Status (BIMS) score was 15 indicating intact cognition. The "MDS" indicated R83 required supervision, oversite and cueing for meals by staff. Review of the current "Nutrition Person Centered Comprehensive Care Plan" located in the EMR under the "Care Plan" tab revealed R83 had a potential for weight changes related to the use of antidepressant medication. The nutrition goal documented R83 would not experience a significant unplanned weight change thru next review. Interventions were noted for staff to honor the resident's food choices, provide assistance as needed with eating, provide diet as ordered, report if resident does not consume most of the meal, and weigh R83 routinely. Review of the weights for R83 located in the EMR under the "Weights and Vitals" tab revealed the following weights: 06/09/21 weight was 171.08 07/06/21 weight was 171.00 08/06/21 weight was 173.00 09/29/21 weight was 153.00 10/06/21 weight was 148.06 10/28/21 weight was 152.04	F 692	weight loss. 3. ADON/designee in-serviced staff on weight management to include but not limited to obtaining monthly weights, reweights and weekly weights. Charge nurse/designee in ensure monthly and weekly weights are obtained and referrals to registered dietician as needed. 4. Director of Nursing or designee will audit resident weights weekly for 6 weeks to ensure resident weights were obtained and Dietician referrals were completed as directed. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	

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Review of the "Nutritional Assessment" dated 06/24/21 located in the EMR located under the "Assessment Tab" revealed R83 was 73 inches tall and weighed 171.80 pounds and his oral nutrition intake was 75-100%. R83 required tray set up due to his vision being highly impaired. The overall summary on the nutritional assessment revealed R83 received a regular no added salt diet with finger foods. R83 was documented to be legally blind. Supplements include a multi vitamin, vitamin D3, vitamin 12, vitamin c, and a liquid protein drink. The assessment revealed R83 weights will continue to be monitored and follow up as needed as he was at risk for malnutrition. A recommendation was made to add an additional nutritional supplement once a day and to monitor his weight weekly. There was no evidence the recommendation for weekly weights was implemented.

Review of a "Nutritional Assessment" dated 09/21/21 located in the EMR under the "Assessment Tab" revealed R83 weighed 173.2 pounds based off the last documented weight from 08/06/21. There were no recorded weights for R83 since 08/06/21 despite the recommendations of the dietician on 08/06/21 to obtain his weights weekly for four weeks. R83 nutritional intake had decreased to 25-50 % oral intake. There was documentation in the clinical notes that R83 would refuse oral intake, refuse weights, and refuse assistance from the staff at mealtime. A clinical note on 08/18/21 documented R83 would allow staff to assist him with his meals at breakfast but did not want any assistance at lunch or supper. The dietary assessment reveled based on R83's current weight record he was in the 94% of his ideal body weight with a body mass index of 22.8 which was defined as normal.

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Weights were to continue to be monitored and a recommendation to increase his nutritional supplement to three times a day due to his poor intake. Review of the medication administration record (MAR) for September and October 2021 revealed R83 received and consumed the nutritional supplement.

Review of a "Nutritional Assessment" dated 10/13/21 located in the EMR under the "Assessment Tab" revealed R83 weighed 148 pounds. This was a significant weight loss since his previous weight of 173 despite the addition of the increased nutritional supplement. The Registered Dietician (RD) observed R83 eat his lunch on 10/06/21 and was noted to have poor oral intake but would not converse with the RD. The RD noted R83 was previously on Remeron, a medication used to stimulate appetite, but this medication was discontinued by the Nurse Practitioner (NP) on 09/23/21 per the family request. The RD indicated she was not aware of the medication being discontinued on 09/23/21 until she conducted her nutritional assessment on 10/13/21. The nutritional assessment revealed based on the current weight records R83 was at 81% of his ideal body weight and his BMI was 19.6. The RD recommended to continue weekly weights and increased R83's liquid protein to 30 milliliters (ml) two times a day and discontinued his no added salt diet.

Observation of R83 on 10/26/21 at 1:12 PM revealed he had five individual bowls of food in front of him with one bowl noted be stacked on top of another bowl. R83 was asking for his milk and was moving his hands around the tray trying to find his milk. There was no milk on the tray and staff was notified of his request for milk. R83

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indicated it was difficult for him to see his food and sometimes needs the staff to assist him with his meals. He stated he does not always want assistance with his meals, but he is legally blind and is not able to see all the items on his tray. R83 indicated they put his food in bowls to make it easier for him to find his food. He would prefer the staff just give him a couple of bowls at a time and tell him where they are on his tray, and he would be able to feed himself better. He stated if he is not able to find items on his tray, he turns on his call light for assistance.

Observation of R83 on 10/27/21 at 1:08 PM revealed the staff were setting the resident up for his lunch and provided him with direction of where his food items were on his tray.

Observation on 10/28/21 at 12:59 PM revealed CNA4 was observed feeding R83 his lunch. Interview with CNA4 after the observation revealed he feeds R83 at times depending on what is served. He stated the resident loves soup and when he receives soup for his meal, he helps the resident eat as R83 can hardly see and it is difficult for him to feed himself soup. CNA 4 stated R83 will often refuse assistance and will also refuse his meals and they offer supplements and increased fluids if he does not eat.

Interview with the RD on 10/28/21 at 11:02 AM regarding R83's weight loss revealed she was aware of his current weight loss. She stated she had conducted a nutritional assessment for R83 on 10/13/21 after being notified of a recent weight loss. She indicated she monitors residents for weight loss by tracking their weights on a spread sheet and by accessing weights in the EMR. The RD indicated the staff are also required to advise

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her when residents experience a weight loss of greater than five pounds. She indicated they will let her know by an email which comes from the nurse, or the staff let her know about resident weight loss when she is in the building. She confirmed she had conducted a nutritional assessment for R83 on 09/21/21 and she utilized the last documented weight from the EMR which was a weight from 08/06/21 as that was the most recent weight she had to reference. She indicated R83's weight loss was not identified until his weight was obtained on 09/29/21 at which time he weighed 153 pounds. She indicated she was not notified of R83's 09/29/21 weight of 153 pounds until the nurse notified her on the 10/11/21. She stated she should have been notified on 09/29/21 of R83's decrease in weight as it was a weight loss of greater than five pounds. The RD indicated once she was made aware of R83's significant weight loss on 10/11/21 she conducted another nutritional assessment on 10/13/21 and increased the resident's protein supplement. Since she had just increased his nutritional supplement on 09/29/21 she did not increase the supplements again at that time. She indicated she also recommended to monitor R83's weight weekly for four weeks but verified during this interview there was no documentation of the resident's weight from last week. She indicated if she had been made aware of R83's weight loss when she conducted her nutritional assessment on 09/21/21 she would have recommended the nutritional interventions to promote weight gain earlier. A request was made by this surveyor on 10/28/21 for a weight to be obtained for R83 and the weight was noted to be 152.40 pounds which was an increase of 3.8 pounds since 10/06/21.

Interview with Licensed Practical Nurse (LPN)5

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F 692	Continued From page 35 on 10/28/21 at 12:30 PM revealed she was aware R83 had experienced a significant weight loss over the past couple of months. She verified the weight obtained on 09/29/21 for R83 of 153 pounds was an accurate weight. She stated she requested the staff reweigh R83 when the weight of 153 pounds was obtained as it indicated a significant weight loss. She stated she observed the reweigh to verify and confirmed the weight of 153 pounds was accurate. She confirmed the RD should have been notified on 09/29/21 when the significant weight loss was identified. She verified she did not send the RD a notification of R83's weight loss until 10/11/21. She was unable to indicate why there was a failure to notify the RD timely of R83's weight loss. LPN5 also verified R83 should be weighed every week per the RD recommendations to monitor for additional weight loss. LPN5 shared that R83 will often refuse to have staff assist him with his meals as he wants to be independent. Review of the facility policy titled, "Nutritional Management," dated 01/18/13 revealed each resident should be weighed at least monthly and if a resident exhibits an unplanned weight gain/loss of 5% in 30 days or 10% in 180 days the physician and family should be notified immediately.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		12/10/21

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F 697	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure a resident received timely pain medication for one of 28 sampled residents (Resident (R) 62). Findings include: Review of the facility's policy titled, "Pain Management", revised 06/15/12, revealed "pain should be assessed and documented at regular intervals to ensure residents receive optimal pain management. Assessments should include the onset, location, frequency, quality, and intensity of pain with the resident self-report as primary indicator of pain. Pain assessments should be ongoing, and if interventions are not effective, the treatment plan and plan of care should be revised accordingly. Pain should be coded at the most severe level when the assessment does not determine the exact frequency or intensity of pain." Review of R62's "Face Sheet" found in R62's Electronic Medical Record (EMR) under the "Admission" tab revealed the resident was admitted to the facility on 02/04/21 and had diagnoses of unspecified fracture upper end of left humerus, repeated falls, and muscle weakness (generalized). Review of R62's Quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 09/09/21, found in R62's EMR under the "MDS" tab revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of eight out of 15, which indicated the resident was	F 697	1. Resident 62 had their pain management regime reviewed and the resident denies concerns with pain and is appropriately managed at this time 2. All residents who are receiving pain medication my potentially be affected. Resident□s charts were reviewed for the past 30 days to ensure residents received timely pain management. Any variances were addressed 3. ADON/designee in-serviced staff on pain management. This included but not limited to timely administration of pain medication, what to do in the absence of prn medications and to include the pathway of contacts for MD correspondence. 4. Director of Nursing or designee will audit pain management assessments weekly for 6 weeks to ensure residents pain was addressed timely. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	

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moderately impaired in cognition.

Review of a "Nursing Progress Note," dated 05/31/21 at 6:42 PM, found in R62's EMR under the "Notes" tab revealed, "R62 was found on the floor in her room and the R62 stated she lost her footing and fell to her buttocks. R62 has complaint of pain to her right hip. NP [nurse practitioner] aware. RP [responsible party] aware. Call placed to on call NP. New orders received. Vital signs taken at this time ... Resident resting in bed. Will continue to monitor."

Review of the "Incident/Accident Report" dated 05/31/21, provided by the facility, revealed an unwitnessed fall in the resident's room at 6:35 PM. Assessment to right hip. Impact from the fall was pain rated on numeric pain intensity scale as a seven. Action Taken: MD [medical doctor] notified, RP notified Resident teaching change in resident monitoring medication change."

Review of a "Nursing Progress Note," dated 05/31/21 at 11:20 PM, found in R62's EMR under the "Notes" tab revealed, "This writer has attempted to reach out to the on-call NP several times."

Review of a "Nursing Progress Note," dated 06/01/21 at 8:47 AM, found in R62's EMR under the "Notes" tab revealed, "One time order given by NP for one Norco (narcotic pain medication) 3-325 milligrams (mg) due to pain in her leg that she complained about. Prescription sent to pharmacy by NP. Med given at 10:10 PM."

Review of a "Nursing Progress Note," dated 06/01/21 at 10:03 AM, found in R62's EMR under the "Notes" tab revealed, "Received report of fx

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[fracture] neck of right femur w/ [with] moderate deformity w/o [without] dislocation. NP paged. 4:00 AM received return call from NP and informed of fx to neck of right femur and said to send to ED [emergency department] ...4:30 AM resident received Tylenol 650 mg and Ativan 0.5 mg po [by mouth] for pain and anxiety."

Observation and interview with R62 on 10/28/21 at 11:19 AM revealed R62 could not remember falling in the facility. Her fall preventions were in place.

Interview on 10/28/21 at 3:54 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed the nurse should assess the resident after a fall occurred and if the resident complained of pain, they should administer pain medication if ordered. The DON stated if pain medication is not ordered for the resident, then the nurse should obtain an order for pain medication immediately from the on-call NP. The DON also stated if the nurse couldn't reach the NP, then the nurse should have contacted the management staff to assist in obtaining pain medication because pain should be managed for the residents.

Interview on 10/29/21 at 11:07 AM with the NP revealed the only call received regarding R62 was from Licensed Practical Nurse (LPN) 2 on 05/31/21 at 8:21 PM for a STAT [immediate] order for pain medication for severe upper right leg pain and an x-ray to the pelvis due to a fall. The NP stated LPN2 should have called immediately after R62 was assessed and complained of pain "because you don't leave anyone feeling uncomfortable, you take care of the residents".

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F 697	Continued From page 39 Interview on 10/29/21 at 3:06 PM with LPN2 revealed she assessed R62 after the fall on 05/31/21 and the resident complained of pain to her right hip. LPN2 stated R62 rated the pain a seven which is moderate to severe pain but R62 wasn't grimacing, crying or yelling. LPN2 also stated she administered R62's scheduled pain medication [Tylenol] at 9:00 PM but she couldn't remember why she didn't administer R62 any pain medication after the fall. LPN2 further stated she called the on-call NP at 6:40 PM then called several times afterwards for pain medication and an x-ray as documented in her progress notes.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.	F 700		12/10/21

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F 700	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to attempt use of alternatives prior to installing bed rails, failed to obtain informed consent, and failed to ensure bed rails were maintained to ensure safety for one of one sampled resident (Resident (R)20) reviewed for bed rails out of a total sample of 28 residents. Findings include: Review of the "Face Sheet" undated, in the electronic medical record (EMR) under the admission tab, revealed R20 was admitted to the facility on 02/17/95. Diagnoses included intellectual disability, epilepsy, aphasia (loss of ability to understand or express speech), and seizure disorder. R20 received all nutrition via a gastrostomy feeding tube. Review of the Annual "Minimum Data Set" (MDS), dated 08/03/21, in the EMR under the MDS tab, revealed the resident had no speech during the assessment period, she was rarely understood, and rarely understood others, and was highly impaired in vision. A Brief Interview for Mental Status test was not completed. R20 had both short term and long-term memory problems and was severely impaired in decision making. R20 was dependent on one to two persons for activities of daily living (ADLs) including bed mobility, transfers, dressing, toilet use and hygiene. No restraints were coded as being in use. Review of the "Bed Rail/Entrapment Risk Evaluation" dated 08/02/21, in the EMR under the assessment tab, revealed the only indication for	F 700	1. Resident 20 bedrails were removed with more less restrictive measures in place to include overlay mattress with bolsters and floor mats. 2. Residents currently utilizing ¿ bedrails were evaluated to ensure alternatives prior installation were documented and informed consent obtained. A safety check was performed on all beds with rails installed. 3. ADON/designee in-serviced staff on the use of bedrails to include but not limited to the use of bedrails, alternatives attempted and consent required for the use of bedrails. Nursing staff should appropriately perform bed rail assessment form to determine if bed rails are appropriate for the resident. 4. Director of Nursing or designee will audit 10 residents a week with bedrails to determine if bed rails alternatives were documented and consent was signed for 6 weeks. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	

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bed rail use was the promotion of the resident's sense of safety and security; however, the resident was severely cognitively impaired and was not able to speak or communicate to indicate the bed rails enhanced her sense of safety. Under risks for bed rail use, the resident was identified as not being able to recognize safety hazards of bed rail use. In addition, the form failed to document the resident's seizure disorder which was an identified risk factor for bed rail use. The question regarding the resident having no uncontrolled body movements or seizures was checked "true" indicating R20 did not have uncontrolled body movements or seizures. The form indicated if there were any false answers, which would have included the resident's inability to recognize safety hazards and uncontrolled body movements/seizures, this presented a risk of injury from bed rails.

Review of the "Care Plan" dated 08/13/20, in the EMR under the care plan tab, revealed R20 was dependent on staff for the provision of ADLs. One of the interventions directed use of two half bed rails for bed mobility due to ADL care. However, R20 was not physically capable of using bed rails for bed mobility; she was totally dependent on staff for ADLs.

The EMR was reviewed, and no documentation of less restrictive interventions attempted prior to bed rail use or evidence of consent obtained by the responsible party for bed rail use was found.

Observations during the survey revealed two half bed rails were in place in the mid-section of the resident's bed. The rails were metal with several horizontal bars; the rails were not padded. Bed rails were observed as follows:

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-On 10/27/21 at 8:39 AM and at 8:52 AM, R20 was lying in bed on her back with both half rails in the up position. There was a gap of approximately 3 - 4 inches on the left side between the mattress and the bed rail and the mattress was flush against the bed rail on the right side.
-On 10/28/21 at 12:08 PM, R20 was lying in bed with both rails in the up position. R20 was awake but unable to respond/speak when greeted. There was a gap on the left side between the mattress and the bed rail and the mattress was flush against the bed rail on the right side. The gap was measured and was three inches wide between the mattress and the rail on the left side, confirmed by the Director of Nursing (DON) who was present. The DON indicated adjustment was needed and stated she would get maintenance staff.
-On 10/28/21 at 12:26 PM the Maintenance Director and the surveyor entered R20's room. R20 was lying in bed with the rails up. The Maintenance Director verified the presence of the three-inch gap on the left side and some play in the left rail (wiggled back and forth). The Maintenance Director stated he was not sure how much of a gap was allowable between the rail and the mattress, but he would check.

During an interview on 10/28/21 at 10:22 AM, Certified Nursing Assistant (CNA)3 stated R20 was bed-bound and required total care from staff. CNA3 stated R20 did not move independently and could not do anything for herself. CNA3 stated R20 did not use bed rails for positioning.

During a joint interview on 10/29/21 at 08:21 AM, the DON and Assistant Director of Nursing

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(ADON) revealed nursing staff completed bed rail assessments quarterly. They indicated most of the time bed rails were not used but at times families and residents requested bed rails. They stated less restrictive interventions were attempted prior to bed rail use; however, they did not verbalize what interventions were attempted for R20 prior to bed rail use. They reviewed the bed rail assessment and verified there was no place on the assessment to document less restrictive interventions that were attempted prior to bed rail use. When asked about obtaining consent for bed rails, they stated they were not sure if there was a consent form in use. The DON and ADON were asked to provide information about less restrictive interventions and for consent. No information regarding less restrictive interventions or consent form were provided.

During an interview on 10/29/21 at 11:51 AM, the Maintenance Director stated he had been employed at the facility for a week. The Maintenance Director stated residents' beds should be assessed when they were admitted or if changes were made to the bed or mattress and stated there should be no more than a 4 ¾ inch gap between the bed mattress and bed rail. The Maintenance Director found an assessment of the resident's bed in dated 04/15/18 showing the bed had been evaluated and found to be acceptable at that time.

During an interview on 10/29/21 at 12:29 PM, the Administrator stated she had reviewed the record but had been unable thus far to find documentation of the bed rail consent form. The Administrator stated bed rails were a risk for R20 related to her seizure disorder and she had discussed this with the resident's family. The

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Administrator stated R20's family wanted bed rails to be used for R20.

During an interview on 10/29/21 at 4:30 PM, the MDS Coordinator stated she made an error on the bed rail assessment completed on 08/03/21, indicating R20's seizure order should have been identified as a risk factor. The MDS Coordinator also verified R20 did not have the ability to recognize safety hazards associated with bed rail use. The MDS Coordinator stated the bed rails were used to promote the resident's safety during repositioning and acted as a barrier, making it safer for staff when moving the resident in bed. The MDS Coordinator stated R20 was totally dependent on staff for ADLs and could not use the rails for repositioning. The MDS Coordinator stated she had looked for the consent form and was not able to find it. The MDS Coordinator stated R20's bed rails were supposed to be padded due to her seizure disorder and indicated, prior to her most recent room change, the bed rails had been padded.

Review of the "Hospital Bed Safety Assessment Policy" undated revealed beds including bed frames, mattresses, and attached accessories were assessed for entrapment risks to promote the safety and well being of residents. The assessment would utilize a multi-faceted approach that included the hospital bed system, clinical assessment of the resident and the resident's individual needs. The assessment included a risk versus benefit analysis to ensure that steps taken to mitigate the risk of entrapment and to ensure bed rails did not create different, unintended risks or reduce the clinical benefits to residents using a hospital bed system.

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F 744	Continued From page 45	F 744		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policy, the facility failed to develop person-centered comprehensive care plans to meet resident preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs for dementia for two (Residents (R)31 and R55) of two residents reviewed with a diagnosis of dementia. Findings include: 1.Review of R31's "Face Sheet" located in the Electronic Medical Record (EMR) located under the "Resident Info" tab revealed R31 was admitted to the facility on 02/25/21 with a diagnosis of dementia. Review of R31's "Minimum Data Set' (MDS) located in the EMR under the "MDS" tab with an assessment reference date of 08/16/21 revealed a diagnosis of dementia. Review of the "Comprehensive Care Plan" in the EMR located under Care Plan" tab revealed there was no evidence of a person-centered comprehensive care plan to address the residents' preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs for dementia.	F 744	1. Resident 31 and 55 had their care plan updated to reflect person-centered care related to the diagnosis of Dementia to address their medical, physical, mental and psychosocial needs for dementia. 2. Residents with a diagnosis of Dementia had their care plan reviewed to ensure the resident□s care plan was person-centered and comprehensive to address their medical, physical, mental and psychosocial needs related to Dementia. 3. ADON/designee in-serviced staff on person-centered care related to the diagnosis of Dementia to address their medical, physical, mental and psychosocial needs for dementia. 4. Director of Nursing or designee will audit the care plan of 5 residents a week with Dementia for 6 weeks to ensure the care plan is person centered and comprehensive. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	12/10/21

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Observation of 10/28/21 at 3:08 PM of Licensed Practical Nurse (LPN)5 was observed redirecting R31 in a calm manner when the resident was observed to be confused about an appointment that had been rescheduled that day. R31 came to the desk several times and was redirected by LPN5 who provided an alternate activity for him in his room to help redirect him.

Interview with LPN5 on 10/28/21 at 3:18 PM revealed R31 becomes confused and requires redirection and reassurance. Review of the current care plan with LPN5 revealed she was unable to find a comprehensive care plan for dementia care that had measurable goals and interventions for R31.

Interview with the "MDS" Coordinator 1 on 10/29/21 at 11:21 AM revealed R31 had a short-term memory care plan but he did not have a person-centered comprehensive care plan addressing the residents' goals and objectives related to his dementia diagnosis. She stated the "MDS" documented the diagnosis of dementia, but it did not trigger the Care Area Assessment (CAA) which would drive the care plan to be generated.

2.Review of R55's "Face Sheet" located in the Electronic Medical Record (EMR) under the "Resident Info" tab, revealed an admission date of 08/27/21 and included diagnoses of vascular dementia with behavioral disturbance.

Review of R55's "Minimum Data Set" (MDS) located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 09/02/21 revealed a diagnosis of dementia.

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F 744	Continued From page 47 Review of R55's EMR revealed no evidence the resident had a comprehensive care plan developed for the diagnosis of dementia. During an interview on 10/28/21 at 09:44 AM, MDS Coordinator2 confirmed she did not develop a comprehensive care plan that addressed R55's dementia. During an interview on 10/28/21 at 02:30 PM, MDS Coordinator1 revealed the CAA are what drives the care plan. She stated, "even though we notated dementia on the MDS, it did not trigger as a CAA. The best practice would have been to add it as another identified concern." During an interview on 10/28/21 at 3:32 PM, the Director of Nursing (DON) stated when completing the care plan for a resident and the CAAs have triggered, the team goes over the triggered areas and review in order to see if anything additional needs to be added. The DON stated it appeared not having a dementia care plan for R55 was an oversight and her expectation is for the dementia care plan to be added. Review of the facility's policy titled, "Person-Centered Baseline and Comprehensive Care Plan" reviewed and approved 05/17/18 indicated "Comprehensive Care plans: address the CAA Summary problems and/or potential problems with appropriate supportive documentation."	F 744		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		12/10/21

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§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and

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F 758	Continued From page 49 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to ensure the resident, his or her family, and/or the resident representative was provided information related to the benefits and risks to the residents for psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) for five of five residents reviewed for unnecessary medications (Resident (R) 17, 31, 55, 86, and 97). Findings include: 1. Review of R17's "Face Sheet" located in the Electronic Medical Record (EMR) under the "Resident Info" tab, revealed an admission date of 04/02/21 and included diagnoses of dementia with behavioral disturbance and anxiety disorder. Review of R17's "Minimum Data Set" (MDS) located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 10/25/21 revealed a diagnosis of dementia and Brief Interview for Mental Status (BIMS) score of 05/15, indicating the resident was severely cognitively impaired. Review of R17's "October 2021 Physician Order Sheet", located in the EMR under the "Orders" tab, revealed the resident was prescribed the	F 758	1. Resident 17, 31, 55, 86 and 97 had the risk and benefits provided information to the resident or resident representative of psychotropic medications 2. All Residents on psychotropic medications had their chart reviewed to ensure the resident/resident representative was provided information on the risk and benefits of the use of any psychotropic medication they are receiving . 3. ADON/designee in-serviced licensed R.N and L.P.N. on providing risk/benefit information to residents/resident responsible on psychotropic medications and ensuring documentation of discussion on of risk/benefits 4. Director of Nursing or designee will audit 10 residents with orders for psychotropic orders weekly for 6 weeks to ensure risk/benefits was provided and documented. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	

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following medication: Buspirone (anti-anxiety medication).

2. Review of R55's "Face Sheet" located in the EMR under the "Resident Info" tab, revealed an admission date of 08/27/21 and included diagnoses of vascular dementia with behavioral disturbance, major depressive disorder, anxiety disorder, and unspecified psychosis not due to a substance or known physiological condition.

Review of R55's "MDS" located in the EMR under the "MDS" tab with an ARD of 09/02/21 revealed a diagnosis of dementia and BIMS score of 13 out of 15, indicating the resident was cognitively intact.

Review of R55's "October 2021 Physician Order Sheet", located in the EMR under the "Orders" tab, revealed the resident was prescribed the following medications: Quetiapine (anti-psychotic) and Sertraline (anit-depressant).

Review of R17's and R55's medical record revealed no evidence the resident's responsible party had been notified of the potential risks and benefits of receiving the prescribed medication, nor had the responsible party been given the opportunity to consent or refuse the drugs' use.

3. Review of R31's "Face Sheet" located in the EMR under the "Resident Info" tab, revealed an admission date of 02/25/21 and included diagnoses of dementia and depression.

Review of R31's "MDS" located in the EMR under the "MDS" tab with an ARD of 08/16/21 and revealed a diagnosis of dementia and anxiety. The "MDS" documented a BIMS score 15

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indicating the resident was cognitively intact. The MDS also indicated R31 was receiving antidepressant and antipsychotic medications seven days a week.

Review of R31's "October 2021 Physician Order Sheet", located in the EMR under the "Orders" tab, revealed current orders for Trazadone 100 milligrams (mg) an antidepressant medication one time a day (QD), Sertraline 100 mg, an antidepressant medication one tablet QD and Abilify 2 mg an antipsychotic medication two tablets QD.

Review of R31's "Clinical Notes" located in the EMR under the "Notes" tab revealed no documentation to indicate the resident or his resident's responsible party had been notified of the potential risks and benefits of receiving the prescribed medication, nor had the resident or responsible party been given the opportunity to consent or refuse the drugs' use.

4. Review of R86's "Face Sheet" located in the EMR under the "Resident Info" tab, revealed an admission date of 08/01/19 and included diagnoses of dementia and depression.

Review of R86's "MDS" located in the EMR under the "MDS" tab with an ARD of 09/17/21 revealed a diagnosis of depression and anxiety. The "MDS" documented a "BIMS" score of 15 indicating the resident was cognitively intact. The MDS also indicated R86 was receiving antidepressant and anti-anxiety medications seven days a week.

Review of R86's "October 2021 Physician Order Sheet", located in the EMR under the "Orders"

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tab, revealed current orders for Trazodone 50 mg, a psychotropic medication, one tablet at hours of sleep Escitalopram 10 mg, an antidepressant medication, one tablet QD.

Review of R86's "Clinical Notes" located in the EMR under the "Notes" tab revealed no documentation to indicate the resident or the resident's responsible party had been notified of the potential risks and benefits of receiving the prescribed medication, nor had the resident or responsible party been given the opportunity to consent or refuse the drugs' use.

5. Review of R97's "Face Sheet" found in R97's EMR under the "Admission" tab revealed the resident was admitted to the facility on 01/07/19 and had diagnoses of major depressive disorder and post-traumatic stress disorder (PTSD).

Review of R97's Quarterly "MDS," with an ARD of 10/06/21, found in R97's EMR under the "MDS" tab revealed the resident had a BIMS score of three out of 15, which indicated the resident was severely impaired in cognition. The "MDS" also indicated that R97 received an antidepressant and anti-anxiety medication seven days of the look back period.

Review of R97's Physician's Order found in R97's EMR under the "Orders" tab, dated 06/10/21, revealed an order for Sertraline (an antidepressant) 50 milligrams (mg) oral daily. Continued review of R97's Physician's Order, dated 05/04/21, revealed an order for Buspirone (an anti-anxiety medication) 15 mg ½ tablet oral three times a day (TID).

There was no documented evidence that R97's

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F 758	Continued From page 53 family and/or Responsible Party (RP) was provided the relative benefits and risks of the antidepressant or the anti-anxiety medication to R97. During an interview on 10/28/21 at 10:41 AM with the Director of Nursing (DON) she shared with the survey team that the facility did not obtain consents from the resident or the residents' representative for psychotropic medications. She indicated information regarding the risk verses the benefits of these medications would be in the "Clinical Notes" in the EMR. Review of the facility's policy titled, "Behavior Management" reviewed and approved 07/10/16 indicated "The resident and family/representatives should be informed about the use of individualized approaches, the proposed course of treatments, potential risk and benefits of a psychopharmalogical medication (e.g. FDA black box warnings), expected duration of use of the medication, plans to evaluate the effects of the treatment, and pertinent alternatives. The discussion should be documented in the resident's record."	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		12/10/21

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F 761	Continued From page 54 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure metal boxes containing Schedule IV (controlled substances) medication located in the refrigerators in one of three medication rooms were secured in permanently affixed compartments. Findings include: The facility was identified to have three medications rooms. One medication room on each unit to include 100 Unit, 300 Unit and 400 Unit. Observation of the 100 Unit medication room on 10/29/21 at 8:25 AM with Licensed Practical Nurse (LPN)5 revealed the medication room door was locked and the refrigerator within the medication room was locked. There was an unlocked metal box in the refrigerator containing	F 761	1. The medication box containing Scheduled IV controlled substance medications was secured to a permanently affixed compartment of the refrigerator on Armistead unit. 2. Each medication box containing Scheduled IV substances was observed to be secured to a permanently affixed area of the refrigerator. 3. ADON/designee in-serviced licensed R.N.□s and L.P.N.□s on label/storage of drugs and biologicals to include but not limited to the importance of proper storage of medications, notifications if medications not secured. Facility added check off box verifying securement device is intact on daily log. 4. Director of Nursing or designee will audit the storage of scheduled IV substance to ensure the medications are stored appropriately in a secured box	

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F 761	Continued From page 55 two unopened vials of Ativan 2 milligram (mg), an anti-anxiety Schedule IV medication. The box was able to be removed from the refrigerator as it was not permanently affixed. There was a chain attached to the inside of the refrigerator, but the chain was not attached to the metal box containing the Scheduled IV medications. LPN5 indicated the chain had been broken for a long time and she was aware the chain should be attached to the metal box, but it had never been repaired. Interview with the Corporate RN on 10/29/21 at 12:51 PM revealed the metal boxes containing Schedule II-V medications in the refrigerators should have been locked and permanently affixed to the fridge. Review of the facility policy titled, "Storage and Expiration Dating of Medications Biologicals Syringes and Needles," dated 06/01/11 revealed the facility should store Schedule II-V Controlled Substances and other medications deemed by the facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts and should have a different key to access the device. The facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security.	F 761	permanently affixed to the refrigerator weekly for 6 weeks. The Director of Nursing/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff	F 925	1. Exit door off of the dining room	12/10/21

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F 925	Continued From page 56 interview, resident interview, interview with the facility's Pest Control Company staff, and facility policy review, the facility failed to maintain an effective pest control program to ensure the facility was free of pests. This affected three of three units, common areas, and the dining rooms in the facility, and had the potential to affect all 126 residents residing in the facility. Findings include: Observation in the dining room on 10/26/21 at 8:58 AM revealed four small white boxes on the floor in each corner of the room. The boxes were observed to have more than 10 dead bugs in each one of them. Some of the bugs were one and a half inches in length and were noted to be sticking out the end of the boxes. These four boxes were in the same room where the door was observed to be propped open with a rock. Interview with the Pest Control Company staff on 10/26/21 at 2:50 PM while he was in the building revealed he sprays for bugs in the building every two weeks. He indicated the bugs he sprays for in the building are roaches and verified he sees them on all units and common areas in the building. This surveyor shared the observations of the dining room door being propped open allowing for an open four-inch gap in the opening of the door. Pest Control Company staff verified this would allow for bugs to enter the facility on a consistent basis and no matter how often he sprays it would not be effective if doors are consistently left open. During an interview with Resident (R)112 on 10/26/21 at 3:40 PM revealed he has live cockroaches in his room and indicated he sees a	F 925	remote access control box was fixed to allow the door to close and allow reentry without propping open the door. 2. All residents may potentially be affected. Resident rooms, communal areas and other areas of the facility were observed for effective pest control 3. Administrator/designee in-serviced staff on pest control to include but not limited to ensuring doors are closed to prevent pests from entering the facility. 4. Administrator/designee will audit building weekly for six weeks to ensure doors are not propped open and has an effective pest control management throughout the facility. Administrator will report any trends or variances to the Quality Assurance and Performance Improvement Committee monthly	

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lot of them on the 400 Unit where he used to reside.

Observation on 10/27/21 at 8:52 AM in the main dining room the door to the outside courtyard was observed to be propped open with a rock. This left a four-inch crack between the door and the door frame which was open to the outside. Three staff were observed to be seated on the patio area where the door was propped open. Interview with Licensed Practical Nurse (LPN)1 during this observation revealed the staff go out onto the enclosed patio area to take a break and they must prop the door open to enable them to get back into the facility. She indicated if the door closes, they are not able to open it from the outside due to the keypad to open the door no longer functions.

Interview with Licensed Practical Nurse (LPN)5 on 10/27/21 at 8:59 AM verified the staff take their breaks in the enclosed courtyard and they must prop the door open, so they are able to reenter the building.

During an interview on 10/28/21 at 9:17 AM with LPN7 she verified the existence of four boxes in the dining room with dead bugs. She verified the staff leave the door propped open with a rock when they take their break in the courtyard and confirmed by propping the door open it allows for a gap where insects and bugs can access the building.

Interview with the Certified Dietary Manager (CDM) on 10/28/21 at 10:54 AM revealed they used to have a bigger problem with bugs in the building but stated it was getting better. She verified the staff take their breaks on the

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courtyard off the dining room and leave the door propped open.

Observation on 10/28/21 at 4:39 PM revealed a live bug was observed crawling on the floor near the Director of Nursing's (DON's) office door. This observation was verified by the MD.

During an interview with the Housekeeper on 10/29/21 at 7:40 AM he verified an observation of a large black bug on the floor in the dining room next to the popcorn machine. He said he sees bugs throughout the facility and indicated the bugs come out more at night. He verified he frequently sees bugs on all units in the building.

A large brown live bug was observed on 10/29/21 at 9:12 AM on the 100 Unit by room 109. Interview with R63 on 10/29/21 at 9:13 AM revealed he has bugs in his room all the time. He indicated he reports them to the staff, but he continues to see them in his room.

Review of the pest control logbook for the 100 Unit revealed bugs were noted in room 128 in the resident's bed.

Review of the pest control logbook for the 300 Unit for September 2021 and October 2021 revealed bugs, also noted as roaches and ants were noted on the unit and in resident rooms on 09/04/21, 09/05/21, 09/08/21, 09/16/2, 10/01/21, 10/12/21, 10/17/21, 10/20/21, 10/27/21 and 10/28/21. These entries were confirmed with the MD on 10/28/21 at 11:00 AM.

Review of the pest control logbook for the 400 Unit for September 2021 and October 2021 revealed bugs, also noted as roaches were noted

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on the unit and in resident rooms. An entry on 09/8/21 indicated roaches were coming out of the electrical box and on 09/28/21 an entry was noted indicating roaches were all over on the 400 Unit.

During an environmental tour with the MD on 10/29/21 at 10:11 AM he verified the four white boxes in the dining room with dead bugs in them. He indicated he also sees dead and live "roaches" in the dining room, kitchen, resident units, and resident rooms. He observed the door in the dining room to the courtyard propped open with a rock and verified the door should not be propped open as it would allow for bugs to enter the facility.

Review of the facility policy titled "Pest Control Program," dated 12/32/20 revealed if pests or pest evidence are identified the facility should begin the containment and mitigation process to include containing and eradicating the pest issue.