STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BOSTON HEALTH & REHAB CENTER	103 ROSEHILL DRIVE REVISED SOUTH BOSTON, VA 24592

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E 000	Initial Comments An unannounced Emergecy Preparedness survey was conducted 1/25/2022 through 1/28/2022. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and extended survey was conducted 01/25/22 through 01/28/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of Resident Rights and Quality of Care at a Scope and Severity Level 4, isolated, which constituted Substandard Quality of Care. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey: VA00054116 unsubstantiated with a related deficiency. VA00051439 substantiated with a related deficiency. VA00054156 unsubstantiated with no deficient practice. VA00054202 substantiated with a related deficiency. VA00054005 substantiated with a related deficiency. VA00052960 unsubstantiated with a related deficiency. The census in this 216 certified bed facility was 166 at the time of the survey. The survey sample	F 000		

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

for P Hall | Administrator | 02/16/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 consisted of 33 current resident reviews and three closed record reviews. The expanded survey sample consisted of four current resident reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		

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F 578	Continued From page 2 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure DNR (Do Not Resuscitate) status was followe for one of 36 residents in the survey sample, Resident # 213. Resident # 213 had an advance directive for a DNR and facility staff initiated emergency services for CPR (Cardiopulmonary Resuscitation). Findings include: Resident # 213 was admitted to the facility 3/13/19 with diagnoses including but not limited to: dementia, GERD, and hypertension. The annual MDS dated 2/25/20 had the resident assessed with long term and short term memory, and severely impaired in daily decision making skills. The resident expired in the facility 5/17/20. On 1/26/22 at 3:30 p.m. the DON (director of nursing) was interviewed. The DON stated "That absolutely happened. The nurse making rounds (who no longer works here) reported that she thought the resident was choking. It actually was the resident taking her last breath. We did a FRI (Facility Reported Incident) about that if you would like to see that." The DON then presented the FRI.	F 578	Past noncompliance: no plan of correction required.	

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F 578	Continued From page 3 The FRI, dated 5/22/20, and the final investigation dated 5/28/20 documented the following: "Staff nurse (name of nurse) reported when she was rounding and walked into (name of resident) room, she indicated it appeared as if the resident had taken her last breath. When she assessed the resident she had an absence of pulse, respirations, and was unable to obtain a blood pressure reading. She then called out for help from co-workers and began the 'code process'. (Name of nurse) did not verify the resident's code status. When she entered the room and saw the resident take her last breath, she reacted with a caution of life. Interview conducted with staff nurse (name of nurse) stated she responded to call for help, followed her lead and called a Code Blue. She then proceeded to complete paperwork to send resident out of facility. EMS arrived at the facility and assisted with the code. Resident pronounced dead at facility. EMS did not remove remains from facility. Resident Representative was contacted and she came to facility to be with her mother before funeral home of choice arrived. Facility Administration met as part of the investigative process to review the facility Code policy to review whether it was a breakdown in the process or with staff. The facility identified that the policy was not followed by responding and involved staff." "Summary of Findings: The facility investigation revealed that the facility did not follow its policy regarding the Code process (i.e. failure to check code status). In response, the facility has developed an action plan to correct the identified problem: (1). Re-educate nursing staff (RN, LPN) of Code Protocol; (2). Mandatory Refresher	F 578		

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F 578	Continued From page 4 course of the Code Process for nursing staff; (3). A section addressing code status has been added to the facility's code debriefing form; and (4). A chart review will be performed as an administrative nursing function on expired residents. The Action Plan and corresponding audit findings will be reported to the Quality Assurance Process Improvement (QAPI) committee for additional oversight and recommendation; (5). The date of these actions will be June 26, 2020. The DON and Administrator shared these findings and plan with the resident representative (name)." No additional issues were identified related to this requirement during this survey. This citation is past non-compliance.	F 578		
F 580 SS=J	THIS IS A COMPLAINT DEFICIENCY. Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		

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F 580	Continued From page 5 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to notify the physician for a need to alter treatment for one of 36 residents in the survey sample, Resident #313. The facility failed to notify the physician	F 580	1). Resident #313 missed four doses of IV Antibiotic and nurses did not notify MD. Medication administered on 01/25/22 at 1530 and MD was notified. Nurses who did not notify MD received 1:1 (one to one) education regarding MD notification on 01/25/22. 2). Any resident with orders for IV medication have the potential to be affected. An audit for IV medications were completed with no discrepancy identified. 3). LPN/RN staff were educated by DON and IP nurse on prompt notification of MD/NP when a medication has been missed or not been administered. Education on prompt notification of physician will be added to new hire education. 4). DON/designee, to complete MD notification of any IV missed meds audit five times weekly for 12 weeks. Analysis of the audits will be submitted to QAPI monthly x 3 months for review and recommendations.	3/1/22

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F 580	Continued From page 6 that Resident #313 had not received physician ordered IV (intravenous) antibiotics for 5 days, and failed to notify the physician that the IV antibiotic medication was not available for administration, which resulted in the identification of Immediate Jeopardy (Level 4-Isolated) on 01/25/2022 at 4:25 PM. Findings include: Resident #313 was admitted to the facility on 01/20/22. Diagnoses for Resident #313 included, but were not limited to: cirrhosis of the liver without ascites, hypotension, collapsed vertebrae/fracture, acute kidney failure, moderate protein calorie malnutrition, hypothyroidism, compression fracture (L-5) secondary to discitis and osteomyelitis, discitis of lumbosacral region, and closed compression fracture of sacrum. The most current MDS (minimum data set) was the admission assessment, which was in progress and not complete for Resident #313. An admission nursing assessment dated 01/20/22 at 7:15 PM documented, "...arrival date & time: 01/20/22 7:15 PM....from hospital...Reason For Admission: IV antibiotic administration...diagnoses/condition...infection...IV meds/fluids...antibiotics...alert and oriented to situation, able to make needs known..." Resident #313's current CCP (comprehensive care plan) documented, "...Resident is on antibiotic therapy...administer the full course of antibiotic as prescribed by physician...resident has infection...Administer antibiotics...per physician orders and monitor side effects...Resident is on intravenous therapy..."	F 580		

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F 580	Continued From page 7 On 01/25/22 at approximately 12:50 PM, during the initial tour of the facility, Resident #313 was observed in her room in bed. A central venous access device was observed in the resident's right upper chest area. Resident #313 was asked how she was doing. Resident #313 began to cry and stated that she was upset and felt as though she was getting worse instead of better. Resident #313 went on to explain that she had a fracture and infection in her spine and that she had been in the hospital receiving IV antibiotics (prior to admission to the facility) and was supposed to be receiving them here as well. Resident #313 stated that she had not received any IV antibiotics since she had arrived here. Resident #313 was asked when she was admitted to this facility. The resident stated that she came late Thursday evening (January 20, 2022). Resident #313 was asked if she had reported to anyone that she had not received the medication. The resident stated, "Everyday," and further stated that the physician had come in to see her (she thought on Friday, 01/21/22) and that he had ordered the medication for her, but she still had not received it. Resident #313 stated that the nurses have kept telling her that the IV antibiotics were coming and that she wasn't sure what was going on. Resident #313 again stated that she was upset, she wanted to get better and was in fear of actually getting worse due to not having the antibiotic medication. Resident #313 stated that she thought she was supposed to have the IV medication therapy for about 4 to 6 weeks. On 01/25/22 at approximately 1:30 PM, Resident #313's clinical record was reviewed. The current physician's orders included an order for, "...Ertapenem Sodium Solution Reconstituted 1	F 580		

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F 580	Continued From page 8 GM (gram) Use 1000 mg (milligrams) intravenously every 24 hours for discitis...Order Status: Active...Order Date: 01/20/22...Start Date: 01/20/22..." The MARs (medication administration records) were reviewed for January 2022. The MARs documented, "...Ertapenem Sodium Solution Reconstituted 1 GM Use 1000 mg intravenously every 24 hours for discitis...Start Date: 01/20/22 (2:30 PM)..." Each day from 01/21/22 through 01/25/22 staff initials were documented with the time and the number "19" in each box for the IV medication. The number 19, on the legend (chart codes) indicated, "19=Other/See Nurse Notes." The MAR was blank on 01/20/22. Resident #313's nursing notes documented each day that the medication was "on order." No nursing or progress notes were found to indicate the physician had been notified that the medication was "on order", not available for administration, or that Resident #313 had not been receiving the medication as ordered. On 01/25/22 at 2:15 PM, Resident #313's physician was interviewed and was asked if he had been notified by staff that Resident #313 had not received the physician ordered IV antibiotic in the last five days. The physician stated, "No, I got something from (name of pharmacy) today that they (pharmacy) were sending a 5 day supply because it's not covered, but I didn't know (she had not received it)." The physician was asked if he was aware that the IV antibiotic for Resident #313 was not available for administration and "on order" per the nursing notes. The physician	F 580		

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F 580	Continued From page 9	F 580		

stated, "No." The physician stated that Resident #313 was getting the medication for discitis and he thought she was to receive it for 6 weeks. The physician was asked about the potential implications of Resident #313 not receiving the IV antibiotic medications as ordered. The physician stated, "...the infection may not be controlled, whether the infection will spread out of the disc or not, I don't know...It could result in hospitalization, prolonged treatment, prolonged stay (in the nursing home)...I don't think it would result in sepsis, but could increase her pain level and cause further deterioration of the disc." The physician was made aware of serious concerns regarding Resident #313 not receiving the IV antibiotics as ordered, and that the facility staff had not notified him that the medication was not administered and was not available for administration. The physician stated that the staff are usually good about contacting him. The physician was made aware of the serious concerns and the potential for harm to Resident #313. The physician stated, "Unfortunately, I agree with you." The physician stated that staff usually let him know when a medication isn't administered or available and stated, "I'm not sure where the breakdown occurred." The physician stated that he had received a note from the pharmacy this morning that the medication wasn't covered by insurance and that they sent a 5 day supply. The physician stated that he had spoken with RN (registered nurse) #3 [UM3 (unit 3 manager)] this morning about that, but the nurse did not mention to him that the medication had not been administered or that the medication wasn't available.

On 01/25/22 at 3:05 PM, the physician was interviewed again. The physician stated that he

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F 580	Continued From page 10 just went to the unit at 3:00 PM to check to see if the IV medication was there. The physician stated that the IV medication, Meropenem was in the stat box (a different IV medication from what he had originally ordered). The physician stated, "That's (Meropenem) what I would have switched her (Resident #313) to, had they (nursing staff) made me aware the (ordered) medication was unavailable or there was a problem getting the ordered medication." The physician then stated, "The Ertapenem came in last night (01/24/22), it's in the medication room." The physician stated that he and RN #3 checked the stat box and that RN #3 found the IV antibiotic medication (Ertapenem) that was ordered in the med room and that it had come in last night. The physician was asked why the IV Ertapenem was not administered last night. The physician stated he wasn't sure, but RN #3 was going to check. The physician stated, "I'm really disappointed, probably more than you are." On 01/25/22 at 4:25 PM, in a meeting with the survey team, the administrator and DON were notified that survey team had consulted and discussed the above information with the State Agency, and identified IJ (Immediate Jeopardy) (Level 4-Isolated) on 01/25/2022 at 4:25 PM, due to the facility's failure to notify the physician that IV antibiotics were not administered per the physician's order and that the IV antibiotics were not available for administration to Resident #313 for the treatment of L5 (lumbar spine vertebrae) discitis/osteomyelitis. The survey team advised the administrator and DON to develop and present a plan of removal regarding the facility's failure to notify the physician for Resident #313. A policy was requested for physician notification regarding unavailable medications at this time.	F 580		

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F 580	Continued From page 11 The policy "Medication shortages/Unavailable Medications" documented, "...upon discovery that the facility has an inadequate supply of medication to administer...should immediately initiate action to obtain the medication from pharmacy...nurse should call pharmacy to determine the status of the order...if the medication is not available in the emergency medication supply...notify pharmacy and arrange for an emergency delivery, if medically necessary...if an emergency delivery is unavailable...nurse should contact the attending physician to obtain orders or directives..." On 01/25/22 at 5:00 PM, RN #3 (also known as the UM3) was interviewed. UM3 was asked if she was aware that Resident #313 had not received her IV antibiotic as ordered by the physician for 5 days. UM3 stated that the physician had brought it to her attention about an hour ago that the IV medication (Ertapenem) was not administered to Resident #313 as ordered. UM3 stated that she had not been made aware that Resident #313 had not received it until the physician told her. UM3 stated that she was not aware the medication was not available for administration. UM3 stated that the physician had come to the unit and gave her an order for an alternate IV antibiotic that was in the stat box (Meropenem). UM3 stated she had been in the medication room earlier today and saw that the original medication (Ertapenem) was in there, but didn't realize that Resident #313 had not received it. UM3 stated that after looking into it further, they had found the medication had arrived the night before (01/24/22). UM3 was asked why the medication wasn't administered last night. UM3 stated, "I can't answer that."	F 580		

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F 580	Continued From page 12	F 580		

On 01/25/22 at 5:20 PM, RNA (Registered Nurse Applicant) #4 was interviewed. RNA #4 had documented on Resident #313's MAR under the IV antibiotic on 01/22/22 and 01/23/22. RNA #4 stated that she works day shift and the medication was scheduled for 2:30 PM. RNA #4 stated that on both days (01/22/22 and 01/23/22) she looked for the medication in the medication room and up front in the Q machine (a place for extra medications) and the Q machine said it wasn't available. RNA #4 stated that a pharmacy delivery guy came and she had asked him about the medication for Resident #313, and he told her it would be in the night shipment. RNA #4 stated that she did not receive the medication. RNA #4 stated that she did not pass this information on in report to the oncoming shift, she did not report it to UM3, and did not notify the physician. RNA #4 stated she did not document anything in the progress notes. RNA #4 stated that on Sunday, she went to the stock room and the medication had not come and she reached out again to the pharmacy delivery person. RNA #4 stated that she did not call the pharmacy directly, and again did not notify UM3 or the physician. RNA #4 stated that she thought the medication may be coming in on the next shipment.

On 01/25/22 at approximately 5:45 PM, LPN (licensed practical nurse) #1 was interviewed. LPN #1 had documented on Resident #313's MAR under IV antibiotic on 01/21/22, 01/24/22 and 01/25/22. LPN #1 stated that she works day shift and the medication was scheduled for 2:00 to 2:30 PM. LPN #1 stated that on Friday (01/21/22) that she realized they didn't have it in stock and she went to the computer and ordered it. LPN #1 stated that she did not report to UM3

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F 580	Continued From page 13 or the physician that the medication was not in stock. LPN #1 stated that she did not pass this information on in report to the next shift. LPN #1 stated, "On Monday (01/24/22) the same thing, I realized we didn't have it. I called the pharmacy and they said IV meds don't come through (the computer) and has to be faxed, I don't know who I talked to, so I faxed it. When I spoke to the woman (at the pharmacy) she said as soon as we get it (fax) we'll send it out." LPN #1 stated that she assumed over the weekend Resident #313 didn't get the medication because the facility didn't have it. LPN #1 stated that she did not report to UM3 or the physician that the resident had not received the medication or that the medication was not available to administer, and she didn't pass it on in report, " ...because it was a day shift thing." LPN #1 stated, "I didn't even realize it was an antibiotic to be honest." On 01/26/22 at 3:41 PM, the administrator and DON presented the following plan for IJ removal: 1) Resident missed 4 doses of IV Antibiotic and nurses did not notify MD. Medication administered on 01/25/22 at 1530 and MD was notified. Nurses who did not notify MD received 1:1 (one to one) education regarding MD notification on 01/25/22. 2) Audit of missed IV medications to be completed by Thursday 01/27/22 by 5:00PM to ensure MD was notified of missing medication to ensure no other residents affected. 3) LPN/RN staff to be educated by Thursday 01/27/22 by 5:00PM on prompt notification of MD when a medication has been missed or has not been administered. LPN/RN staff out on vacation,	F 580		

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F 580	Continued From page 14 leave, or out with illness, will be educated immediately upon return, prior to the beginning of their shift. Education on prompt notification of physician will be added to new hire education. 4) DON/designee, to complete MD notification audit 5 times weekly for 8 weeks. Analysis of the audits will be submitted to QAPI monthly x 3 months for review and recommendations. The survey team accepted the plan of removal for the immediate jeopardy status on 01/26/22 at 4:00 PM. Resident #313 received Ertapenem 1000 mg IV per the physician's orders on 01/25/22 at 3:30 PM. On 01/27/22 between 7:30 AM and 12:00 noon, interviews were conducted with nurses on each nursing unit regarding education for notification of the physician when a resident does not receive medications as ordered and notification of the physician when medications are not available for administration. Telephone interviews were also conducted by the survey team of nurses off duty to ensure education was provided. The administrator and DON presented education in-service records for the education provided, along with sign in sheets and an audit form /tool to ensure that all nursing staff off duty would be educated upon return to work. On 01/27/22 at approximately 9:30 AM, Resident #313 was interviewed and stated, "Thank you, I'm much better now that I'm getting my antibiotics." The survey team abated the IJ on 01/27/22 at 12:46 PM, reducing the scope and severity level	F 580		

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F 580	Continued From page 15 of the remaining deficient practice to level 2, isolated. No further information and/or documentation was presented prior to the exit conference on 01/28/22.	F 580		
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. (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);	F 584	1). Call bell boxes in rooms 126, 129 and 326 have been repaired with the surrounding drywall and paint corrected. The heating unit in room 129 has been repaired with the front cover securely in place and the control panel door functioning properly. The stainless steel outlet has been attached with no visible wires showing beside this panel. 2). Any resident room has the potential to be affected. An audit of all resident rooms is being conducted to identify call bell units, heating/cooling units, and any other exposed wiring that need to be corrected. 3). Administrator will provide education to all staff regarding the positioning of beds within the room to prevent the accidental dislodging of call bell units from the wall, and reporting of damaged items to maintenance. 4). Maintenance Director, or designee, to audit 10 rooms per week x 8 weeks, then 10 rooms for one month to ensure proper maintenance is being completed on call bell units and the environment.	3/1/22

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F 584	Continued From page 16 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to ensure a safe, clean, homelike environment on two of four units. Rooms on unit 1 and unit 3 had damaged call bell panel boxes that were loose and/or pulled from the wall in addition to, a dirty/damaged heat unit panel and scraped wall in room 129. The findings include: On 1/25/22 at 12:51 p.m., the call bell box in room 129 above bed #3 was observed damaged. The box near the head of bed #3 was pulled completely from the wall leaving the inside of the wall visible. Conduit and wiring to the panel were visible in the gap between the wall and the displaced box. A stainless panel on the wall above the bedside table adjacent to this bed had an exposed black and yellow wire and a broken piece of plastic loosely attached beside the light switch. The front cover of the heat unit in this room was dislodged with a gap along the top right edge. The cover to the heat unit controls was bent and unable to close. The top of the heat unit and the louvered vents were covered with lint and debris. Additional observations in room 129 revealed an additional call bell box pulled from	F 584	continued: 4). All findings will be reviewed monthly with the QAPI committee with any variances being discussed and changes made when necessary.	

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F 584	Continued From page 17 the wall beside bed #1. A section of dry wall on the outside right wall of the bathroom near the end of bed #4 was scraped and missing paint. On 1/25/22 at 1:35 p.m., accompanied by two maintenance employees (other staff #7 and #8), the broken call bell panel, damaged heat unit and exposed wiring were observed in room 129. The maintenance employee (other staff #7) stated the frame holding the call bell box was cracked/broken. The maintenance employee stated the exposed wires were where a landline telephone was once attached. The maintenance employee stated some rooms had telephones but he did not know why this room did not have a phone. The maintenance employee (other staff #8) stated he kicked the panel on the heat unit and put it back in place. On 1/26/22 at 2:12 p.m., the call bell box in room 126 was observed. The panel box was on the wall above the resident's bed on the window side of the room and had the call bell plugged into the box. The box was loose and pulled from the wall. There was grooved and damaged dry wall present around the panel box in a circular pattern. On 1/28/22 at 8:30 a.m., Resident #78's room was observed. The call bell box was crooked, loose and pulled from the wall with patched dry wall around the panel. Resident #78 (assessed by the facility as cognitively intact) was interviewed at this time about the loose panel. Resident #78 stated the panel box had been loose and pulled from the wall since he had moved into the room. The clinical record documented Resident #78 moved into this room on 12/6/21. On 1/28/22 at 9:13 a.m., the maintenance	F 584		

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F 584	Continued From page 18 supervisor (other staff #3) was interviewed about the damaged call bell boxes, scraped wall and bent heat unit. The maintenance supervisor stated each unit had a folder for documenting work orders and that any staff member could enter an order for repairs. The maintenance supervisor stated the orders were reviewed each day and assigned to staff. The maintenance supervisor stated the call bell panel boxes stuck out of the wall and when resident beds were moved up/down, the boxes and the walls were easily damaged. The maintenance supervisor stated her "floor guys" performed floor rounds every two weeks and damaged items were repaired. The maintenance supervisor reviewed work orders and stated she had no current orders for the above items. The maintenance supervisor stated the call bell box above bed #3 in room 129 had been previously repaired on 12/16/21. This finding was reviewed with the administrator and director of nursing on 1/28/22 at 11:15 a.m.r	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585	1). Following report of resident #149's missing items an immediate search was conducted. One bra was located in the residents clean laundry, in her drawer. A 2nd bra was located in laundry. When presented to resident, resident stated that item was her bra. Residents missing bra was replaced immediately by facility.	3/1/22

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F 585	Continued From page 19 facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for	F 585	continued: 2). Any resident has the potential to be affected. An audit of all residents to be completed to ensure any missing items or other resident complaints are identified. 3). The administrator will provide education to all staff regarding the facilities grievance process and policies. Education will be added to new employee orientation. 4). Administrator, or designee to monitor 10 residents per week x 8 weeks, then 10 residents per month for one month. All findings will be reviewed monthly with the QAPI committee with any variances being discussed and changes made when necessary.	

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F 585	Continued From page 20 example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585		

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F 585	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to respond to a resident grievance regarding lost and/or missing clothing for one of 36 residents in the survey sample, Resident #149. Findings include: Resident #149 was admitted to the facility on 07/26/21. Diagnoses for Resident #149 included, but were not limited to: diabetes mellitus type II, high blood pressure, history of tumor on kidney, history of ovarian cancer, history of pulmonary embolism, osteoarthritis, chronic pain, GERD (reflux), and increased lipids (hyperlipidemia). The most recent MDS (minimum data set) was a quarterly assessment dated 01/08/22. This MDS assessed the resident with a cognitive score of 13, indicating Resident #149 was cognitively intact for daily decision making skills. Resident #149 was assessed as requiring extensive assistance of one or two staff members for bed mobility, dressing, and personal hygiene, with total dependence upon staff for toileting, transfers, and bathing. On 01/26/22 at 2:50 PM, Resident #149 was interviewed regarding care and services in the facility. Resident #149 stated, "Just like bras, I don't have no (sic) bra on right now." Resident #149 stated that staff help her get dressed and they haven't been putting a bra on her. Resident #149 stated that the staff told her she didn't have any bras. Resident #149 stated that she had three bras and all of them are gone. Resident	F 585		

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F 585	Continued From page 22 #149 stated that last Thursday (01/20/22r) was the last time she had seen her bra, when staff took it off and it went to the wash. Resident #149 stated that she doesn't like to go without a bra on. Resident #149 stated that she had reported it, but staff told her they were either lost or in the laundry, and she hasn't had a bra on for a week. Resident #149 stated that no one followed up with her to let her know anything about her bras and that she has been doing without during this time. Resident #149's current CCP (comprehensive care plan) was reviewed and documented, "...allow resident to choose what clothes to wear each day...help keep personal belongings taken care of in the room and facility...assist with...dressing, grooming...resident will be assisted with normal daily tasks..." On 01/26/22 at approximately 3:00 PM, the UM3 [unit 3 manager] was interviewed regarding Resident #149's lost and/or missing bras. UM3 stated that Resident #149 had reported to her a week or two ago that she didn't have any bras and that she (UM3) reported to the laundry department, and that they (laundry) were supposed to get back with her about it. UM3 was asked if that had happened and she stated, that it had not. UM3 was asked if there was any documentation regarding this issue. UM3 stated that she didn't have anything. UM3 stated that she did not report it to the SW (social worker) or anyone, just laundry. UM3 stated that she had not documented anything about the missing/lost bras for Resident #149. On 01/27/22 at approximately 5:00 PM, the administrator and DON (director of nursing) were made aware of the above concerns. The	F 585		

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F 585	Continued From page 23 administrator stated that he is the main person to contact, along with the SW for lost and or missing items and that they will ask the family if they have receipts for resident items and then will replace the items. The administrator stated that he was not aware the resident had any missing items (specifically bras), but would check on it. A policy on grievances, lost items, etc. was requested. On 01/28/22 at approximately 8:40 AM, the administrator presented two policies. A policy titled, "Resident Personal Property Policy" documented, "...facility will take reasonable care to prevent loss, or theft of...personal property...lock up valuables...label items...all clothing and personal items with name...Immediately Report Loss...residents should report every loss or theft to facility immediately..." A policy, titled, "Social Services" documented, "...the grievance review will be completed in a reasonable time frame consistent with the type...but in no event will a review exceed 30 days...date of grievance...summary...steps taken to investigate...resident notification...administrator notification...corrective action...documentation...will keep evidence of...all grievances..." The administrator was asked what should have been done concerning Resident #149. The administrator stated that the nurse should have reported it to the SW or to him regarding clothing. The administrator stated that they would go to laundry and search and try to do all of that in the same day, in an attempt to find the items, and if not, we'd replace. The administrator was asked if anything had been reported regarding Resident	F 585		

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F 585	Continued From page 24 #149 that he was aware. The administrator stated, "I would think I'd heard by now, but now that I know I'll look." No further information and/or documetnation was presented prior to the exit conference on 01/28/22 at 1:00 PM.	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure one of 36 residents was free from verbal/mental abuse, Resident #121. A certified nurses' aide (CNA) made derogatory remarks/comments to and about Resident #121. CNA #1 berated Resident #121 along with use of a hand gesture regarding the resident's slow consumption of breakfast in the presence of a state surveyor and two roommates.	F 600	1). CNA #1 was removed from the facility immediately and employment was terminated. Resident #121 was interviewed by Social Services following report of this incident to ensure no negative effects on residents psychosocial well-being. 2). Any resident has the potential to be affected. An audit of other residents will be completed with interviews of interview able residents and skin assessments for non interview able residents. 3). All current staff will be educated on the facilities policy on abuse and resident rights. New employees will receive abuse prevent and resident rights training upon hire. 4). DON, or designee, will complete audit of 10 residents weekly x 12 weeks. Findings to be reviewed by the administrator to identify any trends. All findings will be reviewed monthly with the QAPI committee with any variances being discussed and changes made when necessary.	3/1/22

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F 600	Continued From page 25 The findings include: Resident #121 was admitted to the facility on 10/2/15 with diagnoses that included diabetes, dysphagia, protein-calorie malnutrition, glaucoma, peripheral vascular disease, left below knee amputation, history of osteomyelitis, hypertension, lymphedema, diabetic retinopathy with impaired vision, anemia, major depressive disorder, neuromuscular disorder of bladder, congestive heart failure and morbid obesity. The minimum data set (MDS) dated 12/21/21 assessed Resident #121 with moderately impaired cognitive skills. On 1/26/22 at 8:24 a.m., Resident #121 was observed in bed feeding himself breakfast that was positioned on the over-bed table. The resident was eating pureed food from bowls using a therapeutic spoon. The resident had consumed two of the three bowls and was working on the third bowl of food. Resident #121 was asked at this time if everyone was treating him ok and he stated, "No." Resident #121 stated his CNA today (CNA #1) did not treat him good and he always had problems with him. At this time, without knocking or advanced notice, CNA #1 entered Resident #121's room and began removing the resident's breakfast tray from the over-bed table. Resident #121 stated that he was not finished with his breakfast. CNA #1 stated he needed to get the trays back to the kitchen and told the resident that he had had time enough to finish "three little bowls of food." Resident #121 then stated, "See this is what I'm talking about." CNA #1 stated to the resident that the trays needed to go back to the kitchen. CNA #1 was then asked if there was a time limit for eating	F 600		

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meals. CNA #1 stated he had baths to give, the resident had had plenty of time to finish the food, that he had been a CNA for 30 years and knew what he was doing. CNA #1 stated he served Resident #121 the breakfast tray around 8:00 a.m. and the resident had already had 30 minutes to finish his breakfast. CNA #1 stated that the other residents in his room (two roommates) were already done with their breakfast and stated again that Resident #121 had had enough time to finish eating. CNA #1 stated, "He's (Resident #121) a problem." When asked what the problem was, CNA #1 pointed his finger at Resident #121 and while moving his finger in a circular motion stated, "This right here. This is the problem." CNA #1 then left the resident's room. Resident #121 stated at this time that CNA #1 was "always like this" when providing care for him. Resident #121 stated CNA #1 did not care for him often but always gave him a "hard time." Resident #121 stated CNA #1 did not always get him out of bed when he wanted, and at times had cursed him during care. At this time, without knocking or advance notice, CNA #1 returned to Resident #121's bed and stated, "Did he say I cussed him?" CNA #1 stated that Resident #121 had cursed him and another CNA last Thursday for no reason. CNA #1 then stated he did not have time to argue and took the resident's tray from the over-bed table. Resident #121 asked to keep his glass of water. CNA #1 took the tray to the meal cart in the hallway and brought the water back to the over-bed table. CNA #1 stated at this time that this was all Resident #121's problem and said, "I don't have to do this. I've done this for 30 years." CNA #1 stated he was retired and came out of retirement to help at the facility. CNA #1 stated while standing at the foot of Resident #121's bed, "He (Resident #121) can't do nothing

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F 600	Continued From page 27 to me." CNA #1 stated that Resident #121 "tells lies" when he does not get his way and then left the resident's room. CNA #1 made these statements and gestures toward Resident #121 in the presence of the two roommates (Resident #65 and Resident #102). On 1/26/22 at 8:31 a.m., CNA #1 was interviewed at the meal cart about the just witnessed interactions with Resident #121. When the surveyor introduced herself, CNA #1 stated, "I know who you are and you can write up whatever you want." When asked if he had been educated regarding abuse and treating residents with dignity and respect, CNA #1 stated that he had been a CNA for 30 years and that he did not have anything else to say. CNA #1 stated again Resident #121 was a liar and said, "You can just believe everything he says." CNA #1 stated again he had nothing else to say and pushed the meal cart down the hallway. On 1/26/22 at 9:44 a.m., Resident #121 was interviewed again about CNA #1. When asked if he had reported how CNA #1 treated him to any other staff members, Resident #121 stated, "No. We just argue." Resident #121 stated he did not feel reporting the situation would do any good. CNA #1 stated he had no problems with any other staff members except CNA #1. On 1/26/22 at 8:51 a.m., one of Resident #121's roommate (Resident #65) was interviewed about CNA #1. Resident #65 stated he was in the room this morning (1/26/22) and heard CNA #1 talk loudly to Resident #121. When asked if he had witnessed any interactions like that before, Resident #65 stated, "Yea. It's happened before but not that bad." Resident #65 stated CNA #1	F 600		

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had never mistreated him, but CNA #1 and Resident #121 "had words before." Resident #65 stated he had not seen anything physical between CNA #1 and Resident #121. Resident #65 stated he had heard CNA #1 and Resident #121 argue before during care.

On 1/26/22 at 8:55 a.m., the other roommate (Resident #102) was interviewed about CNA #1 and Resident #121. Resident #102 stated, "I heard that this morning" and "I've heard them have words." Resident #102 stated he had not witnessed any physical mistreatment of Resident #121 by CNA #1. Resident #102 stated, "I try to stay to myself but I've heard words before kind of like today."

Resident #121's clinical record documented treatment with the antidepressant medication sertraline 100 milligrams daily for treatment of depression. Resident #121 had routine mental health visits provided by a psychiatric consultant at least three to four times per month. The most recent psychiatric visits were documented on 12/7/21, 12/14/21, 12/21/21, 12/28/21, 1/4/22 and 1/11/22.

Resident #121's plan of care (revised 12/23/21) documented the resident had impaired cognitive function, impaired thought processes due to short-term memory loss and history of trauma "from accident or fire at the age of 20 and seeing someone being killed or seriously injured at age 21." The plan of care listed the resident was at risk of depression due to placement in the facility and major depressive disorder. Interventions to minimize depression, communicate basic needs and promote coping with past trauma included, "...Encourage involvement in/out of room

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F 600	Continued From page 29 activities and visits with family members/staff...assess, document and report to MD any changes in cognitive function...Break tasks into one step at a time. Do not rush or show annoyance/impatience...Encourage resident to make routine, daily decisions...Provide the resident with a homelike environment...Assist (Resident #121) to identifying strength, positive coping skills and reinforce...Be reassuring and listen to concerns...Encourage (Resident #121) to express feelings, listen with empathy and compassion..." (Sic) On 1/26/22 at 10:16 a.m., the director of nursing (DON) and administrator were interviewed about Resident #121 and CNA #1. The DON stated she was aware that Resident #121 and CNA #1 "did not get along" but nothing abusive had been reported. The DON stated that a couple of weeks ago, Resident #121 told her that he did not like CNA #1. The DON stated she asked Resident #121 at that time if CNA #1 had done anything to him and the resident stated no. The DON stated she asked an alert/oriented resident that lived across the hall (Resident #128) about CNA #1 and Resident #128 stated he had previously heard Resident #121 cursing at CNA #1. The DON stated Resident #121 "denied anything" and just stated that he did not like CNA #1. The administrator stated he was not aware of any mistreatment or altercations between Resident #121 and CNA #1. On 1/26/22 at 10:20 a.m., the administrator and DON were informed of the verbal statements and hand gesture made by CNA #1 to Resident #1 witnessed on 1/26/22 at 8:24 a.m. On 1/26/22 at 10:33 a.m., the DON was	F 600		

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interviewed about any previous reports of mistreatment or abuse investigations involving CNA #1. The DON stated nothing formal was documented involving CNA #1. The DON stated again, that Resident #121 had said to her, "I don't like him and he (CNA #1) don't like me." The DON was not aware of any issues with CNA #1 and any other residents.

On 1/26/22 at 1:39 p.m., the DON was interviewed again and stated this morning (1/26/22) that she approached CNA #1 about not wearing his facemask properly. The DON stated CNA #1 "went off on me" and told her she was not going to tell him what to do. The DON stated she asked CNA #1 for his badge and requested him to leave the building. The DON stated the administrator escorted CNA #1 out of the building and his employment was terminated. When asked again about any previous knowledge of conflicts between Resident #121 and CNA #1, the DON stated again, that Resident #121 came to her office about 3 to 4 weeks ago talking about wanting to go home and Resident #121 told her that CNA #1 "got on his nerves." The DON stated she asked Resident #121 if CNA #1 had done anything to him and the resident said no. The DON stated she did not think the situation was reportable abuse and did not investigate any further. The DON had no documentation regarding this conversation with Resident #121 or the interview with the neighboring resident. The DON stated she did not interview CNA #1 about the conflict.

On 1/26/22 at 1:41 p.m., the facility's social worker (other staff #4) was interviewed about Resident #121 and any known behaviors or conflicts with staff or other residents. The social

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F 600	Continued From page 31 worker stated Resident #121 had no history of behaviors with staff or other residents. The social worker stated the resident was usually out of his room daily and interacted appropriately with other residents. The social worker stated she was not aware of any conflicts between Resident #1 and CNA #1. On 1/27/22 at 3:26 p.m., the registered nurse unit manager (RN #2) was interviewed about Resident #121 and CNA #1. RN #2 stated she was not aware Resident #1 and CNA #1 did not get along or had any issues. On 1/28/22 at 8:20 a.m., the licensed practical nurse (LPN #9) routinely caring for Resident #121 was interviewed about CNA #1. LPN #9 stated she was not aware of any conflicts between CNA #1 and Resident #121. LPN #9 stated the only issue she had with CNA #1 was that he sometimes spoke loudly to residents. LPN #9 stated she had previously told CNA #1 to "watch his volume" because some residents might think he was "getting on them." The facility's policy titled Virginia Resident Abuse Policy (revised 7/14/20) documented, "This Facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone..." This policy defines abuse as, "...actions such as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, sexual	F 600		

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F 600	Continued From page 32 abuse, physical abuse, mental abuse..." This policy defined verbal abuse as, "...the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability [to] comprehend, or disability. Examples of verbal abuse included but are not limited to: threats of harm; saying thing to frighten a resident..." The policy defines mental abuse as, "...includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation..." CNA #1's orientation checklist documented review of policies regarding resident abuse and resident rights completed by the employee and his instructor on 10/20/21. The facility's abuse prevention policy was attached to the orientation checklist. CNA #1's annual training record documented completion of online training titled Preventing, Recognizing, and Reporting Abuse on 1/6/22. These findings were reviewed with the administrator, director of nursing and nursing consultant on 1/26/22 at 5:20 p.m.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		

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F 607	Continued From page 33 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of employee personnel files, staff interview, and review of facility policy, the facility failed to implement their Virginia Resident Abuse Policy for the screening of new employees, for 11 of 25 personnel files reviewed. Eleven of 25 employee personnel files did not include a Sworn Statement. The findings were: On 1/26/2022, the Director of Nursing (DON) was provided a list of 25 employees who were identified as new employees in the last two years. Information requested for each employee included the Sworn Statement, Criminal Record Check, License (if applicable), and References. Review of the personnel files revealed 16 of 25 did not have a Sworn Statement. The DON was given a list of the 16 employee files that were missing the Sworn Statement. The DON subsequently provided a Sworn Statement for five of the 16 employee files. The DON also provided a copy of an email addressed to the Human Resources Director of the facility's former owner asking for the Sworn Statements. Review of the facility's "Virginia Resident Abuse Policy," revised on 7/14/2020, noted the following: "Procedure: 1. Screening 1) It is the policy of the facility to undertake background checks of all employees and to retain on file applicable records of current employees	F 607	1). Facility requested sworn statements for those employees identified from the previous ownership of facility. The 11 missing sworn statements were obtained and placed in the employee file. 2). Any resident has the potential to be affected. Facility to complete an audit of all employee records to identify missing sworn statements. 3). One on one education provided to Human Resources Director regarding signed sworn statements in the employee files. Sworn Statements for all staff was obtained. All new hires to complete sworn statement during the application process. 4). Administrator, or designee to audit new hires weekly x 12 weeks to ensure a signed sworn statement has been obtained. All findings will be reviewed monthly with the QAPI committee with any variances being discussed and changes made when necessary.	3/1/22

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F 607	Continued From page 34 regarding such checks. a. The facility will do the following prior to hiring a new employee: b. This Facility will generally require that all potential employees certify as a part of the employment application process that they have not been convicted of an offense or otherwise been found guilty of an offense that would preclude employment in a nursing facility. c. It is the ongoing obligation of all employees to alert the Facility administrator of any conviction or finding that would disqualify them from continued employment with Facility under State or Federal law, or the facility's policies." During an end of day meeting at 5:00 p.m. on 1/27/2022, that included the Administrator, DON, Corporate Nurse Consultant, and the survey team, the missing 11 Sworn Statements was discussed. At the time of the Exit Conference at 12:00 p.m. on 1/28/2022, no further information or additional Sworn Statements was provided.	F 607		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure physician's orders for care of a central venous access device was in place upon admission, for one of 36 residents, Resident #313.	F 635		

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F 635	Continued From page 35 Findings include: Resident #313 was admitted to the facility on 01/20/22. Diagnoses for Resident #313 included, but were not limited to: cirrhosis of the liver without ascites, hypotension, collapsed vertebrae/fracture, acute kidney failure, moderate protein calorie malnutrition, hypothyroidism, compression fracture (L-5) secondary to discitis and osteomyelitis, discitis of lumbosacral region, closed compression fracture of sacrum, and IV Ertapenem for prolonged therapy. The most current MDS (minimum data set) was an admission assessment, which was in progress and not complete. An admission assessment dated 01/20/22 at 7:15 PM documented, "...arrival date & time: 01/20/22 7:15 PM....from hospital...Reason For Admission: IV antibiotic administration...diagnoses/condition...infection...IV meds/fluids...antibiotics...alert and oriented to situation, able to make needs known..." On 01/25/22 at approximately 12:50 PM, during the initial tour of the facility, Resident #313 was observed in her room in bed. A central venous access device was observed in the resident's right upper chest area. Resident #313 stated that the access device had not been touched since she was admitted on 01/20/22. A dressing dated 01/19/22 was over the access device. Resident #313's clinical records and current physician's orders were reviewed. The resident's hospital discharge summary dated 01/20/22 documented, "...Hohn catheter placed yesterday (01/19/22)...discitis..." The current physician's	F 635	1). Physician's orders for the care of the Central Venous Access device was obtained and added to the MAR for resident #313. 2). Any resident with a Central Venous Access device has the potential to be affected. No other residents were identified with Central Venous Access. 3). LPN/RN will be educated on physician orders to ensure proper care of Central Venous Access lines and added to new employee orientation. 4). DON/designee will complete audit weekly x 12 weeks to identify any resident that have a Central Venous Access line to ensure physician orders are present for care and management. Audit findings will be reported to the Quality Assurance Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	3/1/22

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F 635	Continued From page 36 orders did not include any orders for the care and maintenance of the central venous access device (Hohn catheter). The standing orders were reviewed and no orders were found for the central venous access device. Resident #313's CCP (comprehensive care plan) documented, "...Resident is on antibiotic therapy...administer the full course of antibiotic as prescribed by physician...resident has infection...Administer antibiotics...per physician orders and monitor side effects...Resident is on intravenous therapy..." On 01/26/22 at approximately 1:30 PM, Resident #313 was interviewed regarding care of the central venous access line. Resident #313 stated that the dressing had been in place since she left the hospital and that staff had flushed the central access device with saline before and after administering her antibiotic yesterday (01/25/22). The resident's MARs/TARs (medication/treatment administration records) were reviewed for January 2022. There were no care or maintenance orders for the central access device. The nursing notes were then reviewed. There were no nursing or progress notes regarding care of the Resident #313's central venous access device. On 01/26/22 at 2:15 PM, LPN (licensed practical nurse) #1 was observed flushing Resident #313's central venous access line with a 10 ml (milliliter) syringe of sterile saline before the administration of IV (intravenous) medication.	F 635		

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F 635	Continued From page 37 At approximately 3:05 PM, LPN #1 stated that her shift was finished and she was leaving for the day. LPN #1 stated that LPN #3 was taking over for her and would disconnect Resident #313 when the medication was complete. On 01/26/22 at 4:40 PM, RN (registered nurse) #5 was interviewed regarding orders for Resident #313's access device. RN #5 stated that she had not trained on those yet. RN #5 was asked what she would need prior to caring for an access device. RN #5 stated, "Orders." RN #5 was asked what she would do if she found that there were no orders for care of an access device. RN #5 stated, "Contact the physician." On 01/26/22 at 4:45 PM, the UM3 (unit 3 manager) was interviewed. UM3 was asked if she was aware that Resident #313 did not have physician's orders for care and maintenance of the central venous access device. The UM3 stated, "No, I wasn't." On 01/26/22 at 4:50 PM, LPN #3 was interviewed regarding Resident #313's central venous access device. LPN #3 was asked how she knew what to flush the resident's access device with. LPN #3 stated, "I've had training." LPN #3 stated that she disconnected the IV, flushed with 10 ml of NS (normal saline) and stated, "That's how I was trained." LPN #3 was asked where that order came from, as there were no orders on the resident's chart. LPN #3 stated, "Standing orders." LPN #3 was made aware that there were no orders on the standing orders for care of the resident's access device. LPN #3 stated, "It's not a problem, I'm sure I can call (name of physician) and get an order." LPN #3 was made aware that the physician's order should have	F 635		

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F 635	Continued From page 38 been obtained prior to flushing the access device. LPN #3 stated, "Would you rather I didn't flush it?" At 5:00 PM, the physician was interviewed and asked if he was aware that there were no care orders for Resident #313's access device. The physician stated that he was not. The physician stated that the nurses do not draw blood from the access devices, only administer medications as ordered and that what they used to flush was "the usual protocol." The physician was asked if it was ok for them to administer prior to obtaining physician orders. The physician stated, "No, call for orders first." The administrator and DON (director of nursing) were made aware on 01/26/22 at 5:30 PM, that there were no physician orders for care of Resident #313's access device and that the nurses were flushing without orders. The DON stated that the physician's orders should be obtained prior. A policy was requested at this time or care orders for access devices. The policy titled, "Central Vascular Access Devices" documented, "...Specific flush/lock orders must be obtained, documented, and submitted to the pharmacy...A prescriber order is required to flush/lock a catheter...must include: flushing/locking agent(s), strength/concentration, volume, frequency...lock per prescriber orders..." No further information and/or documetnation was presented prior to the exit conference on 01/28/22.	F 635		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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F 656	Continued From page 39 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	1). A care plan was developed for resident #61 for care of her colostomy. A care plan for resident #18 was developed to address the use of Insulin to treat her Diabetes. 2). Any resident that has a colostomy or being treated for Diabetes management has the potential to be affected. An audit have been completed to verify care plans are in place for colostomy care and Diabetes management. 3). The DON educated MDS staff and Nurse Managers on providing a comprehensive care plan for residents that have a colostomy or is receiving Insulin for diabetic management. Education will be added to new hire orientation. 4). Nurse Managers, MDS Coordinator, or designee will audit care plans following the weekly care plan schedule to ensure that the care plans are person centered including but not limited to diabetic management and colostomy care weekly x 12 weeks. Audit findings will be reported to the Quality Assurance Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	3/1/22

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F 656	Continued From page 40 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive plan of care for two of 36 residents in the survey sample, Resident #61 and #18. Resident #61 had no plan of care regarding a colostomy. Resident #18 had no plan of care developed regarding use of insulin. The findings include: 1. Resident #61 was admitted to the facility on 2/5/21 with diagnoses that included peripheral vascular disease, pneumonia, protein-calorie malnutrition, rectal cancer with colostomy, hypertension, benign prostatic hypertrophy, anemia, major depressive disorder, chronic kidney disease and heart failure. The minimum data set (MDS) dated 11/15/21 assessed Resident #61 with severely impaired cognitive skills. Section H of this MDS documented the resident had a colostomy. Resident #61's clinical record documented physician orders dated 3/10/21 for colostomy care every shift and a wafer change to the colostomy each week. The resident's treatment administration record for January 2022 documented colostomy care as ordered. Resident #61's plan of care 11/24/21 documented no problems, goals and/or interventions regarding the colostomy. The plan was updated on 5/19/21 stating the resident was at risk of pain/discomfort related to a cancer diagnosis and "recent	F 656		

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F 656	Continued From page 41 colostomy surgery" but included no problems, goals or interventions regarding the care of the colostomy. On 1/27/22 at 4:00 p.m., the registered nurse (RN #9) responsible for care plan development was interviewed about Resident #61. RN #9 stated she developed care plans and plans were updated as needed by the interdisciplinary team. RN #9 stated colostomy care orders were in place but the care plan only mentioned the colostomy under the pain section. RN #9 stated the care plan should include a specific plan about the colostomy. This finding was reviewed with the administrator, director of nursing and nursing consultant on 1/27/22 at 5:30 p.m. 2. Resident #18 was originally admitted to the facility on 01/23/2021 and readmitted on 10/14/2021 with diagnoses that included hypertension, respiratory failure with hypoxia, neuromuscular dysfunction of bladder, paraplegia, depression, and congestive heart failure. The most recent minimum data set (MDS) dated 01/22/2022 was a quarterly assessment and assessed Resident #18 as cognitively intact for daily decision making with a score of 14 out of 15. Resident #18's clinical record was reviewed on 01/27/22 at 9:30 a.m. Observed on the order summary report were the following orders: "Humalog Solution 100 UNIT/ML (Insulin Lisper) Inject 10 unit subcutaneously three times a day for Diabetes Mellitus. Order Date 10/14/2021. Start Date 10/15/2021."	F 656		

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F 656	Continued From page 42 "Lantus SoloStar Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 40 unit subcutaneously two times a day for Diabetes Mellitus. Order Date: 10/14/2021 Start Date: 10/14/2021." A review of the medication administration reports (MAR) documented Resident #18 was receiving the Humalog and Lantus insulin as ordered since 10/14/2021. A review of the Resident #18's care plan was completed and it did not include a problem/focus area, goals, and interventions for the use of the Humalog or Lantus insulin. On 01/27/2022 at 5:00 p.m., the unit manager, registered nurse (RN) #7 was interviewed regarding the care plan. RN #7 stated, "I know he (Resident #18) receives his insulin, but I'm not sure why it wasn't carried over on his care plan. He (Resident #18) had a couple of discharges and readmissions and it is possible it was missed during one of those times. It would be best to talk with the MDS coordinators about the care plans." The above findings were discussed with the administrator, director of nursing and corporate nurse consultant during a meeting on 01/27/2022 at 5:30 p.m. On 01/28/2022 at 8:54 a.m. the MDS coordinators, licensed practical nurse (LPN) #4 and RN #6, who were responsible for the care plans were interviewed. LPN #4 stated she had recently started and updated the care plan on 01/28/2022 during the care plan meeting. RN #6 stated based on the orders the insulin care plan focus area should have been added when	F 656		

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F 656	Continued From page 43 Resident #18 was readmitted in October. A review of the facility's "Comprehensive Care Planning" policy (revised 07/19/2019) documented the following: "B. An "Interim" Baseline Care plan must be developed within 48 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care plan is completed." "C. A Comprehensive Care Plan must be developed by the interdisciplinary Care Planning Team within seven (7) days after completion of the of the comprehensive assessment (MDS)." "F. The Comprehensive Care Plan is reviewed and updated at least every 90 days by the interdisciplinary team." No additional information was provided to the survey team prior to exit on 01/28/2022 at 1:00 p.m.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		

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F 657	Continued From page 44 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 36 residents in the survey sample, Resident #155 and #94. Resident #155's plan of care was not revised to reflect discontinued use of bed/chair alarms. Resident #94's plan of care was not updated to reflect a change in resuscitation status. The findings include: 1. Resident #155 was admitted to the facility on 11/17/10 with a readmission on 12/31/21. Diagnoses for Resident #155 included cerebral palsy, cognitive communication deficit, left wrist contracture, cardiomyopathy, anemia, obstructive sleep apnea, restless leg syndrome, congestive heart failure, chronic kidney disease, atrial fibrillation, seizure disorder, fractured left femur, chest wall abscess and pneumonia. The minimum data set (MDS) dated 1/6/22 assessed Resident #155 with moderately impaired cognitive skills.	F 657	1). Resident #155's care plan has been revised to reflect that the bed/chair alarm has been discontinued. Resident # 94-care plan has been up dated to reflect current code status. 2). Any resident residing in the facility has the potential to be affected if the care plan has not been reviewed or revised to reflect current needs. Facility audited current residents care plan for code status and bed/chair alarm use. 3). DON educated MDS staff and Nurse Managers on the facilities policy on review and revision of care plans to ensure a patient's care plan is resident centered. Education will be added to new employee orientation. 4). Nurse Managers, MDS Coordinator, or designee will audit re-admissions and new orders to verify care plan has been updated to reflect resident's status weekly x 12 weeks. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	3/1/22

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F 657	Continued From page 45 Resident #155's clinical record documented the resident had a history of frequent falls. Nursing notes documented the resident fell attempting to get out of bed on 12/25/21 and was hospitalized for a fractured femur as a result of the fall. Resident #155's plan of care (revised 12/27/21) documented the resident was at risk of falls due to decreased mobility, weakness, history of falling, poor safety awareness. The plan documented, "...Will attempt to transfer/walke (walk) without staff assist at times. Has Pressure/Alarm for bed/chair..." Interventions listed to prevent falls and/or injuries included, "...Education not to turn off alarm...Pressure alarm bed/chair..." On 1/27/22 at 8:40 a.m., Resident #155 was observed on the bedside eating breakfast. No pressure alarm was observed in use. On 1/27/22 at 9:00 a.m., accompanied by certified nurses' aide (CNA) #11, Resident #155 was observed in bed with no bed alarm in use. CNA #11 was interviewed at this time about the alarm. CNA #11 stated she did not recall the resident using a bed alarm. CNA #11 stated she had cared for Resident #155 routinely since last March (2021) and no bed/chair alarm had been used. On 1/27/22 at 3:30 p.m., the registered nurse unit manager (RN) #2 was interviewed about Resident #155's plan of care indicating alarm use. RN #2 stated the facility did not routinely use bed/chair alarms and the resident's care plan must not have been updated to remove the alarms. On 1/27/22 at 4:00 p.m., RN #9 responsible for MDS and care plans was interviewed. RN #9	F 657		

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F 657	Continued From page 46 reviewed Resident #155's plan of care and stated the alarms were added to the plan on 1/4/21. RN #9 stated the alarms were no longer used with Resident #155. RN #9 stated Resident #155 had a care plan review most recently on 1/7/22 and the alarms should have been deleted from the plan. This finding was reviewed with the administrator, director of nursing and nursing consultant on 1/27/22 at 5:30 p.m. 2. Resident #13 was originally admitted to the facility on 09/20/2021 and readmitted on 11/27/2021 with diagnoses that included routine healing of left humerus and left femur fractures, atrial fibrillation, anxiety disorder, depression, osteoarthritis, chronic obstructive pulmonary disease (COPD), pneumonia due to coronavirus disease, and acute respiratory failure. The most recent minimum data set (MDS) dated 12/02/2021 was a significant change and assessed Resident #13 as cognitively intact for daily decision making with a score of 13 out of 15. Resident #13's clinical record was reviewed on 01/22/2022 at 2:30 p.m. Observed on the order summary report was the following: "DNR (Do Not Resuscitate) Order Date 11/27/2021." Observed on the resident manager contact screen in the electronic health record was the following: "Code Status: DNR." Observed on Resident #13's care plan was the following: "Resident has advanced directives. Resident is a Full Code. Date Initiated/Created: 09/21/2021." On 01/27/2022 at 4:00 p.m., the MDS coordinator (RN #9) who was responsible for the care plans was interviewed. RN #9 reviewed Resident #13's clinical record which included the history and	F 657		

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F 657	Continued From page 47 physical which documented Resident #13 was a DNR (do not resuscitate). RN #9 stated that Resident #13's care plans should have been reviewed and revised to reflect the code status change when Resident #13 was readmitted on 11/27/2021. The above findings were reviewed with the administrator, director of nursing and corporate nurse consultant during a meeting on 01/27/2022 at 5:30 p.m. A review of the facility's "Comprehensive Care Planning" policy (revised 07/19/2019) documented the following: "B. An "Interim" Baseline Care plan must be developed within 48 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care plan is completed." "C. A Comprehensive Care Plan must be developed by the interdisciplinary Care Planning Team within seven (7) days after completion of the of the comprehensive assessment (MDS)." "F. The Comprehensive Care Plan is reviewed and updated at least every 90 days by the interdisciplinary team." No additional information was provided to the survey team prior to exit on 01/28/2022 at 1:00 p.m.	F 657		
F 684 SS=J	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	F 684		

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F 684	Continued From page 48 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to follow physician's orders for one of 36 residents in the survey sample, Resident #313. Resident #313 was not administered IV (intravenous) antibiotic medication as ordered by the physician, which resulted in the identification of Immediate Jeopardy (Level 4-Isolated) on 01/25/2022 at 4:25 PM. The facility also failed to follow physician's orders for four of 36 residents in the survey sample, Resident # 135, 149, 88, and 102. Resident # 135 and 149 were not administered the Shingrix vaccine as ordered by the physician. Resident #88 was administered Metformin without food when the physician's order required the medication to be taken with food. Resident #102's fluid restrictions were not documented as ordered by the physician. Findings include: 1. Resident #313 was admitted to the facility on 01/20/22. Diagnoses for Resident #313 included, but were not limited to: cirrhosis of the liver without ascites, hypotension, collapsed vertebrae/fracture, acute kidney failure, moderate protein calorie malnutrition, hypothyroidism, compression fracture (L-5) secondary to discitis and osteomyelitis, discitis of lumbosacral region, and closed compression fracture of sacrum.	F 684	1). Resident #313 received Ertapenum IV as MD ordered. MD and RR were made aware of missed doses of medication. MD assessed resident to find there were no ill effects. Staff nurses that were responsible for carrying out MD order for IV antibiotic received 1:1 education regarding following MD orders. Resident #135 and #149 received Shingrix Vaccine as ordered. Nurse caring for resident #88 that gave metformin without food was educated on following MD order to give medication with food when ordered. NP notified of inconsistent documentation of fluid restriction of resident #102. 2). Any resident has the potential to be affected if MD orders are not followed. An audit of all residents records were reviewed to see if there was an order for IV medications that were not in compliance. All pharmacy recommendation for the months of October through December were audited for compliance. All resident with orders for metformin were reviewed to verify administration time was schedule in conjunction with mealtime. An audit of residents with orders for fluid restriction has been completed to identify discrepancy in documentation. The MD/FP will be notified of any variances of following physician's orders.	3/1/22

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F 684	Continued From page 49 The most current MDS (minimum data set) was the admission assessment, which was in progress and not complete for Resident #313. An admission nursing assessment dated 01/20/22 at 7:15 PM documented, "...arrival date & time: 01/20/22 7:15 PM....from hospital...Reason For Admission: IV antibiotic administration...diagnoses/condition...infection...IV meds/fluids...antibiotics...alert and oriented to situation, able to make needs known..." Resident #313's current CCP (comprehensive care plan) documented, "...Resident is on antibiotic therapy...administer the full course of antibiotic as prescribed by physician...resident has infection...Administer antibiotics...per physician orders and monitor side effects...Resident is on intravenous therapy..." On 01/25/22 at approximately 12:50 PM, during the initial tour of the facility, Resident #313 was observed in her room in bed. A central venous access device was observed in the resident's right upper chest area. Resident #313 was asked how she was doing. Resident #313 began to cry and stated that she was upset and felt as though she was getting worse instead of better. Resident #313 went on to explain that she had a fracture and infection in her spine and that she had been in the hospital receiving IV antibiotics (prior to admission to the facility) and was supposed to be receiving them here as well. Resident #313 stated that she had not received any IV antibiotics since she had arrived here. Resident #313 was asked when she was admitted to this facility. The resident stated that she came late Thursday evening (January 20,	F 684	continued: 3). All nurses LPN's and RN's have been re-educated on following physician's orders to include but not limited to IV antibiotics, vaccines, fluid restrictions and manufacturer specifications either in person or via telephone. 4). Nurse Managers or designee will audit all resident with IV medication orders and residents with fluid restriction for compliance 5x weekly x 4 then monthly x 2 months. Nurse Manager or designee will conduct two med pass observations weekly x 4 weeks then monthly x 2 to verify medications are being given as per physician order. DON or designee will audit pharmacy recommendation monthly x 3 to verify that recommendation have been followed up on. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	

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F 684	Continued From page 50 2022). Resident #313 was asked if she had reported to anyone that she had not received the medication. The resident stated, "Everyday," and further stated that the physician had come in to see her (she thought on Friday, 01/21/22) and that he had ordered the medication for her, but she still had not received it. Resident #313 stated that the nurses have kept telling her that the IV antibiotics were coming and that she wasn't sure what was going on. Resident #313 again stated that she was upset, she wanted to get better and was in fear of actually getting worse due to not having the antibiotic medication. Resident #313 stated that she thought she was supposed to have the IV medication therapy for about 4 to 6 weeks. On 01/25/22 at approximately 1:30 PM, Resident #313's clinical record was reviewed. The current physician's orders included an order for, "...Ertapenem Sodium Solution Reconstituted 1 GM (gram) Use 1000 mg (milligrams) intravenously every 24 hours for discitis...Order Status: Active...Order Date: 01/20/22...Start Date: 01/20/22..." The MARs (medication administration records) were reviewed for January 2022. The MARs documented, "...Ertapenem Sodium Solution Reconstituted 1 GM Use 1000 mg intravenously every 24 hours for discitis...Start Date: 01/20/22 (2:30 PM)..." Each day from 01/21/22 through 01/25/22 staff initials were documented with the time and the number "19" in each box for the IV medication. The number 19, on the legend (chart codes) indicated, "19=Other/See Nurse Notes." The MAR was blank on 01/20/22.	F 684		

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F 684	Continued From page 51 Resident #313's nursing notes documented each day that the medication was "on order." No nursing or progress notes were found to indicate the physician had been notified that the medication was "on order", not available for administration, or that Resident #313 had not been receiving the medication as ordered. On 01/25/22 at 2:15 PM, Resident #313's physician was interviewed and was asked if he had been notified by staff that Resident #313 had not received the physician ordered IV antibiotic in the last five days. The physician stated, "No, I got something from (name of pharmacy) today that they (pharmacy) were sending a 5 day supply because it's not covered, but I didn't know (she had not received it)." The physician stated that Resident #313 was getting the medication for discitis and he thought she was to receive it for 6 weeks. The physician was asked about the potential implications of Resident #313 not receiving the IV antibiotic medications as ordered. The physician stated, "...the infection may not be controlled, whether the infection will spread out of the disc or not, I don't know...It could result in hospitalization, prolonged treatment, prolonged stay (in the nursing home)...I don't think it would result in sepsis, but could increase her pain level and cause further deterioration of the disc." The physician was made aware of serious concerns regarding Resident #313 not receiving the IV antibiotics as ordered and of the serious concerns and the potential for harm to Resident #313. The physician stated, "Unfortunately, I agree with you." The physician stated that staff usually let him know when a medication isn't administered and stated, "I'm not sure where the breakdown occurred." The physician stated that	F 684		

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F 684	Continued From page 52 he had received a note from the pharmacy this morning that the medication wasn't covered by insurance and that they sent a 5 day supply. The physician stated that he had spoken with RN (registered nurse) #3 [UM3 (unit 3 manager)] this morning about that, but the nurse did not mention to him that the medication had not been administered. On 01/25/22 at 3:05 PM, the physician was again interviewed. The physician then stated, "The Ertapenem came in last night (01/24/22), it's in the medication room." The physician stated that he and RN #3 checked the stat box and that RN #3 found the IV antibiotic medication (Ertapenem) that was ordered in the med room and that it had come in last night. The physician was asked why the IV Ertapenem was not administered last night. The physician stated he wasn't sure, but RN #3 was going to check. The physician stated, "I'm really disappointed, probably more than you are." On 01/25/22 at 4:25 PM, in a meeting with the survey team, the administrator and DON were notified that survey team had consulted and discussed the above information with the State Agency, and identified IJ (Immediate Jeopardy) (Level 4-Isolated) on 01/25/2022 at 4:25 PM, due to the facility's failure to ensure that the IV antibiotics were administered per the physician's order for Resident #313 for the treatment of L5 (lumbar spine vertebrae) discitis/osteomyelitis. The survey team advised the administrator and DON to develop and present a plan of removal regarding Resident #313 not receiving IV antibiotic medication as ordered by the physician. On 01/25/22 at 5:00 PM, RN #3 (also known as the UM3) was interviewed. UM3 was asked if	F 684		

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F 684	Continued From page 53 she was aware that Resident #313 had not received her IV antibiotic as ordered by the physician for 5 days. UM3 stated that the physician had brought it to her attention about an hour ago that the IV medication (Ertapenem) was not administered to Resident #313 as ordered. UM3 stated that she had not been made aware that Resident #313 had not received it until the physician told her. UM3 stated that the physician had come to the unit and gave her an order for an alternate IV antibiotic that was in the stat box (Meropenem). UM3 stated she had been in the medication room earlier today and saw that the original medication (Ertapenem) was in there, but didn't realize that Resident #313 had not received it. UM3 stated that after looking into it further, they had found the medication had arrived the night before (01/24/22). UM3 was asked why the medication wasn't administered last night. UM3 stated, "I can't answer that." On 01/25/22 at 5:20 PM, RNA (Registered Nurse Applicant) #4 was interviewed. RNA #4 had documented on Resident #313's MAR under the IV antibiotic on 01/22/22 and 01/23/22. RNA #4 stated that she works day shift and the medication was scheduled for 2:30 PM. RNA #4 stated that on both days (01/22/22 and 01/23/22) she looked for the medication in the medication room and up front in the Q machine (a place for extra medications) and the Q machine said it wasn't available. RNA #4 stated that a pharmacy delivery guy came and she had asked him about the medication for Resident #313, and he told her it would be in the night shipment. RNA #4 stated that she did not receive the medication. RNA #4 stated that she did not pass this information on in report to the oncoming shift, she did not report it to UM3, and did not notify the physician. RNA #4	F 684		

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F 684	Continued From page 54 stated she did not document anything in the progress notes. RNA #4 stated that on Sunday, she went to the stock room and the medication had not come and she reached out again to the pharmacy delivery person. RNA #4 stated that she did not call the pharmacy directly, and again did not notify UM3 or the physician. RNA #4 stated that she thought the medication may be coming in on the next shipment. On 01/25/22 at approximately 5:45 PM, LPN (licensed practical nurse) #1 was interviewed. LPN #1 had documented on Resident #313's MAR under IV antibiotic on 01/21/22, 01/24/22 and 01/25/22. LPN #1 stated that she works day shift and the medication was scheduled for 2:00 to 2:30 PM. LPN #1 stated that on Friday (01/21/22) that she realized they didn't have it in stock and she went to the computer and ordered it. LPN #1 stated that she did not report to UM3 or the physician that the medication was not in stock. LPN #1 stated that she did not pass this information on in report to the next shift. LPN #1 stated, "On Monday (01/24/22) the same thing, I realized we didn't have it. I called the pharmacy and they said IV meds don't come through (the computer) and has to be faxed, I don't know who I talked to, so I faxed it. When I spoke to the woman (at the pharmacy) she said as soon as we get it (fax) we'll send it out." LPN #1 stated that she assumed over the weekend Resident #313 didn't get the medication because the facility didn't have it. LPN #1 stated that she did not report to UM3 or the physician that the resident had not received the medication or that the medication was not available to administer, and she didn't pass it on in report, " ...because it was a day shift thing." LPN #1 stated, "I didn't even realize it was an antibiotic to be honest."	F 684		

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F 684	Continued From page 55 On 01/26/22 at 3:41 PM, the administrator and DON presented the following plan for IJ removal: 1). Corrective Action: Resident #600537 (identified as Resident #313) received Ertapenem 1000 mg IV as MD ordered on 1/25/22 (3:30 PM). MD (medical doctor) and RR (resident representative) made aware of missed doses of medication on 1/25/22. MD assessed resident to find there were no ill effects. 2). Staff nurses that were responsible for carrying out MD orders received 1:1 (one to one) education regarding following MD orders on 1/25/22. 3). Identification: All residents residing in the facility have the potential to be affected by this practice. 4). Changes: All nurses LPNs and RNs (registered nurses) employed by facility will be re-educated on following physician's orders by 1/27/22. If an employee is out on FMLA (Family Medical Leave Act) or vacation that employee will be in-serviced immediately upon returning to work. 5). Monitoring: DON or designee will audit all MD orders for IV medications for compliance weekly x 4 then monthly x 90 days facility wide. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice. The survey team reviewed the plan of removal and accepted the plan of removal for the	F 684		

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F 684	Continued From page 56 immediate jeopardy status on 01/26/22 at 4:00 PM. Resident #313 received Ertapenem 1000 mg IV per the physician's orders on 01/25/22 at 3:30 PM. On 01/27/22 between 7:30 AM and 12:00 noon, interviews were conducted with nurses on each nursing unit regarding education for following physician orders. Telephone interviews were also conducted by the survey team with nurses off duty to ensure education was provided. The administrator and DON presented education in-service records for the education provided, along with sign in sheets and an audit form /tool to ensure that all nursing staff off duty would be educated upon return to work. On 01/27/22 at approximately 9:30 AM, Resident #313 was interviewed and stated, "Thank you, I'm much better now that I'm getting my antibiotics." The survey team abated the IJ on 01/27/22 at 12:46 PM, reducing the scope and severity level of the remaining deficient practice to level 2, isolated. No further information and/or documetnation was presented prior to the exit conference on 01/28/22. 2. Resident #135 was admitted to the facility on 03/18/21. Diagnoses for Resident #135 included, but were not limited to: diabetes mellitus, high blood pressure, anemia, anxiety, depression, and CHF (congestive heart failure). The most recent MDS (minimum data set) was a	F 684		

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F 684	Continued From page 57 quarterly review, dated 12/25/21. This MDS assessed the resident with a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. On 01/27/22 at 2:59 PM, Resident #135's clinical record was reviewed. Resident #135 had a current physician's order for, "Shingrix 0.5 ml (milliliters) intramuscularly when available from pharmacy, with a second dose administered in 60 days." The date of the order was 10/23/21. No information was found in the resident's clinical record to indicate Resident #135 received the vaccine as ordered. On 01/27/22 at 3:45 PM, the pharmacy was called and interviewed regarding this vaccine. The pharmacist looked up Resident #135 in the system and stated that she did not see an order showing in the system for the vaccine. The pharmacist was made aware that the order was listed on the resident's current physician orders set, signed by the physician as a current order, and was ordered on 10/23/21. The pharmacist stated that the order may have been entered wrong by facility staff in the system and that may be why it wasn't showing for her. The pharmacist stated that there isn't a shortage of this vaccine and it's available and wasn't sure why the resident would not have received it, but stated that it was not showing as an order on her end. The pharmacist stated again, that it may have been entered wrong and if staff entered it in as "other" in the system, it doesn't come to the pharmacy, those orders have to actually be printed and faxed in. The physician's orders were again reviewed and the order was entered as "Other."	F 684		

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F 684	Continued From page 58 On 01/27/22 at 4:15 PM, the UM3 (unit 3 manager]) was interviewed regarding this medication being on order for Resident #135 since October and the resident not receiving the vaccine. UM3 stated that they should should be waiting on a consent. UM3 was asked if a consent had been obtained for Resident #135. The UM stated, "Now that, I don't know." UM3 was asked if that should be documented, and stated that it should. On 01/27/22 at 5:45 PM, the administrator and DON were made aware of the above information and informed that Resident #135 had an order for the vaccine, but there was no evidence the resident had received it and that there was no information regarding consent. The DON was asked if this should be documented. The DON stated that it should. The DON was asked why an order would be given prior to consent. The DON stated that she wasn't sure. The DON and administrator were asked how long it takes to obtain consent, as the order for this vaccine was over three months ago. No response was given. No further information and/or documentation was presented prior to the exit conference on 01/28/22. 3. Resident #149 was admitted to the facility on 07/26/21. Diagnoses for Resident #149 included, but were not limited to: diabetes mellitus type II, high blood pressure, history of tumor on kidney, history of ovarian cancer, history of pulmonary embolism, osteoarthritis, chronic pain, GERD (reflux), and increased lipids (hyperlipidemia). The most recent MDS (minimum data set) was a quarterly assessment dated 01/08/22. This MDS	F 684		

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F 684	Continued From page 59 assessed Resident #149 with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. Resident #149's clinical record was reviewed on 01/26/22. A pharmacy recommendation dated 10/13/21 documented, "(Name of Resident #149) is 50 years of age or older...unless clinically contraindicated, please administer Shingrix 0.5 ml intramuscularly when available from the pharmacy, with a second does administered in 60 days...Physician's Response: (check mark) I accept the recommendation above, please implement as written..signature of physician dated 10/21/21. The current physician's orders included, "Shingrix 0.5 ml (milliliters) intramuscularly when available from pharmacy, with a second dose administered in 60 days." The date of order was 10/23/21. No information was found in the resident's clinical record to indicate Resident #149 received the vaccine as ordered. On 01/27/22 at 3:45 PM, the pharmacy was called and interviewed regarding this vaccine. The pharmacist looked up Resident #149 in the system and stated that she did not see an order showing in the system for the vaccine. The pharmacist was made aware that the order was listed on the resident's current physician orders set, signed by the physician as a current order, and was ordered on 10/23/21. The pharmacist stated that the order may have been entered wrong by facility staff in the system and that may be why it wasn't showing for her. The pharmacist stated that there isn't a shortage of this vaccine and it's available and wasn't sure why the resident would not have received it, but stated	F 684		

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F 684	Continued From page 60 that it was not showing as an order on her end. The pharmacist stated again, that it may have been entered wrong and if staff entered it in as "other" in the system, it doesn't come to the pharmacy, those orders have to actually be printed and faxed in. On 01/27/22 at 4:15 PM, the UM3 (unit 3 manager]) was interviewed regarding this medication being on order for Resident #149 since October and the resident not receiving the vaccine. UM3 stated that they should should be waiting on a consent. UM3 was asked if a consent had been obtained for Resident #135. The UM stated, "Now that, I don't know." On 01/27/22 at 5:45 PM, the administrator and DON were made aware of the above information and informed that Resident #149 had an order for the vaccine, but there was no evidence the resident had received it and that there was no information regarding consent. The DON was asked if this should be documented. The DON stated that it should. The DON was asked why an order would be given prior to consent. The DON stated that she wasn't sure. The DON and administrator were asked how long it takes to obtain consent, as the order for this vaccine was over three months ago. No response was given. A policy was requested at this time on vaccines. The policy was presented titled, "Resident Vaccination Policy" documented, "...residents and/or their responsible party will be asked about prior to vaccinations at admission. Prior doses...and other other vaccines will be documented in the immunization portal (in computer)...All other vaccines: The provider will discuss the indication for any addition vaccines	F 684		

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	495372	A. BUILDING _____ B. WING _____	C 01/28/2022

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F 684	Continued From page 61 not covered above (Shingrix) with the resident/resident representative and such vaccines will be ordered and administered after informed consent is obtained." No further information and/or documentation was presented prior to the exit conference on 01/28/22. 4. Resident #88 was admitted to the facility on 12/22/17 with diagnoses that included diabetes (type 2), chronic kidney disease, diabetic neuropathy, peripheral vascular disease, hyperlipidemia, major depressive disorder, macular degeneration, vascular dementia, left above knee amputation and urinary tract infection. The minimum data set (MDS) dated 12/3/21 assessed Resident #88 with moderately impaired cognitive skills. A medication pass observation was conducted on 1/26/22 at 7:41 a.m. with licensed practical nurse (LPN) #11 administering medications to Resident #88. Among the medications administered was metformin 500 mg (milligrams). Resident #88 took the medicines including the metformin orally with water but no food. LPN #11 did not prompt or offer food with the administration of the metformin. Resident #88 did not eat food until breakfast was served over an hour after the metformin administration. A breakfast tray was served to Resident #88 on 1/26/22 at approximately 8:45 a.m. On 1/26/22 at 8:49 a.m., Resident #88 was observed eating breakfast in bed. Resident #88's clinical record documented a physician's order dated 3/16/21 for metformin 500 mg to be administered each day for diabetes with	F 684		

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F 684	Continued From page 62 instructions, "*TAKE WITH FOOD*." The clinical record documented the resident's blood sugar on 1/26/22 at 5:25 a.m. was 117. Resident #88's plan of care (revised 12/7/21) documented the resident had diabetes mellitus. Interventions to prevent diabetic complications included, "medication as ordered by doctor..." On 1/26/22 at 10:04 a.m., LPN #11 was interviewed about the metformin administered to Resident #88 without food. LPN #11 stated Resident #88 did not like her morning medications with food. LPN #11 stated, "We can't hold the medicine." The Nursing 2022 Drug Handbook on page 942 describes metformin as an antidiabetic agent used as an adjunct to diet for lower glucose levels in patients with type 2 diabetes. Instructions for administration on page 942 include to, "Give drug with meals..." Potential adverse reactions listed on page 943 included hypoglycemia. (1) This finding was reviewed with the administrator, director of nursing and nursing consultant on 1/27/22 at 5:30 p.m. (1) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022. 5. Resident #102 was admitted to the facility on 05/10/2016 with diagnoses that included type 2 diabetes, muscle weakness, chronic kidney disease, congestive heart failure, dementia, and depression. The most recent minimum data set (MDS) dated 12/11/2021 was a quarterly assessment and assessed Resident #102 as severely impaired for daily decision making with a score of 6 out 15.	F 684		

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F 684	Continued From page 63 Resident #102's clinical record was reviewed on 01/27/2022. Observed on the order summary report was the following: "Record fluid intake every shift for 1500 cc/day. Order Date 03/29/2021 Start Date 03/29/2021" Observed on Resident #102's care plans was the following focus area: "Nutritional-Risk for wt (weight) Fluctuations/dehydration RT (related to) Diuretic use, CHF (congestive heart failure), DM (diabetes), Dementia, Fluid Restriction, CKD (chronic kidney disease), HTN (hypertension)... Resident gets snacks from snack machine frequently. Date Initiated: 05/23/2015. Created on: 12/22/2020. Revision on: 06/16/2021. Goal: Resident will have stable WT (weight) this qtr. (quarter) with review ongoing. Interventions: "Record fluid intake every shift for 1500 cc/day.... Date Initiated: 06/15/2021, Revision 10/28/2021..." On 01/27/2022 at 5:45 p.m., the licensed practical nurse (LPN) #7 and unit manager, registered nurse (RN) #7 were interviewed regarding the location of the fluid intake documentation. LPN #7 stated, "The nurses documents the fluid intake on the TAR (treatment administration records). We (nursing) enter the amount we give the resident for example Med Pass, etc. and then CNAs (certified nursing assistants) enter the amount they give the resident in the computer. These amounts are totaled and then placed on the TAR each shift." RN #7 stated, "He (Resident #102) does go to the vending machines and gets snacks so we do have to monitor him to make sure he is complaint with his fluid intake as well. He enjoys snacking."	F 684		

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F 684	Continued From page 64 A review of Resident #102's treatment administration record (TAR) for the period of October 2021 through January 2022 revealed staff nursing staff failed to record fluid intake per physician orders for Resident #102. For the period reviewed, first shift was missing 11 entries, second shift was missing 4 entries, and third shift was missing 2 entries. The above findings were discussed with the administrator, director of nursing (DON) and corporate nurse consultant during a meeting on 01/28/2022 at 11:00 a.m. The DON stated, "(Resident #102) is independent and has been here a few years. I know staff monitors his intake because he likes to snack and goes to the vending machine frequently. They should be recording his fluid intake as well." No additional information was provided to the survey team prior to exit on 01/28/2022 at 1:00 p.m.	F 684		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		

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F 725	Continued From page 65 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, group interview, facility document review and staff interview, the facility staff failed to ensure call bell response was timely on three of four nursing units. Interviews with residents from unit 1, unit 2 and unit 3 revealed call bell response times greater than 20 minutes. The findings include: 1. Resident #57 was admitted to the facility on 8/9/21 with diagnoses that included diabetes, anxiety, schizophrenia, bipolar disorder, vertigo, hypertension, major depressive disorder and gastroesophageal reflux disease. The minimum data set (MDS) dated 11/16/21 assessed Resident #57 with moderately impaired cognitive skills. On 1/25/21 at 1:49 p.m., Resident #57 requested to speak to a surveyor about poor call bell response on her unit (unit 1). Resident #57 stated she frequently waited from 30 minutes to	F 725	1). Resident interviews were conducted on residents # 57, 33, 109, 118, 78, 128, 148, 313, and 149 to note any improvement. 2). Any resident has the potential to be affected. Resident interviews conducted to identify any issues. 3). the administrator will provide education to all staff on the resident communication and call light policy. Education will be added to the new hire orientation process. 4). Administrator, or designee, to complete audits on 10 rooms per week x 8 weeks, then 10 rooms x 1 month. All findings will be reviewed monthly with the QAPI committee with any variances being discussed and changes made when necessary.	3/1/22

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F 725	Continued From page 66 an hour for staff response to call bells especially at night. Resident #57 stated she required assistance with brief changes and rang the bell frequently when she was wet. Resident #57 stated that at times there were not enough staff members working and at other times staff working did not respond quickly. 2. An interview was conducted on 1/25/22 at 4:30 p.m. with five members of the resident council (Residents #33, #109, #118, #128, #148). These residents represented three out of the four nursing units (units 1, 2 and 3). The residents expressed concerns about lack of staffing and slow call bell response. Resident #109 that lived on unit 2 stated he frequently experienced wait times greater than 30 minutes. Resident council meeting minutes dated 1/5/22 documented, "...Call bell response needs works (work)...an acceptable wait time would be 10-15 min (minutes)..." On 1/27/22 at 4:48 p.m., the licensed practical nurse (LPN) #8 working on unit 1 was interviewed about staff response to call bells. LPN #8 stated all staff members were supposed to respond to call bells/lights. LPN #8 stated response to call bells was expected to be no more than 5 to 10 minutes. On 1/27/22 at 4:53 p.m., the certified nurses' aide (CNA #9) caring for Resident #57 on the evening shift was interviewed about call bell response times. CNA #9 stated Resident #57 frequently rang her bell with most requests related to brief changes. CNA #9 stated all staff members were supposed to answer call lights. CNA #9 stated she had been told to respond "As fast as we can."	F 725		

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F 725	Continued From page 67 On 1/28/22 at 8:20 a.m., LPN #9 that routinely worked on unit 1 was interviewed about call bell response times. LPN #9 stated all staff members were supposed to respond to call bells. LPN #9 stated there were issues seeing the call bells on the short hall on unit 1. LPN #9 stated if all the aides and/or nurses were working on the front hall, staff did not always promptly see call lights on the short hall. LPN #9 stated she knew some of the short hall call lights were delayed because they were not always immediately visible. On 1/28/22 at 11:12 a.m., the reports of slow call bell response were reviewed with the administrator and director of nursing (DON). The DON stated at this time that all staff were supposed to respond to call lights but frequently residents wanted their assigned aide to help them instead of some other staff member. 3. Resident #313 admitted to the facility on 01/20/22. Diagnoses for Resident #313 included, but were not limited to: cirrhosis of the liver without ascites, hypotension, collapsed vertebrae/fracture, acute kidney failure, moderate protein calorie malnutrition, hypothyroidism, compression fracture (L-5) secondary to discitis and osteomyelitis, discitis of lumbosacral region, closed compression fracture of sacrum, and IV Ertapenem for prolonged therapy. No completed MDS (minimum data set) information was available yet for this resident. An admission nursing assessment for Resident #313 dated 01/20/22 at 7:15 PM documented, "...arrival date &time: 01/20/22 7:15 PM...from hospital. Reason For Admission: IV antibiotic administration...diagnoses/condition	F 725		

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F 725	Continued From page 68 ...infection...IV meds/fluids...antibiotics...alert and oriented to situation, able to make needs known...ADL (activities of daily living)/mobility: Limitation present: Yes...ambulation: two person assist...bathing, dressing: one person assist...toileting: one person assist...transfer: mechanical lift..." On 01/26/22 at 2:12 PM, Resident #313 was interviewed and stated that the facility was short staffed. Resident #313 stated that sometimes you can ring the call bell and it may take 20 minutes or may take 2 hours and "That's just since I've been here."' Resident #313 stated that she had only been at the facility a week and "That's saying something." Resident #313 was asked why she felt that the facility was short staffed. Resident #313 stated it takes so long for them to respond and that she has heard the nurses in the halls saying that they are short staffed. The resident stated, "If I call at night, it can be 2 hours wait" and that she can't get up and go to the bathroom by herself. Resident #313 stated, "I know they are short staffed...If it gets bad, I say the hell with it and end up wetting myself." Resident #313 was asked when that happens, how long does she have to wait to get cleaned up and dried. The resident stated, "Maybe another half hour." Resident #313 stated that it happens at least three times a week. Resident #313's comprehensive care plan documented, "...self care deficit...assist with...daily living, dressing, grooming, toileting...maintain call light in reach..." 4. On 01/26/22 at 2:50 PM, Resident #149 was interviewed regarding care and services in the facility. Resident #149 was admitted to the facility	F 725		

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F 725	Continued From page 69 on 07/26/21. Diagnoses for Resident #149 included, but were not limited to: diabetes type II high blood pressure, history of tumor on kidney, history of ovarian cancer, history of pulmonary embolism, osteoarthritis, chronic pain and increased lipids (hyperlipidemia). The most recent MDS (minimum data set) was a quarterly review, dated 01/08/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. Resident #149 was assessed as requiring extensive assistance of one or two staff members for bed mobility, dressing, and personal hygiene, with total dependence upon staff for toileting, transfers, and bathing. Resident #149 was assessed as having limited range of motion in both lower extremities, as occasionally incontinent of bladder and frequently incontinent of bowel. Resident #149 stated that sometimes she will ask for help and staff won't do it, and that she didn't know why they don't do it. Resident #149 stated that a whole lot of the staff were nice, but there were some that aren't. The resident did not provide any names of staff members. Resident #149 was asked what she meant about staff being nice, the resident stated, "Getting the help you need." Resident #149 stated that in the morning time when she is laying in the bed, after laying a long time her back and leg starts hurting and she will ask staff to get her up, but they won't help. The resident stated, "I don't know if they are short staffed or if they just don't help." Resident #149 stated that when she has to go to the bathroom, before you get to go to the bathroom, they have to get a lift and that takes more time and "Sometimes I pee on myself, I	F 725		

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F 725	Continued From page 70 can't hold it all time for that long." Resident #149 stated that she will call the staff using the call bell and it takes a long time, maybe an hour or more, and sometimes they come in and push the light off and go on back to whatever they were doing and don't help. Resident #149 stated that she has reported it and she told the manager and stated the unit manager fired one girl and talked to the other people about it. Resident #149 stated, "Just like bras, I don't have no [sic] bra on right now." Resident #149 stated that staff help her get dressed and they haven't been putting a bra on her. Resident #149 stated that they told her she didn't have any bras. Resident #149 stated that she had three bras and all of them are gone. Resident #149 stated that last Thursday (01/20/22) was the last time she had seen it, when staff took it off and it went to the wash. The resident stated that she likes someone to help her get out of bed, and that she has fallen out of the bed twice. Resident #149 stated the most recent fall was about a month ago. The resident stated that she had pushed the call better and no one ever came or would help, so she had tried to get up on her own and fell. Resident #149's current comprehensive care plan documented, "...allow resident to choose what clothes to wear each day...help keep personal belongings taken care of in the room and facility...assist with...dressing, grooming, toileting...keep skin clean and dry...at risk for falls...labs as ordered, contact MD with any abnormal values...meds as ordered, contact MD with any side effects...review medication list for adverse interactions per routine...keep room and hallways clear of clutter...call bell within reach..." On 01/28/22 at 8:20 AM, Resident #149 was	F 725		

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F 725	Continued From page 71 interviewed again regarding call bell response and staffing concerns. Resident #149 stated, "They're doing a little better since they seen you in here the other day." On 01/28/22 at 7:15 AM, CNA (certified nursing assistant) # 2 and #3 were interviewed regarding staffing and call bell response times. Both CNAs worked the night shift. CNA #2 stated that a lot of times, it's just us (two CNAs) for almost 30 residents each. CNA #2 stated that they come in thinking they will have at least three CNAs, but if someone calls off or they are short on another unit, one will get pulled, leaving only two. CNA #2 stated, "I was giving a resident a bath, the other CNA was doing care on one of my residents and a resident with an alarm got up on her own to go to the bathroom." CNA #2 stated that you can't always leave the resident you are with to go check on another. CNA #2 stated that if they have at least three CNAs it's doable, but stated that 2 to 3 days each week we only have two CNAs and it happens almost weekly. CNA #3 stated, "It's when you are in a room and another resident's light goes on, we can't leave that resident." The CNAs' were asked if they are able to complete the tasks for resident's care. CNA #3 stated that some resident's don't like to get up so early, so you have to go on to the next and then go back to that one. CNA #3 stated that there are times when she hasn't been able to get everything done. CNA #3 stated that as far as call bell response time, that they try to get to them as soon as possible, but that isn't always the case, and it really depends on what all is going on and what you may be tied up with in another resident's room.	F 725		

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F 725	Continued From page 72 On 01/28/22 at 8:10 AM, a day shift CNA (#4) was interviewed. CNA #4 stated that she has been there for about 15 years and that she did think call bell response can be slow and staffing could be better. CNA #4 stated that they do work together and do their best to get it all done and stated, "I make sure I do, if I have to stay over." On 01/28/22 at 8:15 AM, CNA #5 was interviewed regarding call bell response and staffing. CNA #5 stated, "If someone calls out." 5. Resident #78 was admitted in November 2021. Diagnoses for this resident included, but were not limited to: PVD (peripheral vascular disease), BPH (benign prostatic hypertrophy) with a history of UTIs (urinary tract infections), high blood pressure, partial surgical amputation of the foot with wound vac placement, and muscle weakness. The most recent MDS was an admission assessment completed November 2021 that assessed Resident #78 was assessed with a cognitive score of 14, indicating the resident is intact for daily decision making skills. Resident #78 was also assessed as requiring limited to extensive assistance of one staff person for ADL's (activities of daily living). On 01/28/22 at 8:30 AM, Resident #78 was interviewed regarding call bell response and staffing. Resident #78 stated that he wasn't sure if they were short of staff, but stated that they are slow on call bell response at times. The resident's current comprehensive care plan documented, "...self care deficit...assist with...daily living, dressing, grooming, toileting..."	F 725		

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F 725	Continued From page 73 The administrator, DON (director of nursing) and the nurse consultant were made aware of the above information in a meeting with the survey team on 01/27/22 at approximately 5:00 PM and again on 01/28/22 at approximately 10:30 AM. No further information and/or documetnation was presented prior to the exit conference on 01/28/22 at 1:00 PM This is a complaint deficiency.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	1). Resident #313 received IV antibiotic upon discovery. MD and RR was made aware of the miss doses of medication. MD assessed resident to find there were no ill effects. Staff nurses that were responsible for carrying out MD order for IV antibiotic received 1:1 education on following MD orders. 2). Any resident that is receiving IV medications has the potential to be affected. An audit of residents records were audited to see if any other resident was receiving IV antibiotic that were out of compliance. No discrepancies were found	3/1/22

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F 755	Continued From page 74 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure physician ordered, IV (intravenous) antibiotic medication was available for administration for one of 36 residents in the survey sample, Resident #313. Findings include: Resident #313 was admitted to the facility on 01/20/22. Diagnoses for Resident #313 included, but were not limited to: cirrhosis of the liver without ascites, hypotension, collapsed vertebrae/fracture, acute kidney failure, moderate protein calorie malnutrition, hypothyroidism, compression fracture (L-5) secondary to discitis and osteomyelitis, discitis of lumbosacral region, and closed compression fracture of sacrum. The most current MDS (minimum data set) was the admission assessment, which was in progress and not complete for Resident #313. An admission nursing assessment dated 01/20/22 at 7:15 PM documented, "...arrival date & time: 01/20/22 7:15 PM....from hospital...Reason For Admission: IV antibiotic administration...diagnoses/condition...infection...I	F 755	continued: 3). RNs and LPNs have been educated on pharmacy protocol on ordering IV medications. Education has been added to new hire orientation. 4). Nurse Managers or designee will audit for IV medication orders 5x weekly x 12 weeks to verify medications were received and administered per MD order. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	

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F 755	Continued From page 75 V meds/fluids...antibiotics...alert and oriented to situation, able to make needs known..." On 01/25/22 at approximately 12:50 PM, during the initial tour of the facility, Resident #313 was observed in her room in bed. A central venous access device was observed in the resident's right upper chest area. Resident #313 stated that she had a fracture and infection in her spine, and that she had been in the hospital receiving IV antibiotics (prior to admission to the facility) and was supposed to be receiving them here as well. Resident #313 stated that she had not received any IV antibiotics since she had arrived here. Resident #313 was asked when she was admitted, and she stated that she came late Thursday evening (January 20, 2022). Resident #313 was asked if she had reported to anyone that she had not received the medication. The resident stated, "Everyday," and further stated that the physician had come in to see her (she thought on Friday, 01/21/22) and that he had ordered the medication, but she still had not received it. Resident #313 stated that the nurses have kept telling her that the IV antibiotics were coming and that she wasn't sure what was going on. Resident #313 stated that she thought she was supposed to have the IV medication therapy for about 4 to 6 weeks. On 01/25/22 at approximately 1:30 PM, Resident #313's clinical record was reviewed. The current physician's orders included an order for, "...Ertapenem Sodium Solution Reconstituted 1 GM (gram) Use 1000 mg (milligrams) intravenously every 24 hours for discitis...Order Status: Active...Order Date: 01/20/22...Start Date: 01/20/22..."	F 755		

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F 755	Continued From page 76 The MARs (medication administration records) were reviewed for January 2022. The MARs documented, "...Ertapenem Sodium Solution Reconstituted 1 GM Use 1000 mg intravenously every 24 hours for discitis...Start Date: 01/20/22 (2:30 PM)..." Each day from 01/21/22 through 01/25/22 staff initials were documented with the time and the number "19" in each box for the IV medication. The number 19, on the legend (chart codes) indicated, "19=Other/See Nurse Notes." The MAR was blank on 01/20/22. Resident #313's nursing notes documented each day that the medication was "on order." No nursing or progress notes were found to indicate the physician had been notified that the medication was "on order", not available for administration, or that Resident #313 had not been receiving the medication as ordered. The resident's current CCP (comprehensive care plan) documented, "...Resident is on antibiotic therapy...administer the full course of antibiotic as prescribed by physician...resident has infection...Administer antibiotics...per physician orders and monitor side effects...Resident is on intravenous therapy..." On 01/25/22 at 2:15 PM, Resident #313's physician was interviewed and was asked if he had been notified by staff that Resident #313 had not received the physician ordered IV antibiotic in the last five days. The physician stated, "No, I got something from (name of pharmacy) today that they (pharmacy) were sending a 5 day supply because it's not covered, but I didn't know (she had not received it)."	F 755		

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F 755	Continued From page 77 On 01/25/22 at 4 :25 PM, the administrator and DON (director of nursing) were made aware of the above information. A policy was requested for unavailable medications. The policy was presented, "Medication shortages/Unavailable Medications." The policy documented, "...upon discovery that the facility has an inadequate supply of medication to administer...should immediately initiate action to obtain the medication from pharmacy...nurse should call pharmacy to determine the status of the order...if the medication is not available in the emergency medication supply...notify pharmacy and arrange for an emergency delivery, if medically necessary...if an emergency delivery is unavailable...nurse should contact the attending physician to obtain orders or directives..." No further information and/or documetnation was presented prior to the exit conference on 01/28/22.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		

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F 756	Continued From page 78 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a timely response to pharmacy recommendations for 4 of 36 residents in the survey sample, Residents #87, #110, #14, and #149. The facility staff failed to act upon pharmacy recommendations regarding the need for the shingles vaccine for Residents #87, #110, #14; for the use of the medication Singular with diagnosed psychiatric conditions that included major depression and anxiety for Resident #14; and a recommendation for a dose reduction	F 756	1). DON reviewed pharmacy recommendation with MD for resident #149 dated 11/13/21. MD stated he had already review recommendation, ordered labs and wishes to continue current medications. Resident #14 pharmacy recommendation was reviewed by the MD, he does not wish to d/c medication no behavior issues. The family of resident #14 has been contacted regarding Shingrix Vaccine for consent; they are undecided at this time. Resident #87 and #110 have received the Shingrix Vaccine. 2). Any resident has the potential to be affected if pharmacy recommendation are not followed up in a timely manner. DON reviewed pharmacy recommendation for October, November, and December 2021. Any discrepancies will be addressed with the attending physician. 3). DON or designee will educate Nurse Managers on the process of reviewing pharmacy recommendation to ensure the MD has acted upon the pharmacy recommendation and placed in chart. Education will be added to the new employee orientation.	3/1/22

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F 756	Continued From page 79 and/or discontinuation of medications related to falls for Resident #149. The findings include: 1. Resident #87 was admitted to the facility on 09/14/2021 with diagnoses that included healing for lumbar fracture, schizophrenia, edema, hypertension, hypokalemia, and muscle weakness. The most recent minimum data set (MDS) dated 12/03/2021 was a quarterly assessment and assessed Resident #87 as severely impaired for daily decision making with a score of 3 out of 15. Resident #87's clinical record was reviewed on 01/27/2022. A pharmacy recommendation dated October 12, 2021 through October 16, 2021 documented the following: "(Resident #87) is 50 years of age or older and documentation of vaccination with Shingrix (zoster vaccine, recombinant) was not found in the medical record. Recommendation: Unless clinically contraindicated, please administer Shingrix 0.5 ml intramuscularly when available from the pharmacy, with a second does administered in 60 days...." The physician accepted the pharmacy recommendation and signed and dated the form on 10/26/2021. A review of Resident #87's electronic clinical record including the immunization record, physician orders, and the medication administration records (MAR) were reviewed for the period of October 2021 through January 2022. There was no documentation evidencing the facility had acted upon the pharmacy recommendation and administered the Shingrix vaccine as approved and ordered by the	F 756	continued: 4). The DON or designee will review pharmacy recommendation monthly x 3 to ensure they have been acted upon by the medical provider and placed in the chart. Any discrepancy will be addressed accordingly. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	

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F 756	Continued From page 80 physician on 10/26/2021. On 01/27/2022 at 3:30 p.m., the unit manager, RN #7 was interviewed regarding why the pharmacy recommendation was not acted upon. RN #7 reviewed the clinical record and stated, "I don't see where the vaccine was administered. I do remember having a conversation with one of the floor nurses who said she had called the pharmacy and was advised they didn't keep the Shingrix vaccine in stock and we would need to wait a couple of weeks to get it in." RN #7 was asked if the order was ever submitted to the pharmacy. RN #7 stated, "I don't think it was, but I'm not sure unless the nurse thought the pharmacy would notify the facility once they had it in stock and then she would order the vaccine." The nurse RN #7 referenced was not available during the survey. On 01/27/2022 at 4:02 p.m. the pharmacist (OS #10) was interviewed via telephone. OS #10 stated there was not a shortage of the Shingrix vaccine. During the telephone interview, OS #10 stated she reviewed resident specific and facility specific reports for the period of October 2021 through January 2022 and did not show any orders were received from the facility for the Shingrix vaccine. These findings were discussed with the administrator, director of nursing, and corporate nurse consultant during a meeting on 01/27/2022 at 5:30 p.m. 2. Resident #110 was admitted to the facility on 02/07/2020 with diagnoses that included hypertension, history of falls, anorexia, dementia, and major depressive disorder. The most recent	F 756		

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F 756	Continued From page 81 minimum data set (MDS) dated 12/16/2021 was a quarterly assessment and assessed Resident #110 as severely impaired for daily decision making, having long and short term memory problems. Resident #110's clinical record was reviewed on 01/27/2022. A pharmacy recommendation dated October 12, 2021 through October 16, 2021 documented the following: "(Resident #110) is 50 years of age or older and documentation of vaccination with Shingrix (zoster vaccine, recombinant) was not found in the medical record. Recommendation: Unless clinically contraindicated, please administer Shingrix 0.5 ml intramuscularly when available from the pharmacy, with a second does administered in 60 days...." The physician accepted the pharmacy recommendation and signed and dated the form on 10/24/2021. Observed on the bottom of the pharmacy recommendation form was the following handwritten note: "Spoke with (resident representative). She gave permission for pt to get Shingrix injection." The note was dated 11/5/21. On 01/27/2022 at 3:30 p.m., the unit manager, RN #7 was interviewed regarding why the pharmacy recommendation was not acted upon. RN #7 reviewed the clinical record and stated, "I don't see where the vaccine was administered. I do remember having a conversation with one of the floor nurses who said she had called the pharmacy and was advised they didn't keep the Shingrix vaccine in stock and we would need to wait a couple of weeks to get it in." RN #7 was asked if the order was ever submitted to the pharmacy. RN #7 stated, "I don't think it was, but I'm not sure unless the nurse thought the pharmacy would notify the facility once they had it	F 756		

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F 756	Continued From page 82	F 756		

in stock and then she would order the vaccine." The nurse RN #7 referenced was not available during the survey.

On 01/27/2022 at 4:02 p.m. the pharmacist (OS #10) was interviewed via telephone. OS #10 stated there was not a shortage of the Shingrix vaccine. During the telephone interview, OS #10 stated she reviewed resident specific and facility specific reports for the period of October 2021 through January 2022 and did not show any orders were received from the facility for the Shingrix vaccine.

These findings were discussed with the administrator, director of nursing, and corporate nurse consultant during a meeting on 01/27/2022 at 5:30 p.m.

3. Resident #14 was admitted to the facility on 10/31/08 with diagnoses that included dementia, diabetes, neuropathy, major depressive disorder, peripheral vascular disease, dysphagia, hypertension, blepharitis, glaucoma, emphysema, diaphragmatic hernia, history of COVID-19, anxiety and urinary tract infection. The minimum data set (MDS) dated 1/15/22 assessed Resident #14 with severely impaired cognitive skills.

Resident #14's clinical record documented a physician's order dated 4/21/21 for the medication montelukast sodium 10 milligrams to be administered once per day for treatment of asthma. The resident's medication administration record for January 2022 documented the medication was administered as ordered.

The clinical record documented a pharmacy consultation recommendation dated 5/20/21 documenting, "(Resident #14) receives a

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F 756	Continued From page 83 leukotriene receptor antagonist, Montelukast Sodium, and has a diagnosed psychiatric condition, anxiety and MDD (major depressive disorder)...Recommendation: Please evaluate this medication as contributing to a worsening or development of this individual's behaviors (e.g., agitation, aggressive behavior/hostility, anxiousness, depression, dream abnormalities, hallucinations, insomnia, restlessness, sleepwalking, dream abnormalities, suicidal thinking and behavior) or severity of psychiatric condition. If appropriate, please consider discontinuing Montelukast Sodium at this time..." There was no response from the physician or any provider to the pharmacy recommendation regarding montelukast sodium. There was no documented assessment listing risks versus benefits or provider statement indicating that the medication was not contributing to any changes in condition. The clinical record documented an additional pharmacy recommendation dated 10/15/21 stating, "(Resident #14) is 50 years of age or older and documentation of vaccination with Shingrix (zoster vaccine, recombinant) was not found in the medical record. Recommendation: Unless clinically contraindicated, please administer a two dose series of Shingrix 0.5 mL (milliliter) intramuscularly. Administer the first dose when available from the pharmacy and schedule the second dose to be administered ideally in 2 months, but no later than 6 months after the first injection..." Resident #14's clinical record documented no administration of the Shingrix vaccine and the provider documented no response to the	F 756		

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F 756	Continued From page 84 10/15/21 pharmacy recommendation for the vaccine. There were no indication to accept the recommendation or any rationale listed to decline the recommendation. There were no signatures from the provider or director of nursing on the form. On 1/27/22 at 3:32 p.m., the registered nurse unit manager (RN) #2 was interviewed about the lack of response to Resident #14's pharmacy recommendations. RN #2 stated the pharmacy recommendations were forwarded to the provider for review and response. RN #2 stated after the physician responded to the recommendation, orders were implemented as needed. RN #2 stated she did not know why the physician did not response to the 5/20/21 and 10/12/21 recommendations for Resident #14. RN #2 stated the providers usually responded to the recommendations in a timely manner. On 1/27/22 at 3:40 p.m., the director of nursing (DON) was interviewed about Resident #14's pharmacy recommendations with no response. The DON stated the physician usually got the consultant psychiatrist to review recommendations regarding psychoactive medications. No other information was presented regarding response to Resident #14's pharmacy recommendations. The 2022 Nursing Drug Handbook on page 1002 describes montelukast sodium as an antiasthmatic used to treat asthma and seasonal allergies. This reference documents on page 1003 that montelukast sodium has a black box warning stating, "The neuropsychiatric events	F 756		

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F 756	Continued From page 85 reported in patients taking montelukast include, but are not limited to, agitation, aggressive behavior or hostility, anxiousness, depression, disorientation, disturbance in attention, dream abnormalities, hallucinations, insomnia, irritability, memory impairment, restlessness, somnambulism, suicidal thinking and behavior (including suicide), and tremor..." (1) These findings were reviewed with the administrator, director of nursing and nursing consultant on 1/27/22 at 5:30 p.m. 4. Resident #149 was admitted to the facility on 07/26/21. Diagnoses for Resident #149 included, but were not limited to: diabetes mellitus type II, high blood pressure, history of tumor on kidney, history of ovarian cancer, history of pulmonary embolism, osteoarthritis, chronic pain, GERD (reflux), and increased lipids (hyperlipidemia). The most recent MDS (minimum data set) was a quarterly assessment dated 01/08/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills. On 01/25/22 at approximately 1:30 PM, Resident #149 was observed sitting in her wheelchair. Resident #149 stated that she had pain in her legs and knees and that she had a recent fall without injury. Resident #149's clinical record was reviewed on 01/26/22. A pharmacy recommendation dated 11/13/21 documented, "(Name of Resident #149) recently experienced a fall. A comprehensive review of the medical record was conducted, identifying the following medications which may contribute to falls: Amlodipine, Famotidine,,	F 756		

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F 756	Continued From page 86 Hydrochlorithiazide, Metformin, Pravastatin...Recommendation: Please evaluate these medications as possibly causing or contributing to this fall and consider decreasing or discontinuing if clinically appropriate...If this therapy is to continue...document an assessment of risk versus benefit, indicating that the medication is not believed to be contributing to falls...Physician's Response: (check mark) I have re-evaluated this therapy and wish to implement the following changes: "Check chem 7, Hgb A1C, lipid profile...signature of physician (dated 11/25/21)...signature of unit manager (dated 12/02/21)." The physician's orders were reviewed from 11/13/21 to present. No orders were found to evidence a medication dose reduction or medication discontinuation had occurred for Resident #149. The progress notes were then reviewed from 11/13/21 to present. No progress notes were found regarding a medication dose reduction or medication discontinuation. No progress notes were found that addressed the pharmacy recommendation dated 11/13/21. Resident #149's current comprehensive care plan documented, "...at risk for falls...labs as ordered, contact MD with any abnormal values...meds as ordered, contact MD with any side effects...review medication list for adverse interactions per routine..." On 01/27/22 at approximately 8:30 AM, the UM3 (unit 3 manager) was interviewed regarding the pharmacy recommendation that had not been acted upon for Resident #149. UM3 stated that	F 756		

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F 756	Continued From page 87 the physician ordered labs. The UM3 was made aware that the pharmacy recommendation specified a dose reduction or medication discontinuation and that the physician ordered labs and nothing was found regarding the medications. UM3 stated that she wasn't sure why it hadn't gone any further. The administrator and DON (director of nursing) were made aware in meeting with the survey team on 01/27/22 at approximately 4:00 PM. No further information and/or documetnation was presented prior to the exit conference.	F 756		
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. §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	F 758		

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F 758	Continued From page 88 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 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 clinical record review, staff interview and facility document review, the facility staff failed to ensure a pharmacy recommendation for a gradual dose reduction (GDR) was completed for one of 36 in the survey sample, Resident #110. Resident #110's physician signed a GDR pharmacy recommendation for the antidepressant, Escitalopram (Lexapro) to be decreased from 15 mg (milligrams) daily to 10 milligrams daily. The order was not completed for over 4 months.	F 758	1). The MD was notified that pharmacy recommendation for GDR on Lexapro for resident #110 was not followed through. MD gave orders to initiate GDR upon discovery. 2). Any resident that had a pharmacy recommendation has the potential to be affected. DON reviewed pharmacy recommendations for the month of September, no other discrepancies were identified. 3). DON or designee will educate Nurse Managers on the process of reviewing pharmacy recommendation to ensure the MD has acted upon the pharmacy recommendation and placed in chart. Education will be added to new employee orientation. 4). The DON or designee will review pharmacy recommendation monthly x 3 to ensure they have been acted upon by the medical provider and placed in the chart. Any discrepancy will be addressed accordingly. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	3/1/22

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F 758	Continued From page 89 The findings include: Resident #110 was admitted to the facility on 02/07/2020 with diagnoses that included hypertension, history of falls, anorexia, dementia, and major depressive disorder. The most recent minimum data set (MDS) dated 12/16/2021 was a quarterly assessment and assessed Resident #110 as severely impaired for daily decision making, having long and short term memory problems. Resident #110's clinical record was on 01/27/2022. A pharmacy recommendation dated September 13, 2021 through September 15, 2021 documented the following: "(Resident #102) has received Escitalopram (Lexapro) 15 mg (milligrams) daily for depression. Recommendation: Please attempt a gradual does reduction while concurrently monitoring for reemergence of depressive and/or withdrawal symptoms...." The physician's response was "I accept the recommendation(s) above WITH THE FOLLOWING MODIFICATION(S): decrease Lexapro to 10 mg (milligrams) q (every) day." The physician signed and dated the pharmacy recommendation on 09/20/21. Resident #102's current physician orders were reviewed. Observed on the order summary report was the following: "ESCITALOPRAM OXALATE F/C (Lexapro) 10 MG Give 1.5 tablet by mouth one time a day. Order Date: 12/12/2020. " A review of Resident #102's medication administration records (MAR) for the period of September 2021 through January 2022 documented Resident #102 has receiving the	F 758		

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F 758	Continued From page 90 Lexapro 15 mg daily instead of the Lexapro 10 mg as ordered by the physician on 9/20/21. Resident #102 was still receiving the Lexapro 15 mg every day. The pharmacy recommendation that was signed and dated by the physician on 09/20/21 had not been carried out and completed. On 01/27/2022 at 4:30 p.m., the unit manager, registered nurse (RN) #7 was interviewed regarding the pharmacy recommendation not being carried out as ordered by the physician. RN #7 reviewed the pharmacy recommendation form and stated, "It doesn't have a nurse's initials and date so I'm not sure who received the order to decrease the medication from (Physician Name)." RN #7 was asked if as the unit manager she received and reviewed the pharmacy recommendations orders to verify they were carried out/completed. RN #7 stated, "No, I don't have to receive the signed recommendation back for review. Once the physician completes and signs the recommendation form it is given back to the floor nurse and they are supposed to carry out/complete the order. Proof of them completing the order is they initial and date the pharmacy recommendation form. Since this doesn't have any initials I'm not sure which nurse was responsible to carry out the order." The above findings were reviewed with the administrator, director of nursing and corporate nurse consultant during a meeting on 01/27/2022 at 5:30 p.m. No additional information was provided to the survey team prior to exit on 01/28/2022 at 1:00 p.m.	F 758		

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F 791	Continued From page 91	F 791		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility	F 791	1). Resident #57 has a follow-up dental appointment scheduled for March 16, 2022. 2). Any resident that had previous dental appointment has the potential to be affected. Social Services to audit current residents to ensure or verify they have been offered dental services and care recommended. 3). DON or Designee to educate Nurse Managers and Social Services to follow-up on any return appointments. Education will be added to new employee orientation 4). Social Services or designee to audit all outside appointments to verify follow up is completed weekly x 12 weeks. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	3/1/22

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F 791	Continued From page 92 policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to provide dental services for one of 36 residents in the survey sample, Resident #57. Resident #57 had no follow-up dental services provided regarding acquisition of dentures. The findings include: Resident #57 was admitted to the facility on 8/9/21 with diagnoses that included diabetes, anxiety, schizophrenia, bipolar disorder, vertigo, hypertension, major depressive disorder and gastroesophageal reflux disease. The minimum data set (MDS) dated 11/16/21 assessed Resident #57 with moderately impaired cognitive skills. On 1/26/21 at 3:40 p.m., Resident #57 was interviewed about quality of care in the facility. Resident #57 stated she had seen a dentist a couple of months ago and had impressions made for dentures. Resident #57 stated she had heard nothing else about getting her dentures. Resident #57's clinical record documented a dental consultation dated 12/1/21 stating, "Patient in need of Dentures. took impressions today to start process and needs to return in 3 + weeks for next step of process." The clinical record made no further mention of the resident's denture	F 791		

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F 791	Continued From page 93 needs and documented no follow-up appointment to obtain the dentures. On 1/27/21 at 5:00 p.m., the facility's social worker (other staff #4) was interviewed about follow-up dental services for Resident #57. The social worker stated she was aware Resident #57 went to the dentist in December 2021 for dentures. The social worker stated the resident was supposed to have a follow-up appointment according to the consult report. The social worker stated she did not know why the appointment had not been scheduled. The social worker stated there were schedulers in the facility that usually made appointments for residents. On 1/27/22 at 5:13 p.m., the scheduler (other staff #5) was interviewed about any follow-up appointment or arrangements regarding Resident #57's dentures. The scheduler stated the dental office usually called with the follow-up appointments. The scheduler stated she had no record of any contact with the dental office and stated nobody had requested that she make the appointment for Resident #57. The scheduler stated, "Nobody called me on this one. I don't have it down." This finding was reviewed with the administrator, director of nursing and nursing consultant on 1/27/22 at 5:30 p.m.	F 791		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		

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F 812	Continued From page 94 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to store and prepare food in a sanitary manner in the main kitchen of the facility. The findings include: On 01/25/2022 at 12:03 p.m., accompanied by the dietary manager, the facility's main kitchen was inspected. Stored in the stand-up cooler #6 was one half-pint carton of Maola reduced fat milk with an expired date of 01/24/22 and one half-pint carton of Maola whole milk with an expired date of 01/22/22. On 01/25/2022 at 12:15 p.m., the dietary manager was interviewed about the cartons of the expired milk. The dietary manager stated kitchen employees were supposed to check the refrigerators and stand-up coolers units daily for expired items and discard them as needed. The dietary manager was asked for a policy regarding	F 812	1). Expired milks were removed from the cooler and discarded. 2). Any resident has the potential to be affected. Assessment of all facility coolers/freezers was conducted to ensure no expired items were present. 3) The Administrator, or designee will provide education to all dietary staff regarding the storage of refrigerated foods. Education will be added to new hire orientation. 4). Dietary manager, or designee, will audit all coolers/freezers 5 x per week x 8 weeks, then 5 times for one month. All findings will be reviewed monthly with the QAPI committee with any variances being discussed and changes made when necessary.	3/1/22

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F 812	Continued From page 95 food storage and expired items. A review of the policy "Freezers and Refrigerators Policy" (revised 06/09/2021) documented the following: "...8. Food and Nutrition Services Director and Staff will be responsible for ensuring food items in refrigerators and freezers are not expired or past perish dates..." On 01/26/2022 at 5:25 p.m., the above findings were discussed with the facility administrator, the director of nursing (DON) and the corporate nurse consultant. No additional information was provided to the survey team prior to exit on 01/28/2022 at 1:00 p.m.	F 812		
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility document review, and review of manufacturer's instructions, the facility staff failed to properly calibrate glucometers on two of four nursing units, Butterfly Path and Serenity.	F 839		

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F 839	Continued From page 96 The findings include: 1. On 1/27/2022 at approximately 8:50 a.m., during an inspection of a medication cart on the Butterfly Path Unit, LPN (Licensed Practical Nurse) # 1, who was using the cart, was asked about the glucometer in the cart. LPN # 1 said she had not used the glucometer, that "Glucometer checks are done on third shift." Asked when the glucometer was calibrated, LPN # 1 said she did not know. At 9:30 a.m. on 1/27/2022, RN (Registered Nurse) # 3, the Unit Manager on the Butterfly Path Unit, was asked about the calibration of the glucometers on the unit. RN # 3 said there were two glucometers on the unit, one on each medication cart, and that glucometer checks are done on the third shift. Asked if she knew how to calibrate the glucometers, RN # 3 said she did not. RN # 3 was asked for the log documenting the calibration of the glucometers, but was unable to find it. A 9:45 a.m., RN # 3 was asked again if she knew how to calibrate a glucometer, and RN # 3 again replied that she did not. RN # 3 was then asked to get a staff member who did know how to calibrate a glucometer. At 10:10 a.m., RN # 1 came to the Butterfly Path Unit to assist RN # 3 in calibrating a glucometer. Going to one of the medication carts on the unit, RN # 1 took a glucometer (Assure Prism Multi Blood Glucose Monitoring System) and inserted a test strip into the test strip port. RN # 1 then opened a small box containing the Level 1 and Level 2 control solutions. Next, RN # 1 opened the Level 1 control solution bottle and applied one	F 839	1) LPN #1, RN #3, RN #1, and LPN #6 were all educated on proper calibration per manufacturer instructions and verified competency. 2. Any resident that have orders for accuchecks has the potential to be affected. 3). ICP or designee will educate and verify competency on all LPNs/RN on proper procedure for calibration of blood sugar monitoring device. Education will also be added to new hire orientation. 4). Nurse Managers will verify competency on calibration of glucose monitoring device on 1 nurse weekly x 12 weeks. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	3/1/22

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	495372	A. BUILDING _____ B. WING _____	C 01/28/2022

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F 839	Continued From page 97 drop of solution to the tip (narrow edge) of the test strip. The control solution result displayed on the glucometer was 158. The test range on the Level 1 control solution was 113 to 170. RN # 1 then discarded the used test strip and inserted a new strip in the test strip port. She then opened the Level 2 control solution bottle and applied one drop of solution to the tip (narrow edge) of the test strip. The control solution result displayed on the glucometer was 237. The test range on the Level 2 control solution was 198 to 297. RN # 1 provided the User Instruction Manual for the Assure Prism Multi Blood Glucose Monitoring System. The "Checking the System" instructions began on page 19 of the Instruction Manual and noted the following: "NOTE: Before using the control solution, shake the bottle, discard the first 1 or 2 drops and wipe the top of the control solution cap clean. Assure Prism Control Solution Testing Step 1 Insert a test strip into the meter's test strip port with the contact bars facing upwards. Gently push the test strip into the test strip port until the meter beeps. Be careful not to bend the strip while pushing it in. The (image) symbol will be displayed on the screen. Step 2 Shake the Assure Prism Control Solution bottle well before each test. Step 3 Remove the cap and discard the first 1 or 2 drops. Apply one drop of control solution to the top of the control solution cap.	F 839		

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F 839	Continued From page 98 Step 4 After the (image) symbol appears on the display, touch the narrow edge of the test strip to the control solution until the meter beeps...." RN # 1 was the given the Instruction Manual and asked to read the test procedure, starting with page 19. After reading the instructions, RN # 1 was asked if that was what she did. "No, I did not do that," RN # 1 replied. 2. At 10:30 a.m. on 1/27/2022, LPN # 6 on the Serenity Unit, was asked about calibrating the glucometers on the medication carts. LPN # 6 said there were two glucometers, one on each medication cart, and that she calibrates them every morning. LPN # 6 then produced a calibration log documenting the calibration of both glucometers. LPN # 6 was asked to calibrate one of the two glucometers. LPN # 6 calibrated the selected glucometer in the same way used by RN # 1 on the Butterfly Path Unit. The Level 1 reading was 120 with a test range of 113 to 170, and the Level 2 reading was 236, with a test range of 198 to 297. LPN # 6 was the given the Instruction Manual and asked to read the test procedure, starting with page 19. After reading the instructions, LPN # 6 was asked if that was what she did. "That is not what I did. I did not shake the (test solution) bottles, but I did roll the box over several times before I took the bottles out," LPN # 6 said. Review of the facility's "Glucometer/Point of Care Blood Testing and Disinfection Procedure," revised on 3/26/2021, and furnished by the	F 839		

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F 839	Continued From page 99 Director of Nursing (DON), noted the following, "Quality Control (QC) testing will occur according to manufacturer guidance and be documented on the QC log." During an end of day meeting at 5:00 p.m. on 1/27/2022, that included the Administrator, DON, Corporate Nurse Consultant, and the survey team, the findings regarding the calibration of the glucometers was discussed.	F 839		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		

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F 842	Continued From page 100 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842	1). The author of the progress note dated 1/10/21 on resident #76 has modified the note to strike out other residents names. The nurse that wrote the progress note dated 1/10/21 received 1:1 education on proper documentation to ensure privacy of the resident's clinical record. 2). Any resident has the potential to be affected. The DON has completed an audit of progress notes for the past 7 days with no discrepancy found. 3). All clinical staff will be educated on privacy and accuracy when entering clinical documentation. Education will be included in new hire orientation. 4). DON or designee will audit 24-hour report 5x weekly x 12 weeks to verify accuracy and privacy of medical records. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	3/1/22

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F 842	Continued From page 101 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure the accuracy and privacy of the resident's clinical record for one of 37 residents in the survey sample, Resident # 76. A nursing Progress Note in Resident # 76's clinical record included the names of three other residents. The findings were: Resident # 76 was admitted to the facility with diagnoses that included atrial fibrillation, aphasia, Non-Alzheimer's dementia, seizure disorder, ataxia, tremors, and hypothyroidism. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 11/23/2021, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 00 out of 15. Review of the Progress Notes in the resident's Electronic Health Record revealed the following entry, dated 1/10/2011 at 15:15 (3:15 p.m.): "Resident was attempting to take (name of first resident) walker and (name of first resident) was telling her to move and leave it alone but (name of Resident # 76) would not leave it alone, staff attempted to redirect (name of Resident # 76), she became agitate (sic) with staff and jerked away from staff, writer told staff to just watch her and let her calm down. At this time (name of Resident # 76) went to (name of second resident) and attempt (sic) to push her w/c (wheelchair) and (name of second resident) became agitated and began fussing at (name of Resident # 76)	F 842		

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F 842	Continued From page 102 and telling her to leave me alone lady, again, attempts to redirect (name of Resident # 76) and she became really agitated. She told staff to kiss her ass, she began hitting at staff until staff had to intervene and take her by the arms and guide her away. While staff was having a meeting, (name of Resident # 76) grabbed the foot of (name of third resident) recliner and attempted to turn her chair over. Writer intervened and removed (name of Resident # 76). She began hitting writer and she spit in writer's face. Another staff member gave her ice cream and she sat down for awhile." At approximately 9:15 a.m. on 1/28/2022, the Progress Note entry was shared with the Director of Nursing (DON). Asked about the inclusion of other resident names in the Progress Note entry for Resident # 76, the DON said it was "...not something I would expect to see." During a meeting at approximately 10:30 a.m. on 1/28/2022 that included the Administrator, DON, Corporate Nurse Consultant, and the survey team, the finding was discussed.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will	F 849		

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F 849	Continued From page 103 arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death.	F 849	1). Hospice notes for resident #122 were obtained and placed in resident chart. 2). Any resident receiving hospice services has potential to be affected. An audit of all hospice residents was conducted to ensure notes were present for all residents. 3). Facility administrator spoke with hospice director regarding providing visit notes in a timely manner. Unit Managers educated on ensuring hospice notes are obtained timely following a hospice visit. 4). Administrator or designee to audit hospice resident charts 3 times per week x 12 weeks. All findings will be reviewed monthly with the QAPI committee with any variances being discussed and changes made when necessary.	3/1/22

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F 849	Continued From page 104 (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility	F 849		

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F 849	Continued From page 105 becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific	F 849		

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F 849	Continued From page 106 to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure professional standards of practice by a hospice provider for one of 36 residents in the survey sample, Resident #122. Records of weekly hospice visits for Resident #122 were not provided to the facility as required in the hospice services agreement. The findings include:	F 849		

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F 849	Continued From page 107 Resident #122 was admitted to the facility on 12/18/2019 with diagnoses that included hemiplegia and hemiparesis, facial weakness, pneumonia, Alzheimer's disease, dementia, anxiety disorder, aphasia, and hospice care. The most recent minimum data set (MDS) dated 12/21/2021 was a significant change and assessed Resident #122 as severely impaired for daily decision making having long and short term memory problems. Under Section O - Special Treatments and Programs, the MDS assessed Resident #122 as receiving hospice services. Resident #122's clinical record was reviewed on 01/26/22. Observed on the order summary report was the following: "Admit to Hospice (Provider Name/Number) dx. Alzheimers. Order Date 12/21/2021." Observed on Resident #122's care plan was the following: "Resident is on Hospice services for end of life care. (Provider Name/Number). Dated Initiated/Created: 12/21/2021." On 01/26/2022, Resident #122's hospice binder was reviewed. Observed in the binder were the hospice assessment, plan of care, and hospice nursing visit notes. The most recent hospice nursing visit note in the binder was 01/05/2022. There were no other updated/current notes in the binder since 01/05/2022. On 01/26/2022 at 2:30 p.m., the unit manager, registered nuse (RN) #7 was interviewed regarding the missing hospice visit notes. RN #7 was asked how often did someone from hospice visit and provide/coordinate care for Resident #122. RN #7 stated, "Someone from hospice	F 849		

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F 849	Continued From page 108 usually comes a couple times per week." RN #7 was asked how hospice notes were received by the facility once visits were completed. RN #7 stated, "They have a liaison who usually comes the following week and she will bring the hospice notes to file in the binder. They don't have access to (electronic system) so they are not able to document there." RN #7 stated, "When the hospice staff come they do talk with the floor nurse and discuss any concerns or updates to (Resident #122) plan of care. I will need to contact someone at hospice regarding the missing notes." RN #7 was asked how were the updates and/or concerns communicated between staff. RN #7 stated, "We have the 24 hour report and also the hospice visits notes." On 01/26/2022 at 5:25 p.m., the above findings were discussed during a meeting with the administrator, director of nursing and the corporate nurse consultant. On 01/27/22 at 5:30 p.m., RN #7 stated, "I spoke with hospice and the hospice liaison who normally printed and filed and notes has been out of work. Someone from hospice is going to fax or email me the missing notes. I may need to request them to do this in the future." A review of the "Nursing Facility Services Agreement" signed on June 3, 2021 between the facility and the hospice provider documented on page 9 the following. "...e. Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments,	F 849		

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F 849	Continued From page 109 treatment planning and care coordination..." No additional information was provided to the survey team prior to exit on 01/28/2022 at 1:00 p.m.	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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F 880	Continued From page 110 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, the facility staff failed to follow infection control practices on one of four units,	F 880	1). PCA #7 and CNA #8 received 1:1 education on proper donning and doffing of PPE and hand hygiene on the Isolation unit. Resident #121 nebulizer set-up has been stored in plastic bag when not in use. 2). Any resident has the potential to be affected when staff do not use proper hand hygiene, donning and doffing of PPE or properly storing nebulizer equipment. 3). All staff educated by ICP or designee on hand hygiene, proper donning and doffing of PPEs when entering Isolation rooms. DON or designee will educate all LPNs/RNs on proper storage of nebulizer equipment. Education will be included in new hire orientation. 4). ICP or designee will conduct observations 3x per week x 12 weeks to verify staff compliance to proper hand hygiene, donning and doffing of PPE properly. Nurse Manager or Designee will audit storage of nebulizer sets 3x per week x 12 weeks to verify proper storage of nebulizer equipment. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendations. The QA Committee will determine when to discontinue this practice.	3/1/22

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F 880	Continued From page 111 and failed to store respiratory equipment in a sanitary manner for one of 36 residents in the survey sample, Resident #121. Facility staff failed to don required personal protective equipment (PPE) and perform required hand hygiene during meal tray service on the yellow (warm) quarantine section of unit 1. On multiple days of the survey, Resident #121's nebulizer mask was observed on the floor with no protective cover. The findings include: 1. A meal observation was conducted on 1/25/22 at starting at 12:30 p.m. on unit 1. Staff were observed at this time, serving meal trays to residents on the "warm" COVID-19 quarantine unit. The warm unit included rooms 104 to 109 and had signs stating full PPE (gown, gloves, N95 mask, face shield) was required when going into resident rooms. On 1/25/22 at 12:34 p.m., patient care aid (PCA #7) was observed delivering and setting up a meal tray for the resident in room 108. PCA #7 had on a N95 mask and face shield but no gown or gloves on when entering the room. PCA #7 performed no hand hygiene upon exit from the room. PCA #7 then went to the tray cart, and took a meal tray to the resident in room 110, who was not on quarantine. Without performing hand hygiene, PCA #7 retrieved the next tray and took that tray to the resident in room 109. PCA #7 had on no gown or gloves when delivering this tray and she touched the resident's bed remote and bed table when setting up the tray.	F 880		

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F 880	Continued From page 112 On 1/25/22 at 12:40 p.m., certified nurses' aide (CNA) #8 was observed delivering trays to quarantined residents in rooms 104 and 106. CNA #8 had on a N95 mask, eye protection but no gown or gloves. On 1/25/22 at 12:38 p.m., PCA #7 and CNA #8 were interviewed about the required PPE when going into rooms on the quarantine "warm" unit. CNA #8 stated, "We are supposed to put on PPE when we go into rooms and use hand sanitizer." CNA #8 stated she was nervous. PCA #7 made no comment about the PPE or lack of hand hygiene. On 1/27/22 at 3:07 p.m., the registered nurse infection preventionist (RN #1) was interviewed about required PPE on the "warm" quarantine unit. RN #1 stated the residents on the warm unit were new admissions that had not been vaccinated for COVID-19 and were on contact/droplet precautions for COVID-19 prevention. RN #1 stated staff members were supposed to perform hand hygiene upon exit from each room and PPE to be worn into rooms included gown, gloves, N95 mask and eye goggles or face shield. RN #1 stated all staff had been educated on contact/droplet precautions. The facility's infection policy titled Admission Covid Protocol (revised 1/4/22) documented the warm "yellow" unit was for new admissions from the hospital that had not previously been COVID positive in past 90 days and documented residents remaining asymptomatic would be moved to a standard room after 14 days. The facility's policy titled Procedure for Creation of Separation-Quarantine Zone (revised 4/10/20)	F 880		

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F 880	Continued From page 113 documented anyone on the observation (yellow/warm) unit was required to use the following PPE: N95 respirator, eye protection, gown (if entering resident room), gloves (if entering resident room). The policy titled Transmission-Based Precautions Policy (revised 5/20/21) documented required PPE for residents on droplet precautions included mask, gloves, gown, eye protection worn according to standard precaution guidelines. This finding was reviewed with the administrator, director of nursing and nursing consultant on 1/27/22 at 5:30 p.m. 2. Resident #121 was admitted to the facility on 10/2/15 with diagnoses that included diabetes, dysphagia, protein-calorie malnutrition, glaucoma, peripheral vascular disease with left below knee amputation, history of osteomyelitis, hypertension, lymphedema, diabetic retinopathy with impaired vision, anemia, major depressive disorder, neuromuscular disorder of bladder, congestive heart failure and morbid obesity. The minimum data set (MDS) dated 12/21/21 assessed Resident #121 with moderately impaired cognitive skills. On 1/25/22 at 12:53 p.m., Resident #121 was observed in bed. There was a nebulizer machine positioned on the bedside table. The nebulizer mask and tubing were in the floor under the resident's bed with no protective cover to prevent contamination. On 1/26/22 at 8:23 a.m., the nebulizer mask was observed in the floor under the resident's bed. Resident #121 was interviewed at this time about the mask. The resident stated he had nebulizer treatments	F 880		

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F 880	Continued From page 114	F 880		

several times each day and he did not know why the mask was in the floor.

Resident #121's clinical record documented a physician's order dated 7/21/21 for Ipratropium-Albuterol solution 0.5-2.5 (3) milligrams/3 milliliters via nebulizer with instructions to inhale four times per day for wheezing and aspiration. The medication administration record documented the medication was administered as ordered.

On 1/27/22 at 8:43 a.m., the licensed practical nurse (LPN) #10 working on Resident #121's unit was interviewed about the nebulizer mask storage. LPN #10 stated the mask/tubing should be discarded if found in the floor. LPN #10 stated the masks were supposed to cleaned and stored in a plastic bag after use to prevent contamination.

On 1/27/22 at 3:04 p.m., the registered nurse infection preventionist (RN #1) was interviewed about storage of nebulizer masks. RN #1 stated masks were supposed to be dated and stored in a plastic bag attached to the wall to prevention contamination. RN #1 stated masks and tubing for nebulizers were changed each week.

On 1/27/22 at 3:27 p.m., the unit manager (RN #2) was interviewed about Resident #121's nebulizer mask found in the floor. RN #2 stated the mask should have been cleaned, stored in a plastic bag and discarded if found in the floor.

The facility's policy titled Nebulizer Administration Policy (revised 12/16/2019) documented in procedure at completion of treatment, "...Empty nebulizer cup, rinse with sterile water/sterile

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F 880	Continued From page 115 saline and air dry. Wipe mask with alcohol wipe and store the neb set in a plastic bag labeled with the patient's name when dried..." This finding was reviewed with the administrator, director of nursing and nursing consultant on 1/27/22 at 5:30 p.m.	F 880		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and facility training record review, the facility staff failed to ensure 2 of 182 employees were up-to-date for abuse, neglect, and exploitation training. Findings include: Beginning 1/27/22/at 4:00 p.m. the facility training records for on abuse, neglect, and exploitation	F 943	1). Two employees identified were educated on abuse, neglect, and exploitation. 2). Any resident has the potential to be affected. A 100% audit of employee education and training was completed to verify compliance. 3). The Administrator or designee will complete abuse training education to all staff and will verify that all staff complete annual abuse training education. Education on abuse will be added to new hire orientation. 4). Administrator, or designee, will review abuse training weekly x 12 weeks.	3/1/22

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F 943	Continued From page 116 were reviewed for all staff. Two staff did not have proof of the required training. The DON (director of nursing) was present, and asked about the two employees with no record of yearly training for this requirement. The DON stated, "The CNA (certified nursing assistant) tells me she has done that; the housekeeping staff doesn't think he completed it. The CNA says she can provide that information, so I told her to have it here as soon as possible." The DON was advised the CNA could provide the proof as soon as possible. The DON was also asked for a copy of the policy for the training. The housekeeping staff electronic signature for the training was dated 10/14/20. The CNA electronic signature was 10/16/20. The policy "Virginia Resident Abuse Policy" was reviewed and documented the following: "2). TRAINING (sic) The facility will educate it's staff upon orientation and periodically thereafter regarding the facility's policy concerning abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property and how to handle resident-to-resident abuse and injuries of unknown source." On 1/28/22 at 9:00 a.m. the DON stated, "The CNA did not provide proof of the training, so I am going to have to say that neither employee is current on that particular training." No further information was provided prior to the exit conference.	F 943		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides.	F 947		

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F 947	Continued From page 117 In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and training hours review, the facility staff failed to ensure one of 44 CNA's (certified nursing assistant) had the required 12 training hours per year. Findings include: On 1/27/22 beginning at 4:00 p.m. training records for CNA staff were reviewed for 12 hours of training per year. The DON (director of nursing) was present during the review, and was advised of the CNA with only 10.25 hours of required training. The DON stated the CNA was sure she had documentation of the training, and would provide the documentation. On 1/28/22 at 9:30 a.m. the DON stated "(Name of CNA) was not able to provide documentation of the training hours. All I have for her is what I	F 947	1). Identified employee has been provided 1:1 education regarding required annual in-services. 2). Any resident has the potential to be affected. An audit of all annual in-services has been completed. 3). The Administrator, or designee, will educate all staff on annual training requirements. Education will be added to new employee orientation. 4). Administrator, or designee, to audit education weekly x 12 weeks. All findings will be reviewed monthly with the QAPI committee with any variances being discussed and changes made when necessary.	3/1/22

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F 947	Continued From page 118 gave you." No further information was provided prior to the exit conference.	F 947		