STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. BUILDING _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF CHARLOTTESVILLE	490 HILLSDALE DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/12/22 through 4/14/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/12/2022 through 04/14/2022. Six complaints were investigated during the survey. VA00054825 was substantiated with no deficient practice. VA00054251 was substantiated with no deficient practice. VA00053241 was unsubstantiated with no deficient practice. VA00050413 was substantiated with deficient practice. VA00050498 was unsubstantiated with no deficient practice. VA00051719 was unsubstantiated with no deficient practice. VA00050209 was unsubstantiated with no deficient practice. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of twenty-three (23) current resident reviews, and six (6) closed record reviews.	F 000		
F 607 SS=D	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	F 607		5/17/22

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

Electronically Signed | 05/05/2022

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F 607	Continued From page 1 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of the facility's personnel files, facility policy and procedures, and staff interviews, the facility staff failed to implement the policy and procedure to ensure applicants for employment completed a Sworn Disclosure Statement disclosing "...any criminal convictions or pending criminal charges..." and also failed to ensure a criminal background check was obtained within 30 days of hire for one of 25 records reviewed. The findings include: On 04/14/2022 at 8:00 a.m., 25 employee files were reviewed. The files included the facility's administrator's personnel file that did not have a signed Sworn Disclosure Statement to disclose any criminal convictions or pending criminal charges. This identified employee file also did not contain a criminal background report from the State police office within 30 days of hire. On 04/14/2022 at 8:45 a.m., the human resources/payroll manager (OS #7) who was responsible for ensuring the employee files were complete and accurate was interviewed about the missing information. OS #7 stated, "I think the information was pulled in Richmond during the hiring process and I didn't receive the information. You can ask (Administrator) about the missing	F 607	The Laurels of Charlottesville wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is May 17, 2022. Preparation and/or execution of this correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or the conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. 1. OS#7 completed criminal background check on 4/15/22. 2. All residents could be affected by the alleged deficient practice. 3. Human Resources Director was educated on the abuse policy requiring criminal background checks by Regional Director of Clinical services. All employee personal files were audited by OS#7 and found to be in compliance with criminal background checks. 4. The Human Resource	

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F 607	Continued From page 2 information." On 04/14/2022 at 8:50 a.m., the facility's Administrator was interviewed regarding the missing information. The Administrator stated, "It was doesn't done. We realized yesterday the recruiter didn't complete all of the new hire screening paperwork." The facility's policy titled "Abuse Prohibition, Investigation, and Reporting (REV 07/19)" documented the following: "A. Screening: 1a. All applicants are to complete an employment application and complete the section regarding their history of criminal conviction(s).... 1e. In states where criminal background checks are conducted (Indiana, Michigan, North Carolina, Ohio, Virginia), the policy and procedure for these checks must be followed.... 2. A review of the applicant's past history must be considered prior to hiring and reasonable efforts must be made to uncover information about any past criminal history...." The administrator was informed of the above findings on 04/14/2022 at 8:50 a.m. The information was reviewed with the facility's administrative team including the administrator, director of nursing, corporate nurse and corporate regional vice president on 04/14/2022 at 11:30 a.m. No additional information was provided to the facility prior to exit on 04/14/2022 at 12:15 p.m.	F 607	Director/designee will audit criminal background checks for all new employees for twelve weeks. The results of the audits will be given to the Administrator for review. The results of audits will be reviewed monthly by the QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education or systemic changes as indicated. 5. May 17, 2022	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622		5/17/22

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F 622	Continued From page 3 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622		

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F 622	Continued From page 4	F 622		

that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;

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F 622	Continued From page 5 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to document a discharge to the hospital in the clinical record for one of 29 residents, Resident #42. The Findings Include: Resident #42 was admitted to the facility with diagnoses that included: Spleen rupture, congestive heart failure, acute on chronic hypoxic respiratory failure, and muscle weakness. The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 2/16/22. Resident #42 was assessed with a cognitive score of 14, indicating cognitively intact. On 4/13/22 Resident #42's medical record was reviewed. The MDS list indicated Resident #42 had been discharged to the hospital on 1/31/22. Review of the progress notes documentation dated 2/1/22 and 2/2/22 read "pt (patient) still in hosp (hospital)." There were no other progress notes or assessment/discharge notes indicating why Resident #42 had gone to the hospital. Review of the hospital notes documented Resident #42 was admitted to the hospital on 1/31/22 with acute on chronic respiratory failure. On 04/13/22 at 2:49 PM, licensed practical nurse (LPN) #1 reviewed Resident #42's medical record	F 622	1. Resident #42 was discharged to hospital 1/31/22 2. All residents have the potential to be affected by this alleged deficient practice. 3. Licensed nurses will be re-educated on policy on transfer and discharge of residents to hospital. 4. DON/designee will conduct audits of any hospital discharges daily Monday through Friday for four weeks, then weekly for 2 months, to ensure proper documentation of the discharge. The results of the audits will be given to the administrator for review. The results of audtits will be reviewed monthly by the QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education or systemic changes as indicated. 5. May 17,2022	

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F 622	Continued From page 6 and could not find any documentation regarding the discharge to the hospital. LPN #1 said there should be a progress note or a transfer assessment when a resident goes out to the hospital. On 04/13/22 at 2:59 PM, the facility regional nurse was also interviewed and reviewed Resident #42's medical record and agreed that there was no documentation of Resident #42's transfer to the hospital, and stated a transfer assessment should have been completed. On 4/13/22 at 5:15 PM the above information was presented to the DON and administrator. No other information was presented prior to exit conference.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and resident interview, the facility failed to accurately complete a Minimum Data Set (MDS) for two of twenty-nine (29) residents in the survey sample, Residents # 28 and 29. The facility failed to accurately assess Section C (Cognitive Patterns), Section D (Mood), and Section E (Behavior) for both residents. The findings include: 1. Resident # 28 was admitted with diagnoses	F 641	1. Residents #28 and #29 still reside in the facility. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Social Service Staff will be re-educated by the Regional MDS Coordinator on completion of MDS sections C,D,E before the ARD. 4. Regional MDS nurse/designee will	5/17/22

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F 641	Continued From page 7 that included hypertension, viral hepatitis, hyperlipidemia, cerebrovascular accident, left side hemiplegia, malnutrition, depression, chronic pain, glaucoma, dysphagia, insomnia, and abnormal posture. A review of the most recent Minimum Data Set (MDS), a Quarterly review with an Assessment Reference Date (ARD) of 2/4/2022 found Section C (Cognitive Patterns), Section D (Mood), and Section E (Behavior) was not completed. At approximately 2:00 p.m. on 4/12/2022, Resident # 28 was interviewed. The resident was alert and oriented, and answered all questions appropriately. At 3:50 p.m. on 4/13/2022, the Social Worker (SW), who was identified as responsible for completing MDS Section C, D, and E, was interviewed. The SW said the person who actually completed the three sections in question on the Quarterly MDS for Resident # 28 was a Social Worker intern who came in on Friday, Saturday and Sunday. When asked, the SW was unable to say who supervised or reviewed the assessments completed by the intern. The SW agreed that Resident # 28 was alert, oriented, and capable of appropriate conversation. The findings were discussed at 11:00 a.m. on 4/14/2022 during a meeting with the Administrator, Director of Nursing, corporate consultant, and the survey team. 2. Resident # 29 was admitted to the facility with diagnoses that included charcot's joint disease, hypertension, hyperlipidemia, anxiety disorder, depression, gastroesophageal reflux disease, right below the knee amputation, and a history of	F 641	conduct audits. These audits of the MDS section C,D,E will happen three times a week for two weeks, then two times a week for two weeks, then weekly for two months. the results of the audits will be given to the administrator for review. The results of audits will be reviewed monthly by the QAPI committee for patterns and trend. The QAPI committee will make recommendations for further education or systemic changes as indicated. 5. May 17, 2022	

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F 641	Continued From page 8 COVID-19. A review of the most recent MDS, a Quarterly review with an ARD of 2/4/2022 found Section C (Cognitive Patterns), Section D (Mood), and Section E (Behavior) was not completed. At approximately 2:30 p.m. on 4/13/2022, Resident # 29, was interviewed. The resident was alert and oriented, and answered all questions appropriately. At 3:50 p.m. on 4/13/2022, the Social Worker (SW), who was identified as responsible for completing MDS Section C, D, and E, was interviewed. The SW said the person who actually completed the three sections in question on the Quarterly MDS for Resident # 29 was a Social Worker intern who came in on Friday, Saturday and Sunday. When asked, the SW was unable to say who supervised or reviewed the assessments completed by the intern. The SW said Resident # 29 was not only very alert and oriented, but was the Resident Council president. The findings were discussed at 11:00 a.m. on 4/14/2022 during a meeting with the Administrator, Director of Nursing, corporate consultant.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		5/17/22

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F 657	Continued From page 9 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to review and revise a comprehensive care plan for two of 29 residents, Resident #64 and #92. Resident #64 did not have an ADLs (activities of daily living) care plan updated and Resident #92 did not have code status updated. The Findings Include: 1. Diagnoses for Resident #64 included: Parkinson's disease, urinary tract infection, anxiety, and muscle weakness. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/14/22. Resident #64 was assessed with a cognitive score of 15 indicating cognitively intact. Under Section "G, Functional	F 657	1. Resident #64 and resident #92 had care plan updated to reflect current ADL status. 2. All residents have the potential to be affected by alleged deficient practice. 3. The regional MDS coordinator will reeducate the MDS nurses on care plan updates for ADL status. 4. Regional MDS coordinator/designee will audit to ensure compliance of care plans reflecting up to date ADL status. These audits will occur three times a week for two weeks, then two times a week for two weeks, then once weekly for two months. The results of the audits will	

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F 657	Continued From page 10 Status, Resident #64 was assessed for bed mobility, transfer, eating, and toileting use at a 3-2 for all areas indicating extensive assistance with one person assist. A 5 day MDS assessment with an ARD of 1/28/22 was reviewed for comparison. Section "G, Functional Status" indicated bed mobility, transfer, and toileting as a 2-2 indicating limited assistance with one person assist, and eating as 1-1 indicating supervision with set up. Based on the comparison of the 5 day and significant change MDS, Resident #64 had a decline in functional status. Resident #64's ADL care plan was reviewed and did not evidence that the care plan had been revised for the ADL areas listed above. The last date that these areas were revised was on 2/27/2018. On 04/14/22 at 7:39 AM, registered nurse (RN) #2 reviewed MDS and said it should have been revised. On 04/14/22 at 11:44 AM, the above information was presented to the administrator and DON (director of nursing). No other information was provided prior to exit conference on 4/14/22. 2. Resident #92 was admitted to the facility with diagnoses that included displaced left tibial fracture, multiple right side rib fractures, atrial fibrillation, hypertension, hyperlipidemia, and muscle weakness. The most recent minimum data set (MDS) dated 3/21/2022 was a 5-day admission assessment and assessed Resident	F 657	be reviewed monthly by the QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education or systemic changes as indicated. 5. May 17, 2022	

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F 657	Continued From page 11 #92 as cognitively intact for daily decision making with a score of 15 out of 15. Resident #92's electronic health record (EHR) was reviewed on 04/12/2022 at 4:15 p.m. Observed on the order summary report was the following order: "Do Not Resuscitate (No CPR). Order Date 03/30/2022." Observed on the care plans was the following: (Resident #92) is a full code. Date Initiated/Created: 03/16/2022. Observed within the clinical record was a signed durable do not resuscitate (DDNR) order dated and signed by the physician and Resident #92 on 03/23/2022. On 04/13/2022 at 9:59 a.m., the MDS coordinator (RN #3) who was responsible for the care plans was interviewed. RN #3 reviewed Resident #92's EHR and stated Resident #92's code status was a DNR. RN #3 was asked if MDS staff were notified about code status changes. RN #3 stated, "Yes we're normally notified; however, I can't say if we were notified about this one. The care plan should have been updated when the code status change took place." The above findings were reviewed with the administrator, director of nursing (DON) and corporate staff during a meeting on 04/13/2022 at 4:30 p.m.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		5/17/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to assess and initiate treatment for a wound for one of twenty-nine residents in the survey sample, Resident #216; and failed to follow physician orders for one of twenty-nine residents in the survey sample, Resident #49. Resident #216, assessed with a leg wound upon admission, had no treatment orders implemented or ongoing monitoring of the wound. Resident #49 did not have a medication dosage change as ordered by the physician. The findings include: 1. Resident #216 was admitted to the facility with diagnoses that included septic arthritis, cellulitis of left lower leg, sacral pressure ulcer, diabetes, constipation and muscle weakness. The admission nursing assessment dated 4/5/22 assessed Resident #216 as alert and oriented to time, place and person. Resident #216's admission assessment dated 4/5/22 documented, "...has a pressure wound to the coccyx and a wound from cellulitis to the left lower leg..." There was no other description or	F 684	1. Resident #49 no longer resides at the facility. Resident #216 still resides in facility. Resident #216 wound was healed on 4/13/22 and a new order for dermatitis of the leg was initiated on 4/13/22. 2. All residents are at risk of the alleged deficient practices. 3. Licensed nurses will be re-educated by DON/designee on the skin management program and physician orders. CNAs will be re-educated on reporting any skin issues to nurse and documenting in POC. DON/designee will be re-educated by Regional Clinical Coordinator concerning GDR for psychoactive medications with timely follow up. 4. For three months, Mon-Fri, DON/designee will ensure that all residents with wounds have treatment orders and timely notification of MD and RP. DON/designee will review pharmacy recommendations monthly. GDR's will be sent for approval to the MD within three days for implementation	

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assessment of the leg wound indicating any characteristics or location of the wound. There was no treatment order initiated for the leg wound. The resident's treatment administration record (TAR) included no entries about a leg wound.

On 4/12/22 at 4:15 p.m., Resident #216 was observed in bed. There were dried skin flakes scattered about the bedcovers surrounding the left lower leg. Resident #216 was interviewed at the time about the left lower leg. Resident #216 stated she had cellulitis in the left lower leg and at one time had scattered open areas on the leg. The resident stated the areas were "dried up now." The resident pulled her pant leg up and sock down showing her left lower leg. The lower leg was purplish in color and covered with dry, flaky skin with a small open area on the shin. Multiple scabbed areas were on the shin and lower leg. The resident rubbed the shin area and dislodged a scab that started bleeding. The resident stated a dressing had previously been on the leg but the last instruction was to leave the leg open to air.

The clinical record included no assessment of the left lower leg wounds/skin impairments since the admission note that described a wound that area. There were no treatment orders for any topical treatment and/or dressings applied to the area.

On 4/13/22 at 10:38 a.m., the nurses' aide (CNA #3) caring for Resident #216 was interviewed. CNA #3 stated the resident at one time had a dressing on the left lower leg. CNA #3 stated the dressing was no longer in use and the resident had "really scaly" skin on the leg. CNA #3 stated she washed the leg and Resident #216 kept a

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sock over the area.

On 4/13/22 at 10:43 a.m., the licensed practical nurse (LPN #3) caring for Resident #216 was interviewed. LPN #3 stated she had never seen the resident's left lower leg and was not aware of any skin impairments or treatments.

On 4/13/22 at 10:37 a.m., the unit manager (LPN #4) was interviewed about Resident #216's left lower leg. LPN #4 stated there was the physician entered an order on 4/6/22 for dry dressings every other day. LPN #4 stated the order did not specify a location, was incomplete and never activated in the electronic health record. LPN #4 stated there were no orders and/or treatments documented for the resident's left lower leg until the wound consultant assessed the resident on 4/12/22. LPN #4 stated the nurse should have contacted the provider at the time of admission about orders for care of the leg/skin. LPN #4 stated an assessment should include a description of the wound.

On 4/14/22 at 7:55 a.m., the director of nursing (DON) was interviewed about Resident #216's leg wound. The DON stated she reviewed the record and there were no orders of care and treatment for the left lower leg initiated upon admission.

The facility's policy titled Skin Management (originated 5/1/10, revised 7/14/21) documented, "...residents admitted with any skin impairment will have...Appropriate interventions implemented to promote healing...A physician's order for treatment, and...Wound location, measurements and characteristics documented..."

This finding was reviewed with the administrator

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and director of nursing during a meeting on 4/13/22 at 4:30 p.m.
2. Resident # 49 was admitted to the facility with diagnoses to include, but were not limited to: stroke, depression, anxiety, and heart failure.

The most recent MDS (minimum data set) was a quarterly review dated 2/11/22 and assessed the resident as having long term and short term memory problems, and severe impairment in cognition.

The clinical record was reviewed 4/13/22 at approximately 2:30 p.m. A pharmacy recommendation dated 2/21/22 documented: "Comment: (name of resident) has received Buspirone (an anti-anxiety medication) 10 mg tid (three times a day) for anxiety.
Recommendation: Please attempt a gradual dose reduction with the end goal being discontinuation..." The physician response was checked on the form for "I accept the recommendations(s) above, please implement as written."

The physician order was written for "Buspirone tablet 10 mg. Give 1 tablet by mouth two times a day for 30 days, then 1 tablet a day." The form was signed by the nurse practitioner 2/28/22. The former DON (director of nursing) signature for implementation was 3/14/22. A review of the MAR (medication administration record) revealed the new order was implemented 3/14/22.

On 4/13/22 the regional nurse consultant was interviewed about the delay in implementing the order. She stated "I agree, that's a bit of a delay...let me see if we have a policy..." The nurse consultant stated there was no policy to

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F 684	Continued From page 16 address the timeliness of implementing a dose reduction, but the expectation was it should be done as soon as possible, and a 2 week delay was too long. The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings during an end of the day meeting 4/13/22 at 4:00 p.m. No further information was provided prior to the exit conference.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to assess and implement interventions for prevention/care of pressure ulcers for three of twenty-nine residents in the survey sample, Resident #215, #216, and #5.	F 686	1. Resident #215 no longer resides in facility. Resident #216 pressure ulcer of sacrum has resolved. Resident#5's skin area is resolved. 2. All residents have the potential to be affected by this alleged deficient practice.	5/17/22

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F 686	Continued From page 17 Resident #215 developed a pressure ulcer initially identified at a stage 3 status. There were no skin assessments in the weeks prior to the stage 3 ulcer and no follow up assessment of the pressure injury for sixteen consecutive days. Resident #215's pressure ulcer developed necrotic tissue, foul odor/drainage resulting in hospitalization due to sepsis from the infected wound. Resident #216 was admitted with a stage 2 pressure ulcer. There was no thorough assessment or interventions implemented for treatment of the ulcer. Resident #5 clincal record failed to include an assessment or treatment orders for a wound aquired at the facility. The findings include: 1. Resident #215 was admitted to the facility with diagnoses that included traumatic spinal cord injury with quadriplegia, hypertension, benign prostatic hyperplasia, urinary tract infection, diabetes and spinal stenosis. The minimum data set (MDS) dated 10/30/20 assessed Resident #215 as cognitively intact, always incontinent of bowel/bladder and as requiring the extensive assistance of two people for bed mobility and toileting. Resident #215's closed clinical record documented an admission evaluation dated 10/24/20 listing the resident was admitted with a deep tissue injury to the left heel and bogginess on the right heel. There were no other skin impairments identified upon the resident's	F 686	A full house skin sweep was conducted, and one resident identified as having a skin issue. Orders obtained for treatment and RP, MD notified. 3. Licensed nurses will be re-educated by DON/designee on the skin management program and physician orders. CNAs will be reeducated on reporting any skin issues to nurse and documenting in POC. 4. For three months, Mon-Fri, the DON/designee will ensure new admission skin assessments are completed. DON/designee will also ensure that all residents with skin impairment have treatment orders and timely notification of MD and RP. The results of audits will be reviewed monthly by the QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education or systemic changes as indicated. 5. May 17, 2022	

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admission. The form documented Resident #215 was at risk for impaired skin integrity/pressure injuries with interventions that included, "Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician...cue to reposition self as needed...Follow facility policies/protocols for the prevention/treatment of impaired skin integrity...Turn/reposition resident every 2 hours... (Resident #215) is at risk for impaired skin integrity/pressure injury R/T (related to) decreased mobility d/t (due to) Quadriplegia..."

A Braden Scale for Predicting Pressure Sore Risk was completed on 10/24/20 documenting Resident #215 was a high risk for pressure ulcer development due to completely limited sensory perception, skin exposure to moisture, bedfast status, complete immobility and problems with friction/shear due to immobility.

A physician's order was documented on 10/26/20 for Resident #215's buttocks to be washed/dried and a barrier cream applied each shift and as needed following incontinence. The treatment administration record (TAR) documented this order was implemented each shift as ordered until the resident's discharge on 12/11/20.

Resident #215's clinical record documented a physician's order dated 10/28/20 for weekly skin assessments on Wednesdays by the evening shift. There were no skin assessments documented for the week ending 10/31/20 or 11/7/20. The resident's TARs listed the weekly body audits as completed on 10/28/20 and 11/4/20 but there were no results of these assessments providing any description or condition of the resident's skin.

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Resident #215's clinical record documented a wound evaluation form dated 11/6/20 listing, "MASD - IAD" (moisture-associated skin damage - incontinence associated dermatitis) on the resident's coccyx measuring 5.18 cm (centimeters) x 1.98 cm x 0.2 cm (length by width by deepest point). The form listed notification to the physician. There were no new treatment orders entered in response to acquired moisture-associated skin damage.

A total body skin assessment was completed on 11/11/20 and documented only that the resident had no new wounds. There was no description of the resident's skin, no mention of the previously identified moisture-associated skin damage on the coccyx or the condition of the resident's heels.

A nursing note dated 11/12/20 documented continued presence of the moisture-associate skin damage on the buttocks. This nursing note documented, "...Skin breakdown: IAD to sacral/buttocks areas...Add Active Liquid protein 30 ml (milliliters) once a day for wound healing..."

The first assessment indicating a sacral/coccyx pressure ulcer was on 11/18/20 with the ulcer status listed as stage 3. A nursing note dated 11/18/20 documented, "...Stage 3 pressure wound on bottom...Unit Manager...notified of pressure wound..." There was no other assessment on this date of the stage 3 ulcer indicating the exact location, measurements, wound bed type/appearance, presence of pain, odor or drainage or the condition of surrounding skin.

A physician's order was entered for treatment of

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the stage 3 ulcer on 11/19/20 that stated, "Cleanse buttocks and coccyx with soap and water, pat dry. Place Silver Alginate in wound bed, and cover with foam dressing."

The first descriptive assessment of Resident #215's stage 3 pressure ulcer was five days later by a wound consultant nurse practitioner (NP) on 11/23/20. This wound assessment dated 11/23/20 documented, "...Patient is seen for evaluation and management of pressure injury at left heel, and new ulceration at sacrum. Staff noted deep purple ecchymosios (ecchymosis) at site with smal (small) open area a few days ago... Physical Exam...full-thickness wound of the sacrum that measure 9.0 x 8.5 x 0.2 (length x width x depth in centimeters)...Wound base 25% slough and 75% area of purple deep ecchymosis before debridement...small to moderate serous, odorless drainage, Periwound without erythema, induration or signs of cellulitis..." The wound NP performed excisional debridement of the wound with "Removal of devitalized necrotic tissue..." (sic)

A physician's order was entered on 11/23/20 for an air mattress to the resident's bed. This was five days after the identification of the resident's stage 3 pressure ulcer.

The physician's assistant (PA) assessed Resident #215 on 11/27/20, 12/2/20 and on 12/8/20 with no mention of the resident's sacral pressure injury. These PA notes documented regarding skin, "No Rash, ulcers or cyanosis..."

There were no assessments of Resident #215's sacral pressure ulcer from 11/23/20 when assessed by the consultant wound NP, until

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sixteen days later on 12/9/20 when the wound was listed as unstageable and covered with slough and eschar. The skin and wound evaluation form dated 12/9/20 documented the resident had an acquired coccyx pressure ulcer classified as unstageable due to slough and eschar. This assessment listed the wound was 10.5 cm x 8.0 cm (length by width) with 80% of wound bed covered with eschar and 20% covered with slough. The wound progress was listed as "deteriorating."

A physician assessed Resident #215 on 12/9/20 and listed the resident with confusion and disorientation to time and place. The physician's progress note dated 12/9/20 documented the resident had a pressure ulcer with eschar on the left heel but made no mention of the sacral pressure ulcer.

The wound consultant NP assessed Resident #215's sacral pressure ulcer on 12/9/20 and documented, "...full-thickness wound of sacrum that measures 10.5 x 7.5 x 0.2 cm. Wound base 100% moist eschar before debridement...moderate purulent, malodorous drainage...Please treat empirically for sacral wound infection with Doxycycline 100 mg PO (by mouth) BID (twice per day) x 14 days...Wound care to sacrum as follows: Cleanse site with normal saline or wound cleanser...Apply 1/4 strength Dakins moistened gauze to wound base...Cover with ABD pad and tape or foam dressing. Provide this care BID and as needed..."

The clinical record documented a physician's order dated 12/9/20 for the dressing changes with Dakin's solution twice per day as recommended by the wound consultant. There was no order

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entered for the antibiotic Doxycyline as recommended by the wound consultant NP.

The PA assessed Resident #215 on 12/10/20 for confusion and a "buttock wound." The PA progress note dated 12/10/20 documented, "...RN (registered nurse) states concern for worsening buttock wound that was first noted in early November...Buttock wound examined with RN. Stage 3 wound, with foul odor consistent with pseudomonas, with worsening surrounding erythema noted. Dark blood noted in dressing..." The PA diagnosed Resident #215 with a urinary tract infection, wound infection and ordered Bactrim DS 800 - 160 mg (milligrams) twice per day for one week.

A nursing note on 12/11/20 documented Resident #215 was assessed with low blood pressure (90/52), increased heart rate (115/minute) and respiration rate (20/minute). The physician was notified and ordered the resident to the emergency room for evaluation and treatment.

The emergency room report dated 12/11/20 documented upon the physical exam, "...stage IV decubitus ulcer involving sacrum with eschar and foul smelling greenish drainage... (patient) with history of incomplete quadriplegia... presents from his nursing home with concerns for sepsis secondary to either urinary tract infection and/or infected sacral decubitus ulcer...on examination patient's decubitus ulcer with eschar and necrotic tissue with foul smelling drainage...Patient is septic..." The emergency room discharge summary documented Resident #215 was hospitalized and treated with antibiotics for a complicated urinary tract infection and infected pressure ulcer. The discharge summary

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documented, "...hospital course was prolonged and characterized large sacral decubitus ulceration requiring surgical debridement..." The family chose palliative care and the resident was admitted to inpatient hospice services on 12/30/20.

Resident #215's plan of care (revised 11/5/20) made no mention of the sacral pressure ulcer. The care plan documented Resident #215 was at risk of skin impairment and pressure injury due to decreased mobility related to quadriplegia and incontinence and was admitted with a pressure ulcer to the left heel. Interventions to prevent pressure ulcer development included, "...Braden scale per protocol...Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician...Cue to reposition self as needed...Follow facility policies/protocols for the prevention/treatment of impaired skin integrity...Turn/reposition every 2 hours..."

On 4/13/22 at 3:55 p.m., the DON was interviewed about Resident #215's sacral pressure ulcer, lack of prior skin assessments and initially finding the ulcer at stage 3 status. The DON stated she was not working in the facility during Resident #215's stay. The DON stated the unit manager and nurses that cared for Resident #215 during his stay no longer worked at the facility.

On 4/14/22 at 8:00 a.m., the DON stated she reviewed the clinical record and found no skin assessments documented in the weeks prior to the identified stage 3 pressure ulcer. The DON stated she found no rationale of why the pressure ulcer was found at stage 3 and not identified

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earlier. The DON stated the facility policy required a body audit/skin assessment every seven days. The DON stated the audits were supposed to be completed by nursing and the results documented on an assessment form. The DON stated an assessment should have included a description of the skin and characteristics of any wounds. The DON stated when wounds were found, the unit managers were responsible for following wounds. The DON stated a wound consultant came weekly to the facility and typically assessed/monitored stage 3 or higher wounds making recommendations as needed regarding treatments. The DON stated she had no rationale for why the skin impairment was not recognized earlier even with staff applying cream to the buttocks daily.

These findings were reviewed with the administrator and director of nursing during a meeting on 4/13/22 at 4:30 p.m. and on 4/14/22 at 11:10 a.m.

This was a complaint deficiency.

2. Resident #216 was admitted to the facility with diagnoses that included septic arthritis, cellulitis of left lower leg, sacral pressure ulcer, diabetes, constipation and muscle weakness. The admission assessment dated 4/5/22 assessed Resident #216 as alert and orient to time, place and person.

Resident #216's admission assessment dated 4/5/22 documented, "... (Resident #216) has a pressure wound to the coccyx..."

There was no documented assessment of the coccyx pressure ulcer indicating the exact

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location, measurement, wound bed appearance, odor, drainage or pain presence. There was no notification to the physician and/or provider concerning the pressure ulcer and no orders for treatment initiated. Resident #216's treatment administration record (TAR) for April 2022 made no mention of a pressure ulcer or any treatment to the coccyx area.

On 4/12/22 at 4:13 p.m., Resident #216 was interviewed about a coccyx wound. Resident #216 stated she had an open area on her bottom upon admission. Resident #216 stated staff applied a cream to her bottom after using the bathroom. Resident #216 stated her bottom was not painful and she thought the area was "doing ok."

On 4/13/22 at 10:38 a.m., the nurses' aide (CNA #3) caring for Resident #216 was interviewed. CNA #3 stated Resident #216 was incontinent of urine at times and wore a brief or pull-up. CNA #3 stated the resident's coccyx was "clearing up." CNA #3 stated she washed the resident, applied a barrier cream and nurses at one time had a "patch" on the coccyx area.

On 4/13/22 at 10:43 a.m., the licensed practical nurse (LPN) #3 caring for Resident #216 was interviewed. LPN #3 stated she did not know anything about the resident having a pressure ulcer. LPN #3 stated skin assessments were done by the evening shift nurses. LPN #3 stated there were no current orders for treatment of a pressure ulcer.

On 4/13/22 at 10:47 a.m., the unit manager (LPN #4) was interviewed about Resident #216. After reviewing the clinical record, LPN #4 stated the

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physician entered an order for dry dressings every other day on 4/6/22 but the order was incomplete and not activated in the electronic health record. LPN #4 stated the order did not include a wound site and the order was never implemented. LPN #4 stated the admitting nurse should have contacted the provider and obtained orders for care at the time the wound was found. LPN #4 stated the admission nurse should have thoroughly assessed the wound and included documentation of the exact location, size and appearance of the wound. LPN #4 stated the wound consultant nurse practitioner (NP) assessed Resident #216 yesterday (4/12/22) and indicated the pressure ulcer had resolved but the resident had eroded skin.

The wound consultant NP note dated 4/12/22 documented, "...Central buttock with inflammation, and scattered areas of superficial eroded skin...scant amount of serous, odorless drainage noted in brief..." The NP diagnosed MASD (moisture-associated skin damage) and prescribed a zinc-based cream each shift as treatment with instructions to monitor skin for sign of infection, pain, redness, increased warmth, foul odor and increased drainage.

Resident #216's plan of care (initiated 4/5/22) listed the resident had a pressure wound to the coccyx. Interventions to prevent complications included, "...Observe location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration...Treatment to skin as ordered..."

This finding was reviewed with the administrator and director of nursing during a meeting on 4/13/222 at 4:30 p.m.

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The facility's policy titled Skin Management (originated 5/1/10, revised 7/14/21) documented prevention/treatment of skin impairments, "...those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes...The licensed nurse will monitor, evaluate and document changes regarding skin condition (to include: dressing, surrounding skin, possible complications and pain) in the medical record...A weekly total body skin evaluation is completed for each guest/resident by the licensed nurse. The licensed nurse will document findings of the skin evaluation. The CNA's will report any new skin impairment to the licensed nurse that is identified during daily care...resident's (residents) with pressure injury...will be evaluated, measured and staged weekly...in accordance with the practice guidelines until resolved..."

The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury as, "...localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." (1)

The NPIAP defines a stage 2 pressure injury as, "partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible.

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Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis..." (1)

The NPIAP defines a stage 3 pressure injury as, "Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location...Undermining and tunneling may occur..." (1)

The NPIAP defines a stage 4 pressure injury as, "Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur..." (1)

The NPIAP defines an unstageable pressure injury as, "Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, as Stage 3 or Stage 4 pressure injury will be revealed..." (1)

The NPIAP defines a deep tissue pressure injury as, "Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister...This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue

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injury..." (1)

(1) NPIAP Pressure Injury Stages. National Pressure Injury Advisory Panel. 4/15/22. www.npiap.org

3. Resident # 5 was admitted with diagnoses that included traumatic spinal cord dysfunction, incomplete lesion at C8 level of spinal cord, spinal stenosis, neuromuscular dysfunction of the bladder, neurogenic bladder, hypertension, renal insufficiency, diabetes mellitus, hyperlipidemia, morbid obesity, neurogenic bowel, gastroesophageal reflux disease, and history of COVID-19. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 4/4/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Review of the Progress Notes in the resident's Electronic Health Record revealed the following entry:

3/15/2022 - 1:07 p.m. - Skin/Wound Progress Note - "Resident has a three inch open area on his left mid buttock that is open and has slough, zinc ointment and sacral patch applied, supervisor notified."

A thorough review of the resident's Electronic Health Record failed to reveal an assessment of the wound or treatment orders for the wound.

At approximately 4:00 p.m. on 4/12/2022, documentation of the assessment and the treatment orders was requested. No documentation was provided in response to the request.

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At approximately 10:30 a.m. on 4/14/2022, LPN # 1 (Licensed Practical Nurse), the Unit Manager on Unit 2 where Resident # 5's room was located, was interviewed regarding the open area on Resident # 5 identified on 3/15/2022. Asked if she was aware of the area on Resident # 5's buttock, LPN # 1 said she thought she was told about it. Asked if the area was assessed to determine the nature of the wound, and if treatment orders were obtained, LPN # 1 said there was no assessment and no treatment orders. LPN # 1 went on to say she could not explain why there was no follow-up. Asked about skin assessments, LPN # 1 said the assessments are done weekly.

A review of the PCC Skin & Wound - Total Body Skin Assessments, found in Resident # 5's Electronic Health Record revealed an assessment dated 2/24/2022 that noted the resident had no new wounds.

The next PCC Skin & Wound - Total Body Skin Assessment was dated 3/16/2022, three weeks after the assessment of 2/24/2022, which noted the resident had one new wound.

On 4/13/2022, during an end of day meeting with the administrative staff documentation of the assessment and the treatment orders was requested. No documentation was provided in response to the request.

At 10:00 a.m. on 4/14/2022, after receiving permission from the resident, an observation of the wound was made. Also present for the observation was LPN # 7. The wound was an open area measuring 1 cm by 1 cm (centimeter)

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F 686	Continued From page 31 with no depth and no drainage. There was an approximately three (3) inch scar visible. The findings were discussed at 11:40 a.m. on 4/14/2022 during a meeting with the Administrator, Director of Nursing, corporate consultant, and the survey team.	F 686		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		5/17/22

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F 690	Continued From page 32 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, and staff interview, the facility staff failed to follow physician's orders for catheterization for one of 29 residents in the survey sample, Resident # 5. Facility staff failed to catheterize the resident as scheduled according to physician's orders. The findings were: Resident # 5 in the survey sample was admitted with diagnoses that included traumatic spinal cord dysfunction, incomplete lesion at C8 level of spinal cord, spinal stenosis, neuromuscular dysfunction of the bladder, neurogenic bladder, hypertension, renal insufficiency, diabetes mellitus, hyperlipidemia, morbid obesity, neurogenic bowel, gastroesophageal reflux disease, and history of COVID-19. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 4/4/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Resident # 5 had the following physician's order, "IO (In and Out) cath (catheter) q (every) 6 hours for neurogenic bladder." The order date and start date for the order was 2/9/2022.	F 690	1. Resident #5 was discharged to hospital on 4/15/22 and re admitted on 4/22/*22. He continues to have orders for I&O cath every six hours. 2. All residents with an I&O cath order are at risk for alleged deficient practice. 3. Licensed nurses will be re-educated by DON/designee on ensuring residents who have orders for I&O catheterizations, receive the treatment and output is recorded on TAR. Also, licensed nurses will be re-educated by DON/designee on male I&O cath and MD orders. 4. TARs will be monitored for one month daily, Mon-Fri, by DON/designee to assure I&O treatment and output were recorded per MD order. The auditing will be weekly for two months. The results of the audits will be given to the administrator for review. 5. May 17, 2022	

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Review of the Progress Notes in the resident's Electronic Health Record revealed the following entry: 3/13/2022 - 4:48 p.m. Nurses Notes - "This guest said he did not get cathed (catheterized) all day on the 12th. I just cathed him and got 1600 (milliliters) out. He said he had a BM yesterday but was not cathed. MD aware."

Review of the Treatment Administration Record (TAR) for the month of March 2022 revealed entries for all four catheterization opportunities on 3/13/2022, with an entry of 1600 ml for the 6:00 a.m. catheterization.

Further review of the March 2022 TAR revealed there was no catheterization documented for 10 out of 124 opportunities (4 opportunities per day times 31 days).

Review of the February 2022 TAR revealed there was no catheterization documented for 20 out of 77 opportunities.

Review of the April 2022 TAR, as of the date of the survey, revealed there was no catheterization documented for 4 out of 48 opportunities.

Resident # 5's care plan included the following problem, "(Name of resident) is at risk for inadequate bladder emptying, bladder discomfort and infections r/t (related to) neurogenic bladder dysfunction; I&O caths; CKD (Chronic Kidney Disease)." The goals for the problem were, "Resident will be free from complications of BPH (Benign Prostatic Hyperplasia) such as decreased or abnormal urinary output, infection, or UTI (Urinary Tract Infection) through the review date. Resident will be free from bladder pain or discomfort associated with urinary retention

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through the review date."

Interventions to the stated problem included, "Administer medications as ordered (to assist in relaxing the bladder and aide in urinary output and flow) and observe for effectiveness and side effects, report abnormal findings to the physician; Evaluate fluid needs PRN (as needed); Notify MD ASAP (as soon as possible) if resident experiences s/s (signs and symptoms) of UTI. Obtain UA (urinalysis), C&S (culture and sensitivity) as ordered. Report findings to MD and initiate treatment if indicated; Observe for changes in output. Obtain PVRs (post void residual urine test) as ordered. Notify MD if greater than (no residual amount specified); Observe for side effects of medications: dizziness, headache, nausea, weakness, drowsiness, body aches, chest pain, rash/hives. Notify MD if side effects occur; Observe for signs and symptoms; decrease in urine output, bloody or concentrated urine, difficulty initiating stream, distended bladder and or dribbling and report to physician as needed; and, Urology consult as ordered."

At 10:00 a.m. on 4/13/2022, Resident # 5 was interviewed regarding his catheterizations. Asked if any of his catheterizations were missed, the resident said, "Yes they have missed some from time to time." When asked if he experienced any pain or discomfort when the catheterizations were missed, Resident # 5 responded, "There is no pain, but it is very, very uncomfortable."

At 11:20 a.m. on 4/14/2022, the attending physician's Physician's Assistant (PA) was interviewed. When told Resident # 5 was not being consistently catheterized, the PA said he

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F 690	Continued From page 35 was not aware of that. The PA went on to say he usually only reviews the Progress Notes and not the TARs. Asked about the ramifications of not being catheterized as ordered, the PA said it would cause the resident discomfort and could lead to what the PA termed "...urinary overflow." When asked about parameters for the amount of urinary output, the PA said that to his knowledge there were none. The findings were discussed at 11:40 a.m. on 4/14/2022 during a meeting with the Administrator, Director of Nursing, corporate consultant.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		5/17/22

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F 692	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide a therapeutic diet as ordered by the physician for one of twenty-nine residents in the survey sample, Resident #53. Resident #53 was not provided a double-portioned meal as ordered by the physician due to weight loss. The findings include: Resident #53 was admitted to the facility with diagnoses that included protein-calorie malnutrition, cellulitis of right leg, right foot burn, diabetes, cirrhosis of liver without ascites, dementia, COVID-19, hemiplegia from cerebrovascular accident, hypertension and gastroesophageal reflux disease. The minimum data set (MDS) assessed Resident #53 as cognitively intact. Resident #53's clinical record documented a physician's order dated 3/18/22 for consistent carbohydrate regular diet with double portions. The registered dietitian (RD) documented an evaluation on 3/25/22 listing the resident as underweight with a history of weight loss. The nutrition note documented the resident had good appetite and consumption of greater than 75% of meals and supplements. The RD recommended to continue the double portion regular diet, Magic Cup twice per day and snacks. On 4/13/22 at 8:40 a.m., Resident #52 was observed with breakfast served in his room. The resident's breakfast included one muffin, 2 bacon	F 692	1. Resident #53 is receiving double portions as ordered by the physician. 2. All guests with double portions ordered are at risk of alleged deficient practice. 3. Dietary Manager will receive re-education from Regional Dietician on ensuring that orders for double portions are fulfilled. Dietary staff will receive re-education from dietary manager for ensuring that meal trays match the order. 4. Audits will be conducted daily for residents with orders for double portions by dietary manager/designee, for one month, Mon-Fri. Then audits will be reviewed monthly by the QAPI committee will make recommendations for further education or systemic changes as indicated. 5. May 17, 2022	

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F 692	Continued From page 37 slices, a serving of applesauce, and a bowl of Cheerios with a 8 ounce carton of whole milk. The meal ticket with the breakfast documented regular consistent carbohydrate diet with double portions. Resident #52 was interviewed at this time about the double portions. Resident #52 stated he did not always get what was on the ticket and he was not sure if the breakfast served was double portioned. On 4/13/22 at 10:30 a.m., the dietary manager (other staff #1) was interviewed about Resident #52's observed breakfast. The dietary manager stated double portions "would be double on everything." The dietary manager stated the double portion breakfast should have included two muffins, four slices of bacon and two scoops of applesauce. The dietary manager stated one bowl of cereal was provided for all diet types. The dietary manager was not sure why the double portions were not provided as indicated on the meal ticket. This finding was reviewed with the administrator and director of nursing during a meeting on 4/13/22 at 4:30 p.m.	F 692		
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.	F 755		5/17/22

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F 755	Continued From page 38 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure medications were available for administration to one of five residents in the medication pass, Resident #84. Calcium carbonate and Natural Balance Tears were not available for administration to Resident #84 during a medication pass. The findings include: A medication pass observation was conducted on 4/12/22 at 4:36 p.m. with licensed practical nurse (LPN) #6 administering medicines to Resident #84. During this observation, LPN #6 prepared	F 755	1. Resident #84 still resides in the facility. The licensed nurse called the physician on 4/12/22 that meds were not available. New orders obtained. 2. All residents have the potential to be affected by alleged deficient practice. 3. DON/designee will re-educate licensed nurses on procedure when medications not being available. Re-education will also include pharmacy ordering process and time cut off will be reviewed as well as use of back up Omnicel.	

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F 755	Continued From page 39 and administered Colace 100 mg (milligrams), famotidine 20 mg and gabapentin 300 mg. LPN #6 stated she was unable to give two scheduled medicines as they were not available in the cart or the supply room. LPN #6 identified the omitted medicines as calcium carbonate 600 mg and Natural Balance Tears. Resident #84's clinical record documented a physician's order dated 3/23/22 for calcium carbonate 600 mg twice per day as a supplement and an order dated 2/2/22 for Natural Balance Tears solution 0.1-0.3% with one drop in the right eye two times per day for "pink eye." On 4/12/22 at 5:30 p.m., LPN #6 was interviewed about the prescribed medicines not administered to Resident #84. LPN #6 stated, "The meds (medications) are not here." LPN #6 stated she looked in the cart and the supply room and was unable to locate the medicines. LPN #6 stated the eye drops were supplied by the pharmacy and the calcium carbonate was a bulk item ordered by the facility. LPN #6 was not sure why the medications were out of stock. On 4/13/22 at 8:00 a.m., the unit manager (LPN #1) was interviewed about the omitted medicines for Resident #84. LPN #1 stated the calcium and Natural Tears were not administered on the evening of 4/12/22 as ordered/scheduled. LPN #1 stated she was not sure why the medicines were not available. This finding was reviewed with the administrator and director of nursing during a meeting on 4/13/22 at 4:30 p.m.	F 755	4. Nursing Managers/designee will conduct audits of MAR's daily, M-F, for one month to assure medications are available. Then audits will be conducted three times a week for the next two months. The results of the audits will be given to the administrator for review. The results of audits will be reviewed monthly by QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education or systemic changes as indicated. 5. May 17, 2022	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More	F 759		5/17/22

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F 759	Continued From page 40 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview, and clinical record review the facility staff failed to ensure a medication error rate of less than 5 percent. There were three errors out of twenty-six opportunities for an error rate of 11.54 percent. Findings include: A medication pass and pour observation was conducted 4/13/22 beginning at 8:15 a.m. with LPN (licensed practical nurse) # 2. LPN # 2 pulled the medications for administration to Resident # 36. The label for Folic Acid 1 mg (milligram) directed "Place and dissolve 1 tablet buccally (in the cheek) one time a day for supplement." LPN # 2 was observed pushing the tablet from the pill card into the medicine cup with the other medications to be swallowed by Resident #36. On 4/13/22 at 8:45 a.m., the medications observed as administered to Resident # 36 were reconciled. The current physician order for the Folic Acid matched the label directions (to give bucally). On 4/13/22 at 8:50 a.m. LPN # 2 was asked about the Folic Acid administration, and advised what the order and label directed. LPN # 2 then	F 759	1. MD/NP was notified of resident #36 medication error. LPN had administered a medication that was not given buccally. MD changed order to PO. Resdient #84's medications were not given due to availability. MD was notified of this, and new orders were received on 4/2/22. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Licensed nurses will be re-educated on medication administration, how to obtain medications if they are no available, notifying MD for further directions. ADON/designee will conduct education. 4. DON/designee will conduct med pass audits on licensed nurses. Random medication administration observations 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure prescribed physician orders are being followed. The results of the audits will be reviewed monthly by QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education or systemic changes as indicated.	

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F 759	Continued From page 41 pulled up the resident's order summary, and also pulled the medication card, reviewed both and stated "Oh, yes, it does say that...Ok..." The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings during an end of the day meeting 4/13/22 at 4:00 p.m. No further information was provided prior to the exit conference. 2. A medication pass observation was conducted on 4/12/22 at 4:36 p.m. with licensed practical nurse (LPN) #6 administering medicines to Resident #84. During this observation, LPN #6 prepared and administered Colace 100 mg (milligrams), famotidine 20 mg and gabapentin 300 mg. LPN #6 stated she was unable to give two scheduled medicines as they were not available in the cart or in the supply room. LPN #6 identified these omitted medicines as calcium carbonate 600 mg and Natural Balance Tears. Resident #84's clinical record documented a physician's order dated 3/23/22 for calcium carbonate 600 mg twice per day as a supplement and an order dated 2/2/22 for Natural Balance Tears solution 0.1-0.3% with one drop in the right eye two times per day for "pink eye." On 4/12/22 at 5:30 p.m., LPN #6 was interviewed about the prescribed medicines not administered to Resident #84. LPN #6 stated, "The meds (medications) are not here." LPN #6 stated she looked in the cart and the supply room and was unable to locate the medicines. LPN #6 stated the eye drops were supplied by the pharmacy and the calcium carbonate was a bulk item ordered by the facility. LPN #6 stated she did not know why	F 759	5. May 17, 22	

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F 759	Continued From page 42 the medicines were out of stock. On 4/13/22 at 8:00 a.m., the unit manager (LPN #1) was interviewed about the omitted medicines for Resident #84. LPN #1 stated the calcium and Natural Tears were not administered on the evening of 4/12/22 as ordered/scheduled. LPN #1 stated she was not sure why the medicines were not available. This finding was reviewed with the administrator and director of nursing during a meeting on 4/13/22 at 4:30 p.m.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		5/17/22

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F 761	Continued From page 43 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure drugs and biologicals were labeled appropriately on one of three nursing units, Unit 2 medication room. The facility failed to appropriately label one, multi dose vial of Tuberculin on Unit 2. Findings include: On 04/13/22 at 7:30 AM, the Unit 2 medication room was observed with LPN (Licensed Practical Nurse) #1. The refrigerator had one vial of tuberculin medication in it's original box. The vial of tuberculin had been opened and accessed with approximately three quarters of the medication remaining in the vial. Neither the vial of tuberculin, nor the original box had an open date indicating when the the medication had been opened and accessed. LPN #1 stated that the vial of tuberculin should have an open date on it. The manufacturer's label on the vial documented that the medication should be discarded 30 after opening. LPN #1 stated, "We don't know when that is because there's not an open date." The policy titled, "Storage and Expiration Dating of Medications" documented, "...Once any medication or biological package is opened...follow manufacturer/supplier guidelines with respect to expiration dates for opened medication. Facility should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened..."	F 761	1. Unlabeled vial of TB solution was discarded. 2. All residents have the potential to be affected by alleged deficient practice. 3. Licensed nurses will be re-educated on expiration dates and labeling of biologicals when opened. Any unlabeled/undated biologicals will be discarded if not labeled. 4. Med Carts and Med rooms will be audited by DON/designee for proper labeling/dates and storage of biologicals weekly for four weeks and monthly for two months. 5. May 17, 2022	

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F 761	Continued From page 44 The administrator and DON (director of nursing) were made aware in a meeting with the survey team on 04/13/22 at approximately 5:00 PM.	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and during a test tray observation, the facility staff failed to ensure food was prepared in a manner that was palatable and at appetizing temperatures for three of 29 residents in the survey sample, Resident #71, Resident #92, and Resident #46. Findings include: 1. Resident #71's was admitted with diagnoses included, but were not limited to: CHF (congestive heart failure), atrial fibrillation, gastric reflux, increased lipids, arthritis, depression, and sleep apnea. The most recent MDS (minimum data set) was an admission assessment dated 03/03/22. This MDS assessed the resident with a cognitive score of 15, indicating Resident #71 was intact for daily decision making skills. Resident #71 was	F 804	1. No ill effects were noted with resident #17, #71, #46, & #92. They are being served food at a palatable temperature and taste. 2. All residents have the potential to be affected by alleged deficient practice. 3. Dietary Manager will be re-educated by Regional Dietician on serving food that is served hot for meal enjoyment. Dietary Manager will re-educate dietary staff on food temps and palatability. 4. Random test trays audits will be conducted by dietary manager three times a week for a month, twice a week for two months. The results of the audits will be given to the administrator for review. The results of audits will be reviewed monthly	5/17/22

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F 804	Continued From page 45 assessed as independent for meal consumption, with set up only. On 04/12/22 at 12:31 PM, Resident #71 was interviewed. Resident #71 had just finished his lunch and was asked about the food and meals at the facility. Resident #71 stated that the breakfast and lunch time meals aren't that bad, but the supper meal was almost always cold. Resident #71 stated, "It just isn't hot." Resident #71 stated that they serve a lot of french fries and onion rings and those things are hard to keep hot. Resident #71 stated that he doesn't ask them to heat anything up and or ask for an alternate at that time and stated, "They don't have time for that." Resident #71 stated that he has complained about the food to several people, but he doesn't know to who. The resident stated that he hasn't complained to the dietitian or food service people that he is aware of. On 04/12/22 at 5:15 PM, the tray line began in the kitchen. The temperatures of the food had been taken. The BBQ temperature was 179 degrees and the onion rings were 171 degrees. The dinner trays were added to the cart for transport, with the last tray placed on the cart at 5:40 PM. The temperature of the last tray plated was taken at this time. The BBQ was now at 144.5 degrees and the onion rings were at 113.0 degrees. The tray was covered and returned to the cart for transport to unit 3. The cart left the kitchen at 5:43 PM. The tray cart arrived to unit 3 at 5:46 PM and staff began to pass out meal trays. At 5:56 PM, the last tray to be served from this cart was going to	F 804	by the QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education and systemic changes as indicated. 5. May 17, 2022	

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F 804	Continued From page 46	F 804		

be for room # 317 B, (this tray was held for the test tray meal observation). At 5:58 PM, the kitchen was called and asked for a new meal tray for room # 317 B. The DM (dietary manager) was asked to come to the unit with the thermometer for the test tray meal observation. The DM arrived on the unit at 6:00 PM with a new meal tray for room #317 B.

At 6:01 PM, the DM took the temperature of the meal tray, which included: BBQ sandwich, coleslaw, banana/vanilla pudding & onion rings. The BBQ temperature was 128 degrees and the onion rings temperature was 110 degrees. The food was then tasted by two surveyors and the DM. The onion rings were lukewarm, were greasy and bland in flavor. The BBQ was warmer in temperature than the onion rings, but was not hot. The flavor of the BBQ was palatable. The DM agreed that the onion rings were not palatable in flavor or temperature and agreed that the BBQ had a palatable flavor and was edible, but did not have a palatable temperature.

On 04/13/22 at 11:03 AM, Resident #71 was asked how his supper meal was (the night before). Resident #71 stated that the food was again cold to him. Resident #71 was made aware that a test tray observation had been completed. Resident #71 stated that he was hoping the food temperatures would get better. Resident #71 stated, "Thank you and maybe it will help someone else."

On 04/13/22 at 5:00 PM, the administrator, DON (director of nursing), and corporate nurse were made aware of the above information.

No further information and/or documentation was

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F 804	Continued From page 47	F 804		

presented prior to the exit conference on 04/14/22.
2. Resident #46 was admitted to the facility with diagnoses that included cerebrovascular accident (stroke) with hemiplegia, hypertension, diabetes, depression and bipolar disorder. The minimum data set (MDS) dated 2/7/22 assessed Resident #46 as cognitively intact.

On 4/12/22 at 11:45 a.m., Resident #46 was interviewed about quality of life in the facility. Resident #42 stated he was not pleased with the food. Resident #46 stated the food "doesn't taste good" and was most all the time served cold. Resident #42 stated he ate meals in his room and meals "more times than not" were lukewarm.

A test tray was conducted during dinner on 4/12/22 at 6:00 p.m. The test tray evaluation determined that food items were inadequate with temperature and taste at the time of service to residents.

This finding was reviewed with the administrator and director of nursing during a meeting on 4/13/22 at 4:30 p.m.
3. Resident #92 was admitted to the facility with diagnoses that included displaced left tibial fracture, multiple right side rib fractures, atrial fibrillation, hypertension, hyperlipidemia, and muscle weakness. The most recent minimum data set (MDS) dated 3/21/2022 was a 5-day admission assessment and assessed Resident #92 as cognitively intact for daily decision making with a score of 15 out of 15.

Resident #92 was interviewed on 04/12/2022 at 11:00 a.m. about the quality of life and quality of care in the facility since being admitted to the

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F 804	Continued From page 48 facility. Resident #92 stated during the interview that the dinner meals were "often cold, maybe room temperature at best. Breakfast and lunch are fine, but no one wants to eat a meal, unless the food item is supposed to be cold." Resident #92 was asked if this information had been reported to anyone. Resident #92 stated, "Yes they know I've heard other resident's complain too." Resident #92 was asked if dietary had reviewed/discussed food likes/dislikes since being admitted to the facility. Resident #92 stated, "Yes they did when I first got here and I was given a form for alternatives. I like the food items they serve, it's just having cold food doesn't make sense." Resident #92 was interviewed on 04/13/2022 regarding the dinner meal served the previous night on 04/12/2022 which included a BBQ sandwich, onion rings, coleslaw and pudding. Resident #92 stated, "I enjoyed the BBQ sandwich and onion rings, but the food was still only room temperature and should have been warmer. If they could get that straight things would be so much better. I don't understand why breakfast and lunch are fine, but dinner is always cold." The above findings were reviewed with the administrator, director of nursing (DON), and corporate staff during a meeting on 04/13/2022 at 4:30 p.m.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806		5/17/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 49 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview the facility staff failed to ensure food preferences were honored for one of 29 resident's in the survey sample, Resident #71. Findings include: Resident #71's most recent MDS (minimum data set) was an admission assessment dated 03/03/22. This MDS assessed the resident with a cognitive score of 15, indicating the resident was intact for daily decision making skills. The resident's diagnoses included, but were not limited to: CHF (congestive heart failure), atrial fibrillation, gastric reflux, increased lipids, arthritis, depression, and sleep apnea. The resident was assessed as independent for meal consumption with set up only. On 04/12/22 at 12:31 PM, Resident #71 was interviewed and had just finished his lunch. The resident was asked about food. Resident #71 stated that the supper meal is cold and he will often fill out the alternate menu. Resident #71 stated that they serve a lot of french fries and onion rings and stated that he likes vegetables. Resident #71 stated that the vegetables aren't served as often as he'd like. Resident #71stated that he will fill out an alternate food choices menu by circling what he wants and giving it to the	F 806	1. Food preferences for resident 71 have updated. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Facility dietary manager will be re-educated by regional dietician on assuring food matches the tray card. Facility dietary manager will also receive re-education from the regional dietary manager on menu planning, food ordering, and the process for substitutes from written menu. The dietary manager will alert the facility administrator to any food supply issues or substitutions to written menu. 4. Facility leadership will complete meal rounds, food preferences will be identified on tray tickets to ensure residents are provided with appropriate food items. Audits twice a week on each meal time for 4 weeks, then weekly for two months, random guest trays are to be monitored for food preferences and that substitutes are offered; and immediately correcting any discrepancies. The meal round audits reviewed by the dietary manager will be summarized and shared with the	

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	495377	A. BUILDING _____ B. WING _____	C 04/14/2022

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F 806	Continued From page 50	F 806		

aides. Resident #71 stated that even though he fills the menu out, "You may or may not get what alternate you asked for." The resident stated that there have been several occasions where he doesn't get what he has requested. Resident #71 stated that he likes green vegetables, and stated that you don't get a lot here, not much at all.

Resident #71 showed the alternate menu that was completed for that evening's meal (04/12/22). Resident #71 circled chicken with steamed vegetables and noted to get extra vegetables.

Resident #71 stated that the facility lacks on green vegetables and that's what he likes. Resident #71 stated that once staff pick up his tray, he will give the alternate ticket to the aide to take to the kitchen. The resident stated that he doesn't leave it on the tray because it may get put in the trash.

On 04/13/22 at 11:03 AM, Resident #71 stated that the food last night was again cold to him. Resident #71 stated that he had filled out the alternate ticket the day before to get the chicken with extra vegetables, but all that was brought was the chicken. Resident #71 stated that the chicken was cold and he got banana pudding with extra banana pudding, and no steamed vegetables at all. Resident #71 stated that he had a can of pork and beans in his night stand and that is what he ate with his chicken.

On 04/13/22 at 5:00 PM, the administrator, DON (director of nursing), and corporate nurse were made aware of the above information.

On 04/14/22 at 9:28 AM, the DM was interviewed

monthly QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education or systemic changes as indicated.

5. May 17, 2022

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F 806	Continued From page 51 and was asked about the alternate menu and some items not being available or not being given to residents. The DM stated that they served coleslaw for the vegetable the previous night for an alternate vegetable. The DM stated that the menu had gotten "messed up" and there were foods they didn't have and she was trying to fix it. The DM was made aware that Resident #71 had asked for steamed vegetables and that they did not have steamed vegetables available last night during the meal observation. The DM stated that they didn't prepare the steamed vegetables on 04/12/22 and sometimes they don't have them. The DM was made aware that the alternate menu should be updated to reflect foods that are actually available and be of similar nutritive value to what is listed on the regular menu. The DM agreed. The DM stated that as far as the resident's alternate menu choices getting to the kitchen that is done by the CNAs (certified nursing assistants). The DM stated that they honor those alternates, as best they can when they get the tickets. On 04/14/22 at approximately 10:00 AM, the administrator, DON, and corporate nurse were again made aware of the above information regarding alternate food choices not being honored for Resident #71. No further information and/or documentation was presented prior to the exit conference on 04/14/22.	F 806		
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 -	F 812		5/17/22

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F 812	Continued From page 52 §483.60(i)(1) - Procure food from sources 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 failed to ensure food in the main kitchen was stored prepared, distributed and served in a safe and sanitary manner. Findings include: On 04/12/22 at 10:30 AM, during the initial tour of the facility kitchen with the DM (dietary manager), the walk in refrigerator was observed. An open container of cottage cheese did not have an open date or use by date. The DM removed the cottage cheese container and disposed of it. The DM was asked if that was supposed to be dated. The DM stated, "Yes." Two prepared packages of sliced cheese (approximately 12-16 slices per package) were wrapped in plastic wrap. On each package was a sticker with the prepared date of 04/07/22, but there was no use by date. The DM	F 812	1. Dietary staff labeled and dated food stored in the facility kitchen with PREPARED/OPEN dates and USE BY dates. Griddle was cleaned and repaired on 4/28/22 2. All residents have the potential to be affected by the alleged deficient practice. 3. Dietary staff will receive re-education from the dietary manager/designee on the processing of work orders when equipment is not working properly; Dietary manager to re-educate dietary staff on policies for Food Safety, Good Purchasing and Storage, and Dietary cleaning and Sanitation. 4. A kitchen sanitation audit will be completed twice a week by the dietary	

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F 812	Continued From page 53 stated that there should be a use by date on each prepared package of cheese slices. Two partial bags of shredded cheese (one mozzarella and one cheddar), each were wrapped in plastic wrap. The bag of mozzarella had an open date of 04/08/22, but no use by date. The bag of cheddar had an open date of 04/07/22, but no use by date. A large, opened bag of mixed lettuce (for salads) was wrapped in plastic wrap, but did not have any date at all. At approximately 10:45 AM, the kitchen griddle/grill area was observed. On the bottom corner of the griddle/grill was a soiled wash cloth hanging that was partially stuffed into the underside corner of the grill (on the bottom front corner). The DM manager was asked what that was. The DM stated, "It leaks oil/grease." The DM stated that the grill had been like that for a few months and it had been called in for repair about a month ago and was supposed to be fixed/repaired next week. The DM did not have an active work order to evidence that the concern had been addressed. The DM was asked for any documentation regarding the griddle repair and a policy on food storage and labeling. On 04/12/22 at approximately 12:30 PM, a policy was presented on food storage. The policy included a "Use by Date Storage Chart", which documented, "...cheese/sour cream opened 7 days or expiration date (soonest)....All food items must be properly dated and labeled, and must be stored in either containers with lids, foil/film wrapped, sealed food storage bags or their original containers...all food items will in	F 812	manager/designee for eight weeks, then monthly by the Administrator/designee for one month. The results of audits will be reviewed monthly by the QAPI committee for patterns and trends. The QAPI committee for patterns and trends. The QAPI committee will make recommendations for further education or systemic changes as indicated. 5. May 17, 2022	

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F 812	Continued From page 54 refrigerators will be properly dated, labeled, and placed in containers with lids, will be wrapped, or stored in sealed food bags..." On 04/13/22 at 5:00 PM, the DON (director of nursing), administrator and corporate nurse were made aware in a meeting with the survey team. No further information and/or documetnation was presented prior to the exit conference on 04/14/22.	F 812		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure waste was properly disposed of in garbage and refuse containers located outside of the main kitchen. Findings include: On 04/12/22 at approximately 10:50 AM, the facility dumpster/refuse area, located outside of the main kitchen was observed with the DM (dietary manager). The DM stated that these were the only two dumpsters for the facility. On the ground in front of the dumpsters were two used latex type gloves, a plastic fork, scattered pieces of plastic wrap and pieces of scattered cardboard lying on the ground around the dumpsters. The DM stated that the dumpster area is supposed to be kept clean of debris.	F 814	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Regional dietician to in-service dietary, housekeeping and maintenance directors on proper disposal of waste. 4. Dietary Manager, housekeeping and maintenance director will monitor the dumpster for the proper disposal of waste daily, Mon-Fri for three months; with immediate correction of any trash outside the dumpster. The results of the audits will be given to the administrator for review. The results of audits will be reviewed monthly by the QAPI committee for patterns and trends. The QAPI	5/17/22

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F 814	Continued From page 55 The DM was asked for a policy for the dumpster/refuse area. On 04/12/22 at approximately 12:30 p.m., the corporate nurse stated that they did not have a policy regarding the dumpster/refuse area. On 04/13/22 at 5:00 PM, the DON (director of nursing), the administrator and corporate nurse were made aware in a meeting with the survey team. No further information was presented prior to the exit conference on 04/14/22.	F 814	committee will make recommendations for further education or systemic changes as indicated. 5. May 17, 2022	
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	F 842		5/17/22

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F 842	Continued From page 56	F 842		

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

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches 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;

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F 842	Continued From page 57 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for one of twenty-nine residents in the survey sample, Resident #216. Resident #216's record had conflicting documentation of her resuscitation status. The findings include: Resident #216 was admitted to the facility with diagnoses that included septic arthritis, cellulitis of left lower leg, sacral pressure ulcer, diabetes, constipation and muscle weakness. The admission assessment dated 4/5/22 assessed Resident #216 as alert and orient to time, place and person. Resident #216's admission assessment dated 4/5/22 listed the resident as a "full code" indicating a requirement for cardiopulmonary resuscitation in case of cardiac arrest. The record documented a physician's order dated 4/5/22 stating, "Full Resuscitation." The resident's initial care plan (dated 4/5/22) documented the resident as a "full code." Resident #216's clinical record also contained a Durable Do Not Resuscitate Order (DDNR) signed by the physician and resident on 4/6/22 to withhold cardiopulmonary resuscitation in case of cardiac arrest. On 4/13/22 at 1:35 p.m., the licensed practical	F 842	1. The code status of resident #216 is corrected. 2. The social worker will conduct an audit of all residents to assure the code status is correct in PCC and Care Plan. All residents have the potential to be affected by alleged deficient practice. 3. Social worker re-educated by Administrator/designee on Code status/DNR. 4. Social worker/designee will conduct audits three times weekly for two weeks, then weekly for two weeks and monthly for two months to ensure code status are completed on all new admissions. A review of the audits will be taken to QAPI for three months to ensure compliance and will follow committee recommendations. 5. May 17, 2022	

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F 842	Continued From page 58 nurse (LPN) #4, unit manager was interviewed about the conflicting resuscitation status for Resident #216. LPN #4 stated staff were supposed to follow the gold DDNR form if completed. LPN #4 reviewed the clinical record and stated the resident had a gold DDNR form signed on 4/6/22 and that the clinical record had not been updated to reflect the change in code status. LPN #4 stated when the DDNR order was completed, the change in status was supposed to be communicated to nursing and the record updated. This finding was reviewed with the administrator and director of nursing on during a meeting on 4/13/22 at 4:30 p.m.	F 842		