STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495019	A. BUILDING _____ B. WING _____	C 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBINE REHABILITATION & HEALTHCARE CENTER	2729 KING ST ALEXANDRIA, VA 22302

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/15/22 through 02/24/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/15/22 through 02/24/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. All were substantiated. The census in this 302 certified bed facility was 274 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 5 closed record reviews.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		3/30/22

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

Electronically Signed | 03/25/2022

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F 561	Continued From page 1 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, clinical record review and facility document review and in the course of a complaint investigation the facility staff failed to ensure the resident was able to make choices important to the resident as evidenced by staff placement of a Wander Guard device to prevent the resident leaving the nursing unit for 1 of 40 residents in the survey sample (Resident #381). The findings include: Resident #381 was admitted to the facility with diagnoses including surgical aftercare, respiratory failure with hypoxia, cardiopulmonary disease, malnutrition, bronchitis, intra-abdominal hemangioma, hypertension, and gastroesophageal reflux disorder. On the Minimum Data Set assessment with assessment reference date 2/4/2022, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium,	F 561	F Tag 561 Self determination Corrective Action Immediate corrective action was taken by removing the wander guard within minutes of the resident□s request. The Nursing Manager expressed immediate apology to the resident upon removal on 2/5/22. On 2/6/22 The unit manager called the resident and again offered an apology. The Licensed staff responsible for the resident and the supervisor received counseling and were re-educated for procedure for assessing and MD order retrieval prior to placing the guard on a resident. Identification To ensure that no other residents were affected, all residents that had a wander guard in place were re-assessed to	

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F 561	Continued From page 2 psychosis, or behaviors affecting care. The face sheet listed the resident as the responsible party/resident representative. The resident intended a short-term stay for skilled services. The State survey and certification agency received a complaint concerning violation of the resident's rights on 2/9/2022. The complainant alleged the resident's rights had been violated when facility staff placed a wanderguard on the resident to prevent the resident from going outside to smoke. Clinical record review revealed no documentation of safety concerns such as confusion, wandering, or unsteady gait. A Navigation Planning Update (care plan) note dated 2/2/2022 at 13:42 did not mention concerns with the resident's cognitive status or safety. The resident's care plan (printed 2/16/2022 at 12:54 PM) in the electronic record did not address concerns with safety regarding smoking or list concerns that would prohibit the resident from leaving the building. (Note: After the surveyor expressed concern that the resident's care plan did not address smoking, a form titled Interdisciplinary Careplan Smoking Risk was uploaded to the resident's closed record under the miscellaneous tab. This document did not mention restricting residents to the building or placing restraints on residents.) Nursing notes on 2/5/2022 included a Health Status Note on 2/5/2022 at 7:15 AM "During morning shift change resident noted sitting at the lobby area waring a jacket. Writer asked resident if she is planning to go outside. Resident voiced wanting to go outside for smoke. Writer explained to resident about facility protocol and resident agreed and returned to the room.	F 561	ensure that it was appropriate for use, the Resident Representative consented, and an MD order was in place. No areas of non-compliance were identified. Systemic change All licensed staff will participate re-education on administration of wander guard system with emphasis on evaluation, consent and MD order and resident rights. The onsite Unit Manager or his/her designee must review all information prior to placing the wander guard to ensure compliance and place the information on the 24-hour report. Monitoring The ADON (or her designee) will review all new wander guard orders and the 24-hour report to ensure proper evaluation, consent and MD order. Any areas of non-compliance will be corrected immediately, and the clinician will receive counseling and re-education. Notifications made to the MD, resident representative, and the DON. The ADON will submit a Quarterly report of any area of non-compliance to the QAPI Team for further discussion and recommendations.	

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F 561	Continued From page 3 Resident is own RR. Shift supervisor notified." A second Health Status Note on 2/5/2022 at 11:07 AM "Resident requested to leave against medical advice> Resident refused to wear Wander Guard and gave writer her Cigarette lighter. Resident stated 'my Dr will be here at 2pm to discharge me'. Resident is self(Responsible party). Will continue to monitor." The surveyor interviewed the minimum data set (MDS) assessment nurse on 2/16/2022. The MDS nurse indicated that the wander guard was intended to keep the resident from going outside. The Smoking risk did not address strategies to address the resident's desire to smoke other than to apply nicotine patches and monitor compliance with nicotine patches. There was no explanation for lack of interventions to assist the resident in overcoming the desire to smoke or to safeguard a resident who wanted to smoke. The nurse caring for the resident that day stated during an interview on 2/24/22 that the nursing supervisor instructed the nurse to put a wander guard on the resident to keep the resident from trying to go outside, so the nurse did. The administrator and director of nursing were made aware of the concern with resident choice on 2/16/22 during interviews concerning the resident's allegations. This is a complaint deficiency.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		3/30/22

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F 578	Continued From page 4	F 578		

to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:

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F 578	Continued From page 5 Based on staff interview, clinical record review, and facility document review, the facility staff failed to address code status for 2 of 40 residents in the survey sample, Resident #180 and #275. For Resident #180 and #275, the current physician's orders did not address code status. The findings included: 1. Resident #180 diagnosis list indicated diagnoses, which included, not limited to Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure, Dependence on Respirator, Persistent Vegetative State, Type 2 Diabetes Mellitus, Muscle Wasting and Atrophy, Major Depressive Disorder, Dysphagia, Aphonia, and Malignant Neoplasm of Prostate. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 1/20/22 coded the resident as being in a persistent vegetative state. On 2/16/22, surveyor reviewed Resident #180 clinical record and was unable to locate a current physician's order regarding the resident's code status. Surveyor requested and received the facility policy entitled "Advanced Directives" which read in part "20. The director of nursing services or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. The attending physician will not be required to write orders for which he or she has an ethical or conscientious objection". On 2/16/22 at 4:00 pm, surveyor met with the	F 578	F Tag 578 Request/Refuse/Discontinue Treatment Corrective Action Immediate corrective action was taken by calling the family and the MD and receiving orders for code status. Resident #180 had orders obtained on 2/16/22 and resident #275 had orders obtained on 2/16/22. Identification To ensure that no other residents have been affected, all residents on the unit in which residents #180 and #275 reside had the orders audited to ensure that all residents had orders for code status. No other areas of non-compliance were identified. Systemic Change All licensed staff will take part of re-education on obtaining orders on admission the facility for Code Status. The unit manager for the unit which #180 and #275 or his/her designee will review all admission orders within 24 hours to ensure that proper orders have been obtained for Code Status. Any area of non-compliance will be immediately corrected by calling the family and the MD for orders. The nurse that did not obtain orders on admission will receive counseling and re-education.	

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F 578	Continued From page 6 administrator, assistant administrator, and the DON (director of nursing) and discussed the concern of Resident #180 not having a current physician's order addressing their code status. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22. 2. Resident #275's diagnosis list indicated diagnoses, which included, but not limited to Amyotrophic Lateral Sclerosis, Acute and Chronic Respiratory Failure, Dependence on Respirator Status, Type 2 Diabetes Mellitus, Epilepsy, Heart Failure, Severe Protein-Calorie Malnutrition, Dysphagia, Hypotension, and Sacral Pressure Ulcer. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 2/04/22 assigned the resident a BIMS (brief interview for mental status) summary score of 15 out of 15 indicating the resident was cognitively intact. On 2/16/22, surveyor reviewed Resident #275's clinical record and was unable to locate a current physician's order regarding the resident's code status. Surveyor requested and received the facility policy entitled "Advanced Directives" which read in part "20. The director of nursing services or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. The attending physician will not be required to write orders for which he or she has an ethical or conscientious objection".	F 578	Monitoring The ADON or his/her designee will audit 20% of all new admissions monthly on the unit in which resident #180 and #275 resided to ensure that code status orders were obtained for all new admissions. Any area of non-compliance will be immediately corrected by obtaining orders. The clinician and the Unit Manager will receive counseling and re-education. The ADON will submit a Quarterly report of any area of non-compliance to the QAPI Team for further discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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F 578	Continued From page 7 On 2/16/22 at 4:00 pm, surveyor met with the administrator, assistant administrator, and the DON (director of nursing) and discussed the concern of Resident #275 not having a current physician's order addressing their code status. On 2/23/22, the DON provided surveyor with a copy of a physician's order for Resident #275 dated 2/16/22 at 4:57 pm stating "Full Code". No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		3/30/22

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F 580	Continued From page 8 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to promptly consult the provider and inform the resident representative of a significant change in the resident's physical status for 1 of 40 residents in the survey sample, Resident #8. The findings include: For Resident #8, the facility staff failed to promptly notify the provider and RR (resident	F 580	F Tag 580 Notification of Change Corrective Action Immediate corrective action was taken prior to the survey by which on 1/26/22 facility staff communicated to the resident representative and MD and documented in the resident chart that both parties were notified of the significant weight loss. Identification	

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F 580	Continued From page 9 representative) of a significant weight loss. A 21.8 pound weight loss was identified on 1/07/22, however, the provider and RR were not notified until 1/26/22. Resident #8's diagnosis list indicated diagnoses, which included, but not limited to Muscle Wasting and Atrophy, Respiratory Failure, Essential Hypertension, Anoxic Brain Damage, Persistent Vegetative State, Protein-Calorie Malnutrition, Osteomyelitis, Acute Kidney Failure, and Unstageable Pressure Ulcer of Sacral Region. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/12/21 coded the resident as being severely impaired in cognitive skills for daily decision making. Resident #8 was coded as requiring extensive assistance with personal hygiene and being totally dependent on staff for bed mobility, transfers, dressing, eating, toileting, and bathing. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake. Resident #8's current comprehensive person-centered plan of care included a focus area initiated 5/27/21 stating "Resident is at risk for nutritional decline related to multiple wounds, NPO (nothing by mouth) status, recurring hospitalizations, and unplanned wt. (weight) loss. Resident receives 100% of estimated nutritional needs via enteral nutrition". Current interventions include in part "Monitor & evaluate weight/weight changes" and "Notify RD (registered dietician), family, and physician of significant weight changes".	F 580	To ensure that no other residents were affected, all residents with significant weight loss (planned or unplanned) were reviewed to ensure that the resident, the resident representative, and the MD had been notified. No other areas of non-compliance were identified. Systemic Change All registered dieticians and licensed staff were re-educated to ensure understanding that any significant weight loss (planned or unplanned) must be shared with the resident, the resident representative and the MD within 24 hours and documented in the resident chart. The Unit Manager of the unit where resident #8 resides (or designee) will audit all significant weight changes within 24 hours to ensure that if a planned or unplanned significant weight loss is identified, the MD and Resident Representative was notified and that it is documented in the chart. Any areas of non-compliance will be resolved, and the RD and Nurse will be subject to counseling and re-education. Monitoring The ADON or designee will audit 20% of all significant weight losses (planned or unplanned) per month to ensure that the Resident Representative and MD were notified and documentation in the medical record. Any area of non-compliance will be immediately corrected by notification of the Resident Representative and the MD. The clinician and the Unit Manager will receive counseling and re. The ADON will	

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F 580	Continued From page 10 Resident #8's current physician's orders included an order dated 11/09/21 for Jevity 1.5 (tube feeding formula) at 65 ml/hour for 20 hours, up at 12:00 pm and down at 8:00 am. Order states "provides 1300 ml total volume / 1950 kcals/ 88 g pro (protein) / 988 ml H2O (water)". On 2/15/22 at 3:04 pm, surveyor observed Resident #8 in bed receiving Jevity 1.5 via tube feeding pump at 65 ml/hour. Resident did not respond to the surveyor's presence in the room. Surveyor reviewed Resident #8's documented weights in the clinical record and noted a significant weight loss of 21.8 pounds which occurred in a 5 day span from 1/02/22 to 1/07/22. On 1/02/22 the resident weighed 133.8 pounds and on 1/07/22 the resident weighed 112 pounds. Documented weights surrounding the loss were: 12/13/21 135.8, 1/01/22 133.8, 1/02/22 133.8, 1/07/22 112, 1/19/22 114.7. Resident #8's current weight of 113.4 was obtained on 2/23/22. Surveyor was unable to locate documentation of provider or RR notification of the significant weight loss. A RD progress note dated 1/13/22 states in part "Resident triggers for an unplanned significant weight loss. Appears weight mostly stable at 134 - 136 # (pounds) since 11/24 (x approximately 1.5 months), now with a sig (significant) weight loss of -21.8 # in 5 days which is unlikely. Order reweight to confirm weight loss. RD to continue POC (plan of care)". The next documented weight following this RD note was obtained on 1/19/22 and was 114.7 pounds. The RD next addressed Resident #8's weight on	F 580	submit a Quarterly report of any area of non-compliance to the QAPI Team for further discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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F 580	Continued From page 11	F 580		

1/26/22, the progress note states in part "CBW (current body weight) 114.7 #, BMI (body mass index) 18.0 (underweight). Resident triggers for significant weight loss x 1 month and 6 months (unfavorable). Currently with favorable 2.7 # weight gain x 2 weeks. Resident noted with weight fluctuations. Resident at risk for weight fluctuations r/t enteral nutrition" ...."RD recs (recommendations): continue enteral as ordered, continue active protein r/t (related to) wound healing and weight stability/gain".

On 2/24/22 at 2:50 pm, surveyor met with the DON (director of nursing) and DON provided surveyor with a late entry nursing progress note created on 2/23/22 at 2:14 pm for the effective date of 1/26/22 2:11 pm stating "Resident was noted with a significant weight lose [sp]. MD and RR made aware of the above".

On 2/24/22 at 2:58 pm, surveyor spoke with RD #1 who stated Resident #8 was being weighed weekly and weights were stable. RD #1 also stated the resident was tolerating tube feedings well.

Surveyor requested and received the facility policy entitled "Change in a Resident's Condition or Status" which read in part:
1. The nurse will notify the resident's attending physician or physician on call when there has been a(an):
d. significant change in the resident's physical/emotional/mental condition;
4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:
b. there is a significant change in the resident's physical, mental, or psychosocial status;

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F 580	Continued From page 12 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. On 2/24/22 at 4:35 pm, survey team met with the administrator, assistant administrator, and DON and discussed the concern of the delay in notifications regarding of Resident #8's significant weight loss. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		3/30/22

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F 584	Continued From page 13 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure a clean environment for 3 of 40 residents in the survey sample (Resident #8, #62, and #143) whose rooms had a dried, light brown substance visible on multiple surfaces in their rooms. For Resident #8, #62, and #143, a dried, light brown substance was visible on multiple surfaces in their rooms. The findings included: 1. Resident #8's diagnosis list indicated diagnoses, which included, but not limited to Muscle Wasting and Atrophy, Respiratory Failure, Essential Hypertension, Anoxic Brain Damage, Persistent Vegetative State, Protein-Calorie Malnutrition, Osteomyelitis, Acute Kidney Failure,	F 584	F Tag 584 Safe and Clean Environment Corrective Action Immediate corrective action was taken by intense cleaning of the areas of resident rooms #8, #62 and #143. The surveyor indicated that it looked fantastic. Identification To ensure that no other residents were affected, a survey of all rooms that tube feeding is in use were inspected. Any room that was identified of spattered tube feeding or uncleanliness in any way were cleaned. Systemic Change The nursing and housekeeping team were re-educated on the procedure for cleaning	

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F 584	Continued From page 14 and Unstageable Pressure Ulcer of Sacral Region. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/12/21 coded the resident as being severely impaired in cognitive skills for daily decision making. Resident #8 was coded as requiring extensive assistance with personal hygiene and being totally dependent on staff for bed mobility, transfers, dressing, eating, toileting, and bathing. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake. On 2/15/22 at 12:07 pm, surveyor observed Resident #8 in bed with Jevity 1.5 TF (tube feeding) formula hanging on a TF pole beside the resident's bed, TF pump was turned off at this time. The Jevity 1.5 formula was liquid and light brown in color. Surveyor observed five (5) separate spots of a dried, light brown substance on the ceiling tiles at the head of the resident's bed above the TF pole with dried drips down the wall from the ceiling. On 2/23/22 at 11:36 am, surveyor observed the same five (5) separate spots of a dried, light brown substance on the ceiling tiles at the head of the resident's bed above the TF pole with dried drips down the wall from the ceiling and a dried, light brown substance was also present on the base of the TF pole and on the floor near the TF pole. Surveyor requested and received the facility policy entitled "Cleaning and Disinfection of Environmental Surfaces" which read in part:	F 584	spills and hard to clean areas. The housekeeping director or designee will inspect 5 rooms per week on the unit where residents #8, #62, and #143 resident and tube feeding are being used to ensure that there are no spills or uncleanly areas. If any non-compliant areas are identified, the area will be cleaned immediately. Monitoring The Asst. Administrator or designee will each inspect 10 rooms randomly per month on the unit where residents #8, #62 and #143 reside. Any areas found in non-compliance will be cleaned immediately and reported to the Administrator. The housekeeping director and/or the housekeeper for that area will receive counseling and re-education. The Asst. Administrator will submit a Quarterly report of any area of non-compliance to the QAPI Team for further discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.
10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.
11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.

On 2/23/22 at 4:11 pm, surveyor spoke with the DHK (director of housekeeping) who stated resident rooms are cleaned by housekeeping once a day.

On 2/24/22 at 8:09 am, surveyor notified the administrator and director of nursing of the observations of the dried, light brown substance in Resident #8's room.

On 2/24/22 at approximately 2:15 pm, surveyor spoke with Housekeeper #1 who stated they cleaned Resident #8's room. Surveyor accompanied Housekeeper #1 to the resident's room and all previous areas of the dried, light brown substance had been cleaned.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

2. Resident #62's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure, Type 2 Diabetes Mellitus, Left Thigh Myositis, Metabolic Encephalopathy, Persistent Vegetative State, Nutritional Deficiency, Essential Hypertension,

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Orthostatic Hypotension, Post Traumatic Seizures, and Dependence on Respirator.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/21/21 coded the resident as being in a persistent vegetative state. Resident #62 was coded as being totally dependent on staff for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake.

On 2/15/22 at 4:26 pm, surveyor observed Resident #62 in bed receiving Glucerna 1.2 TF (tube feeding) formula via pump at 60 ml/hour. The Glucerna 1.2 TF formula was liquid and light brown in color. Surveyor observed a dried, light brown substance on the tube feeding pump and down the TF pole.

On 2/23/22 at 11:47 am, surveyor observed a dried, light brown substance present on Resident #62's TF pump, at the base of the TF pole, on the floor to the upper left side of the bed and under the bed, and dried drips were present on the wall behind the TF pump.

Surveyor requested and received the facility policy entitled "Cleaning and Disinfection of Environmental Surfaces" which read in part:
9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.
10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly

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soiled.
11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.

On 2/23/22 at 4:11 pm, surveyor spoke with the DHK (director of housekeeping) who stated resident rooms are cleaned by housekeeping once a day.

On 2/24/22 at 8:09 am, surveyor notified the administrator and director of nursing of the observations of the dried, light brown substance in Resident #62's room.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

3. Resident #143's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, Cerebral Edema, Dysphagia, Acute Respiratory Failure, Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3, Essential Hypertension, Chronic Diastolic (Congestive) Heart Failure, and Dependence on Respirator.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/31/21 coded the resident as being severely impaired in cognitive skills for daily decision making. Resident #143 was coded as being totally dependent on staff for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake.

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On 2/15/22 at 3:16 pm, surveyor observed Resident #143 in bed with Jevity 1.2 TF (tube feeding) formula running via pump set at 65 ml/hour. The Jevity 1.2 TF formula was liquid and light brown in color. Surveyor observed a dried, light brown substance present on the TF pump, down TF pole, at the base of the pole, and in the floor.

On 2/23/22 at 11:58 am, surveyor again observed the dried, light brown substance on Resident #143's TF pump, down TF pole, at the base of the pole, and in the floor. The substance was also observed with dried drips down the wall behind the TF pump.

Surveyor requested and received the facility policy entitled "Cleaning and Disinfection of Environmental Surfaces" which read in part:
9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.
10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled.
11. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.

On 2/23/22 at 4:11 pm, surveyor spoke with the DHK (director of housekeeping) who stated resident rooms are cleaned by housekeeping once a day.

On 2/24/22 at 8:09 am, surveyor notified the administrator and director of nursing of the

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F 584	Continued From page 19 observations of the dried, light brown substance in Resident #143's room. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F 604		3/30/22

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F 604	Continued From page 20 restraints. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, clinical record review and in the course of a complaint investigation the facility staff failed to ensure a resident was free from physical restraint not required to treat the resident's medical symptoms as evidenced by staff placement of a Wander Guard device to prevent the resident leaving the nursing unit for 1 of 40 residents in the survey sample (Resident #381). The findings include: Resident #381 was admitted to the facility with diagnoses including surgical aftercare, respiratory failure with hypoxia, cardiopulmonary disease, malnutrition, bronchitis, intra-abdominal hemangioma, hypertension, and gastroesophageal reflux disorder. On the Minimum Data Set assessment with assessment reference date 2/4/2022, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The face sheet listed the resident as the responsible party/resident representative. The resident intended a short-term stay for skilled services. The State survey and certification agency received a complaint concerning violation of the resident's rights on 2/9/2022. The complainant alleged the resident's rights had been violated when facility staff placed a wanderguard on the resident to prevent the resident from going outside to smoke. Clinical record review revealed no documentation	F 604	F Tag 604 Free of Physical Restraint Corrective Action Immediate corrective action was taken by removing the wander guard within minutes of the resident□s request. The Nursing Manager expressed immediate apology to the resident upon removal on 2/5/22. On 2/6/22 The unit manager called the resident and again offered an apology. The Licensed staff responsible for the resident and the supervisor received counseling and re-educated for procedure for assessing and MD order retrieval prior to placing the guard on a resident. Identification To ensure that no other residents were affected, all residents that had a wander guard in place were re-assessed to ensure that it was appropriate for use, the Resident Representative consented, and an MD order was in place. No areas of non-compliance were identified. Systemic change All licensed staff will participate re-education on administration of wander guard system with emphasis on evaluation, consent and MD order and resident rights. The onsite Unit Manager or his/her designee must review all information prior to placing the wander guard to ensure compliance and place the information on the 24 hour report.	

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F 604	Continued From page 21 of safety concerns such as confusion, wandering, or unsteady gait. A Navigation Planning Update (care plan) note dated 2/2/2022 at 1:42 p.m. did not mention concerns with the resident's cognitive status or safety. The resident's care plan (printed 2/16/2022 at 12:54 PM) in the electronic record did not address concerns with safety regarding smoking or list concerns that would prohibit the resident from leaving the building. (Note: After the surveyor expressed concern that the resident's care plan did not address smoking, a form titled Interdisciplinary Careplan Smoking Risk was uploaded to the resident's closed record under the miscellaneous tab. This document did not mention restricting residents to the building or placing restraints on residents.) Nursing notes on 2/5/2022 included a Health Status Note on 2/5/2022 at 7:15 AM "During morning shift change resident noted sitting at the lobby area waring a jacket. Writer asked resident if she is planning to go outside. Resident voiced wanting to go outside for smoke. Writer explained to resident about facility protocol and resident agreed and returned to the room. Resident is own RR. Shift supervisor notified." A second Health Status Note on 2/5/2022 at 11:07 AM "Resident requested to leave against medical advice> Resident refused to wear Wander Guard and gave writer her Cigarette lighter. Resident stated 'my Dr will be here at 2pm to discharge me'. Resident is self(Responsible party). Will continue to monitor." The surveyor interviewed the minimum data set (MDS) assessment nurse on 2/16/2022. The MDS nurse indicated that the wander guard was intended to keep the resident from going outside. The Smoking risk did not address strategies to	F 604	Monitoring The ADON (or her designee) will review all new wander guard orders and the 24-hour report to ensure proper evaluation, consent and MD order. Any areas of non-compliance will be corrected immediately, and the clinician will receive counseling and re-education. Notifications made to the MD, resident representative, and the DON. The ADON will submit a quarterly report of any areas of non-compliance to the QAPI Team for review, discussion, and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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address the resident's desire to smoke other than to apply nicotine patches and monitor compliance with nicotine patches. There was no explanation for lack of interventions to assist the resident in overcoming the desire to smoke or to safeguard a resident who wanted to smoke.

The nurse caring for the resident that day stated during an interview on 2/24/22 that the nursing supervisor instructed the nurse to put a wander guard on the resident to keep the resident from trying to go outside, so the nurse did.

The surveyor determined the resident was restrained for convenience based on the CMS definition of position change alarms and the facility policy Wander Management System, Use of: Policy Interpretation and Implementation 1. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). 2. The staff will implement a wander management system device, if recommended as part of care. 3. The wander management system device will be used in conjunction with other resident-specific interventions for the management of unsafe wandering.

The surveyor found no documented evidence that the resident had been assessed and found to be at risk due to the expressed desire to go outside to smoke and the resident had not been found unable to make decisions concerning daily life.

The facility policy Use of Restraints: Policy Statement- Restraints shall only be used for the safety and well-being of residents and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for

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discipline or staff convenience, or prevention of falls. Policy Interpretation and Implementation 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove the device in the same manner that facility staff applied it given the resident's physical condition and this restricts his/her typical ability to change position or place, this device is considered a restraint. 5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. treat the medical symptom; b. protect the resident's safety; and c. help the resident attain the highest practicable well-being.

During record review and staff interview, the surveyor was unable to discover a medical symptom being treated by placement of a Wander Guard device on the resident. Staff members (MDS nurse and charge nurse) reported the purpose of the device was to prevent the resident leaving the nursing unit without staff knowledge. The resident's decision to leave the facility and make a formal complaint about being unduly restrained indicated the resident was capable of understanding the situation and considered the device to be a restraint.

Facility staff did not assess the resident for need of a restraint device, contact the physician for an order, or contact the resident's family contact to discuss consent for restraint.

The administrator and director of nursing were made aware of the concern with resident restraint on 2/24/22 during interviews concerning the resident's allegations.

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F 604	Continued From page 24 This is a complaint deficiency.	F 604		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655		3/30/22

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F 655	Continued From page 25 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review the facility staff failed to develop and implement baseline care plan in order to provide effective and person-centered care as evidenced by lack of a baseline care plan that included approaches to assist a resident who smokes in coping with residents in a non-smoking facility for 1 of 40 residents, Resident #381. The findings include: Resident #381 was admitted to the facility with diagnoses including surgical aftercare, respiratory failure with hypoxia, cardiopulmonary disease, malnutrition, bronchitis, intra-abdominal hemangioma, hypertension, and gastroesophageal reflux disorder. On the Minimum Data Set assessment with assessment reference date 2/4/2022, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The face sheet listed the resident as the responsible party/resident representative. The resident intended a short-term stay for skilled services. The State survey and certificantion agency received a complaint concerning violation of the	F 655	F 655 Baseline Care plan Corrective Action Immediate correction action was taken to offer counseling and re-education for the team members working with the resident to offer and document interventions to cope with a resident that desires to smoke cigarettes to cope in a healthcare setting that is a non-smoking campus. Identification To ensure that no other resident was affected, all residents that have wishes to smoke or who were identified as individuals who expressed a desire to smoke had their care plans audited to ensure that interventions were updated and in place regarding approaches for residents to cope with living in a non-smoking community. No areas of non-compliance were identified. Systemic Change Licensed staff members that work on the unit where #381 resided and the facility supervisors were re-educated on offering and documenting in the plan of care in the	

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F 655	Continued From page 26 resident's rights on 2/9/2022. The complainant alleged the resident's rights had been violated when facility staff placed a wanderguard on the resident to prevent the resident from going outside to smoke. A Navigation Planning Update (care plan) note dated 2/2/2022 at 1:42 did not mention concerns with the resident's risk for smoking. The resident's care plan (printed 2/16/2022 at 12:54 PM) in the electronic record did not address concerns with safety regarding smoking or list concerns that would prohibit the resident from leaving the building. After the surveyor expressed concern that the resident's care plan did not address smoking, a form titled Interdisciplinary Careplan Smoking Risk was uploaded to the resident's closed record under the miscellaneous tab. The minimum data set assessment nurse reported the facility's care plan did not allow staff to address smoking because the facility was a non-smoking facility. The document uploaded had been stored in that nurse's files. The document listed Goal:Resident will be in compliance with nicotine patch with no episodes of smoking through next review Approaches: 1. Nicotine Patch as MD ordered 2. Monitor resident compliance with nicotine patch. No other interventions were listed. The medication administration record documented the nicotine patches were not administered (code 22) on 2/1, 2/2, 2/3, and 2/5 and refused (code 2) on 2/4. Nursing notes on 2/5/2022 included a Health Status Note on 2/5/2022 at 7:15 AM "During morning shift change resident noted sitting at the lobby area waring a jacket. Writer asked resident if she is planning to go outside. Resident voiced wanting to go outside for smoke. Writer	F 655	care plan regarding residents who have the desire to smoke in a non-smoking healthcare facility. Any resident that is identified as someone who has a desire to smoke will be reviewed by the Nurse Manager or designee to speak to the resident and assure interventions are offered. A list of residents will be submitted to the DON for review. Monitoring The MDS Director (or designee) will review all new residents admitted to the unit where #381 resided will be reviewed within 48 hours to ensure that appropriate interventions are in place. Any areas of non-compliance will be corrected immediately, and a report submitted to the DON. The MDS Director or designee will submit a Quarterly report of any area of non-compliance to the QAPI Team for further review, discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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F 655	Continued From page 27 explained to resident about facility protocol and resident agreed and returned to the room. Resident is own RR. Shift supervisor notified." A second Health Status Note on 2/5/2022 at 11:07 AM "Resident requested to leave against medical advice. Resident refused to wear Wander Guard and gave writer her Cigarette lighter. Resident stated 'my Dr will be here at 2pm to discharge me'. Resident is self(Responsible party). Will continue to monitor." There was no explanation for lack of interventions to assist the resident in overcoming the desire to smoke or to safeguard a resident who wanted to smoke. The administrator and director of nursing were made aware of the concern with care planning on 2/16/22 during interviews concerning the resident's care plan.	F 655		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow physician's orders for 6 of 40 residents in the survey sample, Residents #8,	F 684	F684 Quality of Care Corrective Action Immediate corrective action was taken by	3/30/22

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F 684	Continued From page 28 #92, #143, #180, and #275 . For Resident #8, the facility staff failed to monitor blood pressure prior to the administration of Midodrine HCL, a medication used to increase blood pressure, on 42 separate occasions. The resident's Midodrine HCL was not administered on two (2) separate occasions without a documented reason. For Resident #92, the facility staff failed to monitor blood pressure and/or heart rate prior to the administration of Metoprolol Tartrate, a medication used to treat high blood pressure and prevent chest pain, on 15 separate occasions. Facility staff also failed to monitor blood pressure prior to the administration of Amlodipine Besylate, a medication used to treat high blood pressure, on 13 separate occasions. For Resident #143, the facility staff failed to monitor blood pressure and heart rate prior to the administration of Metoprolol Tartrate, a medication used to treat high blood pressure and prevent chest pain, on 5 separate occasions. For Resident #180, the facility staff failed to monitor blood pressure and heart rate prior to the administration of Metoprolol Tartrate, a medication used to treat high blood pressure and prevent chest pain, on 4 separate occasions. For Resident #275, the facility staff failed to monitor blood pressure prior to the administration of Midodrine HCL, a medication used to increase blood pressure, on 30 separate occasions. The findings include:	F 684	notifying the physician(s) caring for residents #8, #92, #143, #180 and #275 to report that medications were ordered and given without parameters. For residents #8, #92, #143, #180 and #275 new orders were obtained for the medications to be given with parameters. Resident representatives of residents #8, #92, #143, #180 and #275 were notified. Identification In order to ensure that no other residents were affected, the physician orders of all residents in the facility were reviewed to ensure that medication orders that required parameters had appropriate orders in place to track the blood pressure and heart rate and require it to be documented prior to administration. The Unit Manager for each unit audited and if any areas of non-compliance were identified, the attending physician and the resident representative were notified, and a new physician order was obtained. Systemic Change Licensed staff will complete re-education on how to obtain and enter orders that require parameters for blood pressure and heart rate. The Unit manager or designee will audit 20% of all medications with parameters weekly to ensure all parameters are being recorded and followed. Any area of noncompliance will be corrected immediately by notification of the MD and resident representative and reported to the DON. The staff members will be subject to re-education and counseling.	

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F 684	Continued From page 29 1. Resident #8's diagnosis list indicated diagnoses, which included, but not limited to Muscle Wasting and Atrophy, Respiratory Failure, Essential Hypertension, Anoxic Brain Damage, Persistent Vegetative State, Protein-Calorie Malnutrition, Osteomyelitis, Acute Kidney Failure, and Unstageable Pressure Ulcer of Sacral Region. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/12/21 coded the resident as being severely impaired in cognitive skills for daily decision making. Resident #8 was coded as requiring extensive assistance with personal hygiene and being totally dependent on staff for bed mobility, transfers, dressing, eating, toileting, and bathing. Resident #8's current physician's orders included an order dated 11/05/21 for Midodrine HCL tablet 10 mg via PEG-tube every 8 hours for hypotension hold for SBP (systolic blood pressure) greater than 120. A review of Resident #8's clinical record including the Blood Pressure Summary, Progress Notes, and the February 2022 MAR (medication administration record) revealed Midodrine HCL was administered without documentation of assessment of the resident's blood pressure within one (1) hour of the scheduled administration time on the following occasions: 2/01/22 6:00 am, 10:00 pm; 2/02/22 6:00 am, 10:00 pm; 2/03/22 6:00 am; 2/04/22 6:00 am, 2:00 pm, 10:00 pm; 2/05/22 2:00 pm, 10:00 pm; 2/06/22 6:00 am, 2:00 pm, 10:00 pm; 2/07/22 6:00 am, 10:00 pm; 2/08/22 6:00 am, 2:00 pm; 2/09/22 6:00 am, 2:00 pm; 2/10/22 6:00 am, 10:00 pm; 2/11/22 6:00 am, 2:00 pm; 2/12/22	F 684	Monitoring The ADON or designee will audit 20% of medication that require parameters monthly to ensure that the parameters for blood pressure or heart rate are being followed. Any area of noncompliance will be corrected immediately by notification of the physician and the unit manager. The staff members would be subject to re-education and counseling. Any area of noncompliance will be corrected immediately by notification of the MD and resident representative and reported to the DON. The staff members will be subject to re-education and counseling. A Quarterly report of noncompliance will be sent to the QAPI team for review, discussion, and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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6:00 am, 2:00 pm, 10:00 pm; 2/13/22 6:00 am, 2:00 pm, 10:00 pm; 2/14/22 6:00 am, 10:00 pm; 2/15/22 6:00 am; 2/16/22 6:00 am, 2:00 pm; 2/17/22 6:00 am, 10:00 pm; 2/18/22 6:00 am, 2:00 pm, 10:00 pm; 2/19/22 6:00 am, 2:00 pm, 10:00 pm.

Resident #8's February MAR also included documentation that the resident's Midodrine HCL was held on 2/14/22 at 2:00 pm without a documented reason and surveyor was unable to locate a corresponding blood pressure for this administration. Midodrine HCL was not signed on the MAR for 2/14/22 at 10:00 pm as being administered or held, the administration box was left blank.

Resident #8's clinical record included documentation of at least daily blood pressure readings, however, on the occasions listed above, the readings did not occur within one hour of the scheduled administration of Midodrine HCL.

Surveyor requested and received the facility policy entitled "Administering Medications" which states in part "7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals" and "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary".

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of staff administering Midodrine HCL without assessing Resident #8's blood pressure on multiple occasions during

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February 2022.

On 2/24/22 at 10:51 am, surveyor spoke with the DON who stated ideally the nurse should take the blood pressure when administering the medication.

On 2/24/22 at 2:42 pm, the DON returned to the surveyor and stated the facility was educating staff on administering medications with parameters.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

2. Resident #92's diagnosis list indicated diagnoses, which included, but not limited to Acute Respiratory Failure, Dependence on Respirator Status, Type 2 Diabetes, Anxiety Disorder, Essential Hypertension, Dysphagia, and Aphonia.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/16/21 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems.

Resident #92's current physician's orders included an active order dated 1/21/22 for Metoprolol Tartrate tablet 25 mg via G-Tube one time a day for Tachycardia/elevated BP (blood pressure) hold if BP less than 120 or HR (heart rate) less than 60.

A review of Resident #92's clinical record including the Blood Pressure Summary, Progress

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Notes, and the February 2022 MAR (medication administration record) revealed Metoprolol Tartrate was administered without documentation of assessment of the resident's BP and/or HR within one (1) hour of the scheduled administration time on the following days: 2/01/22, 2/03/22, 2/04/22, 2/06/22, 2/07/22, 2/08/22, 2/09/22, 2/10/22, 2/11/22, 2/13/22, 2/15/22, 2/17/22, 2/18/22, 2/19/22, and 2/20/22.

Resident #92 also had an active order dated 12/09/21 for Amlodipine Besylate tablet 10 mg via PEG-tube one time a day for Hypertension hold for SBP (systolic blood pressure) less than 100.

A review of Resident #92's clinical record including the Blood Pressure Summary, Progress Notes, and the February 2022 MAR revealed Amlodipine Besylate was administered without documentation of assessment of the resident's BP within one (1) hour of the scheduled administration time on the following days: 2/01/22, 2/03/22, 2/04/22, 2/06/22, 2/07/22, 2/08/22, 2/09/22, 2/11/22, 2/13/22, 2/15/22, 2/17/22, 2/18/22, and 2/20/22.

Resident #92's clinical record included documentation of at least daily blood pressure readings and heart rates, however, on the occasions listed above, the readings did not occur within one (1) hour of the scheduled administration of Metoprolol Tartrate or Amlodipine Besylate.

Surveyor requested and received the facility policy entitled "Administering Medications" which states in part "7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before

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and after meals" and "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary".

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of staff administering Metoprolol Tartrate and Amlodipine Besylate without assessing Resident #92's blood pressure and/or heart rate on multiple occasions during February 2022.

On 2/24/22 at 10:51 am, surveyor spoke with the DON who stated ideally the nurse should take the blood pressure when administering the medication.

On 2/24/22 at 2:42 pm, the DON returned to the surveyor and stated the facility was educating staff on administering medications with parameters.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

3. Resident #143's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, Cerebral Edema, Dysphagia, Acute Respiratory Failure, Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3, Essential Hypertension, Chronic Diastolic (Congestive) Heart Failure, and Dependence on Respirator.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/31/21 coded the resident as being severely

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impaired in cognitive skills for daily decision making. Resident #143 was coded as being totally dependent on staff for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing.

Resident #143's current physician's orders included an order dated 12/24/21 for Metoprolol Tartrate tablet 25 mg one time a day related to Essential Hypertension hold for SBP (systolic blood pressure) less than 110 or HR (heart rate) less than 60.

A review of Resident #143's clinical record including the Blood Pressure Summary, Progress Notes, and the February 2022 MAR revealed Metoprolol Tartrate was administered without documentation of assessment of the resident's BP and HR within one (1) hour of the scheduled administration time on the following days: 2/03/22, 2/06/22, 2/07/22, 2/12/22, and 2/17/22.

Resident #143's clinical record included documentation of at least daily blood pressure readings and heart rates, however, on the occasions listed above, the readings did not occur within one (1) hour of the scheduled administration of Metoprolol Tartrate.

Surveyor requested and received the facility policy entitled "Administering Medications" which states in part "7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals" and "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary".

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On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of staff administering Metoprolol Tartrate without assessing Resident #143's blood pressure and heart rate on multiple occasions during February 2022.

On 2/24/22 at 10:51 am, surveyor spoke with the DON who stated ideally the nurse should take the blood pressure when administering the medication.

On 2/24/22 at 2:42 pm, the DON returned to the surveyor and stated the facility was educating staff on administering medications with parameters.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

4. Resident #180 diagnosis list indicated diagnoses, which included, not limited to Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure, Dependence on Respirator, Persistent Vegetative State, Type 2 Diabetes Mellitus, Muscle Wasting and Atrophy, Major Depressive Disorder, Dysphagia, Aphonia, and Malignant Neoplasm of Prostate.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 1/20/22 coded the resident as being in a persistent vegetative state.

Resident #180's current physician's orders included an order dated 1/26/22 for Metoprolol Tartrate tablet 50 mg via G-tube one time a day for Tachycardia and HTN (hypertension) hold for

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SBP (systolic blood pressure) less than 120 and HR (heart rate) less than 60.

A review of Resident #180's clinical record including the Blood Pressure Summary, Progress Notes, and the February 2022 MAR revealed Metoprolol Tartrate was administered without documentation of assessment of the resident's BP and HR within one hour of the scheduled administration time on the following days: 2/02/22, 2/03/22, 2/09/22, 2/13/22, and 2/14/22.

Resident #180's clinical record included documentation of at least daily blood pressure readings and heart rates, however, on the occasions listed above, the readings did not occur within one (1) hour of the scheduled administration of Metoprolol Tartrate.

Surveyor requested and received the facility policy entitled "Administering Medications" which states in part "7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals" and "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary".

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of staff administering Metoprolol Tartrate without assessing Resident #180's blood pressure and heart rate on multiple occasions during February 2022.

On 2/24/22 at 10:51 am, surveyor spoke with the DON who stated ideally the nurse should take the blood pressure when administering the

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medication.

On 2/24/22 at 2:42 pm, the DON returned to the surveyor and stated the facility was educating staff on administering medications with parameters.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

5. Resident #275's diagnosis list indicated diagnoses, which included, but not limited to Amyotrophic Lateral Sclerosis, Acute and Chronic Respiratory Failure, Dependence on Respirator Status, Type 2 Diabetes Mellitus, Epilepsy, Heart Failure, Severe Protein-Calorie Malnutrition, Dysphagia, Hypotension, and Sacral Pressure Ulcer.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 2/04/22 assigned the resident a BIMS (brief interview for mental status) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #275 was coded as requiring extensive assistance with dressing and being totally dependent with bed mobility, transfers, toileting, personal hygiene, and bathing.

Resident #275's current physician's orders included an active order dated 1/28/22 for Midodrine HCL tablet 10 mg via PEG-tube three times a day for hypotension hold for SBP (systolic blood pressure) greater than 120.

A review of Resident #275's clinical record including the Blood Pressure Summary, Progress Notes, and the February 2022 MAR (medication

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administration record) revealed Midodrine HCL was administered without documentation of assessment of the resident's blood pressure within one hour of the scheduled administration time on the following occasions: 2/01/22 8:00 am; 2/02/22 8:00 am, 12:00 pm; 2/03/22 8:00 am, 12:00 pm; 2/04/22 8:00 am, 12:00 pm; 2/05/22 12:00 pm, 4:00 pm; 2/07/22 4:00 pm; 2/08/22 8:00 am, 12:00 pm; 2/09/22 8:00 am, 12:00 pm; 2/10/22 8:00 am, 12:00 pm, 4:00 pm; 2/12/22 4:00 pm; 2/13/22 4:00 pm; 2/14/22 8:00 am, 12:00 pm; 2/15/22 8:00 am, 12:00 pm; 2/16/22 12:00 pm; 2/17/22 8:00 am, 12:00 pm; 2/18/22 12:00 pm, 4:00 pm; 2/19/22 12:00 pm; 2/20/22 4:00 pm.

Resident #275's clinical record included documentation of at least daily blood pressure readings, however, on the occasions listed above, the readings did not occur within one hour of the scheduled administration of Midodrine HCL.

Surveyor requested and received the facility policy entitled "Administering Medications" which states in part "7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals" and "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary".

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of staff administering Midodrine HCL without assessing Resident #275's blood pressure on multiple occasions during February 2022.

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F 684	Continued From page 39 On 2/24/22 at 10:51 am, surveyor spoke with the DON who stated ideally the nurse should take the blood pressure when administering the medication. On 2/24/22 at 2:42 pm, the DON returned to the surveyor and stated the facility was educating staff on administering medications with parameters. At 2:55 pm, the DON provided a nursing progress note dated 2/24/22 1:13 pm stating "(physician name omitted) notified that Midodrine order was noted without BP parameters, order to put parameters in place". No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		3/30/22

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F 755	Continued From page 40 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 staff interview, clinical record review, and facility document review, the facility staff failed to ensure the physician ordered medication Oxybutynin was available for administration for 2 of 40 residents, Resident #7 and Resident #380.Resident #7's physician ordered medication Oxybutynin was not administered by the nursing staff on 02/06/22. The nursing staff documented "awaiting from pharmacy." Resident #380's dexamethasone was not administered on 02/21/22 for three administrations. The findings included: 1. This was a closed record review. Resident #7's face sheet included the diagnoses fusion of cervical spine, traumatic subdural hemorrhage with loss of consciousness, Parkinson's disease, diabetes, and neuromuscular dysfunction of bladder. Section C (cognitive patterns) of Resident #7's	F 755	F 755 Pharmacy Services □ Services/Procedures/Pharmacist Corrective Action Immediate corrective action was taken by providing re-education for the licensed team members that did not follow the correct procedure when a medication is not available for residents #7 and #380. The physician and pharmacy were also notified. Identification To ensure that no other residents were affected an audit was conducted for identification of any medication that was unavailable. If any areas of non-compliance were found, the pharmacy and MD would be immediately notified. The licensed staff would be subject to 1:1 re-education or counseling. Systematic Change	

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F 755	Continued From page 41 admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/09/21 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Resident #7's comprehensive care plan included the focus area neurogenic bladder. Interventions included, but were not limited to, administer medications as ordered. Resident #7's physician orders included an order for "Oxybutynin Chloride ER tablet extended release 24 hour 10 MG Give 1 tablet by mouth at bedtime for BLADDER SPASM." The order date was documented as 11/02/21. A review of Resident #7's eMARs (electronic medication administration records) revealed that on 02/06/22 at 9:00 p.m. the nursing staff documented a "22" on the eMAR for the medication Oxybutynin. Per the code on the eMAR a "22=Drug/Treatment not available." On 02/06/22 8:18 p.m., the nursing staff documented "Oxybutynin...The medication is on order." On 02/15/22 at 2:30 p.m., the DON (director of nursing) was made aware of that Resident #7's Oxybutynin was not available for administration on 02/06/22. 02/15/22, the DON provided the surveyor with a copy of the stat box list. A review of this list revealed that this medication was not available in the stat box for administration. The DON also provided the surveyor with a copy	F 755	All licensed staff will complete re-education regarding the steps to take when a medication is unavailable. The night shift supervisor or designee will audit the charts to identify any medication that is noted as unavailable and review to ensure that proper steps are taken for notification of pharmacy and MD. Any area of non-compliance will be reported to the DON and the licensed staff member will receive counseling and re-education. Monitoring The ADON or designee will audit weekly 20% of all medications to ensure that any medication marked as unavailable followed proper procedure. Any area of noncompliance will be reported immediately to the DON. The ADON will submit a quarterly report of noncompliance for review, discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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of their policy titled, "Unavailable Medication." This policy read in part, "In conjunction with the contracted pharmacy, the facility will make every effort to ensure that a medication ordered for the resident is available to meet their needs...In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall ...Contact the pharmacy regarding the unavailable medication...Obtain a hold order for the unavailable medication ..."

No further information regarding the unavailable medication was provided prior to the exit conference.

2. Resident #380's face sheet listed diagnoses which included but not limited to acute and chronic respiratory failure, heart failure, malignant neoplasm of bronchus or lung, atrial fibrillation, and hypertension.

Resident #380's admission MDS (minimum data set) with an ARD (assessment reference date) of 02/10/22 assigned the resident a BIMS (brief interview for mental status score of 6 out of 15 in section C, cognitive patterns. This indicates the resident is moderately cognitively impaired.

Resident #380's comprehensive care plan was reviewed and contained a care plan for "Resident is at risk for chronic pain r/t (related to) Disease Process from S/P (status post) Fall, Metastatic Right Lung Cancer..."

Resident #380's clinical record was reviewed and contained a physician's order summary for the month of February 2022 which read in part, "Dexamethasone Tablet 4 mg. Give 1 tablet by mouth three times a day related to MALIGNANT

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NEOPLASM OF UNSPECIFIED PART OF UNSPECIFIED BRONCHUS OR LUNG (C34.90)".

Resident #380's eMAR (electronic medication administration record) for the month of February 2022 was reviewed and contained an entry which read in part, "Dexamethasone Tablet 4 mg. Give 1 tablet by mouth three times a day related to MALIGNANT NEOPLASM OF UNSPECIFIED PART OF UNSPECIFIED BRONCHUS OR LUNG (C34.90)". This entry was coded "22" on 02/21/22 for all three administration times. Chart code "22" is the equivalent of "Drug/Treatment Not Administered".

Resident #380's nurse's progress notes were reviewed and contained notes which read in part, "Effective Date: 2/21/2022 13:40 eMAR-Medication Administration Note. Dexamethasone Tablet 4 MG. Give 1 tablet by mouth three times a day related to MALIGNANT NEOPLASM OF UNSPECIFIED PART OF UNSPECIFIED BRONCHUS OR LUNG (C34.90). Medication pending delivery. None available in STAT box." and "Effective Date: 2/21/2022 21:31 eMAR-Medication Administration Note. Dexamethasone Tablet 4 MG. Give 1 tablet by mouth three times a day related to MALIGNANT NEOPLASM OF UNSPECIFIED PART OF UNSPECIFIED BRONCHUS OR LUNG (C34.90). Medication is on order."

Surveyor requested and was provided a list of medications located the facility stat medication supply. Dexamethasone was not listed.

Surveyor requested and was provided with a facility policy entitled "Unavailable Medication"

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F 755	Continued From page 44 which read in part, "Policy: In conjunction with the contracted pharmacy, the facility will make every effort to ensure that medication ordered for the resident is available to meet their needs. Procedure: 2. In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: a. Contact the pharmacy regarding the unavailable medication. b. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication, explain the circumstances, report the date of expected availability, and provide the alternative medication(s) recommended by pharmacy. i. Obtain a new order and discontinue prior order, or ii. Obtain a hold order for the unavailable medication. d. Notify the pharmacy, if applicable." The concern of Resident #380's medications not being available for administration was discussed with the administrative staff (administrator, assistant administrator, director of nursing) during a meeting on 02/24/22 at 4:35 pm.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		3/30/22

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F 756	Continued From page 45 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, the facility staff failed to ensure medication regimen reviews (MRRs) were addressed by a medical provider for one (1) of 40 sampled residents, Resident #78. The findings include: Resident #78's MRR dated 12/21/21 had yet to be acted on at the time of Resident #78 clinical	F 756	F 756 Drug Regimen Review Corrective Action Immediate corrective action was taken by notification to the attending MD. Psychiatry examined the patient on 2/25/22 and addressed the drug review recommendations made by the pharmacist.	

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F 756	Continued From page 46 record review on 2/24/22. Resident #78's diagnoses included, but were not limited to: high blood pressure, thyroid disorder, dementia, Parkinson's disease, and lung disease. Resident #78's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/10/21, was signed as completed on 12/25/21. Resident #78 was assessed as able to make self understood and as able to understand others. Resident #78 was assessed as having a BIMS (Brief Interview for Mental Status) Summary Score of a 13 out of 15; this indicated intact or borderline cognition. Resident #78 was assessed as requiring assistance with bed mobility, eating, dressing, toilet use, and personal hygiene. Resident #78 was assessed as receiving antipsychotic medications. The following information was found in a facility policy titled "Medication Regimen Reviews" (this document was not dated): - "The consultant pharmacist performs a medication regiment review (MRR) for every resident in the facility receiving medication." - "The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication." - "The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities ..." - "The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it."	F 756	Identification To ensure that no other residents were affected, an audit was completed on all of the drug regimen reviews. Any drug regimen review that was found non-compliant was immediately addressed by the attending physician or designee. Systemic Change Copies of all drug regimen reviews will be given to the Unit Manager after the pharmacists makes a recommendation. The Unit Manager or designee will contact the attending physician to ensure of notification. If there is any delay in assessment, the DON and Medical Director will be notified for follow-up. Monitoring The ADON or designee, will review 20% of the recommendations made on the unit where resident #78 resides. Any areas of non-compliance will be corrected immediately, and a report submitted to the DON and Medical Director. The ADON will submit a Quarterly report of any area of non-compliance to the QAPI Team for further discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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Resident #78's clinical record included the following "Pharmacy Consultant" note dated 12/21/21 at 2:42 a.m.: "Medication Regimen Review: Recommend re-evaluation of a muscle relaxant, methocarbamol and concomitant use of quetiapine and risperidone." (Methocarbamol is a muscle relaxant medication. Quetiapine and risperidone are antipsychotic medications.)

The following communication of the above MRR was found in Resident #78's clinical record on a "PHYSICIAN RECOMMENDATIONS" form dated 12/21/21. The information on this form included:
- "This resident is receiving the muscle relaxant, Methocarbamol. Current clinical guidelines indicate that these drugs are poorly tolerated in the elderly, leading to anticholinergic side effects, sedation, and weakness. Additionally, their effectiveness at doses tolerated by the elderly is questionable. Please consider one of the following options:
( ) Medication should be continued, patient responds well to this medication, and it improves the quality of the resident's life. The benefits of therapy outweigh the risks of adverse effects.
( ) Taper Methocarbamol to discontinuation". This form also included an area for a medical provider to mark if they agree, disagree, or have other responses.
This "PHYSICIAN RECOMMENDATIONS" form did not include information about the "concomitant use of quetiapine and risperidone." No evidence was found or provided to indicate a medical provider was notified of the MRR recommendation to re-evaluation the "concomitant use of quetiapine and risperidone."

A medical provider responded to the aforementioned 12/21/21 "PHYSICIAN

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RECOMMENDATIONS" form on 12/22/21. The medical provider did not select from the options to either continue or taper the methocarbamol. From the agree, disagree, or other options, the medical provider selected "OTHER" and wrote in that psychiatry follows the resident. No evidence was found or provided to indicate a psychiatry staff member had reviewed and/or acted upon the 12/21/21 MRR recommendations."

On 2/24/22 at 1:10 p.m., the Director of Nursing (DON) was interviewed about Resident #78's 12/21/21 MRR. The DON was asked for evidence that psychiatry had acted on the recommendations. The failure of the 12/22/21 "PHYSICIAN RECOMMENDATIONS" form to include the pharmacist's comments about the "concomitant use of quetiapine and risperidone" was also discussed.

On 2/24/22 at 3:03 p.m., the DON was unable to provide evidence of psychiatry acting on the aforementioned MRR recommendations. The DON reported they had telephoned the nurse practitioner (NP) for psychiatry related to Resident #78's 12/21/21 MRR. The DON stated the NP for psychiatry confirmed they were behind but were working to catch-up. The DON acknowledge the MRR information provided to the doctor as part of the "PHYSICIAN RECOMMENDATIONS" form did not include all the medication concerns documented in the pharmacy consultant note.

The facility's Administrator, Director of Nursing, and Assistant Administrator met with the survey team on 2/24/22 at 4:39 p.m. The absence of psychiatry action on Resident #78's 12/21/21 MRR was discussed. No additional information

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F 756	Continued From page 49 was provided related to this issue.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		3/30/22

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F 758	Continued From page 50 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure two (2) of 40 residents were free of unnecessary psychotropic medications, Resident #90 and Resident #92. For Resident #90 and Resident #92, it was determined the facility staff failed to ensure as needed psychotropic medication orders were renewed every 14 days by a medical provider. The findings include: 1. Resident #90's diagnoses included, but were not limited to: cancer, anemia, high blood pressure, diabetes, depression, respiratory failure. Resident #90's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/15/21, was signed as completed on 12/21/21. Resident #90 was assessed as able to make self understood and as able to understand others. Resident #90 was assessed as having a BIMS (Brief Interview for Mental Status) Summary Score of a 12 out of 15; this indicated	F 758	F Tag 758 □ Free from unnecessary Psychotropic Med/PRN Use Corrective Action Immediate corrective action was taken for resident #92 by receiving an updated physician order for a stop date. Resident #90 was discharged from the facility on 2/20/22 and therefore all orders were discontinued. Identification To ensure that no other residents were affected, an audit of residents receiving psychotropic medications on the unit where residents #90 and #92 resided was completed. If any psychotropic medication order did not include a stop date, the attending physician would be called immediately to obtain a stop date. Systemic Change All licensed staff on the unit where Resident #90 and Resident #92 resided were re-educated to ensure when	

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F 758	Continued From page 51 moderate cognitive impairment. Resident #90 was documented as depending on others for bed mobility, dressing, personal hygiene, and bathing. Resident #90 was documented as requiring assistance with eating and toilet use. Resident #90 was assessed as receiving antianxiety medications. The facility staff failed to provide a stop date for an 'as needed' psychotropic medication ordered for Resident #90. Resident #90's medical documentation included an order for alprazolam 0.5 mg to be given via the resident peg-tube every six (6) hours as needed for anxiety. This order did not include a stop date. Resident #90 clinical documentation did not include documentation for this 'as needed' order to be continued for greater than 14 days. Resident #90's care plan included the following focus area: "Resident use anti-anxiety and antidepressant medications (related to) Anxiety disorder and Depression". One of the interventions for this focus area was to "Give anti-anxiety medications ordered by physician" [sic]. The following information was found in a policy titled "Antipsychotic Medication Use" (this document was not dated): - "Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record." - "The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rational for the extended order. The duration of the PRN order will be indicated in the order."	F 758	obtaining an order for psychotropics that the physician to include a stop date of 14 days. The unit manager or designee of the unit where resident #90 and resident #92 resided will audit all psychotropic medications within 24 hours to ensure that an appropriate stop date was included by the physician. Any areas of non-compliance would be addressed to the physician. The nurse that received the order would be subject to counseling and re-education. Monitoring The ADON or designee will conduct an audit of 20% of new orders for psychotropics weekly. Any area of non-compliance will be discussed with the physician to obtain new or clarification orders. A report of non-compliance will be sent to the DON. The ADON will submit a quarterly report of non-compliance to the QAPI team for further discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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(PRN is a medical abbreviation for a Latin phrase meaning 'as needed'.)

Resident #90's medication administration record (MAR) was reviewed for 1/1/22 through 2/20/22. Documentation indicated the resident was administered at least one dose of the 'as needed' alprazolam all but one (1) day during this time. (Resident #90's MAR documentation for 1/5/22 did not have a dose of the alprazolam recorded as being given.)

The failure Resident #90's medical record to address a stop date for an 'as needed' anti-anxiety medication was discussed with the facility's Administrator, Director of Nursing, and Assistant Administrator on 2/24/22 at 4:39 p.m. No additional information was provided related to this issue.

2. Resident #92's diagnosis list indicated diagnoses, which included, but not limited to Acute Respiratory Failure, Dependence on Respirator Status, Type 2 Diabetes, Anxiety Disorder, Essential Hypertension, Dysphagia, and Aphonia.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/16/21 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #92 was also coded for the active diagnosis of anxiety disorder.

Resident #92 was admitted to the facility on 12/09/21. Resident #92's current physician's orders included an active order dated 12/09/21 for Lorazepam 2 mg via PEG-tube every 6 hours

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F 758	Continued From page 53 as needed for anxiety. This order did not include a limitation of 14 days or less. Lorazepam is a benzodiazepine used to treat anxiety. A review of Resident #92's February 2022 MAR (medication administration record) revealed the resident received Lorazepam 2 mg on 2/01/22 and 2/06/22. A NP (nurse practitioner) progress note dated 2/16/22 stated "Anxiety - cont. (continue) Lorazepam tablet 0.5 mg). Surveyor requested and received the facility policy entitled "Antipsychotic Medication Use" which read in part "14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rational for the extended order. The duration of the PRN order will be indicated in the order". On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of Resident #92 receiving Lorazepam PRN, a psychotropic medication, without a duration indicated in the order. On 2/24/22 at 2:55 pm, the DON provided the surveyor with a copy of an order for Resident #92 dated 2/24/22 9:36 am for Lorazepam 2 mg via PEG-tube every 6 hours as needed for anxiety until 3/10/22. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		3/30/22

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F 760	Continued From page 54 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure 5 out of 40 residents were free of significant medication errors, Resident #249, Resident #380, Resident #8, Resident #92 adn #275. For Resident #249, the facility staff held the resident's blood pressure medication, Metoprolol, when it should have been administered, and failed to obtain blood pressure prior to administering the blood pressure medication Amlodipine. For Resident #380, the facility staff administered the resident's blood pressure medication, Metoprolol, when it should have been held, on three separate occasion. For Resident #8, the facility staff failed to follow physician's orders for the administration of Midodrine HCL, a medication used to increase blood pressure, on six (6) separate occasions. For Resident #92, the facility staff failed to follow physician's orders for the administration of Metoprolol Tartrate, a medication used to treat high blood pressure and prevent chest pain, on two (2) separate occasions. For Resident #275, the facility staff failed to follow the physician's orders for the administration of Midodrine HCL, a medication used to increase blood pressure, on five (5) separate occasions.	F 760	F Tag □ 760 □ Free of Significant Med Errors Corrective Action Immediate corrective action was taken for residents #249, #380, #8, #92 and #275 by notification of the physician and resident representative. All residents that were currently at Woodbine a new order was obtained to ensure that parameters were included in the order for giving this medication and a space to document the appropriate blood pressure or heart rate was set. Identification In order to ensure that no other residents are affected, an audit of all medications that require parameters for blood pressure or heart rate were audited. Any area of non-compliance immediate corrective action of notification of physician and resident representative took place. A new order to ensure proper documentation of the blood pressure or heart rate was obtained. Systemic Change All licensed staff will complete re-education on how to obtain a proper order for medications with parameters and what to do if the blood pressure or heart rate is out of the parameters. The	

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F 760	Continued From page 55 The findings included: 1. Resident #249's face sheet listed diagnoses which included but not limited to Type 2 diabetes mellitus, hypertensive chronic kidney disease, depression, insomnia, and hypertension. Resident #249's most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 01/26/22 assigned the resident a BIMS (brief interview for mental status) score of 13 out 15. This indicates that the resident is cognitively intact. Resident #289's clinical record was reviewed and contained a physician's order summary for the month of February 2022 which read in part, "Amlodipine Besylate 5 mg tab. Give 1 tablet orally in the evening every Mon, Wed, Fri, Sun related to ESSENTIAL (PRIMARY) HYPERTENSION (I10). HOLD FOR SBP (systolic blood pressure) <110. Do not give prior to dialysis", and "Metoprolol Succinate ER (extended release) Tablet Extended Release 24 Hour 50 mg. Give 1 tablet by mouth one time a day every Mon, Wed, Fri, Sun related to ESSENTIAL (PRIMARY) HYPERTENSION (I10). HOLD FOR SBP (systolic blood pressure) <110, HEART RATE <60. Do not give blood pressure med prior to dialysis treatment due to hypotension during dialysis treatment..." Resident #289's eMAR (electronic medication administration record) was reviewed and contained entries which read in part, "Amlodipine Besylate 5 mg tab. Give 1 tablet orally in the evening every Mon, Wed, Fri, Sun related to ESSENTIAL (PRIMARY) HYPERTENSION (I10).	F 760	Unit Manager or designee will review all new medications with parameters for heart rate or blood pressure to ensure parameters are correctly in place. The Unit Managers will audit 20% of medications that require parameters weekly to ensure that orders with parameters are being followed. Any area of non-compliance the physician and resident representative will be notified. The licensed staff would be subject to counseling and re-education. Monitoring The ADON or designee will audit 20% of orders that require parameters monthly. Any area of non-compliance will have the physician and resident representative notified. The licensed staff will be subject to 1:1 re-education and counseling. The DON will be notified. A quarterly report of non-compliance will be submitted to the QAPI team for review, discussion, and further recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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HOLD FOR SBP (systolic blood pressure) <110. Do not give prior to dialysis", and "Metoprolol Succinate ER (extended release) Tablet Extended Release 24 Hour 50 mg. Give 1 tablet by mouth one time a day every Mon, Wed, Fri, Sun related to
ESSENTIAL (PRIMARY) HYPERTENSION (I10). HOLD FOR SBP (systolic blood pressure) <110, HEART RATE <60. Do not give blood pressure med prior to dialysis treatment due to hypotension during dialysis treatment..." The administration time for the Amlodipine was listed as 8 pm. The entry for Amlodipine was coded "5" on 02/04/22 and documented as administered on the remaining days. Chart code "5" is the equivalent of "Hold". There was no corresponding blood pressure recorded related to these times of administration.

The entry for Metoprolol was coded as "5" on 02/02/22, with a corresponding blood pressure of 114/68.

Resident #289's blood pressure summary was reviewed and contained blood pressure readings of 99/68 on 02/04/22 at 10:07 am, 99/68 on 02/07/22 at 9:48 am, 98/62 on 02/09/22 at 9:58 am, and 98/62 on 02/18/22 at 9:56 am.

Surveyor spoke with the DON (director of nursing) on 02/24/22 at 11:00 am regarding Resident #289's medications and blood pressures. Surveyor asked DON when a blood pressure related to a medication should be taken, and DON stated, "prior to the administration of the medication". Surveyor asked the DON if blood pressure obtained in the morning was valid for a medication administered in the evening and DON stated that it was not.

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The concern of not checking the resident's blood pressure prior to the administration of Amlodipine and administering the medication Metoprolol outside the physician ordered parameters was discussed with the administrative team (administrator, assistant administrator, director of nursing) on 02/24/22 at 4:35 pm.

No further information was provided prior to exit.

2. Resident #380's face sheet listed diagnoses which included but not limited to acute and chronic respiratory failure, heart failure, malignant neoplasm of bronchus or lung, atrial fibrillation, and hypertension.

Resident #380's admission MDS (minimum data set) with an ARD (assessment reference date) of 02/10/22 assigned the resident a BIMS (brief interview for mental status score of 6 out of 15 in section C, cognitive patterns. This indicates the resident is moderately cognitively impaired.

Resident #380's clinical record was reviewed and contained a physician's order summary for the month of February 2022 which read in part, "Metoprolol Tartrate Tablet 25 mg. Give 1 tablet by mouth every 12 hours related to ESSENTIAL (PRIMARY) HYPERTENSION (I10); UNSPECIFIED ATRIAL FIBRILLATION (I48.91) HOLD FOR SBP (systolic blood pressure) <110, HEART RATE <60"

Resident #380's eMAR (electronic medication record) for the month of February was reviewed and contained and entry which read in part, "Metoprolol Tartrate Tablet 25 mg. Give 1 tablet

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by mouth every 12 hours related to ESSENTIAL (PRIMARY) HYPERTENSION (I10); UNSPECIFIED ATRIAL FIBRILLATION (I48.91) HOLD FOR SBP (systolic blood pressure) <110, HEART RATE <60". This entry was documented as administered on 02/05/22 at 9 pm with a corresponding blood pressure of 105/65, on 02/10/22 at 9 pm with a corresponding blood pressure of 103/60, and on 02/14/22 at 9 pm with a corresponding blood pressure of 109/61.

Surveyor spoke with DON (director of nursing) on 02/24/22 at 11:00 am regarding Resident #380's blood pressure medication. DON stated that the medication should not have been administered on the aforementioned dates/times.

The concern of administering Resident #380's blood pressure medication, Metoprolol, outside the physician ordered parameters was discussed with the administrative staff (administrator, assistant administrator, director of nursing) on 02/24/22 at 4:35 pm.

No further information was provided prior to exit.

3. Resident #8's diagnosis list indicated diagnoses, which included, but not limited to Muscle Wasting and Atrophy, Respiratory Failure, Essential Hypertension, Anoxic Brain Damage, Persistent Vegetative State, Protein-Calorie Malnutrition, Osteomyelitis, Acute Kidney Failure, and Unstageable Pressure Ulcer of Sacral Region.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/12/21 coded the resident as being severely impaired in cognitive skills for daily decision

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making. Resident #8 was coded as requiring extensive assistance with personal hygiene and being totally dependent on staff for bed mobility, transfers, dressing, eating, toileting, and bathing.

Resident #8's current physician's orders included an order dated 11/05/21 for Midodrine HCL tablet 10 mg via PEG-tube every 8 hours for hypotension hold for SBP (systolic blood pressure) greater than 120.

A review of Resident #8's February 2022 MAR (medication administration record) revealed Midodrine HCL was administered with a SBP greater than 120 on the following occasions:
2/03/22 2:00 pm - BP 129/81
2/05/22 6:00 am - BP 138/62
2/07/22 2:00 pm - BP 124/70
2/10/22 2:00 pm - BP 130/78
2/15/22 2:00 pm - BP 136/70
2/20/22 2:00 pm - BP 132/77

Surveyor requested and received the facility policy entitled "Administering Medications" which states in part "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary".

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of Resident #8 receiving Midodrine HCL with a SBP greater than 120 on six (6) separate occasions.

On 2/24/22 at 2:42 pm, the DON returned to the surveyor and stated the facility was educating staff on administering medications with parameters.

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No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

4. Resident #92's diagnosis list indicated diagnoses, which included, but not limited to Acute Respiratory Failure, Dependence on Respirator Status, Type 2 Diabetes, Anxiety Disorder, Essential Hypertension, Dysphagia, and Aphonia.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/16/21 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems.

Resident #92's current physician's orders included an active order dated 1/21/22 for Metoprolol Tartrate tablet 25 mg via G-Tube one time a day for Tachycardia/elevated BP (blood pressure) hold if BP less than 120 or HR (heart rate) less than 60.

A review of Resident #92's February 2022 MAR (medication administration record) revealed Metoprolol Tartrate was administered with a BP less than 120 on 2/02/22 at 9:00 am with a BP of 110/76 and 2/16/22 at 9:00 am with a BP of 102/68.

Surveyor requested and received the facility policy entitled "Administering Medications" which states in part "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary".

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On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of Resident #92 receiving Metoprolol Tartrate on two (2) separate occasions with BP less than 120.

On 2/24/22 at 2:42 pm, the DON returned to the surveyor and stated the facility was educating staff on administering medications with parameters.

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

5. Resident #275's diagnosis list indicated diagnoses, which included, but not limited to Amyotrophic Lateral Sclerosis, Acute and Chronic Respiratory Failure, Dependence on Respirator Status, Type 2 Diabetes Mellitus, Epilepsy, Heart Failure, Severe Protein-Calorie Malnutrition, Dysphagia, Hypotension, and Sacral Pressure Ulcer.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 2/04/22 assigned the resident a BIMS (brief interview for mental status) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #275 was coded as requiring extensive assistance with dressing and being totally dependent with bed mobility, transfers, toileting, personal hygiene, and bathing.

Resident #275's current physician's orders included an active order dated 1/28/22 for Midodrine HCL tablet 10 mg via PEG-tube three times a day for hypotension hold for SBP (systolic

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F 760	Continued From page 62 blood pressure) greater than 120. A review of the Resident #275's February 2022 MAR (medication administration record) revealed Midodrine HCL was administered with a SBP greater than 120 on the following occasions: 2/02/22 4:00 pm - BP 131/75 2/06/22 12:00 pm - BP 132/66 2/11/22 4:00 pm - BP 130/80 2/16/22 4:00 pm - BP 121/70 2/20/22 8:00 am - BP 123/66 Surveyor requested and received the facility policy entitled "Administering Medications" which states in part "11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary". On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and discussed the concern of Resident #275 receiving Midodrine HCL with a SBP greater than 120 on five (5) separate occasions. On 2/24/22 at 2:42 pm, the DON returned to the surveyor and stated the facility was educating staff on administering medications with parameters. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.	F 760		
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	F 761		3/30/22

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F 761	Continued From page 63 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to store drugs and biologicals in locked compartments on 1 of 6 facility units, TCU. For the TCU Unit, the facility staff failed to lock an unattended medication cart containing resident medications and left a bottle of Vitamin C 500 mg unattended on top of the medication cart. The findings included: On 2/17/22 at 9:10 am, surveyor observed an unlocked, unattended medication cart in the	F 761	F Tag 761 Label/Store Drugs and Biologicals Corrective Action Immediate corrective action was taken to lock the medication cart. The nurse who left the cart briefly was re-educated on the security of all medication and ensuring that the medication cart is locked and secured prior to walking away from it. Identification To ensure that no other residents were affected, all medication carts on the TCU	

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F 761	Continued From page 64 hallway of the TCU Unit. On top of the medication cart was a multi-dose bottle of Vitamin C 500 mg tablets. Surveyor remained beside the medication cart for approximately three (3) minutes until LPN (licensed practical nurse) #1 emerged from a resident room into the hall. LPN #1 acknowledged it was not normal practice to leave the medication cart unlocked but stated they had ran into a resident's room to check an alarm. LPN #1 placed the bottle of Vitamin C into the medication cart and locked the cart. Surveyor requested and received the facility policy entitled, "Storage of Medications" which read in part "1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications" and "6. Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medications carts are not left unattended". On 2/24/22 at 4:35 pm, survey team met with the administrator, assistant administrator, and the director of nursing and discussed the concern of LPN #1 leaving an unlocked medication cart with a bottle of Vitamin C tablets on top of the cart unattended in the hall. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/24/22.	F 761	unit were inspected to ensure that all medication carts were locked if the nurse was not at the cart. All other carts were found to be secured. Systemic Change The licensed nurses on the unit where the cart was found unlocked were re-educated on securing and locking medication carts when walking away. The Unit Manager or designee will be responsible for making rounds on the unit randomly weekly and checking 5 carts. If any cart is found to be unlocked, the cart will be secured immediately and the nurse that is assigned to that cart will receive counseling and re-education on securing medication carts. Any area of non-compliance will be reported to the ADON. Monitoring The ADON or designee will check 10 medication carts randomly in one month on the unit where the cart was found unlocked/unsecured. If any carts are found to be unlocked, it will be locked/secured immediately and the nurse in charge of the cart will receive counseling and re-education. The ADON will submit a Quarterly report of any area of non-compliance to the QAPI Team for further discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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F 772 SS=D	Lab Services Not Provided On-Site CFR(s): 483.50(a)(1)(iv) §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain physician ordered laboratory tests for 1 of 40 residents in the survey sample, Resident #180. For Resident #180, the facility staff failed to obtain a sputum culture and a stool for occult blood for testing. The findings included: Resident #180 diagnosis list indicated diagnoses, which included, not limited to Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure, Dependence on Respirator, Persistent Vegetative State, Type 2 Diabetes Mellitus, Muscle Wasting and Atrophy, Major Depressive Disorder, Dysphagia, Aphonia, and Malignant Neoplasm of Prostate. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 1/20/22 coded the resident as being in a persistent vegetative state.	F 772	F Tag 772 □ Lab Services no provided On-site Corrective Action Immediate corrective action was taken by obtaining an occult blood obtained and results were negative. The sputum culture was not able to be obtained, the physician was notified and discontinued the order. Identification To ensure that no other residents are affected, an audit of ordered labs for occult blood and sputum culture on the unit where resident #180 resides was conducted. Any area of non-compliance for completing the lab was corrected by notifying the physician and resident representative. Any new orders by the physician will be followed. Systemic Change The licensed staff will complete re-education to ensure that they know the proper steps if a lab is not able to be completed per physician order. The night	3/30/22

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F 772	Continued From page 66 A review of Resident #180's clinical record included a NP (nurse practitioner) note dated 2/14/22 at 2:48 pm stating in part "Patient has been seen and examined today because nurse reported patient had brown emesis on 2/13/22 and this morning (he/she) had another episode. Assess patient noted clear saliva in patient's mouth. Ordered sputum culture and stool for occult blood". Corresponding physician orders dated 2/14/22 2:35 pm stated "stool for occult blood" and 2/14/22 3:53 pm stated "Sputum C&S (culture and sensitivity)". Upon reviewing Resident #180's clinical record on 2/16/22, surveyor was unable to locate results for the sputum culture and stool for occult blood. On 2/16/22 at 4:00 pm, surveyor met with the administrator and DON (director of nursing) and requested the results. As of 2/23/22, surveyor had not received the results of Resident #180's sputum culture and stool for occult blood results. On 2/23/22, surveyor again reviewed the resident's clinical record and the following documentation was noted in the resident's progress notes: 2/16/22 10:10 pm "Lab for sputum culture and occult blood done result pending". 2/16/22 10:57 pm "sputum specimen sent to the lab for culture. Result pending". 2/17/22 4:07 am "(name omitted) Laboratory called about the resident stool for occult blood that they could not do the testing due to wrong kit. NP notified and [sp] reorder the test". Resident #180 was seen by a NP on 2/17/22 at 5:11 pm, the progress note stated in part "has	F 772	shift supervisor or designee will review all lab orders daily for the unit where #180 to ensure that they were completed. Any area of noncompliance will be immediately addressed to ensure that proper protocols are completed. A report will be sent to the Unit Manager and DON. Monitoring The ADON or designee will audit 20% of all occult blood and sputum culture orders monthly. Any area of noncompliance will be addressed by notifying the physician and resident representative. A quarterly report of noncompliance will be submitted to the QAPI team for review, discussion, and further recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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F 772	Continued From page 67	F 772		

brownish sputum draining from side of (his/her) mouth, issue has been addressed by another provider, labs have been ordered. Awaiting results which usually takes couple of days. In the meantime, patient will be continually monitored for any bleeding as (he/she) has chronic anemia".

A progress note dated 2/18/22 5:19 pm stated in part "Writer unable to collect the stool for occult [sp] due to stool kit is unavailable. Nurse on evening shift and manager notified". A progress note dated 2/21/22 at 12:41 pm states "Resident stool for occult blood done, result negative, MD notified".

A progress note dated 2/22/22 at 3:09 pm states "Lab called for resident result for sputum culture, according to result culture cancelled 2/17/22 due to specimen quality is inadequate for culture. NP notified assessment done order to discontinue culture repeat test not needed at this time, resident [sp] remain stable".

Surveyor requested and received the facility policy entitled "Lab and Diagnostic Test Results - Clinical Protocol" which read in part: "1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility".

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON and discussed the concern of Resident #180's stool for occult blood ordered on 2/14/22 was not completed until 2/21/22 and the sputum culture which was also

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F 772	Continued From page 68 ordered on 2/14/22 was never successfully obtained and the order was discontinued on 2/22/22. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.	F 772		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources 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 the facility staff failed to store food in a safe and sanitary manner on 2 of 6 units in the facility. The findings include: During rounds on 2/24/2022, the surveyor	F 812	Corrective Action Immediate corrective action was taken to clean both refrigerators inside and out. Identification To ensure that no other residents we affected, all nourishment refrigerators	3/30/22

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F 812	Continued From page 69 observed that the refrigerator in the nutrition room on unit 1 North had debris in the refrigerator compartment handle and there was a sticky substance on the freezer handle and down the front of the refrigerator compartment and in the floor in front of the refrigerator. On 2 north, a vanilla magic cup in the freezer appears to have melted, then refrozen (lying on its side with the white substance in a stream around the lid and on the bottom of the freezer). There was also hair and debris on the floor of the freezer. There was no thermometer in the freezer, but the nurse found a second thermometer in the refrigerator compartment and moved it to the freezer. The temperature record sheet said the unit was clean. The nurse on the unit stated night shift take care of the temperatures and cleaning. The surveyor notified the dietary manager of the concern. The administrator and director of nursing were notified of the concern during a summary meeting on 2/24/2022.	F 812	were inspected and if and any were found non-compliant, there were immediately cleaned inside and outside. Systemic Change The nursing team will be re-educated on how to wipe up after splattering liquids. Housekeeping will be re-educated on the process for inspecting and cleaning the nourishment refrigerators. The Unit Manager or designee will be responsible for inspecting the nourishment refrigerator weekly. Any area of non-compliance will be immediately corrected, and report of non-compliance will be given to the Asst. Administrator. The housekeeping supervisor will be required to inspect the nourishment refrigerators weekly, any area of non-compliance will be immediately corrected, and a report of non-compliance will be given to the Asst. Administrator. Monitoring The Assistant Administrator or designee will inspect the nourishment refrigerators weekly. Any area of non-compliance will be immediately corrected. The Asst. Administrator will submit a Quarterly report of any area of non-compliance to the QAPI Team for further discussion and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	
F 825 SS=D	Provide/Obtain Specialized Rehab Services	F 825		3/30/22

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F 825	Continued From page 70 CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide specialized rehabilitative services as ordered by the physician for 1 of 40 residents in the survey sample, Resident #275. For Resident #275, the facility staff failed to provide occupational therapy as ordered by the physician. The findings included: Resident #275's diagnosis list indicated diagnoses, which included, but not limited to Amyotrophic Lateral Sclerosis, Acute and Chronic	F 825	F Tag 825 □ Obtain specialized Rehab Corrective Action Immediate corrective action was taken by contacting the nurse practitioner for resident #275 to notify that the resident had not received the occupational therapy per the MD order. This was also communicated directly with the resident with understanding. The resident was seen by OT on February 18, 2022. Identification To ensure that no other resident was affected, an audit of all residents on the	

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F 825	Continued From page 71 Respiratory Failure, Dependence on Respirator Status, Type 2 Diabetes Mellitus, Epilepsy, Heart Failure, Severe Protein-Calorie Malnutrition, Dysphagia, Hypotension, and Sacral Pressure Ulcer. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 2/04/22 assigned the resident a BIMS (brief interview for mental status) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #275 was coded as requiring extensive assistance with dressing and being totally dependent with bed mobility, transfers, toileting, personal hygiene, and bathing. In section O, Special Treatments, Procedures, and Programs, the resident was coded as receiving 1 day of OT (occupational therapy) for at least 15 minutes in the last 7 days and 43 individual minutes of OT in the past 7 days. On 2/15/22 at 4:14 pm, surveyor spoke with Resident #275 with the resident communicating using a dry-erase board. Surveyor asked the resident if they had any concerns and the resident responded they were not getting therapy. A review of Resident #275's clinical record revealed a current physician's order dated 1/28/22 stating "Occupational Therapy Eval (evaluation) and Treat as Indicated" and an order dated 1/31/22 stating "OT clarification order: Skilled OT tx (therapy) QD (every day) 3 x a week x 8 weeks for self care management training, therapeutic activities, therapeutic exercises". Resident #275's current comprehensive person-centered plan of care included an intervention dated 1/29/22 stating "PT (physician	F 825	unit where resident #275 resides was conducted to ensure that physicians orders for occupational therapy are being followed. Any area of non-compliance was reported to the physician for instruction and to the administrator. The resident and resident representative would be notified. The therapist would receive 1:1 counseling regarding following physicians orders. Systemic Change The rehab staff were re-educated regarding following physicians orders and if unable to, the physician, the administrator and the resident representative would need to be contacted immediately. The Rehab Director will review with OT staff daily if any resident that resides on the unit where resident #275 resided did not receive OT per physician order. The physician, the administrator and the resident or resident representative would be contacted. Monitoring The URCM or designee will audit 20% of residents receiving OT on the unit where resident #275 resides to ensure that physicians orders for OT are being followed. Any area of non-compliance would be reported immediately to the physician and the administrator. The Rehab Director would be subject to counseling and re-education. The URCM or designee will submit a report of non-compliance to the QAPI team quarterly for further discussion and	

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F 825	Continued From page 72 therapy)/OT evaluation and treatment as per MD orders". Surveyor was unable to locate OT evaluation or any treatment notes in the resident's clinical record. On 2/16/22 at 4:00 pm, surveyor met with the administrator, assistant administrator, and DON (director of nursing) and requested to review any OT documentation regarding Resident #275. On 2/23/22 at 10:47 am, the DON (director of nursing) provided surveyor with a copy of the resident's "OT Evaluation & Plan of Treatment" dated 1/31/22. "The OT Evaluation & Plan of Treatment" stated in part "Reason for Skilled Services: Skilled OT services are warranted to assess safety with adaptive equipment, assess the need for adaptations/assistive devices, develop and instruct in exercise program, develop and instruct on adaptation techniques, develop and instruct on compensatory strategies, facilitate dynamic standing balance, facilitate independence with ADLs (activities of daily living), facilitate sitting tolerance and postural control, increase functional activity tolerance and increase safety awareness in order to enhance patient's quality of life by improving ability to be able to return to prior level of living". Along with the "OT Evaluation & Plan of Treatment", the administrator provided copies of OT Treatment Encounter Note(s) for 1/31/22 and 2/18/22. On 2/24/22 at 9:01 am, surveyor spoke with OT (occupational therapist) #1 and requested OT treatment encounter notes between 1/31/22 and 2/18/22. OT #1 checked in the computer and	F 825	recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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stated the resident did not have OT visits between 1/31/22 and 2/18/22. OT #1 stated they were unsure of the reason and stated their supervisor makes the treatment schedule, OT #1 attempted to call their supervisor, however, they were unavailable.

On 2/24/22 at 9:21 am, surveyor spoke with IDOR (Interim Director of Rehab and Area Manager) via phone who verified Resident #275 was not seen by OT between 1/13/22 and 2/18/22 due to OT staff being out due to COVID-19. IDOR stated the facility has a total of four (4) OTs and one COTA (certified occupational therapy assistant) and one OT was out with suspected COVID-19 and another OT out due to testing positive for COVID-19. IDOR stated during this time residents were seen based on priority with the biggest focus being on residents with falls and Skilled residents and Resident #275 was not skilled. IDOR further stated employees are now returning and they are working to improve in the future and a new OT has been hired. IDOR stated Resident #275 will now be seen three (3) times per week.

On 2/24/22 at 10:26 am, surveyor informed the administrator of the call and information received from the IDOR. Administrator stated they would contact the IDOR and see what has been done.

On 2/24/22 at 1:20 pm, the administrator returned to the surveyor and stated they are doing an audit to identify other residents whose OT may have been affected. Administrator provided surveyor with a therapy clinical update note dated 2/24/22 at 1:11 pm stating "This interim DOR (director of rehab) spoke with NP (nurse practitioner) to discuss inability to meet frequency on POC (plan

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F 825	Continued From page 74 of care) starting on 1.31.2022. NP reports understanding in the matter and has no further questions". A second therapy clinical update note dated 2/24/22 at 1:15 pm was provided, note stated in part, "This interim DOR spoke with resident via phone regarding the inability to meet frequency during this POC. Resident able to report understanding via head nod". On 2/24/22 at 4:35 pm, survey team met with the administrator, assistant administrator, and director of nursing and discussed the concern of Resident #275 not receiving OT as ordered. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/24/22.	F 825		
F 842 SS=E	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	F 842		3/30/22

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F 842	Continued From page 75 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches 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;	F 842		

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F 842	Continued From page 76 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure a complete and accurate clinical record for 8 of 40 residents, Resident #279, #214, #236, #260, #62, #92, #143 and #180. For Resident #279, the nurse practitioner documented the resident expired in the ED (emergency department). When in fact the resident was pronounced and expired at the nursing facility. Resident #214 and Resident #236's clinical documentation failed to include evidence of the collection of laboratory samples for a C. auris test and for a CRE test. Resident #214's clinical documentation failed to include laboratory results for the C. auris test and for the CRE test. Resident #260's clinical documentation failed to include evidence of the collection of a laboratory specimen for a C. auris test. Resident #260's clinical documentation failed to include laboratory results for the C. auris test. Candida auris (C. auris) is a fungus that is often multidrug-resistant (https://www.cdc.gov/fungal/candida-auris/index.html on 3/2/22). Carbapenem-resistant Enterobacterales (CRE) are bacteria "that	F 842	F Tag 842 Resident Records Corrective Action Immediate corrective action was taken for resident #279 by notifying the nurse practitioner who wrote the note. The nurse practitioner immediately made an addendum and clarified the error in the medical record. For residents #214 and #236, immediate corrective action was taken by confirming that the local health department had not received physical results from the Maryland State Lab for these two residents. Forms were then completed to indicate that the labs for C. Auris and CRE were drawn, and results recorded on those forms with information given to Woodbine from the City of Alexandria Health Department via email. These forms were then uploaded into the EMR for residents #214 and #236. For resident #260 immediate corrective action was taken by confirming that the local health department had not received physical results from the Maryland State Lab. Forms were then completed to indicate that the lab for CRE was collected and result recorded on that form with information given to Woodbine from the	

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F 842	Continued From page 77 commonly cause infections in healthcare settings ... CRE are difficult to treat because they do not respond to commonly used antibiotics." (https://www.cdc.gov/hai/organisms/cre/ on 3/2/22). For Resident #62, the facility staff documented the administration of Levothyroxine by mouth when the medication was being administered via PEG-tube. For Resident #92, the facility staff documented the administration of Famotidine and Keppra by mouth when the medications were being administered via PEG-tube. For Resident #143, the facility staff documented the administration of Hydralazine by mouth when the medication was being administered via PEG-tube. For Resident #180, the facility staff documented the administration of Ferrous Sulfate by mouth when the medication was being administered via PEG-tube. The findings included: 1. This was a closed record review. Resident #279's face sheet included the diagnoses, unilateral primary osteoarthritis left hip, dementia with behavioral disturbance, and peripheral vascular disease. Section C (cognitive patterns) of Resident #279's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of	F 842	City of Alexandria Health Department via email. This form was then uploaded into the EMR of resident #260. For resident #62 the physician was contacted, and a new order was received to administer the levothyroxine via PEG-tube. For resident #92, the physician was contacted, and a new order was received to administer the famotidine and Keppra via PEG-tube. For resident #143, the physician was contacted, and a new order was received to administer the hydralazine via PEG-tube. For resident #180, the physician was contacted, and a new order was received to administer the Ferrous Sulfate via PEG-tube. Identification To ensure that no other residents were affected, an audit was completed on all death summaries in the last 30 days to ensure proper information was in the clinical record. Any areas found in non-compliance, the physician or his/her designee will be contacted to make an addendum to correct the information. All residents that had a lab drawn for C. Auris or CRE while the Maryland State Lab computer system has been down, have a form completed to indicate that a lab was drawn and the results. Any area of non-compliance will have the form complete until the official results are sent from the Maryland State Lab to the City of Alexandria Health Department. All residents that receive their medications	

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F 842	Continued From page 78 01/07/22 was coded 1/1/2 to indicate the resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. Resident #279's clinical record was reviewed on 02/15/22 and included the following progress notes. 01/24/22 Nurse Practitioner documented a "Death Summary" that read in part, "...was found unresponsive 1/23 CPR initiated and EMS called...passed away in ED." 01/23/22 LPN (licensed practical nurse) #1, "...Resident was finally pronounced expired at 09:53, by Dr. _____ per 911 staff member____ Dr. ____ was informed and gave order to release resident's remains to _____ Funeral home...At 14:15, resident remains was released to _____ Funeral Home with family at bedside." 02/15/22 2:30 p.m., the DON (director of nursing) stated a code was called and the resident expired at the facility. 02/15/22 the DON provided the surveyor with a copy of their policy titled, "Charting and Documentation." This policy read in part, "...Documentation in the medical record will be objective...complete and accurate..." No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Resident #214's diagnoses included, but were not limited to: high blood pressure, orthostatic	F 842	via PEG-tube will have their medication route reviewed. Any medication that indicates the wrong route, the physician will be contacted for an order to have the medication delivered via PEG-tube. Systemic Change The Nurse Practitioner received re-education on ensuring correct information is placed in the clinical record. Director of Medical Records or designee will audit all death summaries to ensure proper information is in the summary. Any areas of non-compliance will be shared with the Medical Director to speak to Physician or designee to correct the information and provide education. The infection preventionist and nursing leadership will be educated to utilize a paper form anytime a lab is drawn using the Maryland State Laboratory until their computer system is working. This form will indicate when the lab was drawn, and the results once received via email from the City of Alexandria Health Department from the Maryland State Laboratory. The Director of Clinical Records or designee will audit the monthly PPS and weekly Admissions that the tests are run to ensure that the forms are completed and uploaded. Any areas of non-compliance will be shared with the Infection Preventionist and Director of Nursing. Re-education and counseling of the licensed staff that drew the lab will be completed. All licensed staff received re-education on ensure to that physician orders are	

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hypotension, neurogenic bladder, diabetes, and respiratory failure.

Resident #214's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/24/21, was signed as completed on 12/29/21. Resident #214 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #214 was assessed as having severely impaired cognitive skills for daily decision making. Resident was documented as dependent on others for bed mobility, transfers, dressing, eating, toilet use, personal hygiene, and bathing.

The following information was found in a facility policy titled "Charting and Documentation" (this document was not dated):
- "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care."
- "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate."

Resident #214 lived in an area of the facility that was having C. auris and CRE laboratory test completed on residents as part of a plan to prevent the spread of these organisms. Review of Resident #214's clinical record failed to provide evidence the resident had been tested for C. auris and/or CRE.

On 2/23/22 at 10:37 a.m., the facility's Director of

received for medications via proper route. Unit Manager or designee will review all new orders for residents that have a PEG-tube to ensure that the proper route is indicated for medication route.

Monitoring
The Assistant Administrator or designee will review 20% of all death summaries per month to ensure that the correct information is in the summary. Any area of non-compliance will be corrected by notifying the physician for an addendum in the medical record. A quarterly report of non-compliance will be submitted by the Assistant Administrator to the QAPI team for review and further discussion.
The ADON or designee will audit 20% of the PPS and Admission tests completed by the Maryland State Lab to ensure that the form has been completed until the lab computer system is working. Any area of non-compliance will be immediately corrected and the Infection Preventionist or designee will receive re-education on the completion of the form. A quarterly report of non-compliance will be submitted to the QAPI team to review for discussion and recommendations.
The ADON or designee will review 20% of the new orders for residents that use a PEG-tube to ensure that the proper route is indicated in the physician order. Any areas of non-compliance will be corrected by contacting the physician for an order for the correct route. A quarterly report of non-compliance will be submitted to the QAPI team for review, discussion, and recommendations. This will continue for a

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Nursing (DON) provided a copy of a spreadsheet that included specimen collection information and test results information for facility residents. Resident #214's specimen collection information and tests results were included on this spreadsheet. The spreadsheet indicated the specimen collection for the C. auris and CRE laboratory test were obtained on 1/25/22 at 4:13 p.m. and 4:12 p.m. respectively. The spreadsheet indicated Resident #214 had negative results, reported on 2/8/22, for both test. The specimen collection information and tests results were not documented as part of Resident #214's clinical record.

On 2/23/22 at 11:53 a.m., a local health department employee (LHDE #1) was interviewed via telephone. LHDE #1 reported the laboratory that performs the C. auris and CRE tests has had computer issues that resulted in them having to change the way they report the results of these laboratory tests. LHDE #1 reported the laboratory test results were being communicated via email. LHDE #1 reported their understanding was that the facility's staff were going to document the results in the clinical record via a "health note" indicating if the tests were negative or positive.

On 2/23/22 at 4:12 p.m., the facility's Administrator was interviewed about the absence of documentation of C. auris and CRE specimen collection and test results in residents' medical records. The Administrator stated they could provide the test results, which were sent via a secure email from the local health department. The Administrator reported they would implement a form to be completed that will be used to document the test results in the residents' medical records. The Administrator reported a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.

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provider order for the C. auris and CRE test should be signed off, in residents' medical records, as completed when the specimens are collected.

The failure of facility staff to document Resident #214's laboratory specimen collection and test results, for C. auris and CRE, was discussed for a final time with the facility's Administrator, Director of Nursing, and Assistant Administrator on 2/24/22 at 4:39 p.m.

3. Resident #236's diagnoses included, but were not limited to: high blood pressure, neurogenic bladder, diabetes, and respiratory failure.

Resident #236's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/25/22, was signed as completed on 1/31/22. Resident #236 was assessed as sometimes able to make self understood and as usually able to understand others. Resident #236's BIMS (Brief Interview for Mental Status) Summary Score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #236 was documented as requiring assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.

The following information was found in a facility policy titled "Charting and Documentation" (this document was not dated):
- "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's

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condition and response to care."
- "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate."

Resident #236 was living in an area of the facility that was having C. auris and CRE laboratory test completed on residents as part of a plan to prevent the spread of these organisms. Review of Resident #236's clinical record failed to provide evidence the resident had been tested for C. auris and/or CRE.

On 2/23/22 at 10:37 a.m., the facility's Director of Nursing (DON) provided a copy of a spreadsheet that included specimen collection information and test results information for facility residents. Resident #236's specimen collection information and tests results were included on this spreadsheet. The spreadsheet indicated the specimen collection for the C. auris and CRE laboratory test were obtained on 1/25/22 at 4:13 p.m. and 4:12 p.m. respectively. The spreadsheet indicated Resident #236 had negative results, for both tests, reported on 2/8/22. The specimen collection information and tests results were not documented as part of Resident #236's clinical record.

On 2/23/22 at 11:53 a.m., a local health department employee (LHDE #1) was interviewed via telephone. LHDE #1 reported the laboratory that performs the C. auris and CRE tests has had computer issues that resulted in them having to change the way they report the results of these laboratory tests. LHDE #1 reported the laboratory test results were being communicated via email. LHDE #1 reported their understanding was that the facility's staff were going to document the

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results in the clinical record via a "health note" indicating if the tests were negative or positive.

On 2/23/22 at 4:12 p.m., the facility's Administrator was interviewed about the absence of documentation of C. auris and CRE specimen collection and test results in residents' medical records. The Administrator stated they could provide the test results, which were sent via a secure email from the local health department. The Administrator reported they would implement a form to be completed that will be used to document the test results in the residents' medical records. The Administrator reported a provider order for the C. auris and CRE test should be signed off, in residents' medical records, as completed when the specimens are collected.

The failure of facility staff to document Resident #236's laboratory specimen collection and test results, for C. auris and CRE, was discussed for a final time with the facility's Administrator, Director of Nursing, and Assistant Administrator on 2/24/22 at 4:39 p.m.

4. Resident #260's diagnoses included, but were not limited to: high blood pressure, neurogenic bladder, diabetes, kidney disease, and respiratory failure.

Resident #260's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 2/7/22, was signed as completed on 2/9/22. Resident #260 was assessed as being in a persistent vegetative state and/or having no discernible consciousness. Resident #260 was documented as being dependent on others for bed mobility, transfers, dressing, eating, toilet

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use, personal hygiene, and bathing.

The following information was found in a facility policy titled "Charting and Documentation" (this document was not dated):
- "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care."
- "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate."

Resident #260 was living in an area of the facility that was having C. auris laboratory tests completed on residents as part of a plan to prevent the spread of these organisms. Review of Resident #260's clinical record failed to provide evidence the resident had been tested for C. auris.

On 2/23/22 at 10:37 a.m., the facility's Director of Nursing (DON) provided a copy of a spreadsheet, which included specimen collection information and test results information for facility residents. Resident #260's C. auris specimen collection information and test results were included on this spreadsheet. The spreadsheet indicated the C. auris specimen was obtained on 12/14/21. The spreadsheet indicated Resident #260 C. auris test had been reported as positive on 12/22/22. The specimen collection information and tests results were not documented as part of Resident #260's clinical record.

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On 2/23/22 at 11:53 a.m., a local health department employee (LHDE #1) was interviewed via telephone. LHDE #1 reported the laboratory that performs the C. auris and CRE tests has had computer issues that resulted in them having to change the way they reported the results. LHDE #1 reported the laboratory test results were being communicated via email. LHDE #1 reported their understanding was that the facility's staff members were going to document the results in the clinical record via a "health note" indicating if the tests were negative or positive.

On 2/23/22 at 4:12 p.m., the facility's Administrator was interviewed about the absence of documentation of the C. auris specimen collection and test results in residents' medical records. The Administrator stated they could provide the test results, which were sent via a secure email from the local health department. The Administrator reported they would implement a form to be completed that will document the test results in the residents' medical records. The Administrator reported a provider order for the C. auris test should be signed off as completed, in residents' medical records, when the specimens are collected.

The failure of facility staff to document Resident #260's laboratory specimen collection and test results, for C. auris, was discussed for a final time with the facility's Administrator, Director of Nursing, and Assistant Administrator on 2/24/22 at 4:39 p.m.

5. Resident #62's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure, Type 2 Diabetes Mellitus, Left Thigh Myositis, Metabolic

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Encephalopathy, Persistent Vegetative State, Nutritional Deficiency, Essential Hypertension, Orthostatic Hypotension, Post Traumatic Seizures, and Dependence on Respirator.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/21/21 coded the resident as being in a persistent vegetative state. Resident #62 was coded as being totally dependent on staff for bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake.

Resident #62's current comprehensive person-centered plan of care included a focus area stating "Resident requires tube feeding r/t (related to) NPO status".

A review of Resident #62 clinical record indicated the resident was ventilator dependent, in a persistent vegetative state, receives nutrition via tube feeding, and has a current physician's order for an NPO (nothing by mouth) diet.

Surveyor reviewed the resident's current physician's orders and noted an active order dated 10/05/21 for Levothyroxine Sodium tablet 137 mcg 1 tablet by mouth one time a day for low thyroid. Resident #62's February 2022 MAR (medication administration record) indicated Levothyroxine was being signed as administered by mouth despite the resident's NPO status.

On 2/23/22 at 11:32 am, surveyor spoke with LPN (licensed practical nurse) #2 who stated Resident #62 does not take any PO (by mouth) meds

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(medications).

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and informed them of Resident #62 having a current physician's order for Levothyroxine to be given by mouth.

On 2/24/22 at 2:55 pm, DON provided a copy of a physician's order dated 2/24/22 9:00 am for Resident #62 stating Levothyroxine Sodium tablet 137 mcg to be administered via PEG-tube. DON also provided a nursing progress note dated 2/24/22 1:05 pm stating in part "Clarification: (physician name omitted) made aware ... ... levothyroxine change from PO to G-tube".

Surveyor requested and received the facility policy entitled "Administering Medications" which read in part "10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication". Surveyor also reviewed the facility policy "Charting and Documentation" which read in part "3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate".

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

6. Resident #92's diagnosis list indicated diagnoses, which included, but not limited to Acute Respiratory Failure, Dependence on Respirator Status, Type 2 Diabetes, Anxiety Disorder, Essential Hypertension, Dysphagia, and

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Aphonia.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 12/16/21 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake.

A review of Resident #92's current physician's orders revealed a current order dated 12/17/21 for a NPO (nothing by mouth) diet. The resident's current physician orders included active orders for the medications Famotidine and Keppra to be administered by mouth, all other oral medications were ordered to be given via PEG-tube. The resident's February 2022 MAR (medication administration record) indicated the Famotidine and Keppra were signed as being administered by mouth despite the resident's NPO status.

On 2/23/22 at 11:32 am, surveyor spoke with LPN (licensed practical nurse) #2 who stated Resident #92 does not take any PO (by mouth) meds (medications).

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and informed them of Resident #92 having current physician's orders for Famotidine and Keppra to be given by mouth.

Surveyor requested and received the facility policy entitled "Administering Medications" which read in part "10. The individual administering the medication checks the label THREE (3) times to

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verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication". Surveyor also reviewed the facility policy "Charting and Documentation" which read in part "3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate".

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

7. Resident #143's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, Cerebral Edema, Dysphagia, Acute Respiratory Failure, Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3, Essential Hypertension, Chronic Diastolic (Congestive) Heart Failure, and Dependence on Respirator.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/31/21 coded the resident as being severely impaired in cognitive skills for daily decision making. Resident #143 was coded as being totally dependent on staff for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake.

A review of Resident #143's current physician's orders revealed a current order dated 2/08/22 for a NPO (nothing by mouth) diet. The resident's current physician orders included an active order dated 12/24/21 for the medication Hydralazine to

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be administered by mouth, all other oral medications were ordered to be given via PEG-tube. The resident's February 2022 MAR (medication administration record) indicated the Hydralazine was signed as being administered by mouth despite the resident's NPO status.

On 2/23/22 at 11:32 am, surveyor spoke with LPN (licensed practical nurse) #2 who stated Resident #143 does not take any PO (by mouth) meds (medications).

On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and informed them of Resident #143 having a current physician's order for Hydralazine to be given by mouth.

On 2/24/22 at 2:55 pm, the DON provided surveyor with a physician's order dated 2/24/22 8:56 am for Resident #143 for Hydralazine to be administered via G-tube.

Surveyor requested and received the facility policy entitled "Administering Medications" which read in part "10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication". Surveyor also reviewed the facility policy "Charting and Documentation" which read in part "3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate".

No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.

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8. Resident #180 diagnosis list indicated diagnoses, which included, not limited to Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure, Dependence on Respirator, Persistent Vegetative State, Type 2 Diabetes Mellitus, Muscle Wasting and Atrophy, Major Depressive Disorder, Dysphagia, Aphonia, and Malignant Neoplasm of Prostate.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 1/20/22 coded the resident as being in a persistent vegetative state. The resident was coded for the presence of a feeding tube in which they received 51% or more of total calories and 501 cc/day or more average fluid intake.

A review of Resident #180 clinical record indicated the resident was ventilator dependent, in a persistent vegetative state, receives nutrition via tube feeding, and has a current physician's order dated 2/08/22 for an NPO (nothing by mouth) diet.

Resident #180's current comprehensive person-centered plan of care included a focus area stating "Resident requires tube feeding r/t (related to) Dysphagia, Swallowing problem".

Resident #180's current physician's orders included an active order dated 1/26/22 for the medication Ferrous Sulfate to be administered by mouth, all other oral medications were ordered to be given via PEG-tube. The resident's February 2022 MAR (medication administration record) indicated the Ferrous Sulfate was signed as being administered by mouth despite the resident's NPO status.

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F 842	Continued From page 92 On 2/23/22 at 11:32 am, surveyor spoke with LPN (licensed practical nurse) #2 who stated Resident #180 does not take any PO (by mouth) meds (medications). On 2/24/22 at 8:05 am, surveyor met with the administrator and DON (director of nursing) and informed them of Resident #180 having a current physician's order for Ferrous Sulfate to be given by mouth. Surveyor requested and received the facility policy entitled "Administering Medications" which read in part "10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication". Surveyor also reviewed the facility policy "Charting and Documentation" which read in part "3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate". No further information regarding this concern was presented to the survey team prior to the exit conference on 2/24/22.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		3/30/22

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F 880	Continued From page 93 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 94 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility document review, and in the course of a complaint investigation, the facility staff failed to implement infection control and prevention program processes, including actions to decrease the risks of transmission of COVID-19 and/or other infectious organisms, for three (3) of 40 residents (Resident #135, Resident #162, and Resident #226. The facility staff failed to ensure a staff member completed COVID-19 screening prior to starting their work shift. For Resident #135, the facility staff failed to implement facility COVID-19 quarantine processes for a readmitted resident who had not yet received the COVID-19 booster. For Resident #135, Resident #162, and Resident #226, the facility staff failed to ensure proper	F 880	F Tag 880 Infection Control and Prevention Corrective Action Immediate corrective action was taken by re-education for staff member #21 on the requirement for screening when entering the facility. Immediate corrective action was taken to post the droplet precaution sign on the resident #135 door and receive orders from the MD for droplet and contact precautions. Staff member #24 received re-education regarding the requirement of proper PPE for a room with both droplet and contact precautions. Immediate corrective action was taken by	

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F 880	Continued From page 95 personal protective equipment (PPE) was worn by individuals entering the residents' rooms, which required transmission-based precautions (TBPs). The findings include: 1. Staff Member (SM) #21 failed to consistently complete COVID-19 screenings prior to starting work. The review of SM #21's "Daily Timecards" information for the period of 12/26/21 to 2/5/2022 indicated they worked 25 days (12/26/21; 12/28/21; 12/29/21; 12/30/21; 12/31/21; 1/4/22; 1/6/22; 1/7/22; 1/8/22; 1/9/22; 1/11/22; 1/12/22; 1/13/22; 1/14/22; 1/17/22; 1/18/22; 1/21/22; 1/22/22; 1/23/22; 1/25/22; 1/26/22; 1/27/22; 1/28/22; 1/31/22; and 2/5/22). Review of SM #21 COVID-19 screening documentation prior to starting work (for the same time period) indicated they had only completed COVID-19 screening for two (2) days: 12/30/21 and 1/26/22. On 2/16/22 at 3:31 p.m., the Director of Nursing (DON) reported SM #21 had not consistently being completing the employee COVID-19 screening prior to starting work. On 2/23/22 at 3:40 p.m., Staff Member (SM) #21 reported they had not been completing the COVID-19 screening prior to starting work because the thermometers were providing a temperature that was too low; SM #21 reported they did not want to use an incorrect temperature. The following information was found in a facility document titled "Screening of Staff, Visitors & Residents - VA" (dated August 9, 2021):	F 880	placing a contact precaution sign on the door of resident #162. Immediate corrective action was taken for resident #226 by providing re-education for the family of resident regarding proper PPE and the reasoning for it. Identification To ensure that no other residents were affected, an audit of screening kiosk and the daily schedule was completed to ensure compliance. An audit of all residents that came from the hospital within the last 14 days were reviewed to ensure that all residents that were not up to date with Covid Vaccines were in proper observation. An audit of all Covid Precaution signs was completed to ensure proper signage was on each door that required droplet or contact precautions. Families with loved ones in contact isolation were re-educated on the proper use of PPE while visiting. Systemic Change All staff members are completing competencies on DONNING and DOFFING of PPE for isolation and Hand Hygiene. All staff will be re-educated to ensure that they complete screening at the entrance of the facility prior to starting their shift. All families that have loved ones in Contact Pre-cautions will be re-educated to wear the proper PPE. The infection preventionist or designee will make rounds daily and conduct observations daily on: Signage for Contact and Droplet precautions to ensure that all	

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F 880	Continued From page 96 - "Staff, visitors, and residents will be screening for COVID-19 in accordance with guidance from VDH, CMS, and CDC." - "HCP (healthcare personnel) screening must be conducted at the beginning of every shift." - "HCP must be screened for: - Signs and symptoms of COVID-19 including: fever (greater than or equal to) 100.0 (degrees Fahrenheit), cough, shortness of breath, sore throat, myalgia, chills, and new onset of loss of smell or taste; and - Prolonged close contact with someone with COVID-19 infection in the 14 days prior ..." The failure of SM #21 to consistently complete COVID-19 screening prior to starting work was discussed with the facility's Administrator, Director of Nursing, and Assistant Administrator on 2/24/22 at 4:39 p.m. 2. Resident #135's diagnoses included, but were not limited to: anemia, high blood pressure, anxiety, depression, lung disease, and respiratory failure. Resident #135's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/29/21, was signed as completed on 1/5/22. Resident #135 was assessed as able to make self understood and as able to understand others. Resident #135 was assessed as having a BIMS (Brief Interview for Mental Status) Summary Score of a 15 out of 15; this indicated intact or borderline cognition. Resident #135 was assessed as requiring assistance with bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. The following information was found in a facility document titled "CDC Guidance - New	F 880	signs are correct, Donning and Doffing of PPE of staff going into and out of room, Hand-hygiene of staff and ensuring that families visiting are wearing the proper PPE. Any areas of noncompliance will be corrected immediately, and the staff member or family member will be re-educated. Monitoring The staffing coordinator or designee will review 20% the staffing schedule and the screening kiosk to ensure that the staff that worked completed screening prior to the start of their shift. Any areas of non-compliance will be reported immediately to the ADON and Infection preventionist for re-education and counseling. The ADON or designee will conduct 30 observations per day that could include for Donning and Doffing, hand-hygiene, family visitation in rooms with PPE or Signage of Contact or Droplet Precautions to ensure that is being conducted properly. Any area of non-compliance will be immediately corrected and reported to the DON and Infection Preventionist. The ADON will send a monthly report of non-compliance to the QAPI team for review, discussion, and recommendations. This will continue for a minimum of 3 months and thereafter until 100% compliance is achieved; The QAPI Team will make a formal recommendation when the monitoring can conclude based on 100% compliance.	

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Admissions and Residents Who Leave the Facility" (dated April 2, 2021 and last updated February 2022): "Residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and residents who left the facility for more than 24 hours will be placed in quarantine." This document did not provide details for placing a resident in quarantine.

The facility's Administrator and Director of Nursing (DON) were interviewed on 2/24/22 at 8:40 a.m. The failure of the "CDC Guidance - New Admissions and Residents Who Leave the Facility" document to detail the process for placing a resident on quarantine was discussed. The Administrator reported a resident placed on quarantine due to potential COVID-19 exposure would be placed on Droplet Isolation precautions.

During an interview on 2/24/22 at 10:21 a.m., the DON reported Resident #135 would have required quarantine after their re-admission to the facility due to the resident not having received the COVID-19 vaccine booster.

Resident #135's clinical record included an order for "CONTACT AND DROPLET ISOLATION" dated six (6) days after the resident was re-admitted to the facility. (The re-admission was after a hospital stay.)

On 2/16/22 at 1:10 p.m., Staff Member (SM) #22 (a unit manager) was asked why Resident #135's room had a sign posted for Contact Isolation but not Droplet Isolation. SM #22 reported no Droplet Isolation sign was posted because the resident was only on observation after readmission from the hospital. Resident #135 had an order for both

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"CONTACT AND DROPLET ISOLATION" at the time of this observation.

On 2/16/22 at 1:26 p.m., SM #23 (a licensed practical nurse) was observed posting a Droplet Isolation sign on the door leading into Resident #135's room.

On 2/16/22 at 2:30 p.m., the facility's Director of Nursing and Infection Preventionist reported that Resident #135's room should have had signage posted for both Contact Isolation and Droplet isolation from the time of the resident's readmission after the hospital stay.

On 2/17/22 at 8:55 a.m., SM #24 (a certified nurse aide) was observed to enter Resident #135's room without donning a gown and gloves. SM #24 placed clean linen on a table in Resident #135's room and exited the room. On 2/17/22 at 9:00 a.m., SM #22 (a unit manager) was interviewed about SM #24 entering Resident #135's room to drop-off clean linen; SM #22 reported SM #24 should have donned a gown and gloves prior to entering the room.

The facility's Administrator, Director of Nursing, and Assistant Administrator met with the survey team on 2/24/22 at 4:39 p.m. The failure of the facility staff to ensure Resident #135 had orders for Droplet Isolation precautions for quarantine when re-admitted to the facility after a hospital stay was discussed. The observations of a staff member entering Resident #135's room without donning a gown or gloves was discussed.

3. Resident #162's admission record listed diagnoses to include but not limited to, Parkinson's disease, immobility syndrome

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(paraplegic), Alzheimer's disease, dementia, and open wound, right lower leg. The quarterly minimum data set (MDS) with an assessment reference date (ARD) of 01/01/2022, in Section C (cognitive patterns) coded Resident #162's BIMS (brief interview for mental status) score of 99 meaning the resident was unable to complete the interview. Section G (functional status) coded the resident required extensive assistance with bed mobility, eating, and toilet use with personal hygiene coded as total dependence.

The resident's order summary report contained an order to start on 08/09/2021 with no end date, for contact precautions and read, "Contact precautions for CRE (carbapenem-resistant Enterobacterales) in urine. Staff members providing ADL (activities of daily living) care must wear an isolation gown and gloves when providing ADL care." The care plan's focus areas included, but not limited to, risk for infection due to: incontinence, history of CRE in urine, and right knee abscess with interventions that included contact precautions for CRE in urine and staff members providing ADL care must wear an isolation gown and gloves when providing ADL care.

On 02/15/2022 at approximately 1:03 p.m., the surveyor (wearing an N-95 mask and goggles) entered room 210 to meet Resident #162. There was a CNA (certified nursing assistant) assisting the resident with eating. The CNA was wearing a mask and faceshield. The resident did not respond to the surveyor and continued eating. When the surveyor left the room, a contact precautions sign was noted on the door which had not been there prior to the surveyor entering. The ADON (assistant director of nursing) met the

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surveyor at the door and acknowledged having just hung the contact precautions sign on the resident's door while the surveyor was in the room. The resident had recently changed rooms and the precautions sign and personal protective equipment (PPE) cart had not been moved to the new room until right then. The CNA reported knowing Resident #162 was on contact precautions and acknowledged they should have worn a gown and gloves too and did not know why they had not donned all of the expected PPE. At approximately 2:30 p.m., the same CNA was interviewed again and reported that since the resident had moved rooms (within the same unit) and there was no contact precautions sign on the door, the CNA thought the resident may no longer be on precautions. The contact precautions sign indicated that prior to entering the room everyone must clean their hands, don gloves and a gown.

On 02/15/2022 at 9:15 a.m. when the survey team entered the facility, the administrator reported everyone was required to wear an N-95 mask and goggles/faceshield throughout the facility.

4. Resident #226's admission record listed diagnoses to include, but not limited to, functional quadriplegia, conversion disorder with seizures or convulsions, resistance to unspecified beta lactam antibiotics, and aphasia (inability to communicate). The minimum data set (MDS) with an assessment reference date (ARD) of 01/27/2022, in Section C (cognitive patterns) coded Resident #162 as rarely/never understood and therefore no BIMS (brief interview for mental status) interview was completed. Section G (functional status) coded the resident required total dependence for bed mobility, transfer,

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eating, toilet use, and personal hygiene.

The resident's order summary report contained an order, with a start date of 02/10/2022 and no end date, for contact and droplet isolation. On 2/24/2022 the director of nursing (DON) provided an order dated 2/23/2022 at 5:36 p.m., for Resident #226 that read, "The resident is to remain on contact precautions for CRE colonization." The DON reported the resident had been on contact and droplet precautions on 02/10/2022 due to their readmission from a hospitalization. The care plan's focus areas included, but not limited to, the resident had CRE (carbapenem-resistant Enterobacterales) colonization. The interventions included, but not limited to, contact isolation and educate resident/family/caregivers regarding the importance of hand washing.

On 02/15/2022 while initially meeting residents on 2 South, the surveyor donned required PPE (personal protective equipment) prior to entering room 203 which had a contact precautions sign on the door and a cart with PPE at the door. The room was semi-private with both residents being positive for CRE per the census listed. According to the precautions sign, the PPE required included gloves after hand hygiene and a gown. The surveyor was already wearing an N-95 mask and goggles as required by the facility for all individuals. Upon entering the room, the surveyor encountered Resident #226's mother who was wearing a mask but no gown, no gloves, no faceshield or goggles. The surveyor observed the resident's mother picking up the resident's legs and moving them around and also touching the resident's arms. When asked whether she was aware of the PPE required for contact

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precautions (per the sign on the door or other education), she did not respond directly to the question. Resident #226's mother shook her head but the surveyor could not distinguish whether she was gesturing a yes or a no. The surveyor repeated the question with no response from the mother. The assistant director of nursing (ADON) was informed of this observation and they stated Resident #226 had been at the facility long-term and they had spoken with the mother many times.

Resident #226's clinical record contained a note created by the ADON, dated 02/15/2022 at 5:35 p.m. that read the ADON had spoken with the resident's mother and reviewed his CRE status. The mother voiced knowing about the resident's history of CRE and also that his sister who was his usual caregiver was very knowledgeable about his CRE status. The mother understood the need for PPE and said she would be compliant and start wearing the appropriate PPE needed to protect herself whenever she visits. The note included the ADON reviewed the need for gowns and gloves. The surveyor did not have any further observations of Resident #226's visitors during the survey.

The DON provided the facility's policy titled, "Isolation - Categories of Transmission-Based Precautions" which read, in part, that contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Staff and visitors will wear gloves when entering the room and removed with hand hygiene performed before

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leaving the room. Staff and visitors will wear a disposable gown upon entering the room and removed before leaving the room.

The DON was informed of the observations regarding Resident #162 and Resident #226 on 2/16/2021 at approximately 12:30 p.m. The administrator, DON, and assistant administrator were informed of these observations on 02/16/2022 at 4:00 p.m. The surveyor requested any specific evidence of Resident #226's family/caregivers' education regarding PPE multiple times. The DON provided the care plan that read to educate the family as mentioned above. No further information was provided prior to the end of the survey.

This is a complaint deficiency.