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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 4/05/22 through 4/07/22. 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<br><br>An unannounced Medicare/Medicaid standard survey was conducted 04/05/22 through 04/07/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>Complaint #VA00052507 (unsubstantiated) and #VA00052115 (unsubstantiated) were investigated during the survey.<br><br>The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 4 closed record reviews. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(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-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial | F 580 | | 5/17/22 |

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

Electronically Signed | 05/18/2022

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

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| F 580 | Continued From page 1<br>status in either life-threatening conditions or clinical complications);<br>(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<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>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).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record | F 580 | What corrective action(s) will be | |

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| F 580 | Continued From page 2<br>review, the facility staff failed to consult with the physician the need to review current treatment due to possible adverse medication interactions for 2 of 23 residents in the survey sample, Residents #29 and #359.<br><br>For Resident #29, the facility staff failed to consult the physician regarding drug protocol alerts for possible drug interactions between Xanax (a benzodiazepine used to treat anxiety) and Norco (a narcotic used to treat pain), Xanax and Nizoral Shampoo (a topical antifungal), and Xanax and Depakote Sprinkles (an antiepileptic used to treat seizures).<br><br>For Resident #359, the facility staff failed to consult the physician regarding drug protocol alerts for possible drug interactions between trazodone (a serotonin modulator used to treat depression) and buspirone (an anxiolytic used to treat anxiety), and remeron (an antidepressant used to treat depression) and buspirone.<br><br>The findings included:<br><br>1. Resident #29's diagnosis list indicated diagnoses, which included, but not limited to Vascular Dementia, Chronic Obstructive Pulmonary Disease, Generalized Anxiety Disorder, Pulmonary Hypertension, and Peripheral Vascular Disease.<br><br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 2/07/22 assigned the resident a BIMS (brief interview for mental status) summary score of 0 out of 15 indicating the resident was severely cognitively impaired. | F 580 | accomplished for those residents found to have been affected by the deficient practice?<br><br>For resident #29, the physician was notified of a possible drug interaction between Xanax and Norco, Xanax and Nizoral shampoo, and Xanax and Depakote Sprinkles on 4-7-2022. For resident #359, the physician was notified of a possible drug interaction between Trazodone and Buspar, and Remeron and Buspar on 4-7-2022.<br><br>How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken?<br><br>Quality review conducted by the DCS/designee of current residents for notification of the physician for potential drug interactions in the previous 30 days.<br>What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;<br><br>Licensed staff re-educated by the DCS/Designee on/by 5/19/2022 regarding notification of the physician for potential drug interactions.<br><br>How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;<br><br>The ED/DCS/designee to conduct quality monitoring of physician notification of | |

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| F 580 | Continued From page 3<br>Resident #29's current physician's orders included an order dated 1/21/22 for Xanax 0.5 mg by mouth every Wednesday and Saturday one hour prior to baths. Resident #29's clinical record included an Orders Progress Note dated 1/21/22 4:25 pm stating in part the system has identified a possible moderate drug interaction between Norco and Xanax, a possible severe interaction between Xanax and Nizoral Shampoo 2%, and a possible moderate interaction between Xanax and Depakote Sprinkles. Surveyor was unable to locate documentation of physician notification of these possible drug interactions.<br><br>On 4/06/22 at 3:02 pm, surveyor spoke with the DON (director of nursing) regarding system identified possible drug interaction alerts. DON stated the nurse should make a list of the interactions and notify the doctor.<br><br>On 4/06/22 at 3:08 pm, surveyor spoke with UM (unit manager) #1 regarding system identified possible drug interaction alerts and the UM stated if there is an interaction the pharmacy notifies them and they do not have to do anything for the auto-generated system identified interactions.<br><br>On 4/06/22 at 4:05 pm, surveyor met with the administrator and DON and discussed the concern of Resident #29's physician not being notified of the system identified possible drug interactions.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 4/07/22.<br><br>2. Resident #359's diagnosis list indicated diagnoses, which included, but not limited to | F 580 | potential drug interactions for 5 residents 3 x weekly x 4 weeks, 2 x weekly x 4 weeks.<br>The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 580 | Continued From page 4 | F 580 | | |

Metabolic Encephalopathy, Dementia, Essential Hypertension, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Generalized Anxiety Disorder, Restlessness and Agitation, and Type 2 Diabetes Mellitus.

The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 3/08/22 did not assess the resident's BIMS (brief interview for mental status) summary score. Resident #359 was coded as usually makes self understood and sometimes understands others.

Resident #359's current physician's orders included an order dated 3/11/22 for Trazodone HCL 50 mg at bedtime for insomnia, an order dated 3/19/22 for Buspirone HCL 10 mg by mouth two times a day for anxiety, and an order dated 3/22/22 for Remeron 15 mg by mouth at bedtime for poor appetite.

The resident's clinical record included an Orders Progress note dated 3/11/22 7:06 pm stating in part the system has identified a possible severe drug interaction between Trazodone and Buspirone in which the additive serotonergic effects may occur during co-administration and the risk of developing serotonin syndrome may be increased. Additional Orders Progress notes dated 3/17/22 10:24 am and 3/19/22 5:23 pm again identified a possible severe drug interaction between Trazodone and Buspirone. Surveyor reviewed Resident #359's clinical record and was unable to locate documentation of physician notification of the possible severe interaction between Trazodone and Buspirone.

Orders Progress Notes dated 3/17/22 10:24 am and 3/19/22 5:23 pm also documented the

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| F 580 | Continued From page 5<br>system has identified a possible severe drug interaction Buspirone and Remeron in which the additive serotonergic effects may occur during co-administration and the risk of developing serotonin syndrome may be increased. Surveyor reviewed Resident #359's clinical record and was unable to locate documentation of physician notification of the possible severe interaction between Buspirone and Remeron.<br><br>On 4/06/22 at 3:02 pm, surveyor spoke with the DON (director of nursing) regarding system identified possible drug interaction alerts. DON stated the nurse should make a list of the interactions and notify the doctor.<br><br>On 4/06/22 at 3:08 pm, surveyor spoke with UM (unit manager) #1 regarding system identified possible drug interaction alerts and the UM stated if there is an interaction the pharmacy notifies them and they do not have to do anything for the auto-generated system identified interactions.<br><br>On 4/06/22 at 4:05 pm, surveyor met with the administrator and DON and discussed the concern of Resident #359's physician not being notified of the system identified possible drug interactions.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 4/07/22. | F 580 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the | F 637 | | 5/18/22 |

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| F 637 | Continued From page 6<br>resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, clinical record review, and facility document review, the facility staff failed to complete a Significant Change Minimum Data (MDS) assessment for 1 of 23 sampled residents, Resident #160.<br><br>The findings include:<br><br>Resident #160's comprehensive minimum data set (MDS) assessment, with an assessment reference date of 2/23/22, was dated as completed on 3/1/22. Resident #160 was assessed as able to make self understood and as able to understand others. Resident #160's Brief Interview for Mental Status (BIMS) summary score was documented as an eight (8) out of 15; this indicated moderate cognitive impairment. Resident #160 was documented as requiring assistance with bed mobility, transfers, toilet use, and personal hygiene. Resident #160's diagnose included, but were not limited to: high blood pressure, thyroid disease, arthritis, and Alzheimer's disease. Resident #160 was assessed as not having unhealed pressure ulcers. Resident #160 was assessed as not having an indwelling urinary catheter. | F 637 | A significant change assessment was completed for resident #160 with an ARD of 4-11-22.<br><br>Quality review conducted by the DCS/designee of current residents who have had a significant change in condition in the previous 30 days to ensure a comprehensive assessment was completed.<br><br>Licensed staff re-educated by the DCS/designee on/by 5/19/2022 regarding completing a comprehensive MDS assessment after a significant change in condition.<br><br>The ED/DCS/designee to conduct quality monitoring of current residents who have had a significant change to ensure a comprehensive assessment is scheduled and completed 3 x weekly x 4 weeks, 2 x weekly x 4 weeks.<br><br>The findings of these quality monitoring□s to be reported to the Quality | |

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| F 637 | Continued From page 7<br>Resident #160's clinical documentation indicated, on 2/25/22, the resident was ordered an indwelling urinary catheter. The indwelling urinary catheter was noted to be in use on 4/5/22. Resident #160's treatment administration records (TARs) indicated the indwelling urinary catheter had been in place since ordered on 2/25/22.<br><br>Resident #160's clinical documentation indicated, on 2/28/22, a stage two pressure wound was noted to the resident's left heel and a stage one pressure wound was noted to the left calf. On 4/6/22 at 1:50 p.m., Resident #160 was observed to receive wound care: (a) for a left heel pressure wound documented as a stage II wound and (b) for a left calf pressure wound that had been documented as progressing to an unstageable wound on 3/28/22). Suspected deep tissue injuries were documented to the left medial foot on 3/7/22 and to the lower spine on 3/16/22.<br><br>Resident #160's clinical documentation did not include a significant change MDS assessment to address the changes in skin condition and the addition of an indwelling urinary catheter.<br><br>The following information was found in a facility policy titled "MDS" (with a revision date of 9/25/17): "The center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every three months for each resident including, but not limited to, the collection of data regarding functional status, strengths, weaknesses and preferences using the federal and/or state required RAI."<br><br>On 4/07/22 at 11:25 a.m., the facility's MDS nurse reported a significant change MDS assessment | F 637 | Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 637 | Continued From page 8<br>should have been completed for an ARD date of 3/4/22 instead of the "Interim Payment" MDS assessment that was completed with an ARD date of 3/4/22.<br><br>A survey team meeting was conducted with the facility's Administrator and Director of Nursing on 4/07/22 at 12:52 p.m. The failure of the facility staff to complete a significant change MDS assessment to address Resident #160's indwelling urinary catheter and skin condition changes was discussed. | F 637 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. | F 657 | | 5/18/22 |

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| F 657 | Continued From page 9<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the comprehensive person-centered plan of care for 1 of 23 residents in the survey sample, Resident #29.<br><br>Resident #29's comprehensive person-centered plan of care was not revised following discovery of the resident inappropriately touching another resident.<br><br>The findings included:<br><br>Resident #29's diagnosis list indicated diagnoses, which included, but not limited to Vascular Dementia, Chronic Obstructive Pulmonary Disease, Generalized Anxiety Disorder, Pulmonary Hypertension, and Peripheral Vascular Disease.<br>The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 2/07/22 assigned the resident a BIMS (brief interview for mental status) summary score of 0 out of 15 indicating the resident was severely cognitively impaired.<br><br>A review of Resident #29's clinical record revealed a physician's progress note dated 11/30/21 stating in part "On rounds 11-23-21 for eval (evaluation) of dementia and sexual behaviors. (He/she) recently had an incident of inappropriate touching another impaired residents [sp]. They were discovered quickly by staff and | F 657 | The care plan was updated on 4/6/22 for resident #29 to include behaviors of inappropriate touching.<br><br>Quality review conducted by the DCS/designee of current residents to ensure behaviors are care planned appropriately.<br><br>Licensed staff re-educated by the DCS/designee on/by 5/19/2022 regarding care planning behaviors appropriately.<br><br>The ED/DCS/designee to conduct quality monitoring of 5 residents 3 x weekly x 4 weeks, 2 x weekly x 4 weeks for appropriate care planning of behaviors.<br><br>The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 657 | Continued From page 10 | F 657 | | |

easily redirected. (He/she) has no recall of the event ...". On 4/05/22, the DON (director of nursing) provided the surveyor with a copy of a FRI (facility reported incident) dated 11/18/21 and follow-up investigation dated 11/22/21 regarding the aforementioned incident.

Upon review on 4/06/22, Resident #29's current comprehensive person-centered plan of care did not address the incident of inappropriate touching occurring on 11/18/21. On 4/06/22 at 1:54 pm, surveyor spoke with the MDS Nurse regarding revision of Resident #29's care plan following the incident of inappropriate touching. The MDS Nurse reviewed the resident's care plan and stated it was not listed under the behaviors care plan and this was the first time knowing of the incident.

Surveyor requested and received the facility policy entitled "Plans of Care" which read in part "Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being."

On 4/06/22 at 4:05 pm, surveyor met with the administrator and director of nursing and discussed the concern of Resident #29's care plan not being revised following an incident of inappropriately touching another resident.

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| F 657 | Continued From page 11<br>No further information regarding this concern was presented to the survey team prior to the exit conference on 4/07/22. | F 657 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review the facility staff failed to provide ADL (activities of daily living) care for a dependent resident for 1 of 23 residents, Residents #69. The facility staff failed to provide nail care.<br><br>The findings included:<br><br>Resident #69's diagnoses included, but were not limited to, chronic kidney disease, anxiety disorder, hypertension, anorexia, adult failure to thrive, and benign prostatic hyperplasia.<br><br>Section C (cognitive patterns) of Resident #69's quarterly MDS assessment with an ARD (assessment reference date) of 02/15/22 included a BIMS (brief interview for mental status) summary score of 00. Section G (functional status) was coded 3/2 for personal hygiene to indicate the resident required extensive assistance of one person for this task.<br><br>Resident #69's comprehensive care plan included the focus area-Has ADL self-care performance deficit related to diagnosis Alzheimer's dementia | F 677 | For resident #69 nail care was provided on 4/6/2022.<br><br>Quality review conducted by the DCS/designee of current residents to ensure nail care has been completed.<br><br>Facility staff re-educated by the DCS/designee on/by 5/19/2022 regarding providing nail care to residents.<br><br>The ED/DCS/designee to conduct quality monitoring of 5 residents for appropriate nail care 3 x weekly x 4 weeks, 2 x weekly x 4 weeks.<br><br>The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | 5/18/22 |

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| F 677 | Continued From page 12<br>with behaviors, confusion. Interventions included, "Check nail length and trim and clean on bath day and as necessary."<br><br>04/05/22 11:39 a.m., toenails observed to be long, thick, and jagged.<br><br>04/06/22 10:40 a.m., checked toenails with MDS coordinator, toenails remain long, thick, and jagged in appearance.<br><br>04/06/22 1:50 p.m., CNA (certified nursing assistant) #1 stated they were responsible for cutting the residents nails unless the person is a diabetic.<br><br>04/06/22 4:05 p.m., the issue with Resident #69's nails was discussed during an end of the day meeting with the administrator and DON (director of nursing).<br><br>04/07/22 12:51 p.m., during a meeting with the survey team the DON stated Resident #69 had been placed on the podiatrist list.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference. | F 677 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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 | F 684 | | 5/18/22 |

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| F 684 | Continued From page 13<br>practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow physician's orders for 2 of 23 residents in the survey sample, Resident #7 and #110.<br><br>For Resident #7, the facility staff failed to perform weekly skin assessments as ordered by the physician.<br><br>For Resident #110, the facility staff failed to transcribe a physician's order from the hospital discharge summary for wound care.<br><br>The findings included:<br><br>1. Resident #7's diagnosis list indicated diagnoses, which included, but not limited to Epilepsy, Alzheimer's Disease, Orthostatic Hypotension, Generalized Anxiety Disorder, Repeated Falls, Chronic Kidney Disease, and Essential Hypertension.<br><br>The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 1/07/22 assigned the resident a BIMS (brief interview for mental status) summary score of 2 out of 15 indicating the resident was severely cognitively impaired. Resident #7 was coded as requiring extensive assistance with bed mobility, transfers, toilet use, and personal hygiene. The resident was coded as being at risk of developing pressure ulcers.<br><br>Resident #7 had a current physician's order dated | F 684 | For resident #7 a weekly skin assessment was completed on 4/8/2022. Resident #110 was discharged on 5/26/2021.<br><br>Quality review conducted by the DCS/designee of current residents for completion of skin assessments and transcribing physician□s orders from the hospital discharge summary.<br><br>Licensed staff re-educated by the DCS on/by 5/19/2022 regarding timely completion of weekly skin assessments and transcribing physician□s orders from the hospital discharge summary.<br><br>The ED/DCS/designee to conduct quality monitoring of 5 residents 3 x weekly x 4 weeks, 2 x weekly x 4 weeks for completion of weekly skin assessments and transcription of orders from the hospital discharge summary.<br><br>The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 684 | Continued From page 14<br>12/31/21 stating "Weekly Skin Checks". Surveyor reviewed the resident's clinical record and was unable to locate documentation of any weekly skin checks.<br><br>On 4/06/22 at 10:22 am, surveyor spoke with the UM (unit manager) regarding Resident #7's weekly skin assessments. UM reviewed the resident's clinical record and acknowledged the lack of documented weekly skin assessments and stated "I am going to fix that".<br><br>Surveyor requested and received the facility policy entitled "Skin Evaluation" which read in part "A Licensed Nurse will complete a total body evaluation on each resident weekly and document the observation on the "Skin Evaluation" form.<br><br>On 4/06/22 at 4:05 pm, surveyor met with the administrator and director of nursing and discussed the concern of Resident #7's lack of weekly skin assessments as ordered by the physician.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 4/07/22.<br><br>2. Resident #110's diagnosis list indicated diagnoses, which included, but not limited to Surgical Aftercare following Surgery on the Circulatory System, Presence of Aortocoronary Bypass Graft, Atherosclerotic Heart Disease of Native Coronary Artery, Peripheral Vascular Disease, Hyperlipidemia, Essential Hypertension, Abdominal Aortic Aneurysm, and Monoplegia of Upper Limb following Cerebral Infarction Affecting Left Non-Dominant Side. | F 684 | | |

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| F 684 | Continued From page 15<br><br>The admission MDS (minimum data set) with an ARD (assessment reference date) of 5/18/21 assigned the resident a BIMS (brief interview for mental status) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #110 was coded as requiring extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and being totally dependent on staff for bathing. The resident was coded for the presence of an unstageable pressure ulcer due to coverage of the wound bed by slough and/or eschar and another unstageable pressure ulcer presenting as a deep tissue injury. Each pressure ulcer was coded as being present on admission to the facility. Resident #110 was also coded for the presence of four (4) venous and arterial ulcers and surgical wounds.<br><br>Resident #110's comprehensive person-centered plan of care included venous/stasis ulcers to the left lateral foot, top of left foot, left medial knee, left lateral knee; surgical wounds to the left medial calf and left groin; and a DTI (deep tissue injury) to the left heel.<br><br>Resident #110 was discharged from (hospital name omitted) and admitted to (facility name omitted) on 5/11/21 following a coronary artery bypass graft x four and a left femoral popliteal artery bypass with intraoperative angiogram and left femoral endarterectomy. Follow-up instructions included "keep wounds clean with hydrogen peroxide daily".<br><br>Resident #110's "Admission/Readmission Data Collection-CHC - V3" dated 5/11/21 documented in part that resident had the following skin areas present on the lower extremities: groin rash and | F 684 | | |

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| F 684 | Continued From page 16<br>incision from procedure, wound to front of left knee, abrasion to front of left lower leg, DTI (deep tissue injury) to left heel, large darken area to left heal, and "? Excoriation" to "left toe(s)".<br><br>Surveyor reviewed Resident #110's 5/11/21 admission orders and could not locate an order to clean wounds daily with hydrogen peroxide. An order dated 5/12/21 stated "skin prep to areas on left foot and heel and leg every day shift". On 4/06/22 at 9:09 am, surveyor spoke with the DON (director of nursing) regarding the reason for the hydrogen peroxide on the hospital discharge summary not being ordered upon admission to the facility. DON stated they would look into it. On 4/07/22 at 9:42 am, DON stated they did not know why the hydrogen peroxide treatment was not ordered on admission. Surveyor asked if it should have been and the DON stated "it was on the discharge summary".<br><br>On 4/07/22 at 12:52 pm, surveyor met with the administrator and DON and discussed the concern of the treatment of hydrogen peroxide not being ordered upon admission for Resident #110's wounds as documented on the discharge summary.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 4/07/22. | F 684 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | F 756 | | 5/18/22 |

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| F 756 | Continued From page 17<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(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.<br>(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.<br>(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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review and facility document review the facility staff failed to follow up on monthly drug regimen reviews for 2 of 23 residents, Resident #72 and Resident | F 756 | For resident #72 a drug regimen review was completed by the pharmacist on 4/26/2022 with no recommendations. For resident #74 a drug regimen review was | |

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| F 756 | Continued From page 18<br>#74.<br><br>For Resident #72, the facility staff failed to follow up on pharmacist recommendations for the months of September 2021 and December 2021.<br><br>For Resident #74, the facility staff failed to follow up on a pharmacist recommendation for the month of September 2021.<br><br>The findings included:<br><br>1. Resident #72's face sheet included diagnoses which included but not limited to Alzheimer's disease, dementia, Type 2 diabetes mellitus, depression, hypertension, and gastroesophageal reflux disease.<br><br>Resident #72's most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 02/21/22 assigned the resident a BIMS (brief interview for mental status) score of 2 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired.<br><br>Resident #72's clinical record was reviewed and contained monthly MRR's (medication regimen review) dated 09/24/21 and 12/29/21, which read in part "See report for any noted irregularities and/or recommendations. This resident's medical record including electronic documentation was reviewed on this date". These reviews were signed by the consultant pharmacist. The surveyor could not locate the recommendations in the resident's clinical record.<br><br>Surveyor spoke with the DON (director on nursing) on 04/06/22 at 3pm regarding the | F 756 | completed by the pharmacist on 4/25/2022 with a recommendation to decrease Lexapro to 10mg daily. The order was given and started on 4/29/2022.<br><br>Quality review conducted by the DCS/designee of current residents to ensure that monthly drug regimen reviews are followed up on and orders are obtained as needed.<br><br>Licensed staff re-educated by the DCS/designee on/by 5/19/2022 regarding appropriate follow-up on monthly drug regimen reviews.<br><br>The ED/DCS/designee to conduct quality monitoring of 5 residents 3 x weekly x 4 weeks, 2 x weekly x 4 weeks for appropriate follow-up on monthly drug regimen reviews.<br><br>The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 756 | Continued From page 19 | F 756 | | |

missing pharmacy recommendations. DON informed surveyor on 04/07/22 at 10:30 am that the recommendations had not been located.

Surveyor requested and was provided with a facility policy entitled "Medication Regimen Review", which read in part "1. The Consultant Pharmacist will conduct MRR's if required under a Pharmacy Consultation Agreement and will make recommendation based on the information available in the resident's health record. 6. The pharmacist will address copies of residents' MRRs to the Director of Nursing and /or the attending physician and to the Medical Director. Facility staff should ensure that the attending physician, Medical Director, and Director of Nursing are provided with copies of the MRR's. 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon recommendations contained in the MRR. 7.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been take to address it. 8. Facility should alert the Medical Director where the MRR's are not addressed by the attending physician in a timely manner."

The concern of the missing pharmacy recommendations was discussed with the administrative team during a meeting on 04/07/22 at 12:50 pm.

No further information was provided prior to exit.

2. Resident #74's face sheet listed diagnoses which included but not limited to heart failure,

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| F 756 | Continued From page 20<br>acute kidney failure, atrial fibrillation, type 2 diabetes mellitus, hypertension, anxiety, depression and schizoaffective disorder.<br><br>Resident #74's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 02/22/22 assigned the resident a BIMS (brief interview for mental status) score of 13 out of 15 in Section C, cognitive patterns. This indicates that the resident is cognitively intact.<br><br>Resident #74's clinical record was reviewed and contained a monthly MRR (medication regimen review) dated 09/24/21, which read in part ""See report for any noted irregularities and/or recommendations. This resident's medical record including electronic documentation was reviewed on this date". This review was signed by the consultant pharmacist. The surveyor could not locate the recommendation in the resident's clinical record.<br><br>Surveyor spoke with the DON (director on nursing) on 04/06/22 at 3pm regarding the missing pharmacy recommendation. DON informed surveyor on 04/07/22 at 10:30 am that the recommendation had not been located.<br><br>Surveyor requested and was provided with a facility policy entitled "Medication Regimen Review", which read in part "1. The Consultant Pharmacist will conduct MRR's if required under a Pharmacy Consultation Agreement and will make recommendation based on the information available in the resident's health record. 6. The pharmacist will address copies of residents' MRRs to the Director of Nursing and /or the attending physician and to the Medical Director. Facility staff should ensure that the attending | F 756 | | |

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| F 756 | Continued From page 21<br>physician, Medical Director, and Director of Nursing are provided with copies of the MRR's. 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon recommendations contained in the MRR. 7.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been take to address it. 8. Facility should alert the Medical Director where the MRR's are not addressed by the attending physician in a timely manner."<br><br>The concern of the missing pharmacy recommendation was discussed with the administrative team during a meeting on 04/07/22 at 12:50 pm.<br><br>No further information provided prior to exit. | F 756 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, facility document review, and during a medication pass and pour observation, the facility staff failed to ensure a medication error rate of less than 5% there were 3 errors in 30 opportunities for a medication error rate of 10%. These errors effected Residents #12 and #42. | F 759 | For resident #12 an order was obtained on 4-6-22 that read Senna 8.6mg give 2 tablets by mouth twice daily. For resident #42 the Lexapro 5mg was administered on 4-6-22 as well as the Carboxymethylcellulose sodium PF solution. | 5/18/22 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 759 | Continued From page 22<br>The findings included:<br><br>1. Section C (cognitive patterns) of Resident #12's annual MDS (minimum data set) assessment with an ARD (assessment reference date) 01/05/22 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points.<br><br>The clinical record included the diagnoses Alzheimer's, dementia, glaucoma, and chronic kidney disease.<br><br>04/06/22 7:48 a.m., LPN (licensed practical nurse) #1 prepared Resident #12's morning medications to include Senna 8.6 mg 2 tablets.<br><br>Resident #12's clinical record included a physicians order for Senna 8.6 mg give 1 tablet by mouth two times a day for constipation.<br><br>04/06/22 9:34 a.m., LPN #1 stated they administered Senna 2 tablets. LPN #1 reviewed the clinical record and stated the order read 1 tablet and they were going to contact the doctor as the resident could use 2 tablets.<br><br>04/06/22 10:30 a.m., the DON (director of nursing) provided the survey team with a copy of a policy titled, General Dose Preparation and Medication Administration." This policy read in part, "...Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record..."<br><br>4/06/22 4:05 p.m., during an end of the day meeting the medication error rate was discussed with the administrator and DON (director of | F 759 | Quality review conducted by the DCS/designee of medication administration for current nurses.<br><br>Licensed staff re-educated by the DCS/designee on/by 5/192022 regarding medication administration.<br><br>The ED/DCS/designee to conduct quality monitoring of a licensed nurses□ medication administration 3 x weekly x 4 weeks, 2 x weekly x 4 weeks.<br><br>The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 759 | Continued From page 23<br>nursing).<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference.<br><br>2. Section C (cognitive patterns) of Resident #42's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/09/22 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points.<br><br>The clinical record included the diagnoses, Alzheimer's and major depressive disorder.<br><br>04/06/22 8:28 a.m., the surveyor observed LPN (licensed practical nurse) #2 prepare Resident #42's morning medications to include the medication Escitalopram (Lexapro) 10 mg.<br><br>Resident #42's clinical record included a physicians order for Escitalopram give 15 mg by mouth one time a day for major depressive disorder. The clinical record also included an order for Carboxymethylcellulose sodium PF solution instill 1 drop in both eye two times a day for eye dryness. The surveyor did not observe any eye drops being administered.<br><br>04/06/22 9:40 a.m., the surveyor and LPN #2 checked the medication cart for the Escitalopram. The medication card read Escitalopram 10 mg give with 5 mg. LPN #2 stated they did not have a 5 mg card of this medication and they had not administered the residents eye drops. LPN #2 later stated they had found the 5 mg card of Escitalopram in the medication drawer but it was turned backwards. | F 759 | | |

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| F 759 | Continued From page 24<br><br>04/06/22 10:30 a.m., the DON (director of nursing) provided the survey team with a copy of a policy titled, General Dose Preparation and Medication Administration." This policy read in part, "...Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record..."<br><br>4/06/22 4:05 p.m., during an end of the day meeting the medication error rate was discussed with the administrator and DON (director of nursing).<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference. | F 759 | | |
| F 888 SS=D | COVID-19 Vaccination of Facility Staff<br>CFR(s): 483.80(i)(1)-(3)(i)-(x)<br><br>§483.80(i)<br>COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.<br><br>§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for | F 888 | | 5/18/22 |

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| F 888 | Continued From page 25 | F 888 | | |

the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of

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| F 888 | Continued From page 26<br>additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;<br>(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;<br>(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;<br>(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;<br>(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;<br>(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:<br>(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and<br>(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 | F 888 | | |

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| F 888 | Continued From page 27<br>vaccination requirements for staff based on the recognized clinical contraindications;<br>(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and<br>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.<br><br>Effective 60 Days After Publication:<br>§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and facility document reviews, the facility staff failed to correctly implement contingency plans for staff who were not fully vaccinated for COVID-19.<br><br>The findings include:<br><br>Two (2) staff members (SMs), with COVID-19 vaccine exemptions, were reviewed as part of the COVID-19 immunization review (SM #21 and SM #22). | F 888 | SM #21 and #22 were given a respirator to wear on 4-6-22.<br><br>Quality review conducted by the DCS/designee of current employees with COVID-19 vaccine exemptions to ensure they were wearing a N95 mask.<br><br>Facility staff re-educated by the DCS/designee on/by 5/19/2022 regarding wearing N95 mask if employee has a COVID-19 vaccine exemption. | |

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| F 888 | Continued From page 28<br>On 4/6/22 at 9:30 a.m., SM #21 was observed to have a KN95 mask. SM #21 reported, as part of the facility's exemption contingency plan, they had to wear the mask when not eating or drinking. SM #21 also reported they had to have weekly COVID-19 test completed. On 4/6/22 at 9:40, SM #21 was asked about wearing a N95 mask verses a KN95 mask; SM #21 indicated their understand was the KN95 was okay to wear.<br><br>On 4/6/22 at 9:35 a.m., SM #22 was observed to be wearing a KN95 mask. SM #22 reported, as part of the facility's exemption contingency plan, they had to wear the mask. SM #22 also reported they had to have weekly COVID-19 test completed. SM #22 was asked if the mask should be a N95 mask instead of a KN95; SM #22 indicated they believed the mask they were wearing was appropriate.<br><br>The following information was found in a facility policy titled "Employee COVID-19 Vaccinations" (with a revised date of 3/23/22): "Exempted Employees and Reasonable Accommodation: ... Current guidance, which is subject to change, requires the use of Universal Source Control depending on Community Transmission rates and regular testing for all unvaccinated personnel working in Care Centers ... Staff will use Respirators [sic] as source control ..."<br><br>A survey team meeting was conducted with the facility's Administrator and Director of Nursing on 4/6/22 at 4:05 p.m. The facility's policy requiring staff members with COVID-19 vaccine exemptions to use "respirators" for source control and the observations of SM #21 and SM #22 to be using KN95 mask was discussed. The administrative team reported that the expectation | F 888 | The ED/DCS/designee to conduct quality monitoring of 5 employees with COVID-19 vaccine exemptions 3 x weekly x 4 weeks, 2 x weekly x 4 weeks to ensure N95 masks are worn.<br><br>The findings of these quality monitoring□s to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee. | |

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| F 888 | Continued From page 29<br>was that the staff with COVID-19 vaccine exemptions would wear N95 masks not KN95 masks. The Administrator reported the facility provided its staff with N95 masks. | F 888 | | |