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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/24/2022 through 7/27/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 7/24/2022 through 7/27/2022. Six complaints (VA00055349 - Unsubstantiated, VA00055210 - Substantiated with deficiency, VA00055111 - Substantiated without deficiency, VA00054750-Unsubstantiated, VA00054360-Unsubstantiated, VA00051426-Subtantiated without deficiency) were investigated during the survey. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 85 certified bed facility was 70 at the time of the survey. The survey sample consisted of 19 current resident reviews and 7 closed record reviews. The Life Safety Code survey/report will follow.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578	1. Resident # 39 code status was changed from a full code to DNR per his request. 2. Any resident has the potential to be affected. Social Services or designee will complete 100% audit to verify resident's code status is correct and entered into the EMR correctly. 3. Social Services and Staff Nurses will be educated on Resident Rights for decision making regarding Advanced Directives and reviewing the 24 hour report by the DON or designee. Education will be reviewed in New Hire orientation. 4. Social Services or designee to conduct an audit of 5 charts per week to verify Code status weekly x 4 weeks, then monthly x2 months. DON or designee will review findings and report to QAA committee monthly x 3 months. 5. September 8, 2022	

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

Cheri Asbill | Regional Vice President of Operations | 8/16/22

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

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F 578	Continued From page 1 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: Based on staff interview and clinical record review, the facility staff failed to ensure the correct code status for 1 of 19 residents in the survey sample, Resident #39. For Resident #39, the facility staff failed to carry out the resident's and family's decision to change	F 578		

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F 578	Continued From page 2 their code status to do not resuscitate (DNR). The findings included: Resident #39's diagnosis list indicated diagnoses, which included, but not limited to End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, Atherosclerotic Heart Disease of Native Coronary Artery, Dementia. Essential Hypertension, and Cognitive Communication Deficit. The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 5/31/22 assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 indicating the resident was severely cognitively impaired. Resident #39's current physician's orders included an advanced directive order dated 7/05/22 for "Full Code" and a 7/12/22 order stating "resident is comfort care". The resident's clinical record included an "Advance Care Planning Tracking" form dated 12/09/21 indicating the resident's advanced directive was "Full Code". Resident #39's comprehensive person-centered care plan included a focus area dated 7/19/22 stating "Resident/Responsible party has chosen Full Code". An intervention stated "If resident/responsible party chooses to change code status, necessary protocol will be completed ie new order, update documentation/care plan". Resident #39's clinical record included a physician's progress note dated 7/08/22 at 3:47 pm stating in part "D/w (discussed with) wife over the phone and explained his overall deteriorated	F 578		

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F 578	Continued From page 3 condition. As per wife she wants him to be DNR ..." Surveyor was unable to locate documentation following the 7/08/22 physician's progress note related to the responsible party's decision to change the resident's code status from full code to DNR. On 7/25/22, surveyor requested to speak with the social worker, however, they were no longer working at the facility and the new social worker had not started yet. On 7/25/22 at 4:10 pm, the survey team met with the Administrator, Director of Nursing (DON), Regional Director of Clinical Services, and the Regional Vice President of Operations and discussed the concern regarding Resident #39's code status. On 7/26/22 at 1:35 pm, the DON stated a social worker was coming in today to address Resident #39's code status. On 7/26/22 at 3:15 pm, surveyor spoke with registered nurse (RN) #4 who stated they have spoken with the resident and the family and they want to be a DNR. RN #4 provided surveyor with a progress note dated 7/26/22 2:22 pm stating "This nurse, DOR, and (name omitted), SW (social worker) talked to (Resident #39's) family and (Resident #39) concerning his desire to be a DNR. (Resident #39) cannot sign the DNR but he was able to verbalize his desire to have no heroics and to die naturally. DNR form will be left for wife to sign the next time she is in the facility". No further information regarding this concern was presented to the survey team prior to the exit conference on 7/27/22.	F 578		

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to follow physician's orders for 2 of 19 residents, Resident #59 and Resident #68. For Resident #59 the facility staff failed to notify the physician when the resident's blood sugars were outside of the ordered parameters. For Resident #68 the facility staff failed to administer the medication, Keflex as ordered by the physician. The findings included: 1. Resident #59's face sheet included diagnoses which included but not limited to type 2 diabetes mellitus with diabetic polyneuropathy, other specified complication and other circulatory complications, depression, benign prostatic hyperplasia with lower urinary tract symptoms, other seizures, and hypertension. Resident #59's admission minimum data set with an assessment reference date of 06/09/22 assigned the resident a brief interview for mental	F 684	1. For resident #68, the MD and RP was notified of failure to administer medication. Medication schedule was adjusted to ensure resident #68 received all doses. For resident #59, blood sugar was rechecked after insulin administered outside of parameters. MD and RP notified. Resident had no adverse effect from insulin administration. 2. Any resident has the potential to be affected. 100% audit will be conducted for the past 7 days on all residents to ensure that physician orders are being followed. 3. All licensed nursing staff will be educated on the procedure for implementing physicians orders as ordered. This education will be conducted by the DON or designee and reviewed in new hire orientation. 4. A random audit of 5 charts will be conducted by DON or designee on physician orders to ensure compliance weekly x 4 weeks, then monthly x 2 months. Audit results will be reported to the QAA committee monthly x 3 months. 5. September 8, 2022	

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F 684	Continued From page 5 status score of 15 of 15 in section C, cognitive status. Resident #59's comprehensive care plan was reviewed and contained a care plan for "At risk for hypoglycemia/hyperglycemia r/t (related to) Diabetes, insulin". Interventions for care plan include "Monitor blood sugar levels as ordered". Resident #59's clinical record was reviewed and contained a physician's order summary for July, which read in part "Accuchecks BID (twice a day) two times a day for DM (diabetes mellitus) 2 Notify MD if BS is less than 60 or greater than 400". Resident #59's electronic medication administration record for the month of July was reviewed and contained an entry as above. The blood sugar on 07/06/22 at 5 pm was recorded as 488. The blood sugar on 07/10/22 at 5 pm was recorded as 409. There was no recorded blood sugar on 07/09/22 at 5 pm. Surveyor reviewed Resident #59's nurse's progress notes and could not locate any notes indicating that the physician had been notified that the resident's blood sugars were outside the specified parameters. Surveyor spoke with the director of nursing (DON) on 07/26/22 at 2:35 pm regarding Resident #59's blood sugars. DON stated that the physician should have been notified if the resident's blood sugars fell outside the ordered parameters. The concern of not following the physician's orders for notifying the physician of blood sugars outside of ordered parameters was discussed	F 684		

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F 684	Continued From page 6 with the administrative team (administrator, DON) during a meeting on 07/27/22 at 12:55 pm. No further information was provided prior to exit. 2. Resident #68's admission record listed their diagnoses to include, but were not limited to, multiple sclerosis, cognitive communication deficit, neuromuscular dysfunction of bladder, history of urinary tract infections, pressure ulcer of unspecified site, and anxiety disorder. Section C (cognitive patterns) of the resident's quarterly minimum data set with an assessment reference date of 07/06/22 coded the resident's brief interview for mental status at 13 out of 15. Resident #68's clinical record contained a nursing progress note that read the resident was seen by the hospice on-call nurse on 7/23/2022 after the facility nurse could not get the resident's suprapubic catheter to drain urine. Resident #68 was subsequently sent to a local emergency department (ED) where the catheter was replaced and the resident was discharged back to the nursing home without being admitted to the hospital. The ED discharge summary information read the diagnoses included, but not limited to, cystitis. The provider wrote the resident did not have a urinary tract infection however, ordered the resident to received Keflex Capsule 500mg (Cephalexin) give 1 capsule by mouth four times a day until 08/02/2022. The medication administration record (MAR) in Resident #68's clinical record failed to indicate the 7/24/2022 4:00 p.m. dose was administered; there were no staff initials or any "checks" in the box for that date/time. The director of nursing	F 684		

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F 684	Continued From page 7 (DON) was asked about this dose and acknowledged that medication (Cephalexin 500mg capsule) was available in the facility's medication dispensing system (Omnicell). On 7/27/2022 at approximately 11:40 a.m. the DON reported Resident #68 did not receive the 4:00 p.m. dose of Keflex on 7/24/2022. No further information was provided prior to the exit conference.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents with pressure ulcers receive necessary treatment and services to promote healing for 1 of 19 residents in the survey sample, Resident #39. For Resident #39, the facility staff failed to follow	F 686	1. Resident #39's wound dressing was immediately changed per the current wound MD's orders. 2. Any resident has the potential to be affected.A 100% audit of all residents with wounds will be conducted to ensure treatment are carried out per MD order. 3. Licensed Nursing staff will be educated by DON or designee on the procedure for reviewing Wound Care MD assessments for new orders and implementation and education will be reviewed in new hire orientation. 4. A random audit of 5 charts will be conducted by DON or designee on all residents with wounds to ensure compliance with orders x 4 weeks, then monthly x 2 months. Audit results will be reported to the QAA committee monthly x 3 months. 5. September 8, 2022	

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F 686	Continued From page 8	F 686		

the wound care physician's treatment plan for pressure areas to the left and right buttocks.

The findings included:

Resident #39's diagnosis list indicated diagnoses, which included, but not limited to End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, Atherosclerotic Heart Disease of Native Coronary Artery, Dementia, Essential Hypertension, and Cognitive Communication Deficit.

The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 5/31/22 assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 indicating the resident was severely cognitively impaired. The resident was coded as requiring extensive assistance with bed mobility, transfers, toilet use, and limited assistance with dressing and personal hygiene. Resident #39 was coded for the presence of one Stage 3 pressure ulcer present upon admission/entry or reentry.

Resident #39's current comprehensive person-centered care plan included a focus area revised on 7/14/22 stating sacral into left and right buttocks wounds with an intervention for meds, labs, and treatment as ordered.

Resident #39's current physician's orders included a treatment order to the sacrum/left buttocks dated 7/06/22 to clean with soap and water, pat dry, apply adaptic and foam dressing and change daily or if becomes soiled.

Resident #39 was last assessed by the wound

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F 686	Continued From page 9	F 686		

physician on 7/12/22. The progress note described the pressure area to the left buttocks as full thickness measuring 7.5 x 1.4 x 0.1 cm with a moderate amount of serous exudate with 50% slough and 50% granulation tissue present. The pressure area to the right buttocks was described as full thickness measuring 2.0 x 2.5 x 0.2 cm with a moderate amount of serous exudate with 50% slough and 50% granulation tissue present. The progress note documented the treatment plan to the left and right buttocks as Alginate Calcium and Santyl to be applied once daily for 30 days covered with a superabsorbent silicone dressing. Treatment also included the application of Zinc ointment once daily to the peri wound for 30 days. Surveyor reviewed Resident #39's clinical record and was able to locate documentation indicating the wound physician's treatment plan from 7/12/22 had been carried out.

On 7/26/22 at 8:20 am, surveyor spoke with registered nurse (RN) #2 who stated they were currently working with resident wounds. RN #2 reviewed Resident #39's current wound treatment orders and immediately stated "man, I got to change that". RN #2 further stated she thought she had changed the order but will correct it now. Surveyor asked RN #2 if the order should be the treatment documented by the wound physician and RN #2 stated yes.

Surveyor requested and received the facility policy entitled "Pressure Injury Prevention and Treatment Policy" which read in part " ...Pressure injuries identified will be documented and orders obtained from providers for treatment ..."

On 7/27/22 at 12:52 pm, the survey team met with the Administrator, Director of Nursing,

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F 686	Continued From page 10 Regional Director of Clinical Services, and the Corporate Administrator and discussed the concern of Resident #39's pressure ulcer treatments not being carried out as directed by the wound physician. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/27/22.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility document review, the facility staff failed to ensure water temperatures were maintained in acceptable parameters to decrease the risk of resident injury. The findings include: On the afternoon of 7/24/22, water temperatures at the sinks of two (2) resident bathrooms were noted to be uncomfortably hot. On 7/24/22 at approximately 4:30 p.m., the facility's Administrator checked the water temperatures from the sinks in two (2) resident bathrooms (the bathroom that was shared by resident rooms 210 and 212 and the bathroom that was shared by	F 689	1. Water temperatures were immediately adjusted in the 2 identified rooms by the Maintenance Director. 2. Any resident has the potential to be affected. A 100% audit of water temperatures in resident rooms will be conducted to ensure appropriate regulatory temperatures by the Maintenance Director or designee. 3. Education will be provided to the Maintenance Director by Administrator on the regulation for monitoring water temperatures for correct temperature and the education will be reviewed in new hire orientation. 4. An audit will be conducted by the Maintenance Director or designee on 5 rooms to ensure appropriate water temperature weekly x 4 weeks then monthly x 2 months. Administrator or designee will review findings and report to QA committee for further recommendations monthly x 3 months. 5. September 8, 2022	

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F 689	Continued From page 11	F 689		

resident rooms 209 and 211). The water temperature for the sink in the bathroom shared by resident rooms 210 and 212 was 121.5 degrees Fahrenheit. The water temperature for the sink in the bathroom shared by resident rooms 209 and 211 was 120.6 degrees Fahrenheit.

On 7/25/22 at 4:37 p.m., the Administrator reported the facility did not have a written policy or guidance detailing: (a) how often facility water temperatures should be check or (b) temperature range limits. The Administrator reported the facility staff followed state and federal guidance/regulations related to water temperatures.

On 7/25/22 at 8:59 a.m., the Administrator provided a copy of the facility's July "WATER TEMPERATURE LOG" form. This form provided evidence of water temperatures being checked daily (Monday through Friday); the water temperatures ranged between 114 degrees Fahrenheit and 117 degrees Fahrenheit. The Administrator reported the goal is for the facility's hot water is to be less than 120 degrees Fahrenheit.

On 7/26/22 at 4:36 p.m., the facility's Director of Maintenance reported they had adjusted the temperature of the facility's hot water. The Director of Maintenance provided the survey team with a copy of a form with water temperature checks throughout the facility dated 7/25/22; none of the temperatures were above 120 degrees Fahrenheit.

On 7/27/22 at 12:51 p.m., the aforementioned water temperatures were discussed, during a

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F 689	Continued From page 12 survey team meeting, with the facility's Administrator and DON.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to provide oxygen therapy according to the physician's order and the comprehensive person-centered care plan for 1 of 19 residents in the survey sample, Resident #53. For Resident #53, the facility staff failed follow the physician's order for oxygen administration. The findings included: Resident #53's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia, Dysphagia, Dysarthria and Anarthria, Chronic Pain Syndrome, Anxiety Disorder, Essential Hypertension, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease (COPD). The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD)	F 695	1. Resident #53's oxygen rate was immediately adjusted to prescribed flow rate upon discovery. 2. Any resident has the potential to be affected. A 100% audit of all residents receiving oxygen will be conducted to verify flowrate per MD order by the DON or designee. 3. Licensed Nursing staff will be educated by the DON or designee on the policy of ensuring the oxygen flow rates are administered per MD order and the education will be reviewed in new hire orientation 4. A random audit of 5 residents will be conducted by the DON or designee on residents receiving oxygen to verify prescribed flow rate for accuracy weekly x 4 then monthly x 2 months.The DON or designee will review findings and report to QA for further recommendations monthly x 3 months. 5. September 8, 2022	

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F 695	Continued From page 13	F 695		

of 6/16/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #53 was coded as requiring extensive assistance with bed mobility, dressing, toileting, personal hygiene, and being totally dependent on staff for transfers. The resident was also coded as receiving oxygen therapy within the last 14 days.

Resident #53's current comprehensive person-centered care plan included a focus area dated 6/21/22 stating "Resident is on oxygen therapy r/t (related to) COPD, hx (history) sob (shortness of breath)/wheezing". Interventions included "Administer oxygen as ordered" and "Oxygen: O2 (oxygen) at 2 LPM (liters per minute) via NC (nasal cannula)".

Resident #53's current physician's orders included an order dated 4/19/22 for oxygen at 2 liters per minute via NC.

On three separate occasions, 7/24/22 at 4:36 pm, 7/25/22 at 7:53 am, and 7/25/22 at 12:32 pm, surveyor observed Resident #53 in bed receiving oxygen via nasal cannula at the rate of 5 liters per minute per the oxygen concentrator.

On 7/25/22 at 4:10 pm, the survey team met with the Administrator, Director of Nursing (DON), Regional Director of Clinical Services, and the Regional Vice President of Operations and discussed the concern of Resident #53 not receiving oxygen at the rate ordered by the physician.

On 7/27/22 at 10:15 am, surveyor spoke with the DON who stated she spoke with Resident #53

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F 695	Continued From page 14 and the resident stated they were supposed to be getting oxygen at 4 l/m. DON stated she was not sure if the resident could change the oxygen setting on the concentrator by themselves. DON provided a nursing progress note dated 7/25/22 6:50 pm stating in part "In to assess resident states (he/she) is supposed to be getting 4 liters of O2 per nasal cannula. Resident educated on order for 2 LPM. Resident states "No 4, 4." Obtaining clarification for O2 order from MD ..." Surveyor requested and received the facility policy entitled "Oxygen Administration (all routes)" which read in part "Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider". No further information regarding this concern was presented to the survey team prior to the exit conference on 7/27/22.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700	1. Resident # 372 bed rail assessment was immediately completed. Maintenance Director completed bed safety assessment to verify safety with grab bar use for Resident #372. 2. Any Resident has the potential to be affected. A 100% audit will be conducted to ensure that all residents have side rail assessments completed and side rails are being used appropriately by the DON or designee. A 100% audit will be conducted to ensure all residents beds have been assessed for risk of entrapment by the Maintenance Director. 3. Education will be provided to all nursing staff and the Director of Maintenance on the regulations and policies surrounding side rail assessments and bed entrapment assessment and risks by the Administrator or designee and education will be reviewed in new hire orientation. 4. An audit of 5 residents will be conducted by the Maintenance Director to verify bed safety and risk of entrapment weekly x 4 weeks then monthly x 2months. The DON or designee will conduct an audit on 5 residents to verify bed rail assessments are complete on residents requiring bed rails bars weekly x 4 weeks then monthly x 2 months. The DON or designee will review findings and report to QAA committee monthly x 3 months. 5. September 8, 2022	

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§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to inspect the bed frame, mattress, and the bed rails for the risk of entrapment prior to resident use and failed to assess for the safe use of side rails and risk of entrapment following an incidence of entrapment for 1 of 19 residents in the survey sample, Resident #372.

For Resident #372, the facility staff failed to assess the resident for the safe use of side rails and risk of entrapment following an incident where the resident's neck became stuck between the bed and bed rail. Facility staff was unable to provide evidence of a bed safety inspection for Resident #372's bed prior to the incident.

The findings included:

Resident #372's diagnosis list indicated diagnoses, which included, but not limited to Generalized Muscle Weakness, Dementia with Behavioral Disturbance, Dysphagia, Hypothyroidism, Essential Hypertension, Morbid Obesity, Sequelae of Cerebral Infarction, Fracture of Third Thoracic Vertebra, Displaced Fracture of Second Cervical Vertebra, and Displaced Bimalleolar Fracture of Right Lower Leg.

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The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 6/20/22 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired. The resident was coded as being totally dependent on staff for transfers and toilet use and requiring extensive assistance with bed mobility, dressing, and personal hygiene.

Resident #372's current comprehensive person-centered care plan included an intervention dated 7/13/22 for bilateral ¼ assist bars for bed mobility and an intervention dated 6/15/22 for an air mattress to the bed. The resident's current physician's orders included an order dated 7/12/22 for bilateral ¼ assist bars for bed mobility and an order dated 5/13/22 for a pressure reducing mattress to bed.

On 7/25/22 at 7:50 am, surveyor observed Resident #372 in bed with an air mattress and one-quarter side rails/assist bars present on each side of the bed. The resident had a personal sitter present in the room.

A review of Resident #372's clinical record revealed a progress note dated 6/05/22 at 3:00 am stating in part "Resident was also sitting/laying on the ground. Both the sitter and the CNA (certified nursing assistant) immediately explained that while attempting to change resident, the resident turned started hitting, scratching. Once the resident let go of the sitter she finished falling. Nurse noted that is [sp] appeared that resident's neck was stuck between the bed and bed rail. Once resident allowed us to help her we were able to get her turned around

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and sitting on her bottom against the bed. Resident stated that her neck hurt. Resident has recently had cervical spine surgery within two weeks. Resident refused to allow staff to take vitals, do a neuro-check, or skin assessment. Resident also refused to allow staff to put her back in bed. Nurse immediately called DON (director of nursing) and was told to call provider that this is normal behavior for this resident. Nurse reached out to provider and explained the situation including residents C/O (complaints of) pain to her neck, the possible injury to her neck R/T (related to) her recent surgery, and the fact that initially resident stated she wanted to go to the hospital. Provider stated that she does not need to go to the hospital and that her family does not need to be notified. It was stated that she has dementia and that this behavior is normal for [sp] as she does this type of thing all the time ...Evidence of pain noted neck pain is throbbing pain is sharp pain level is 7 out of 10 ...Residents family/responsible party was notified of the occurrence ..."

Surveyor attempted to interview the nurse present on 6/05/22 at 3:00 am, however, they were an agency nurse and no longer working for the facility. On 7/26/22 at 2:15 pm, surveyor spoke with the DON and requested to speak with the CNA present on 6/05/22 at 3:00 am, DON stated they would find out who the CNA was and if they were still working at the facility. Information regarding the CNA was not provided to the surveyor prior to the exit conference.

Surveyor reviewed Resident #372's clinical record and was unable to locate an assessment for the safe use of side rails and risk of entrapment following the 6/05/22 incident. The most recent

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Bed Rail Assessment for the resident was completed on 5/13/22 indicating the resident needed the side rails for transfers and bed mobility to aide in turning and repositioning promoting patient independence. No potential risks were indicated on the form. Question #1.3. on the assessment stated "Alternatives attempted that failed to meet resident's need / alternatives considered but not attempted because they were considered inappropriate / or refused by resident/resident representative, prior to the use of side rails", for the response, the nurse documented "n/a".

On 7/25/22 at 3:40 pm, surveyor met with the DON, Administrator, and Regional Director of Clinical Services regarding Resident #372's incident on 6/05/22. The DON stated a new side rail assessment was not completed because an assessment was just recently done on 5/13/22. DON stated a new side rail assessment was completed today for the resident and they were determined safe to have the current side rails. DON also provided surveyor with an inservice sheet dated 6/06/22 for the topic "Documentation - bed rail assessments to verify ability to utilize appropriately" signed by 13 attendees.

On 7/25/22 at 3:52 pm, surveyor received a copy of a form entitled "Bed and Bed Rail Safety Inspection" dated 6/05/22 completed by the Maintenance Director indicating Resident #372's bed, labeled #43, passed inspection.

On 7/26/22 at 1:12 pm, surveyor requested evidence of the bed and bed rail safety inspection for bed #43 prior to 6/05/22. At 2:20 pm, the administrator stated they do not have documentation of a prior inspection for bed #43.

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F 700	Continued From page 19 On 7/26/22 at 3:08 pm, surveyor spoke with the Maintenance Director who stated they began working at the facility at the end of April 2022 and began working on the bed safety inspections during the first part of June and have 26 beds left to inspect and plans to have them completed by the end of the day. The Maintenance Director stated that prior to this, the last time bed inspections were done was back in 2020. The Maintenance Director returned at 4:28 pm and stated they had completed all of the bed inspections and all beds had passed inspection. Surveyor requested and received the facility policy entitled "Bed Rail Policy" which read in part: 1. The facility will attempt to use appropriate alternatives prior to installing a side or bed rail. 2. If a bed or side rail is used, the facility will: a. Assess the potential risks associated with the use of bed rails including the risk of entrapment, prior to bed rail installation. d. Ensure appropriate dimensions of the bed, based on the resident's size and weight. e. Ensure correct installation of bed rails, including adherence to manufacturer's recommendations and/or specifications. f. Ensure correct use of an installed bed or side rail. g. Ensure scheduled maintenance of any bed rail in use according to manufacturer's recommendations and specifications. Surveyor requested and received the facility policy entitled "Bed Identification and Safety Inspection Policy" which read in part "5. Inspections will be completed annually and as needed when bed/mattress configuration changes. The inspection checklists will be kept in	F 700		

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F 700	Continued From page 20 a separate binder or tab kept current by environmental services / maintenance. The checklists will be kept for a minimum of 3 years". On 7/27/22 at 12:52 pm, the survey team met with the Administrator, DON, Regional Director of Clinical Services, and the Corporate Administrator and discussed the concern of Resident #372's one-quarter side rails. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/27/22.	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	1. Resident # 59's medication has been obtained from pharmacy and given per MD order. The MD has been notified of medication omission. Resident #59 is his own RP and is aware of omission. 2. Any resident has the potential to be affected. A audit of the past 3 days medication orders will be conducted to ensure that medications were available as ordered by the DON or designee. 3. Licensed Nursing staff will be educated on regulation and procedure to ensure that medications are present from pharmacy to administered as ordered by the DON or designee and education will be reviewed in new hire orientation. 4. A random audit of 5 charts will be conducted by the DON or designee to ensure that medications are administered as ordered weekly x 4 weeks and monthly x 2 months. The DON or designee will review findings and report to QA for further recommendations monthly x 3 months 5. September 8, 2022	

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F 755	Continued From page 21 §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, facility document review, and clinical record review the facility staff failed to ensure medications were available for administration for 1 of 19 residents, Resident #59. For Resident #59 the facility staff failed to ensure the medication Neurontin was available for administration for 5 consecutive doses. Neurontin (gabapentin) is a medication used in the treatment of neuropathy and seizures. The findings included: Resident #59's face sheet included diagnoses which included but not limited to type 2 diabetes mellitus with diabetic polyneuropathy, other specified complication and other circulatory complications, depression, benign prostatic hyperplasia with lower urinary tract symptoms, other seizures, and hypertension. Resident #59's admission minimum data set with an assessment reference date of 06/09/22 assigned the resident a brief interview for mental status score of 15 of 15 in section C, cognitive status.	F 755		

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F 755	Continued From page 22 Resident #59's comprehensive care plan was reviewed and contained a care plan for "At risk for pain r/t (related to) decreased mobility/weakness, compression FX (fracture), spastic left sided hemiplegia, polyneuropathy, RBKA (right below the knee amputation), HX (history) of phantom limb pain". Interventions for the care plan included "Medications as ordered". Resident #59's clinical record was reviewed and contained a physician's order summary for the month of July 2022 which read in part "Neurontin Capsule 400 MG (Gabapentin) Give 1capsule by mouth three times a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY (E11.42)" Resident #59's electronic medication administration record for the month of July 2022 was reviewed and contained an entry as above. This entry was coded "19" on 07/24/22 at 8 pm, 07/25/22 at 6 am and 8 pm, and coded "16" on 07/25/22 at 2 pm and 07/26/22 at 6 am. Chart code "19" is the equivalent of "Other/See Nurses Notes". Chart code "16" is the equivalent of "Hold/See Nurses Notes". Resident #59's nurse's progress notes were reviewed and contained notes which read in part "7/24/2022 21:30 Note Text: Neurontin Capsule 400 MG. Give 1 capsule by mouth three times a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY on order", "7/25/2022 06:06 Note Text: Neurontin Capsule 400 MG. Give 1 capsule by mouth three times a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY on order", "7/25/2022 15:30 Note Text: Neurontin Capsule	F 755		

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400MG. Give 1 capsule by mouth three times a day related to TYPE 2DIABETES MELLITUS WITHDIABETIC POLYNEUROPATHY(E11.42). Not available, withdraw form faxed, no response, ... (MD name omitted) made aware, adm. (administer) when available.", "7/25/2022 22:00 Note Text: Neurontin Capsule 400MG Give 1 capsule by mouth three times a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY", "7/26/2022 05:21 Note Text: Neurontin Capsule 400MG Give 1 capsule by mouth three times a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY on order".

Surveyor spoke with registered nurse (RN) #1 on 07/26/22 at 10:10 am regarding the procedure for unavailable medications. RN #1 stated when it is discovered that a medication is not in the medication cart, the nurse should check the Omnicell to see if medication is available to pull from there, no need to call pharmacy, unless medication is a narcotic. RN #1 stated, if the medication is a narcotic, the nurse should fill out a "Request for Removal of Controlled Substance Medication Contingency Supply" form and fax to the pharmacy. Pharmacy will send a code, once you get the code, can pull from the Omnicell in the presence of a witness. Surveyor asked RN #1 what they would do if they don't receive a code from the pharmacy, or the medication is not available in the Omnicell and RN #1 stated they would call the physician and ask for a substitute.

Surveyor spoke with pharmacist on 07/26/22 at 12:30 pm regarding Resident #59's Neurontin. Pharmacist stated they had received a new prescription for the medication today, they had given code to pull medication from the Omnicell.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 24 Pharmacist also stated the previous prescription was dated 07/03/22 and the medication had been discontinued out of the system on 07/14/22. Pharmacist stated they were unable to refill the medication without a new prescription. Pharmacist stated they had received a request to pull the medication from the Omnicell on 07/25/22, but had faxed a denial to the facility due to not having a current prescription. Surveyor spoke with the director of nursing (DON) on 07/26/22 at 2:35 pm regarding Resident #59's Neurontin. DON stated the issue should have been taken care of prior to the resident missing that many doses. DON stated the physician and the pharmacy should have been notified. DON also stated that all staff had been given inservice on pharmacy procedures. Surveyor requested and was provided with a facilty policy entitled "Medication Shortages/Unavailable Medications" which read in part, "This Policy 7.0 sets forth procedures relating to medication shortages and unavailable medications. 2. If a medication is unavailable during normal Pharmacy hours: 2.1 A Facility nurse should call Pharmacy to determine the status of the order...If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery caused delay or missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, Facilty staff should notify Pharmacy and arrange for an emergency delivery, if medically necessary. 3. If a medication	F 755		

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F 755	Continued From page 25 unavailable is discovered after normal Pharmacy hours: 3.1 A Facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery or 3.2.2 Use of an emergency (back-up) Third Party Pharmacy. 4. If emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions." The concern of Resident #59's medications not being available for administration was discussed with the administrative team (administrator, DON) during a meeting on 07/27/22 at 12:55 pm. No further information was provided prior to exit.	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 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	F 756	1. Resident # 53 is his own RP and is aware of GDR. The MD was notified that the Xanax was not started as ordered. No negative clinical outcome was identified. Resident 53's pharmacy recommendation for Xanax was immediately carried out per the pharmacy recommendation and MD order. 2. Any resident has the potential to be affected. A 100% Audit of Pharmacy Recommendations will be conducted to ensure that pharmacy recommendations have been completed by the DON or designee. 3. Education will be provided to the Licensed Nursing staff on protocol to follow regarding Pharmacy Recommendations by the DON or designee and education will be reviewed in new hire orientation. 4. An 100% audit will be conducted by the DON or designee of all Pharmacy Recommendations to ensure recommendations are carried out in a timely manner monthly x 3 months. The DON or designee will review findings and report to QAA committee monthly x 3 months.	

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F 756	Continued From page 26 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to act upon drug regimen review recommendations for 1 of 19 residents in the survey sample, Resident #53. For Resident #53, the facility staff failed to carry out a physician approved, drug regimen review recommendation for Alprazolam, a benzodiazepine used to treat anxiety and panic disorders. The findings included: Resident #53's diagnosis list indicated diagnoses,	F 756	5. September 8, 2022	

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F 756	Continued From page 27 which included, but not limited to Hemiplegia, Dysphagia, Dysarthria and Anarthria, Chronic Pain Syndrome, Anxiety Disorder, Essential Hypertension, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease (COPD). The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/16/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #53's clinical record included a drug regimen review dated 7/08/22 in which the reviewing pharmacist recommended a gradual dose reduction (GDR) of alprazolam to 0.5 mg twice a day (BID) with the end goal of discontinuation. The physician's response of "I accept the recommendation(s) above, please implement as written" was indicated with a check mark and the form was signed by the physician on 7/08/22. The director of nursing (DON) also signed the drug regimen review on 7/08/22. On 7/25/22, surveyor reviewed Resident #53's clinical record and noted an active physician's order dated 2/28/22 for Alprazolam 0.5 mg three times a day related to Anxiety Disorder. According to the resident's July 2022 Medication Administration Record (MAR), Resident #53 was receiving Alprazolam 0.5 mg daily at 9:00 am, 4:00 pm, and 10:00 pm. On 7/26/22 at 4:46 pm, surveyor informed the DON of the above findings. On 7/27/22 at 10:16 am, surveyor again spoke with the DON who stated the nurse working at the time was an agency nurse.	F 756		

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F 756	Continued From page 28 On 7/27/22 at 12:52 pm, the survey team met with the Administrator, DON, Regional Director of Clinical Services, and the Corporate Administrator and discussed the concern of Resident #53's July 2022 drug regimen review not being carried out as directed by the physician. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/27/22.	F 756		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) 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 interviews, clinical record reviews, and facility document reviews, the facility staff failed to ensure 1 of 19 residents, Resident #6, was free of significant medication errors. Resident #6 did not receive their insulin per provider orders. The findings include: Resident #6's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/14/22, was dated as being completed on 4/26/22. Resident #6 was assessed as able to make self understood and as able to understand others. Resident #6 was documented as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #6's diagnoses included, but were not limited to: high blood pressure, diabetes, stroke, and depression.	F 760	1. Resident #6 is his own RP and is aware of insulin given outside of parameters. Resident #6's blood sugar was rechecked after insulin administered outside of parameters with no adverse effects identified. MD was notified. 2. Any resident has the potential to be affected. An audit for the past 3 days will be conducted by the DON or designee of residents receiving insulin administered per MD order to ensure that parameters are in the order and the insulin was administered per MD orders. 3. Licensed Nursing staff will be educated on following MD orders and verifying specific parameters by the DON or designee and the education will be reviewed in new hire orientation. 4. An audit of 5 residents will be conducted by the Unit Manager or designee on resident's receiving insulin to verify insulin is administered per MD order weekly x 4 weeks then monthly x 2 months. The DON or designee will review findings and report to QA for further recommendations monthly x 3 months. 5. September 8, 2022	

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F 760	Continued From page 29 Resident #6's medication administration records (MARs) were reviewed on the afternoon of 7/25/22. The following medication order was found on Resident #6's July 2022 MAR: "NovoLOG PenFill Solution Cartridge 100 UNIT/ML (Insulin Aspart) Inject 10 unit subcutaneously before meals for diabetes Hold Novolog if BS (blood sugar) is less than 200". Documentation on the MAR indicated Resident #6's 7/25/22 9:00 a.m. dose of insulin was administered. Resident #6's blood sugar was documented as "85" on 7/25/22 at 6:30 a.m. On 7/25/22 at 1:50 p.m., the facility's Director of Nursing (DON) and Registered Nurse (RN) #1 was interviewed about Resident #6's aforementioned insulin administration. RN #1 confirmed they administered Resident #6's 7/25/22 9:00 a.m. insulin dose. RN #1 reported there was no order to check the resident blood sugar prior to the 9:00 a.m. insulin dose; the DON stated the insulin should not have been given due to the 6:30 a.m. blood sugar results being documented as "85". Review of Resident #6's July MARs indicated Resident #173 had been provided their 9:00 a.m. insulin does when their 6:30 a.m. blood sugar results were less than 200 on the following dates: 7/2/22, 7/3/22, 7/4/22, 7/5/22, 7/6/22, 7/7/22, 7/10/22, 7/11/22, 7/12/22, 7/14/22, 7/15/22, 7/17/22, 7/19/22, 7/21/22, 7/23/22, 7/24/22, and 7/25/22. According to the medical provider's orders these insulin doses should have been held due to the resident blood sugar being less than 200. On 7/25/22, Resident #6's current care plan	F 760		

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F 760	Continued From page 30 included a focus area of being at risk for hypoglycemia (low blood sugar)/hyperglycemia (high blood) sugar due to a diagnosis of diabetes. This care plan included the following intervention: "Give medications as ordered". The following information was found in a document/policy titled "General Dose Preparation and Medication Administration" (with a revision date of 1/1/22): "Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: ... Verify each time a medication is administered that it is the correct medication, at the correct dose ..." On 7/26/22 at 2:36 p.m., it was discussed with the facility's Administrator and Director of Nursing that multiple does of insulin, during July 2022, were administered to Resident #6 when they should have been held based on the medical provider's order. On 7/27/22 at 12:51 p.m., Resident #6's incorrect insulin administration was discussed for a final time, during a survey team meeting, with the facility's Administrator and DON.	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 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761	1. Insulin pens on Medication Cart A were reordered and replaced and all contained appropriate label with an open/use by date. Expired medications on Medication cart B were immediately discarded and reordered if needed. 2. Any resident has the potential to be affected. A 100% Audit of all Medication Cart and medication refrigerators will be conducted to ensure insulin pens were dated and no medications were expired by the DON or designee. 3. Licensed Nursing staff will be educated on the policies and procedures of dating insulin pens and discarding of expired medications by the DON or designee. Education will be reviewed in new hire orientation 4. All insulin pens will be checked by Unit Manager or designee weekly x 4 weeks, then monthly x 2	

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F 761	Continued From page 31 §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, facility document review and in the course of a complaint investigation the facility staff failed to properly store and/or label medications. For medication cart A, the facility staff failed to discard expired medication, failed to ensure an insulin pen had a label, failed to ensure medication label contained an expiration date, and failed to place an opened on/use by date on 13 opened insulin pens. For medication cart B, the facility staff failed to dispose of expired medications. The findings included: Surveyor observed medication cart B on 07/24/22 at 2:30 pm. Surveyor observed a medication card of Vitamin D 50,000, containing one capsule. This	F 761	months to verify that the insulin pens are labeled and dated appropriately. Medications on each cart will be checked weekly x 4 weeks, then monthly x 2 months 2 months to ensure all are in date. The DON or designee will review findings and report to QA for further recommendations monthly x 3 months. 5. September 8, 2022	

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F 761	Continued From page 32	F 761		

card had a hand written expiration date of 12/21. Surveyor asked licensed practical nurse (LPN) #2 to look at the medication card and confirm the expiration date. LPN #2 confirmed that the medication had expired on 12/21. Surveyor asked LPN #2 what they were going to do with the medication, and LPN #2 stated they would discard it.

Surveyor observed medication cart B on 07/24/22 at 3:00 pm. Surveyor observed a medication card of 400 mg ibuprofen, containing 8 tablets. This card had an expiration date of 02/28/22. Surveyor asked LPN #1 to look at the medication card, and LPN #1 confirmed that the medication had expired. Surveyor also observed one opened Lantus insulin pen with no cap/label on it and 13 opened insulin pens with no 'opened on/use by" date. These insulin pens contained a label with a space to place an "opened on" date. Surveyor asked LPN #1 if the pens should have an "opened on" date on them and LPN #1 stated they should, and stated there is no way to know when to discard the insulin without an "opened on" date on them. Surveyor also observed one bottle of Keppra solution 100 mg/ml with no expiration date on the label.

Surveyor requested and was provided a facility policy entitled "Storage and Expiration Dating of Medications, Biologicals" which read in part, "4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or

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F 761	Continued From page 33	F 761		

biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has shortened expiration date once opened or opened. 5.3 If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needlepunctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial".

Surveyor was also provided with a facility policy entitled "General Medication Dose Preparation and Medication Administration", which read in part '3. Dose Preparation: Facility should take all measure required by Facility policy and Applicable Law, including, but not limited to the following: 3.12 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.). 4. Prior to administration of medication, Facility staff should take all measure required by Facility policy and Applicable Law, including, but not limited to the following: 4.1.3 Check the expiration date on the medication."

The concern of not disposing of expired medications, failing to include an expiration date on a medication label, not placing an "opened on/use by" date on insulin pens, and not ensuring an insulin pen contained a label was discussed with the administrator, regional nurse consultant, and director of nursing on 07/25/22 at 4:10 pm. Regional nurse consultant stated that the insulin pens should have either an "opened on" date or a "use by" placed when they are opened.

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F 761	Continued From page 34 Surveyor checked insulin pens on medication cart A on 07/27/22 at 9:40 am. All pens were labeled with "opened on" dates. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY.	F 761		
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, and facility document review, the facility staff failed to ensure food was prepared and stored under safe and sanitary conditions in the kitchen and 2 of 2 nourishment rooms.	F 812	1. Hairnet was immediately applied by identified dietary aide and education provided to her on food safety and sanitation. All unlabeled, undated and outdated items identified in the nourishment rooms were discarded. The ice chest identified with an insect was immediately taken to the kitchen for sanitizing. 2. Any resident has the potential to be affected. A 100% audit will be conducted by the Dietary Manager or Designee of all nourishment rooms and refrigerators to ensure that items are dated. An audit was conducted on all dietary staff to ensure proper hair covering. An audit will be conducted on all ice chests to ensure cleanliness by Dietary Manager or designee. 3. Dietary Manager to educate dietary staff on the importance of wearing hairnets to ensure food safety. Education will be provided to all staff on the policy and procedures of dating food/drink items and ensuring sanitary ice chests by the DON or designee. Education will be reviewed in new hire orientation. 4. Administrator or designee to conduct random rounds in kitchen 2 times per week x 4 weeks, then weekly for 2 months to ensure hairnets are worn by dietary staff. Dietary Manager or designee will conduct random audits weekly x4 weeks, then monthly x2 months to ensure items are dated in the nourishment rooms and ice chests are clean and sanitary. Administrator or designee will review findings and report to QAA committee monthly x 3 months. 5. September 8, 2022	

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F 812	Continued From page 35	F 812		

A dietary aide was observed working in the kitchen without a hair restraint, the refrigerators in each nourishment room contained unlabeled and undated items, the 400 Hall nourishment room contained outdated juice, and the 400 Hall ice chest contained an insect within the ice.

The findings included:

On 7/24/22 at 2:40 pm, surveyor observed a dietary aide standing at a counter near the silverware without a hair restraint in place. Surveyor asked the dietary aide if she was wearing a hair net and she stated "no, I don't have mine today". A supply of individually wrapped hair nets were available directly outside of the kitchen entrance.

On 7/25/22 at 4:09 pm, the survey team met with the Administrator, Director of Nursing, Regional Director of Clinical Services, and the Regional Vice President of Operations and discussed the concern of the observation of the dietary aide working in the kitchen without a hair net.

On 7/26/22 at 10:49 am, the Administrator provided surveyor with a "Disciplinary Action Form" dated 7/26/22 indicating the dietary aide had received a verbal warning related to not wearing a hair net on 7/24/22.

Surveyor requested and received the facility policy entitled "Employee Sanitary Practices" which read in part "2. FNS (food and nutrition services) staff is required to have their hair styled so that it does not touch the collar, wear hair restraints, clean clothes, and shoes. Food and Nutrition Service staff should bathe daily. Hair restraints are required and should cover all hair

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F 812	Continued From page 36 on the head ..." On 7/27/22 at 8:45 am, surveyor observed the refrigerator containing resident food in the 200 Hall nourishment room. The refrigerator contained the following items of concern: - an uncovered styrofoam cup with liquid and an open straw with no name or date - a plastic bag with two styrofoam containers labeled with a resident's name and "6/26/22" and 6/29/22" - a pre-package chef's salad labeled with a resident's name but no date, pre-printed on the package was "use by 7/07/22" - a white paper bag containing wrapped items with no name or date - a plastic bag with two plates covered with foil with no name or date - a plastic bag with a styrofoam tray with no name or date On 7/27/22 at 8:52 am, surveyor observed the mobile ice chest and refrigerator containing resident food in the 400 Hall nourishment room. The refrigerator contained the following items of concern: - a fast food bag of items with no name or date - an opened 46 ounce container of Ready Care Nectar Thick Cranberry Cocktail with "best if used by 14 June 2022" printed on the container The mobile ice chest in the 400 Hall nourishment room contained a small amount of ice and water with a dead winged insect on top of the ice. At 9:03 am, the Activity Director also observed the inside of the ice chest and stated "it has wings". On 7/27/22 at 9:06 am, surveyor informed the Regional Director of Clinical Services of the	F 812		

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F 812	Continued From page 37 above concerns. On 7/27/22 at 9:08 am, surveyor spoke with the Dietary Manager (DM) and asked who was responsible for maintaining the nourishment room refrigerators. The DM stated dietary and certified nursing assistants (CNAs) were responsible. DM stated dietary was supposed to check them every day but they do not have time to go down and check them every day. On 7/27/22 at 10:34 am, surveyor received a written statement from the Assistant Director of Nursing (ADON) stating they have cleaned the cooler and threw out food that was not dated from the refrigerators. Surveyor requested and received the facility policy entitled "Food Brought in From Outside the Facility" which read in part: 1. Food Storage If the food brought in from an outside source needs refrigeration: - Store in a clean, sealed container - The container will be labeled with name of food item and Resident name, dated, and placed in an appropriate non-dietary refrigerator (floor/unit fridge/neighborhood fridge, activities fridge) - Food dated by facility staff will be discarded within seven days from the date mark, with the exception of condiments, see dietary department for clarification On 7/27/22 at 12:52 pm, the survey team met with the Administrator, Director of Nursing, Regional Director of Clinical Services, and the Corporate Administrator and discussed the concerns of the dietary aide without a hair restraint, the insect in the ice chest, and the items	F 812		

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F 812	Continued From page 38 of concern in the nourishment room refrigerators. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/27/22.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident 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;	F 842	1. Resident # 59, who is his own Responsible Party and the MD were notified nurse did not sign off on MAR on 7/7/2022 and 7/9/2022 and failed to document resident's blood sugar reading. 2. Any resident has the potential to be affected. A 100% audit will be conducted on all residents to ensure completeness of MAR/TAR for the past 7 days by the DON or designee. 3. Licensed Nursing staff will be educated on the policy to administer and document medications and treatments accordingly by the DON or designee. Education will be reviewed in new hire orientation. 4. A audit will be conducted on MAR/TAR documentation 5x week x 4 weeks then monthly x 2 months by DON or designee. The DON or designee will review findings and report to QAA committee monthly x 3 months. 5. September 8, 2022	

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F 842	Continued From page 39 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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 1 of 19 residents, Resident #59.	F 842		

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F 842	Continued From page 40 For Resident #59 the facility staff failed to record the resident's blood sugar and failed to document medications as administered on the medication administration record. The findings included: Resident #59's face sheet included diagnoses which included but not limited to type 2 diabetes mellitus with diabetic polyneuropathy, other specified complication and other circulatory complications, depression, benign prostatic hyperplasia with lower urinary tract symptoms, other seizures, and hypertension. Resident #59's admission minimum data set with an assessment reference date of 06/09/22 assigned the resident a brief interview for mental status score of 15 of 15 in section C, cognitive status. Resident #59's physician's order summary for the month of July 2022 was reviewed and contained orders which read in part, "Accuchecks BID (twice daily) two times a day for DM (diabetes mellitus) 2 Notify MD if BS (blood sugar) is less than 60 or greater than 400", "Flomax Capsule 0.4 MG (Tamsulosin HCl)Give 0.4 mg by mouth two times a day related to BENIGN PROSTATIC HYPERPLASIA WITH LOWER URINARY TRACT SYMPTOMS", "HumuLIN 70/30 Suspension (70-30) 100 UNIT/ML (Insulin NPH Isophane & Regular) Inject 45 unit subcutaneously two times a day for Uncontrolled diabetes related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION (E11.69) hold if blood sugar is less than 200", "levETIRAcetam	F 842		

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F 842	Continued From page 41 Tablet 500 MG Give 1000 mg by mouth two times a day related to OTHER SEIZURES", "Torsemide Tablet 20 MG Give 20 mg by mouth two times a day related to CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE" and "Neurontin Capsule 400 MG (Gabapentin) Give 400 mg by mouth three times a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY". Resident #59's medication administration record for the month of July 2022 was reviewed and contained entries as above. The entries for Flomax, Humulin insulin, levetiracetam had not been initialed as completed on 07/09/22 at 5pm. The resident's blood sugar had not been recorded on 07/09/22 at 5pm. The entries for Neurontin and Torsemide had not been initialed as completed on 07/09/22 at 2 pm. During an end of day meeting with the administrative team (administrator, regional vice president of operations, director of nursing, assistant director of nursing, regional nurse consultant) on 07/25/22 at 4:10 pm the concern of the missing documentation was discussed. Assistant director of nursing stated there should not be blank spaces on the medication administration record. Surveyor requested and was provided with a copy of a facility policy entitled "General Dose Preparation and Medication Administration" which read in part "6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g., when medications are opened,	F 842		

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F 842	Continued From page 42 when medications are given, injection site of a medication, if medications are refused, PRN (as needed) medications, application site) on appropriate forms;" On 07/26/22 at 4:30 pm, the director of nursing provided the surveyor with a handwritten statement signed by licensed practical nurse (LPN) #2, which read in part "For shifts I worked on 7-7-22 + 7-9-22 ... (Resident #59 name omitted) rec. (received) all medications as ordered. His/her FSBS (fingerstick blood sugar) was taken, and although I cannot recall the exact reading I do remember that it fell WNL (within normal limits). I failed to check my MAR (medication administration record) before leaving the facility." The concern of the failure to complete documentation was discussed with the administrative team (administrator, DON) during a meeting on 07/27/22 at 12:55 pm. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880	1. Resident #372's MD order for isolation was immediately discontinued due to no evidence of bed bugs. 2. All residents have the potential to be affected. A 100% Audit of residents with MD orders for isolation will be conducted to ensure correct precautions are in place by the DON or designee. 3. Licensed Nursing staff will be educated on the Policy and procedure for placing residents on isolation by DON or designee and education will be reviewed in new hire orientation. 4. The DON or designee will conduct an audit on all isolation resident's weekly x4 weeks and monthly x 3 months to ensure that precautions are implemented per MD order. DON or designee will review findings and report to QA for further recommendations monthly x 3 months. 5. September 8, 2022	

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F 880	Continued From page 43 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 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	F 880		

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F 880	Continued From page 44 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the transmission of communicable diseases and infections for 1 of 19 residents in the survey sample, Resident #372. For Resident #372, the facility staff failed to follow a physician's order for contact precautions following a report of bed bugs in the resident's room. The findings included: Resident #372's diagnosis list indicated diagnoses, which included, but not limited to Generalized Muscle Weakness, Dementia with Behavioral Disturbance, Dysphagia, Hypothyroidism, Essential Hypertension, Morbid Obesity, Sequelae of Cerebral Infarction, Fracture	F 880		

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F 880	Continued From page 45	F 880		

of Third Thoracic Vertebra, Displaced Fracture of Second Cervical Vertebra, and Displaced Bimalleolar Fracture of Right Lower Leg.

The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 6/20/22 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively impaired. The resident was coded as being totally dependent on staff for transfers and toilet use and requiring extensive assistance with bed mobility, dressing, and personal hygiene.

During initial facility rounding on the afternoon of 7/24/22, surveyor observed Resident #372 in their room in bed. The resident's room did not have any visible signage indicating the requirement of transmission based precautions, additional personal protective equipment (PPE) was not available outside of the room, and no isolation/biohazard waste receptacles were present in the resident's room.

On 7/25/22, surveyor reviewed Resident #372's clinical record and noted an active physician's order dated 7/22/22 to maintain contact precautions and isolation with all care and services to be provided in the resident's room.

On 7/25/22 at 10:35 am, surveyor spoke with the Infection Preventionist (IP) regarding Resident #372's order for contact precautions without signage present at the room. IP stated the resident had an order for contact precautions because their sitter reported on Friday that the resident had bed bugs. IP stated the facility Maintenance Director checked the room and did

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F 880	Continued From page 46 not see any evidence of bed bugs and the room chairs were removed and placed outside of the facility. IP stated the resident's skin was assessed and there was no evidence of bed bugs. Surveyor asked the IP if bed bugs have been an issue at the facility and the IP stated "not since I've been here". On 7/25/22 at 10:44 am, surveyor observed Resident #372's room and again there was no signage indicating the need for contact precautions, no additional PPE available outside of the resident's door, and no isolation waste receptacles in the room. Surveyor spoke with certified nursing assistant (CNA) #2 and asked if Resident #372 was on isolation precautions and CNA #2 stated "no ma'am". At 10:48 am, surveyor spoke with the resident's nurse, licensed practical nurse (LPN) #3, and asked if Resident #372 was on isolation precautions. LPN #2 stated "I have no idea", LPN #2 then stated it was in their record but they were not sure of the reason. Surveyor asked LPN #2 what PPE they wore earlier that morning while administering the resident's medication and LPN #2 stated gloves, N95 mask, and safety glasses. Surveyor requested and received the facility policy entitled "Transmission-Based Precautions" which read in part: A. 1. Contact Precautions ...Personal Protective Equipment recommended: a. Gloves - whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident. b. Gowns - whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the resident.	F 880		

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F 880	Continued From page 47 E. Signage indicating the appropriate type[s] of precautions and indicating that visitors should stop at Nurses Station before entering, will be placed on the resident's door. Staff will educate visitors regarding donning appropriate Personal Protection Equipment while adhering to the resident's right for privacy protection. On 7/25/22 at 12:24 pm, surveyor observed a sign by Resident #372's door stating "Contact Enteric Precautions" instructing staff to wear gloves and gown when entering the room. A three-drawer caddy was placed by the resident's door containing N95 masks, gloves, and disposable isolation gowns. Isolation receptacles were also present in the resident's room at this time. On 7/25/22 at 4:09 pm, the survey team met with the Administrator, Director of Nursing, Regional Director of Clinical Services, and the Regional Vice President of Operations and discussed the concern of Resident #372 not having contact precautions in place as ordered by the physician. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/27/22.	F 880		