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COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/25/22 through 10/28/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 10/25/22 through 10/28/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey as follows: VA00056556--Substantiated VA00056103--Substantiated VA00055763--Substantiated The census in this 196 certified bed facility was 179 at the time of the survey. The survey sample consisted of 55 resident reviews and 29 staff reviews.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff	F 565		

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

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person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.
(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on Resident interviews, staff interviews, and facility documentation review, the facility staff failed to act promptly to Resident grievances in July 2022 and August 2022.

The findings included:

The facility staff failed to evidence a resolution to concerns raised by residents about call device response times in the July and August 2022 Resident Council meetings.

According to Resident #93's quarterly Minimum Data Set with an Assessment Reference Date of

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08/31/2022, the Brief Interview for Mental Status was coded as "13" out of possible "15" indicative of intact cognition.

On 10/25/2022 at approximately 1:15 P.M., Resident #93 was interviewed. When asked about the timeliness of call devices being answered, Resident #93 stated that sometimes they wait "an hour or two" for staff to answer the call device. Resident #93 stated that it is not convenient to get into the wheelchair but will sometimes have to get up into their wheelchair and go looking for staff.

On 10/26/2022, the Resident Council minutes from July 2022 through September 2022 were reviewed. The Resident Council minutes dated 07/25/2022 documented the following excerpt: "Residents stated that at times staff would answer their lights [call devices] and not come back with what they went for." The Resident Council minutes dated 08/08/2022 documented the following excerpt: "Residents reported that on Madison Wing they have issues with staff answering the call bells. They say staff come in, turn off the light and leave."

On 10/26/2022 at approximately 10:35 A.M., a meeting with interviewable Residents in Resident Council was conducted. When reviewing previous Resident Council concerns and asked if there were improvements of staff answering call lights, Residents in Resident Council collectively indicated staff are still not answering call devices timely. One Resident stated, "We still have to wait about an hour for someone to show up." Another Resident stated that the night shift was the worst (responding to call devices) of the three shifts. When asked about the facility's response to their

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concerns, one Resident stated the staff said to give them time, and they were working on it.

On 10/26/2022, the facility staff provided a copy of their policy entitled, "Service Concerns/Grievances." Under the header, "Policy", it was documented, "The patient has the right to voice/file grievances/complaints (orally, in writing, or anonymously) without fear of discrimination or reprisal. The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion."

On 10/26/2022 at approximately 5:45 P.M., the Administrator and Director of Nursing (DON) were notified of findings. When asked about facility response to Resident concerns about untimeliness of answering call devices, the DON stated that staff were in-serviced on answering call lights promptly and that all staff were responsible for answering call lights as soon as possible. When asked how the effectiveness of the staff training was measured, the DON stated that she monitors all the units for the call bells going off and staff response. A copy of staff education sheets and call device monitoring audits were requested.

By the end of survey on 10/28/2022, there was no evidence staff was in-serviced in response to the call device concerns identified by the Residents in July and August 2022.

On 10/28/2022, a copy of their policy pertaining to answering call devices was requested and the facility staff provided a copy of their policy entitled, "Nurse Call System." The policy did not

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F 565	Continued From page 4 address the process or the timeliness of answering call devices. On 10/26/2022, the facility staff provided a copy of their policy, "Service Concerns/Grievances." Under the header, "Policy", it documented, "The patient has the right to voice/file grievances/complaints (orally, in writing, or anonymously) without fear of discrimination or reprisal. The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion." No further information was provided prior to exit.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		

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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 observation, Resident interview, staff interview, and clinical record review, the facility staff failed to communicate the Resident's choice for advanced directives for one Resident (Resident #396) in a sample size of 55 Residents.

The findings included:

For Resident #396, the facility staff failed to communicate to staff responsible for his care of Resident #396's choice to receive resuscitative measures in the event of an emergency.

On 10/27/2022, Resident #396's clinical record was reviewed. Resident #396 was admitted on 10/24/2022. A review of Resident #396's admission note dated 10/24/2022 revealed, in part: "Cognitive state on arrival: cognitively intact,

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oriented to person, oriented to place, oriented to time, oriented to situation, able to make needs known." A review of a physician's note dated 10/25/2022 revealed, in part: "[Resident #396 is] alert, pleasant, and cooperative."

A review of the physician's orders revealed that there were no orders addressing Resident #396's code status. Also, there was no code status listed on the electronic health record banner.

On 10/27/2022 at 3:17 P.M., Resident #396 was interviewed. When asked about his preference pertaining to advanced directives, Resident #396 stated he would prefer to receive CPR (cardiopulmonary resuscitation) "if it came to that."

On 10/27/2022 at 3:20 P.M., Certified Nursing Assistant D (CNA D) was interviewed. CNA D confirmed they were assigned to care for Resident #396. When asked about Resident #396's code status, CNA D stated they were "just coming on shift," so would ask the nurse to find out the code status.

On 10/27/2022 at 3:26 P.M., Registered Nurse C (RN C) was interviewed. RN C verified they were assigned to care for Resident #396 this day. When asked about the code status for Resident #396, RN C stated that she did not know, but would have to check the electronic health record. RN C then attempted to log in to the electronic health record without success. RN C then stated she would treat [Resident #396] as a full code until Resident #396's code status could be determined.

On 10/27/2022 at 4:00 P.M., the social worker

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F 578	Continued From page 7 was interviewed. When asked about the process for obtaining code status preference from Residents, the social worker stated that the nurses look at the hospital documents to find out what it is, and insert it on the electronic health record banner. The social worker then stated that "I don't do code status information." The social worker went on to say, "I care plan it within 24 hours (of admission)." When asked about the code status for Resident #396, the social worker stated that she notified nursing department on 10/25/2022 that she did not see the code status posted on the electronic health record banner. On 10/27/2022 at 4:15 P.M., the administrator and Director of Nursing were notified of findings. On 10/28/2022, Resident #396's admission agreement documents as provided by the facility staff were reviewed. On page 17 of the admission agreement under the header entitled, "Does the Resident/Patient have Advanced Directives?" the answer selected was "No" with the following comment: "Documents not yet obtained, but Facility informed of existence." A review of the facility policy, "Advanced Directives," failed to reveal procedures to be followed if a resident wants to be a full code. No further information was provided prior to exit.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		

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by:
Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure an accurate MDS (minimum data set)/RAI (resident assessment instrument) was completed for two residents (Residents #142 and #152) in a survey sample of 55 residents.

The findings included:

1. For Resident # 142, the facility staff failed to complete Section C: Cognitive Patterns in a Quarterly assessment dated 9/20/2022.

Resident #142's clinical record review revealed the most recent MDS assessment was a Quarterly Assessment with an ARD (assessment reference date) of 9/20/2022. Review of Section C for Cognitive Patterns revealed Section C0100, which asked if a Brief Interview for Mental Status (Section C0200-C0500) be conducted. The facility staff answered "yes".

Further review of the MDS revealed dashes in several sections in Section C for Cognitive Patterns.:
Sections C0200-C0500 were documented as "not assessed."
The next section C0600- Should staff assessment be conducted? -"not assessed."
C0700-Short Term Memory- "not assessed."
C0800-Long Term Memory-"not assessed."
C0900- Memory Recall Ability- Staff answered "no" to all of the questions regarding: A. Current Season, B: location of own room, C. staff names and faces, and D. that he or she is in a nursing home... and Z. none of the above recalled.
C1000- Cognitive Skills for Daily Decision

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Making-"not assessed."

Review of the MDS Quarterly Assessment with an ARD of 8/26/2022 and the MDS Annual Assessment with an ARD of 02/28/2022 revealed Section C was completed and Resident # 142 was coded with a BIMS (Brief Interview for Mental Status) score of "13" out of 15 indicating no cognitive impairment.

Throughout the clinical record in the nurses' progress notes and physicians' progress notes, Resident # 217 was documented as alert and oriented x 3 (person, place and time).

On 10/26/2022 at approximately 2:20 p.m., an interview was conducted with the MDS Coordinator who stated it was important to complete all sections of the MDS. She stated Section C should have been completed but was not done. She stated the section on Cognition was important to determine if there was any cognitive impairment and would help to guide the care plan.

On 10/26/2022 at 2:30 p.m., an interview was conducted with the Director of Nursing who stated the entire MDS should be completed. She stated the MDS was an important assessment tool. She stated the section on Cognition was very important to help determine if there was any cognitive impairment.

There was no BIMS (Brief Interview for Mental Status Score) calculated due to the assessment not being completed as indicated by the dashes.

A review of the facility policy titled, "Resident Assessment & Care Planning", was conducted.

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This policy read, "MDSs will be completed according to the most current version of the RAI Manual".

The Administrator, DON (Director of Nursing), and Corporate Nurse Consultant were informed of the failure of the staff to complete Section C100-C1000 accurately for a quarterly MDS during the end of day debriefing on 10/27/2022.

Review of CMS's (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 Manual CH 3: Overview of Guide to MDS Items page 3-4 read, "Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system. - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed."

CMS's RAI Version 3.0 Manual CH 3: Overview of Guide to MDS Items page C2 read, "Coding Tips: Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood. The resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items. Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done."

No further information was provided prior to exit.

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2. For Resident #152 the facility staff failed to assess the Resident's cognitive functioning on the 9/22/22 quarterly MDS (minimum data set).

On 10/26/22 and 10/27/22, a review of Resident #152's clinical record was conducted. During this review it was identified that Resident #152's most recent MDS assessment with an ARD (assessment reference date) of 9/22/22 was coded as a quarterly assessment. Resident #152 had not been assessed for cognitive skills and daily decision making on this assessment.

Review of Resident #152's MDS with an ARD of 9/22/22 revealed that in section C, items C0100-C0500, the Resident interview had not been conducted and a dash (-) had been entered. Review of section C, questions C0600-C1000, also had a dash (-) entered. Questions C0600-C1000 are in regards to a staff assessment for mental status.

Review of Resident #152's previous MDS, with an ARD of 8/3/22, revealed that the Resident was coded as having had a cognitive assessment conducted. Resident #152 scored 13 out of 15, which indicated she was cognitively intact.

On 10/27/22 at 12:33PM, during an interview with the MDS staff, LPN F and RN D, they both confirmed that they follow the RAI [Resident assessment instrument] manual for directions on how to conduct the MDS assessment and coding. They both accessed Resident #152's MDS and confirmed that she had not been assessed for cognitive functioning on this assessment and should have been.

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F 641	Continued From page 12 On 10/27/22, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No further information was provided prior to exit.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645		

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COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

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§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on interview, facility record review and facility documentation, the facility staff failed to ensure Preadmission Screening and Resident

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F 645	Continued From page 14 Review (PASARR) was completed prior to admission to the facility for one Resident (#53) in a survey sample of 55 Residents. The findings included: For Resident #53 the facility staff failed to have the PASARR prior to or since admission on 3/24/21 for a Resident with known history mental illness. Resident #53 was admitted to the facility with diagnoses of but not limited to seizure disorder, bipolar disorder, anxiety disorder, depression, psychotic disorder and schizophrenia. On 10/26/22 a request was made to Employee E (Social Services Director) for the PASARR for Resident #53. The Social Worker stated she could not locate the PASARR. She stated a PASARR had not been completed prior to admission, and has not been done since admission. Employee E was asked when the PASSAR was supposed to be completed and she stated that it should be done prior to admission. When asked the purpose of the PASSAR, she stated that it was to see if the Resident required special services for his or her condition. On 10/26/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 645		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		

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must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to follow the nursing standard of practice for two Residents (Resident #21 and 117) in a survey sample of 55 Residents.

The findings included:

1. For Resident #21, the facility staff failed to notify the physician when insulin was not available for administration. The facility staff administered blood pressure medication when the blood pressure was outside of parameters to hold the medicine on eight occasions in October, 2022.

On 10/25/22 and 10/26/22, Resident #21 was visited in her room. Resident #21 was asked about her medications and was disorganized in her responses.

A review of Resident #21's clinical record revealed, in part, the following:
i. A physician order dated 7/27/22, that read, "Humulin N 100 UNIT/ML Suspension Inject 30 unit subcutaneously two times a day related to Type 2 Diabetes Mellitus Without Complications".
ii. An excerpt from the care plan for Resident #21 that read, "Endocrine system related to Insulin Dependent Diabetes and dx of Hypothyroidism." This was created on 10/20/2020. An associated intervention for this focus/problem area read, "Administer medications per physician orders".
iii. The MAR (medication administration record)

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revealed that on 10/7/22, the 5PM dose of Humulin insulin was not administered and had a code "5" entered, which, according to the legend, indicated "5=Hold/See Nurse Notes"
iv. The nursing notes for 10/7/22, read, "Humulin N 100 UNIT/ML Suspension
Inject 30 unit subcutaneously two times a day related to Type 2 Diabetes Mellitus without Complications. Awaiting arrival from pharmacy".

There was no indication that the physician had been made aware of the unavailable insulin and lack of administration.

Further review of the clinical record also revealed the following:
i. Resident #21 had an order for "Lisinopril Tablet 20 mg, give 1 tablet by mouth one time a day for Essential Hypertension. Hold for systolic blood pressure less than 130."
ii. Review of Resident #21's blood pressure readings revealed on 10/1/22, 10/3/22, 10/9/22, 10/10/22, 10/14/22, 10/18/22, 10/20/22 and 10/21/22, she had a systolic blood pressure of less than 130.
iii. On the above dates, Resident #21 was administered the blood pressure medication, despite the order to hold for systolic blood pressure of less than 130.

On 10/26/22 at 5:24 PM, during an end of day meeting, the Director of Nursing and Corporate Director of Clinical Services confirmed that the nursing standard of practice the facility follows was Lippincott. When asked to clarify what a blank on the MAR (medication administration record) meant, the DON (director of nursing) stated, "the MAR should have some response as to why the medication was not given, a blank

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means it would leave to question if it was given or not".

On 10/27/22 at 10:30 a.m., the facility Director of Nursing stated that Residents are to receive medications as ordered by the physician and in the event medications are not available she expects the doctor to be made aware, so that they can be offered the opportunity to make alternate treatment decisions if they so desire.

The facility was asked to provide a policy regarding following physician orders. On 10/27/22, the facility Administrator reported that they had no such policy.

A review was conducted of the facility policy titled, "Medication Administration: Medication Management". This policy did not address the administration of medications in accordance with physician orders.

The "Lippincott Manual of Nursing Practice" Eights Edition was referenced. On page 18, in box 2-3 "Common Legal Claims for Departure from Standards of Care" read, "...Failure to implement a physician/NP/PA order properly or in a timely fashion, Failure to administer medications properly and in a timely fashion, or to report and administer omitted doses appropriately..."

On 10/27/22, during an end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings.

No additional information was provided.

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2. For Resident #117, the facility staff failed to notify the physician on 10/14/2022 when Resident #117 was observed by facility staff to be snorting an unknown substance.

On 10/27/2022, Resident #117's clinical record was reviewed. A progress note dated 10/14/2022 at 1:17 A.M. documented, "Aid [sic] reported saw resident snorting something. Asked another nurse to come witness conversation w/ (with) resident. Resident admitted to snorting something and showed nurses a pill container w/ four white pills. When asked what they were resident denied that he knew what they were. After asking again what they were resident stated that they were trazodone or something like that. blue pill hold (sic) taken from resident and explained that he could not take any medications other than what we give him. Also explained that he could get over medicated with serious issues to follow. Resident was cooperative in this situation." There was no evidence in the progress notes that the physician was notified of the incident.

On 10/27/2022 at approximately 4:15 P.M., the Administrator and Director of Nursing (DON) were notified of findings. At 4:38 P.M., the DON entered the conference room to inform the survey team that the MD (medical doctor) was notified today of the incident and ordered a toxicology report.

On 10/28/2022 at 8:30 A.M., the DON was asked for a copy of their "Change in Condition" policy.

On 10/28/2022 at 10:40 A.M., Employee Q,

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F 658	Continued From page 19 Resident #117's physician, was interviewed. When asked if he was notified of the incident on 10/14/2022, the physician verified he was not notified on the day of the incident but was notified today (14 days after the incident occurred). According to the Lippincott Manual of Nursing Practice, 10th edition, 2014, under the section entitled, "Common Departures from the Standards of Nursing Care" in Box 2-1, excerpts of departures from Standards of Care included: "Failure to communicate ...a significant change in a patient's condition to appropriate professional." On 10/28/2022 by the end of survey, the Administrator stated no further information was available.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to assist Residents who were dependent upon staff for ADL (activities of daily living) assistance, affecting 3 Residents (Residents #82, 163, and 53) in a survey sample of 55 Residents. The findings included: 1. The facility staff failed to assist Resident #82 to	F 677		

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open the milk carton served with breakfast on 10/27/22.

On 10/27/22, a clinical record review of Resident #82's electronic chart was conducted. This review revealed that on an MDS (minimum data set assessment), a significant change assessment with an ARD (assessment reference date) of 8/26/22, Resident #82 was coded as requiring one supervision and one person physical assistance for the task of eating.

On 10/27/22 at 8:25 AM, Resident #82 was observed in her room with her breakfast. Surveyor observed that her milk carton was not open on her tray. When questioned, Resident #82 asked Surveyor C to open it for her. Resident #82 was encouraged to attempt to open herself and then again said, "Will you please open it for me? I can't."

The care plan for Resident #82 identified a focus area that read, "Altered nutrition," and the associated goal for this focus area stated, "Will consume appropriate amounts of food and fluids to maintain nutritional status."

On 10/27/22, during a meeting with the Director of Nursing (DON), she was made aware of the above findings. The DON stated she would expect staff to open beverages and containers when setting up meal trays for Residents.

Review of the facility policy titled, "Food Service/Distribution," was conducted. This policy did not address the opening of containers for Residents who were dependent upon facility staff for such tasks.

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The facility policy titled, "Shift Responsibilities for CNA", was reviewed. This policy read, "4. Perform shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call lights and notify the licensed nurse of any pertinent patient findings."

On 10/27/22, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings.

No further information was provided.

2. The facility staff failed to assist Resident #163 to open the milk carton served with breakfast n 10/27/22.

On 10/27/22, a clinical record review of Resident #163's electronic chart was conducted. This review revealed that on an MDS (minimum data set assessment), a quarterly assessment with an ARD (assessment reference date) of 9/27/22, Resident #163 was coded as having required supervision and meal set-up assistance, for the task of eating.

On 10/27/22 at approximately 8:30 AM, Resident #163 was observed sitting in her bed with a bowl of food on her over bed table. The remainder of the breakfast tray was at the foot of her bed, out of reach. Her milk, unopened and out of reach, was on the tray. Employee C, who was an RN, entered the room and removed the breakfast tray without offering the Resident her milk. When Employee C was asked if Resident #163 drinks her milk normally, Employee C said she didn't know. Employee C was made aware that her

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milk had never been opened and provided to her. Employee C continued to collect breakfast trays, and made no attempts to return the milk to Resident #163 to see if she would drink it.

The care plan for Resident #163 identified a focus area that read, "Altered nutrition...pro/kcal mal [protein and kilocalorie malnutrition]." An intervention for this focus area read, "Encourage and assist as needed to consume foods and/or supplements and fluids offered at and between meals..."

On 10/27/22, during a meeting with the Director of Nursing (DON), she was made aware of the above findings. The DON stated she would expect staff to open beverages and containers when setting up meal trays for Residents.

On 10/27/22, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings.

No further information was provided.

Complaint related deficiency.

3. For Resident #53 the facility staff failed to ensure the Resident received necessary services to maintain good grooming and personal hygiene.

On the morning of 10/26/22 Resident #53 was observed to have greasy, uncombed hair, and she had food stains on her dress and on her surgical mask.

On 10/26/22 at 9:05 AM an interview was

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conducted with the CNA B who was asked about the shower schedule. CNA B stated showers are given 2 times a week. She stated if the Resident refuses a shower, the nurse is notified. She stated she tries to find out why the resident is refusing, and if the shower can be rescheduled. She also stated another staff member may be asked to attempt the shower. She stated the RP (responsible party) is notified when the resident refuses the shower. CNA B showed the shower book for the unit. She stated that every CNA fills out a shower sheet when they shower a Resident. The shower sheets are signed and given to the nurses to show any changes in skin condition. She stated the nurses know to look at the shower sheets to identify concern. There was no evidence of shower sheets for the month of October 2022 for Resident #53. CNA B searched, and could not find these sheets. CNA B stated CNAs also documented about showers in the electronic health record in the Point of Care (POC) documentation.

A review of POC revealed that Resident #53 was documented as having been given bed baths on the following dates: 10/3/22, 10/10/22, 10/13/22, and 10/24/22. There was no documentation of showers or hair washing for this Resident.

On 10/26/22 at approximately 11:00 AM an interview was conducted with Resident #53, who stated, "I don't mind showers, but they always tell me, 'Here is your soap and towels - now time to wash up.' I don't remember when was the last time I got in the shower."

On 10/26/22 at approximately 2:00 PM Resident #53 was observed again wearing the same red dress, and with the same mask, which had food

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F 677	Continued From page 24 stains on it. She did not appear to have had a shower, as her hair was unchanged from the earlier observation. On 10/26/22 at approximately 4:50 PM an interview was conducted with the DON who was asked what the expectation is for Residents getting showered. The DON stated it was the facility's expectation that Residents received 2 showers a week at minimum more if they requested. On 10/27/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 677		
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, clinical record review, and facility document review, the facility staff failed to administer a medication per a physician's order for one of 55 residents in the survey sample, Resident #99. The findings include: For Resident # 99, the facility staff failed to	F 684		

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administer the Antibiotic medication, Cephalexin 500 milligrams on 10/3/2022 at 8:53 p.m. and 10/4/2022 at 11:39 a.m.

A review of nursing notes revealed, in part: "10/2/2022- "Skin Wound Note-area on back side of scrotum. Round, pus filled area. MD aware."

"10/4/2022 11:39 -Orders - Administration Note- Cephalexin Capsule 500 MG. Give 1 capsule by mouth every 6 hours for abscess to scrotum for 10 Days. Will give upon arrival from pharmacy."

10/3/2022 20:53-Orders - Administration Note-" Cephalexin Capsule 500 MG. Give 1 capsule by mouth every 6 hours for abscess to scrotum for 10 Days. Awaiting from pharmacy"
Review of the Physician Orders revealed an order dated 10/3/2022 for Cephalexin 500 milligrams one capsule every 6 hours for abscess for 10 days.

Review of the October 2022 Medication Administration Record revealed the medication order for Cephalexin 500 milligrams one capsule every 6 hours for abscess to scrotum for 10 days, dated 10/3/2022 at 7:28 a.m. The scheduled times for administration were: 12 noon, 6 p.m., 12 midnight and 6 a.m. for 10 days. Further review indicated the medication was not available for administration on 10/3/2022 at 8:53 p.m. and 10/4/2022 at 11:39 a.m.

On 10/26/2022 during the end of day meeting, the Administrator, Corporate Nurse Consultant and Director of Nursing (DON), were informed of this concern. The facility staff were asked if the medication was available in the STAT

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F 684	Continued From page 26 (Emergency) medications available in the CUBEX inventory onsite. The Director of Nursing stated she would provide the list of medications available of site. Review of the CUBEX inventory revealed the medication, Cephalexin 250 milligrams, quantity 20 capsules, was available in the CUBEX inventory. On 10/28/2022 at 11:40 a.m., an interview was conducted with LPN (Licensed Practical Nurse) B who stated that medications should be given as ordered by the physician. LPN B stated it was important to start medications as soon as possible. LPN B stated medications should come from the pharmacy and that nurses should check the inventory onsite to see availability if a new medication was ordered. During the end of day debriefing on 10/28/2022, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were again informed of these concerns. The Director of Nursing stated the staff should have used the supply from the inventory onsite, and that it was important for antibiotics to be given as prescribed. No further information was provided prior to exit.	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	F 686		

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pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to implement interventions to prevent and treat pressure ulcers for one Resident (Resident #152) in a survey sample of 55 Residents.

The findings included:

For Resident #152, the facility staff failed to provide Prevalon boots to both feet of Resident #152, and failed to have the air mattress settings correct, causing the mattress to be too firm, which in turn increased the risk of skin breakdown/development of pressure sores.

On 10/25/22 at approximately 1:45 PM, Resident #152 was observed in her bed. The Resident was asleep and not available for an interview. She was observed to have an air mattress and the setting was on 350 lbs., The Resident was thin. Both of her feet/heels were visible, and they were resting directly on the mattress, without any offloading to relieve pressure on her heels.

On 10/25/22 at approximately 4:15 PM, Resident #152 was again observed lying in bed on her back. Her air mattress remained on the setting of 350 lbs. The Resident's legs were crossed and

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her heels were resting directly on the bed. A bunny boot (soft boot that can be worn over the heels to alleviate pressure) was located in the corner of the room, beside the bed.

On 10/26/22 at approximately 8:45 AM, Resident #152 was observed lying in bed, on her back, being fed by a staff member. Resident #152's feet/heels were resting directly on the bed, with no floating or protective device in place and the side of her foot was pressed against the foot board. The air mattress setting remained on 350 lbs. A bunny boot was still in the corner of the room, beside the bed.

On 10/26/22 at 2:39 PM, LPN G accompanied Surveyor C to Resident #152's room. LPN G was asked to observe the setting of the air mattress. LPN G confirmed it was currently set for a Resident that weights 350 lbs. LPN G said she knew Resident #152 didn't weigh that much, but would have to confirm how much she did weigh. LPN G decreased the setting on the bed to 150 lbs. She then removed the socks of Resident #152 so that observations of her feet could be made. Resident #152's heels were not floating and were directly on the bed. Resident #152's right heel was discolored, but the skin was not broken. When asked about the bunny boot in the corner, LPN G said she would have to check on that.

LPN G went to the nursing station, accessed Resident #152's EHR (electronic health record) confirmed her weight of 112 pounds, and confirmed an order was in place for Prevalon boots. LPN G and Surveyor C then returned to the room of Resident #152. LPN G decreased the air mattress setting to 125 lbs. When asked,

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Resident #152 said the bed already felt better and wasn't as hard. LPN G then looked in the closet and found one Prevalon boot; she looked in the corner of the room and found two bunny boots, and applied the bunny boots to the resident's feet. When asked the purpose of the boots, she stated the boots are to relieve pressure. When asked to explain the difference between the bunny boot and Prevalon boot, she said she would have to research it.

On 10/26/22 at 3:18 PM, an interview was conducted with LPN H, who was the facility's treatment/wound care nurse. LPN H said Resident #152 has had a sacral wound that has persisted through the duration of her (LPN H's) tenure at the facility, and remains at high risk for development of new pressure wounds. When asked about the mattress she said it was to relieve pressure from her sacrum and other pressure points. When asked about the setting, she said nursing should be checking it daily. When advised that it was set on 350 lbs., she confirmed that Resident #152 weighs far less than that, and said the mattress set on 350 lbs. would cause it to be too firm/hard and not relieve pressure. When asked about the heel protectors, LPN H said, "It is to keep her feet from rubbing, causing sheering, and helps the heels get better. LPN H accompanied Surveyor C to the room of Resident #152 and she confirmed that bunny boots had been put on the Resident versus Prevalon boots as ordered.

On 10/25/22 and 10/26/22, a clinical record review was conducted. This review revealed that Resident #152's most recent weight was 112 lbs. Resident #152, had a pressure ulcer on her buttocks which was receiving daily treatment.

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The following physician orders were noted:
a. "Air mattress applied every shift for Skin integrity," dated 7/14/22.
b. "Prevalon boots while in bed every shift for Treatment," dated of 5/12/22.
c. "Skin prep to right heel. Every shift for skin integrity," dated 5/26/22.
d. "Right buttock: cleanse with normal saline/wound cleanser apply honey cover with bordered gauze daily and prn [as needed]. Every day shift for wound care," dated 8/26/22.

Resident #152's care plan was reviewed. It read, "At risk for further alteration in skin integrity... Needs assist with ADL (activities of daily living) ...hx history of sacral and thigh wound, Because of current hx and dx resident is at high risk for skin breakdown and for further breakdown of current area, anemia with blood transfusions, bilateral hand splints [sic] ...Air Pressure Mattress to bed ...use assistive devices as needed, Pressure redistributing device on bed/chair, Suspend/float heels as tolerated, Use pillows/positioning devices as needed..."

The facility policies titled, "General Wound Care/Dressing Changes" and "Pressure Ulcer Monitoring and Documentation" were reviewed. Neither policy addressed the use of preventative interventions with regards to pressure wounds.

On 10/27/22, during an end of day meeting, the facility Administrator and Corporate Staff were made aware of the above findings with regards to Resident #152.

No additional information was provided prior to exit.

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F 689	Continued From page 31	F 689		
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 observation, interview, clinical record review, and facility documentation, the facility staff failed to provide adequate supervision to prevent accidents and hazards for one Resident (#78) in a survey sample of 55 Residents. The findings included: For Resident #78 the facility staff failed to provide adequate supervision for a Resident with dementia to prevent wandering into other Resident rooms. Resident #78 has diagnoses to include dementia, with wandering behaviors. She wears a wander guard bracelet to prevent her from leaving the premises unescorted. A review of the clinical record revealed the following progress note: "8/17/2022 9:30 PM Text: RP (responsible party) aware of event. Voiced that they are aware of Mom pursuing [name of a man] she believe he is her husband. Frequent monitoring implemented."	F 689		

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An interview with LPN (licensed practical nurse) E was conducted on the afternoon of 10/24/22, and when asked if the patient was on frequent rounding, she stated that she was not aware of such. When asked if frequent rounding should be care planned, she stated that she believed it should be. LPN E reviewed the care plan and stated there was no mention of frequent rounding. When asked to quantify "frequent rounding for a dementia patient" she stated that there was no specific time or way to document how frequently the resident should be checked.

A review of the care plan for Resident #78 revealed: "At risk for behavior symptoms such as wandering into other resident's room, thinking other male residents are her husband and packing her personal belongings to leave facility related to Alzheimer's disease/dementia. Observed kissing another resident Created on: 07/22/2022 Revision on: 08/17/2022 ...Will accept care and medications as prescribed Created on: 07/22/2022 Target Date: 11/22/2022 ...Will reduce risk of behavioral symptoms ...Administer medications per physician order created on: 07/22/2022 ...Observe for mental status/behavioral changes when new medication started or with changes in dosage Created on: 07/22/2022 ...Psych (psychiatric) referral as needed Created on: 07/22/2022." "Frequent rounding" was not listed as an intervention.

On 10/24/22 at approximately 9:45 AM an interview was held with Employee E who stated that Resident #78 only had a BIMS (Brief Interview of Mental Status) score of 01 /10 indicating severe cognitive impairment.

On 10/24/22 during the end of day meeting the

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F 689	Continued From page 33 concerns were expressed to the Administrator and no further information was provided.	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, facility documentation review, and clinical record review, the facility staff failed to administer oxygen in a manner to prevent the spread of infection for three Residents (Residents # 179, # 105 and # 28) in a survey sample of 55 Residents. The findings included: 1. For Resident # 179, the nebulizer tubing was not dated and was not stored in a plastic bag. Resident # 179 was admitted to the facility with the diagnosis of Chronic Obstructive Pulmonary Disease. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 9/16/2022. The MDS coded Resident #179 as requiring oxygen therapy. Review of the clinical record was conducted on 10/25/2022 - 10/27/2022.	F 695		

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During the initial tour on 10/25/2022 at 12:50 PM, a red "Oxygen in Use" sign was posted on the outside of Resident # 179's bedroom door. Resident # 179 was sitting on the side of the bed. The resident's nebulizer tubing was on the nightstand. There was no date on the nebulizer tubing and it was not in a plastic bag. The nasal cannula oxygen tubing on the nightstand was not dated. Was the cannula tubing lying on the nightstand, as well?

On 10/25/2022 at 1:20 PM, LPN (Licensed Practical Nurse) B observed Resident # 179's nebulizer. LPN B stated there should have been a date on the nebulizer tubing and it should have been in a plastic bag. LPN B stated the facility staff should change the nebulizer tubing according to the policy. LPN B stated that if there is no date on the tubing, there is no way to know when the tubing was last changed. LPN B also stated the standard for the facility was for all of the oxygen tubing to be changed weekly. LPN B stated Resident # 179 had an order for PRN (as needed) use of oxygen. LPN B stated the facility staff should change the tubing weekly and staff should check the date on the tubing prior to using it to make sure it is not longer than a week.

A review of the Physicians Orders revealed the following orders for oxygen therapy: "6/9/2022 for Oxygen as needed 2 lpm (Liters per minute) via nasal cannula as needed shortness of breath."

Review of the facility policy, "Respiratory/Oxygen Equipment, Effective date-11/1/2019," revealed, in part: "Rinse out nebulizer reservoir with tap water, dry and place in a plastic bag when not in use. Nebulizers and bags must be changed every

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Monday, Wednesday and Friday and dated ...Nasal cannulas, simple masks, Venturi mask and oximizer must be changed every week, dated and initialed."

When interviewed 10/27/2022 at 3:55 p.m., the Director of Nursing stated nebulizer tubing should be changed per policy, dated, and kept in a bag. The Director of Nursing also stated oxygen tubing should be changed weekly and dated. She stated if the tubing was not dated, staff would not know the date the tubing was changed.

During the end of day debriefing on 10/27/2022, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the failure of the staff to label and date the nebulizer tubing and failure to label and date oxygen tubing. The Administrator and Corporate Nurse Consultant stated the nebulizer tubing and oxygen tubing should have been changed, labeled and dated when the oxygen (respiratory) equipment was scheduled to be changed.

No further information was provided.

2. For Resident #105, the oxygen tubing was not dated.

Review of the clinical record was conducted on 10/25/2022 - 10/27/2022.

During the initial tour on 10/25/2022 at 1:00 PM, Resident # 105 was lying in bed with nasal cannula oxygen tubing in both nostrils. A red "Oxygen in Use" sign was posted on the outside of the door. An oxygen concentrator was located on the right side of the bed. The oxygen tubing

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and bag connected to the oxygen concentrator were not labeled and dated.

On 10/25/2022 at 1:25 PM, LPN (Licensed Practical Nurse) B observed Resident # 105's oxygen equipment. LPN B stated there should have been a date on the oxygen tubing and concentrator. LPN B stated the facility staff should change the oxygen tubing weekly, and staff should check the date on the tubing prior to using it to make sure it is not longer than a week. She stated this is to prevent infection. LPN B stated that if there is no date on the tubing, there is no way to know when the tubing was last changed.

Review of the Physicians Orders revealed the following orders for oxygen therapy:
"9/9/2022 for Oxygen at 2 Liters per minute via nasal cannula every shift."

When interviewed 10/27/2022 at 3:55 p.m., the Director of Nursing stated oxygen tubing should be changed weekly and dated. She stated if the tubing was not dated, staff would not know the date the tubing was changed.

During the end of day debriefing on 10/27/2022, the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the failure of the staff to change, label and date the oxygen tubing weekly. The Administrator and Corporate Nurse Consultant stated the oxygen tubing should have been changed and dated when all of the oxygen equipment was scheduled to be changed.

No further information was provided.

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F 695	Continued From page 37 3. For Resident #28, facility staff failed to change the oxygen tubing weekly as ordered. During initial tour on 10/25/22 at approximately 12:45 PM, Surveyor E observed Resident #28 with oxygen being administered via nasal cannula. There was no date on the oxygen tubing. Surveyor E conducted a staff interview with LPN B who stated, "Oxygen tubing should be changed weekly and it [the oxygen tubing] should be labeled and dated". A review of Resident #28's clinical record revealed a physician's order that read, "Change all disposable oxygen supplies every week and as needed. Label and date all supplies." The Facility Administrator was informed of the findings on 10/27/22. No further information was provided.	F 695		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		

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as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility documentation review, the facility staff failed to use the services of a registered nurse for one day (01/08/2022) out of the 6 days reviewed.

The findings included:

On 10/27/2022, the facility staff provided the nursing time punches for 01/07/2022-1/09/2022 and 02/05/2022-02/07/2022. Of the 6 days reviewed, there was no evidence of Registered Nurse (RN) coverage for one day (01/08/2022).

On 10/27/2022, the facility's assessment dated 07/21/2022 was reviewed. The staff needed in a 24-hour period for RNs, LPNs, and CNAs was determined to be 4 RN', 11-15 LPNs, and 22-46 CNAs.

On 10/27/2022 at approximately 4:15 P.M., the administrator was notified there was no evidence of RN coverage on 01/08/2022.

On 10/28/2022 at approximately 9:50 A.M., Employee P, the scheduler, was interviewed. When asked about the process for staffing, the scheduler stated that the process included ensuring there was one RN in the building for at least one shift in a 24-hour period. When asked about RN coverage for 01/08/2022, the scheduler verified there was no RN coverage for that day. The scheduler stated a staff RN was not scheduled so she asked the staffing agency for an RN to staff that particular day, but an RN from the agency never showed up.

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F 727	Continued From page 39 No further information was provided prior to exit.	F 727		
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. §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:	F 755		

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Based on staff interview and clinical record review, the facility staff failed for one resident (Resident # 21) of 55 residents in the survey sample to ensure medications were available for administration.

The findings include:

For Resident #21, the facility staff failed to administer insulin as ordered by the physician because it was not available for administration.

On 10/25/22 and 10/26/22, a clinical record review of Resident #21's chart was conducted. This review revealed the following:
i. A physician order dated 7/27/22, that read, "Humulin N 100 UNIT/ML Suspension Inject 30 unit subcutaneously two times a day related to Type 2 Diabetes Mellitus Without Complications".
ii. An excerpt from the care plan for Resident #21 read, "Endocrine system related to Insulin Dependent Diabetes and dx of Hypothyroidism created on: 10/20/2020..."Administer medications per physician orders".
iii. The MAR (medication administration record) revealed that on 10/7/22, the 5PM dose of Humulin insulin was not administered and had a code "5" entered, which according to the legend indicated "5=Hold/See Nurse Notes."
iv. The nursing notes for 10/7/22, read, "Humulin N 100 UNIT/ML Suspension
Inject 30 unit subcutaneously two times a day related to Type 2 Diabetes Mellitus without Complications. Awaiting arrival from pharmacy".

The facility policy titled, "Medication Administration" was reviewed. This policy did not address the availability of medications.

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F 755	Continued From page 41 On 10/26/22 at 5:24 PM, during an end of day meeting, the Director of Nursing (DON), was asked to clarify what a blank on the MAR (medication administration record) meant, the DON (director of nursing) stated, "the MAR should have some response as to why the medication was not given, a blank means it would leave to question if it was given or not." On 10/27/22, the facility Director of Nursing stated that Residents are to receive medications as ordered by the physician and in the event medications are not available she expects the doctor to be made aware, so that they can be offered the opportunity to make alternate treatment decisions if they so desire. A review of the contents within the Omnicell (a system for back-up medications that is maintained onsite) revealed that the he insulin for Resident #21 was not available in the Omnicell. The above findings were discussed with the facility Administration and Corporate Staff during an end of day meeting on 10/27/22. No further information was provided.	F 755		
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 Resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure one Resident	F 760		

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(Resident #38) was free of significant medication errors, in a survey sample of 55 Residents.

The findings included:

For Resident #38, the facility staff failed to administer an antibiotic as ordered by the physician to treat pneumonia on 10/22/22.

On 10/25/22, during an interview with the Resident, Resident #38 reported that frequently in the evenings he doesn't receive his medications.

On 10/25/22 and 10/26/22, a clinical record review was conducted. This review revealed the following:
i. A physician order dated 10/18/22, read, "Levaquin Tablet 500 MG (Levofloxacin) Give 1 tablet by mouth one time a day for Pneumonia for 7 Days".
ii. The care plan contained a focus area that read, "Infection of respiratory tract pneumonia". A related intervention read, "Administer medication per physician orders".
iii. Review of the Medication Administration Record (MAR) revealed that on 10/22/22, there was no indication that the Resident was administered Levaquin as ordered.
iv. There were no progress notes to indicate why the Levaquin had not been administered.
v. There was no indication that the physician was made aware of the missed dose of antibiotic, so that the physician could be afforded to opportunity to determine if the treatment regime alterations needed to be made.

A review of the contents within the Omnicell (a system for back-up medications that is maintained onsite) revealed that the generic of

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F 760	Continued From page 43 the Levaquin, which is Levofloxacin, was available in the Omnicell for administration to Resident #38. The facility policy titled, "Medication Administration" was reviewed. This policy did not address the availability of medications. On 10/26/22 at 5:24 PM, during an end of day meeting, the Director of Nursing (DON), was asked to clarify what a blank on the MAR (medication administration record) meant, the DON (director of nursing) stated, "the MAR should have some response as to why the medication was not given, a blank means it would leave to question if it was given or not." On 10/27/22, the facility Director of Nursing stated that Residents are to receive medications as ordered by the physician and in the event medications are not available she expects the doctor to be made aware, so that they can be offered the opportunity to make alternate treatment decisions if they so desire. The above findings were discussed with the facility Administration and Corporate Staff during an end of day meeting on 10/27/22. No further information was provided.	F 760		
F 761 SS=E	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	F 761		

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instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and facility documentation review, the facility staff failed to ensure that expired medications were discarded on one of two medication carts on the Monroe unit, and in one of three medication storage rooms, the Monroe unit medication room.

The findings included:

1. The facility staff had available for administration, multiple medications that were expired on 1 medication cart on the Monroe unit.

On 10/27/22 at approximately 9 AM, LPN (licensed practical nurse) D was during an inspection of the 200 hall medication cart #2. The following medications, all of which were expired,

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were in the cart, available for administration: Liquid pain relief 160mg/5 ml, 16 oz., which expired 6/2022; Bottles of Zinc 50 mg which expired 08/2022; Aspirin 325 mg which expired 9/2022; Vitamin B complex which expired 9/2022; A vial of Humulin 70/30 insulin which was labeled as being opened on 9/13/22. LPN D confirmed that insulin is to be used "within 30 days of when opened." When asked why, she said, "It loses its effectiveness." A vial of Humulin R insulin was not labeled as to which Resident it belonged, and which had no opening date.

2. In the Monroe unit medication room, multiple expired medications were available for use.

On 10/26/22 in the afternoon, the medication room on the Monroe unit was inspected in the presence of LPN (licensed practical nurse) J. During the inspection, the supply clerk, Employee N, came in, as well. The following expired items were available for use/administration: Slow Mag (Magnesium Chloride, a dietary supplement): 15 bottles that were expired with expiration dates of 8/2021 and 01/2022; Vitamin B-1 that expired 8/2022; Salonpas pain patches, 2 boxes containing 60 patches each which expired 4/2022; Milk of Magnesia, 10 bottles with an expiration date of 09/2021.

On 10/26/22, LPN J stated if residents received expired medications, these medications could cause adverse reactions or not be as effective. LPN J and Employee N both indicated that they check dates on items regularly and aren't sure how this happened.

On 10/27/22 at 10:30 AM, the Director of Nursing (DON) was made aware of the above findings.

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F 761	Continued From page 46 She stated, "Normally the unit manager will check the carts for expired medications. We do it weekly except on the skilled unit (Monroe) we do it daily there." The DON also said, "The pharmacist was here last week and did an audit and removed some expired items." When asked how the expired medications had not been removed if they are checking daily on that unit, she said, "That is concerning to me." When asked to discuss the risks of having expired medications available for administration, the DON said, "It puts them at risk for getting expired medications, they [the medications] are not as effective after the expiration date." Review of the facility policy titled, "Storage of Medications," revealed, in part: "Expiration Dating...F. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a 'date opened' sticker on the medication and enter the date opened and/or the new date of expiration... I. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining..." On 10/27/22, the facility Administrator, Director of Nursing and Corporate staff were made aware of the expired medications being available for administration. No further information was provided.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 47 §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 documentation review, the facility staff failed to store, prepare and distribute food in accordance with professional standards for food service safety in one of one kitchen inspected. The findings included: 1. The facility staff failed to store food in a manner consistent with professional standards for food service safety with regard to, labeling and protection from contaminates. On 10/25/22 at 11:45 AM, observations were made in the facility kitchen. The facility's dietary manager was present. On a cart on the outside of the walk-in freezer, a bag of open, undated oatmeal was present. The dietary manager said, "We have to date items	F 812		

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when opened and when it comes in, so we know we are serving right things to Residents," and she threw away the oatmeal.

In the dry storage room a bag of rice was open and not secured in a manner to protect from environmental contaminates. The bag was open to air, not secured, and had no labeling to indicate when it was opened or to be used. The dietary manager said, "We have to know when it is opened and when it comes in so we are serving the right thing to the Residents," and threw the rice away.

On 10/25/22, during the initial tour, inside the walk-in freezer a box contained patties that the Dietary Manager identified as Salisbury steak. The bag was open to air and had no date as to when it was opened or to be used. The enclosed patties had ice crystals on them. The dietary manager said she would expect staff to close and tie the bag, "To make sure no frostbite occurs, no insects get in and nothing can contaminate the food." She tied the bag and returned the box of food to the freezer.

The dietary manager acknowledged all of the above observations, and stated that it was of concern to her as well.

Review of the facility policy titled, "Food Receiving and Storage," was conducted. This policy read, "7. Dry foods that are stored in bins will be removed from original packaging, labeled and dated ("use by" date). Such foods will be rotated using a 'first in - first out' system. 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)...11. The freezer must keep frozen foods frozen solid.

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Wrappers of frozen foods must stay intact until thawing..."

According to "ServSafe" Fourth Edition manual pages 7-13: "When food is stored improperly and not used in a timely manner, quality and safety suffer. Poor storage practices can cause food to spoil quickly with potentially serious results. General Storage Guidelines: Label food. All potentially hazardous, ready-to-eat food prepared onsite that has been held for longer than twenty-four hours must be properly labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded ...Discard food that has passed the manufacturer's expiration date."

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.12, pages 73-74: "Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food service establishment, shall be identified with the common name of the food."

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.15, page 64 stated: "Package Integrity. FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants."

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food &

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Drug Administration chapter 3, section '3-305.11 Food Storage...D. A date marking system that meets the criteria...(2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded...'Section 3-501.17 Ready-to-eat, Time/temperature control for safety food, date marking ...(A)...refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...."

On 10/26/22 and on 10/27/22, during end of day meetings the facility Administrator was made aware of the findings.

No further information was provided.

2. The facility staff failed to thaw ground beef appropriately, and maintain a safe temperature to prevent food borne illness.

On 10/25/22, during an initial tour of the kitchen, a roll of ground beef was in the sink. The dietary manager was asked how meats are thawed. The dietary manager said, "In the walk-in cooler or under running water." When asked to look in the sink, the dietary manager identified that it was ground beef that was not used for making the chili for lunch today. She stated: "We will put it back in the cooler and use it later this week." The outside of the package the beef was just cool to touch. The dietary manager was asked to provide a thermometer and obtain a temperature of the meat. She used an infrared thermometer, which read, 50 degrees Fahrenheit. The dietary

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manager then used a probe thermometer, and obtained a temperature of 52 degrees Fahrenheit. She said, "That is one of my big 7's- you don't want to leave meat out; it can cause food borne illness." The dietary manager then asked, "Can I redeem this one and throw it away?"

Review of the facility policy titled, "Food Preparation and Service" was conducted. This policy read, "Food and nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices...Thawing Frozen Food ...1. Foods will not be thawed at room temperature. Thawing procedures include: Thawing in the refrigerator in a drip-proof container; Submerging the item in cold running water (70°F or below); Thawing in a microwave oven and then cooking and serving immediately; or Thawing as part of a continuous cooking process.

Food Preparation, Cooking and Holding Temperatures and Times
1. The 'danger zone' for food temperatures is between 41°F and 135°F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness.
2. Potentially hazardous foods (PHF) include meats, poultry, and seafood, cut melon, eggs, milk, yogurt and cottage cheese.
3. The longer foods remain in the 'danger zone' the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41°F or above 135°F. Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause foodborne illness..."

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F 812	Continued From page 52 According to "ServSafe" Fourth Edition manual pages 7-13 read, "Thawing food properly: Freezing does not kill microorganisms. When frozen food is thawed and exposed to the temperature danger zone, any foodborne microorganism present will begin to grow. To prevent this growth, food should never be thawed at room temperature. There are only four acceptable methods for thawing potentially hazardous food. In a refrigerator, at 41 degrees or lower, submerged under running potable water at a temperature of 70 degrees or lower, in a microwave oven, if the food will be cooked immediately after thawing, as part of the cooking process ...Follow these additional guidelines when working with raw meat, fish, and poultry. ...Remove from refrigerated storage only as much product as you can prepare at one time..." On 10/26/22 and again on 10/27/22, during an end of day meeting, the facility Administrator and Corporate staff were made aware of the above findings. No additional information was provided.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		

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	495115	A. BUILDING _____ B. WING _____	C 10/28/2022

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immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

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F 883	Continued From page 54	F 883		

immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide pneumococcal immunizations for 2 residents in a survey sample of 5 residents reviewed for pneumococcal vaccination.

The findings included:

The facility staff failed to provide pneumococcal immunizations for Residents #54 and #176.

On 10/27/22, clinical record review was performed for both Resident #54, admission date 8/10/22, and Resident #176, admission date 8/31/22. This review revealed no documentation with regard to pneumococcal immunization, including the resident's current pneumococcal vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication for either resident.

An active physician's order was found in the clinical record for both Resident #54 and Resident #176 that read, "May have Pneumovax with consent."

A staff interview was conducted with the facility's Infection Preventionist who confirmed the findings and stated, "We are supposed to assess whether or not a resident has received a [pneumonia] vaccine or not when they are admitted here, and

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F 883	Continued From page 55 offer them one if they have not had it,." She stated it does not appear that this was done for Residents #54 and #176. A facility policy on pneumococcal immunization was requested and received. On 10/26/22, review of the facility policy entitled, "Influenza & Pneumococcal Vaccinations", dated 02/06/20, read: "Policy...Vaccination against pneumonia will be offered to Center patients as indicated ...New patients' names will be placed on the log at the time of admission and offered the Pneumococcal vaccination if not received as indicated". On 10/26/22 at approximately 4:30 PM, the Facility Administrator and the Director of Nursing were updated on the findings. No further information was provided.	F 883		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, Resident interview, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain an effective pest control program to mitigate the presence of pests on for one of 55 residents in the survey sample, Resident #195; and in three out of three units of the facility in October 2022. The findings included:	F 925		

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The facility staff failed to follow the recommendations of the pest control company on 10/19/2022 and 10/26/2022 to mitigate the ongoing presence of pests.

According to Resident #195's admission Minimum Data Set with an Assessment Reference Date of 10/09/2022, the Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition.

On 10/26/2022 at approximately 9:30 A.M., Resident #195 was interviewed. When asked about pests, Resident #195 stated that there are flies in her room and stated that she saw one that morning. Resident #195 was finished eating breakfast but the breakfast tray was still on the tray table in front of her. During the course of the interview, there was a fruit fly observed flying around Resident #195's breakfast tray.

On 10/28/2022, the pest control service receipts were reviewed. Under the "Recommendations" heading of the service receipts dated 10/19/2022 and 10/26/202, 16 resident rooms were identified, spanning all three facility units, with the following recommendation: "Pipes extending through wall allowing pest access. Please fill in gaps between pipes and wall to prevent pest entry."

On 10/26/2022 at approximately 9:50 A.M., the Director of Maintenance, Employee F, was interviewed. When asked about a problem with pests, the Maintenance Director stated that in the summer there was a problem with fruit flies and now a roach may be seen from time to time. When asked about the process for monitoring pests in the facility, the Maintenance Director

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stated that there is a book at the nurse's station where nurses will log pest sightings. The Maintenance Director stated that the pest control technician will read the log weekly and "see what needs to be treated."

On 10/28/2022, the pest sighting log was reviewed. The entries included, but were not limited to, nine entries on 10/05/2022 of ants, gnats, and flies sightings.

On 10/28/2022 at approximately 9:00 A.M., the pipe under the room sink in Resident #195's room was observed. There were gaps in the wall where the room sink pipe was seated. The pipe collar was approximately an inch away from the wall.

On 10/28/2022 at approximately 9:15 A.M., a roach was observed on the floor walking out from under the room sink and toward the B bed in room 133.

On 10/28/2022 at approximately 9:30 A.M., the Maintenance Director was interviewed. When asked if the gaps between the pipes and walls were sealed as per the pest control company recommendations, the Maintenance Director stated he had not sealed any of the gaps. The Maintenance Director stated he will just push the collar to be flush with the wall. When asked why the gaps were not sealed, the Maintenance Director's reason was unclear.

On 10/28/2022 at approximately 10:00 A.M., the administrator was notified of findings.