STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 10/19/2022

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WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/11/2022 through 10/14/2022 and 10/17/2022 through 10/19/2022. 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 standard survey was conducted 10/11/2022 through 10/14/2022 and 10/17/2022 through 10/19/2022. Fifteen complaints were investigated during the survey. (VA00056367- substantiated without deficiency; VA00055565- substantiated with deficiency; VA00053700- unsubstantiated without deficiency; VA00056361- substantiated without deficiency; VA00055165- substantiated with a related deficiency; VA00055414- substantiated with deficiency; VA00054012- substantiated without deficiency; VA00055136- substantiated without deficiency; VA00054670- unsubstantiated without deficiency; VA00054624- substantiated with deficiency; VA00054629- substantiated with deficiency; VA00056401- unsubstantiated without deficiency; VA00054845- substantiated with deficiency; VA00055084- substantiated with deficiency; and VA00053549- substantiated with deficiency). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 225 certified bed facility was 202 at the time of the survey. The survey sample	F 000		

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

Electronically Signed | 11/07/2022

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F 000	Continued From page 1 consisted of 61 current resident reviews and 17 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		11/15/22

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain dignity for two of 78 residents in the survey sample, Residents #130 and #54. The findings include: 1. For Resident #130 (R130), the facility staff failed to cover the resident's exposed lower body on 10/11/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/14/22, R130 was coded as being moderately cognitively impaired for making daily decisions, having scored eight out of 15 on the BIMS (brief interview for mental status). R130 was coded as requiring the extensive assistance of two staff members for bed mobility. On 10/11/22 at 2:03 p.m., R130 was sitting up in bed. The door to the resident's room was open, and the resident could be clearly seen from the hallway. R130 had nothing covering their lower body, and was wearing an incontinence brief. R130 intermittently called out to staff members as they walked by the resident's door. Staff members passed by R130's door 22 times (on four of these observations, staff looked in the room) however did not go in the room to cover	F 550	The statements made in the following plan of correction are for the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 Resident Rights /Exercise of rights 1. Staff is providing privacy for Resident #130 when it is observed he is exposed. Resident #54 is being assisted with her meals at the time the tray is delivered to the room. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate all certified and licensed nurses and facility staff on the process for response to call bells, maintaining resident dignity with respect to exposure of body if not clothed, utilization of privacy curtains, and delivery of meal trays to rooms of residents requiring additional assistance with feeding.	

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F 550	Continued From page 3 R130's lower body. One visitor also passed the door. At 2:14 p.m., R130 rang the call bell. The light outside R130's room lit up. In the four minutes it took for a staff member to answer the call bell, ten staff members passed by R130's door without acknowledging the call bell or going inside to assist R130. One visitor passed R130's door during these four minutes. R130 was not interviewable. A review of R130's care plan dated 4/12/22 and updated 6/13/22 revealed no information related to treating the resident with dignity. On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. When asked what should be done for a resident whose lower body is exposed to view from the hallway, she stated she would go in and make sure the resident is safe. She stated she would cover the resident. She stated it is a violation of a resident's dignity to be exposed to others as they pass by the resident's doorway. On 10/17/22 at 1:39 p.m., CNA (certified nursing assistant) # 4 was interviewed. She stated if she observed an exposed resident from the hallway, she would stop what she was doing and cover the resident. She stated: "I would not want anybody seeing me half dressed." She stated it is not dignified treatment of a resident to leave the resident exposed to view as others pass by the resident's doorway. On 10/17/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of	F 550	4. The Unit Managers or designee will observe 5 x weekly to ensure residents have their dignity maintained. The Unit Manager or designee will observe 3 x weekly those residents who require feeding assistance to ensure trays are not left in room. 5. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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F 550	Continued From page 4	F 550		

nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "Quality of Life - Dignity," revealed, in part: "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation
1. Residents shall be treated with dignity and respect at all times.
2. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth."

No further information was provided prior to exit.
2. For Resident #54 (R54), the facility staff failed to promote dignity during dining.

R54's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/9/2022, the resident scored 8 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section G documented R54 requiring extensive assistance of one person for eating.

On 10/12/2022 at 8:38 a.m., an observation was made of R54 in their room. R54's breakfast meal tray was observed sitting on an overbed table to the right of the bed. All of the containers on the tray were observed to be covered and unopened. R54 was observed to be lying flat in the bed. No staff were observed in the room. At 9:03 a.m., a staff member entered R54's room and advised them that they were there to feed them breakfast.

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F 550	Continued From page 5	F 550		

On 10/12/2022 at 8:38 a.m., an observation was made of R54 in their room. An attempt was made to interview R54, however due to their cognitive status the interview was not completed.

The comprehensive care plan for R54 dated 11/02/2017 documented in part, "Nutrition: [R54] is at nutritional risk RT (related to) hx (history) of weight loss, dysphagia (1) s/p (status post) cerebral infarction, hemiplegia, COPD (chronic obstructive pulmonary disease), asthma, HTN/HLD (hypertension/hyperlipidemia), dementia, gout, wasting/atrophy, hx sig (significant) wt (weight) loss/gain. Created on: 11/02/2017. Revision on: 08/29/2022." Under "Interventions" it documented in part, "Assist to feed meals. Created on: 12/20/2020. Revision on: 09/08/2022..."

On 10/17/2022 at 12:35 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that staff should not leave meal trays at the bedside of residents who could not feed themselves. LPN #8 stated that staff were supposed to leave the trays on the meal cart until they were ready to feed the resident and then bring it into the room and sit down at the bedside to feed the resident. LPN #8 stated that it was a dignity issue for the resident and also they did not want to serve the resident cold food from leaving it sitting in the room.

On 10/17/2022 at 4:05 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated that when they were passing out the meal trays that they passed them in the order that they were on the cart. CNA #1 stated that some staff placed the trays in the rooms and left them for the assigned CNA to come back and

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F 550	Continued From page 6 feed their resident and some left the trays on the meal cart. CNA #1 stated that their practice was to leave the tray on the meal cart until they were ready to go to the room and feed the resident. CNA #1 stated that they would not want the food to get cold from sitting in the room or the resident to see the tray and feel like no one was going to feed them. On 10/17/2022 at approximately 4:59 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern. No further information was provided prior to exit. References: (1) dysphagia difficulty or pain when swallowing. This information was obtained from the website: https://medlineplus.gov/swallowingdisorders.html	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health	F 561		11/15/22

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F 561	Continued From page 7 care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to honor a resident's right to make choices about their ADL (activities of daily living) care for two of 78 residents in the survey sample, Resident #195 and Resident #140. The findings include: 1. For Resident #195 (R195), the facility staff failed to provide showers as per their preference. On the most recent MDS (minimum data set), a 5-day admission assessment with an ARD (assessment reference date) of 9/30/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily	F 561	F561 Self-Determination 1. Resident #195 and #140. Both residents plan of care updated to indicate preference of showers. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all licensed nurses and nursing management on the process to ensure preferences for bathing is discussed upon admission to center and changes in resident preferences with plan of care updated. 4. The Director of Nursing or designee will review new admissions/readmissions weekly for scheduling of bathing/showers to ensure that the resident preferences are honored, and care planned.	

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F 561	Continued From page 8 decisions. Section G documented R195 being totally dependent on one staff member for bathing. On 10/12/2022 at 9:18 a.m., an interview was conducted with R195 in their room. R195 stated that they had only received bed baths since being admitted to the facility and had not been offered a shower. R195 stated that they would love to have a shower if the staff would offer it to them. R195 stated that they felt that the staff were too busy to have time to give them a shower and the bed bath was faster for them. The comprehensive care plan for R195 dated 9/19/2022 documented in part, "ADL: [R195] has an ADL selfcare performance deficit r/t (related to) Confusion, Impaired balance, Limited Mobility. Created on: 09/19/2022. Revision on: 09/26/2022." Under "Interventions" it documented in part, "BATHING/SHOWERING: The resident is able to shower with 1 person assistance/supervision. Created on: 09/19/2022. Revision on: 09/26/2022." Review of the ADL-Bathing documentation for 9/1/2022-9/30/2022 for R195 documented in part, "ADL-Bathing (Prefers: Shower)..." It documented a bed bath given on 9/29/2022 and 9/30/2022. It failed to evidence documentation of a bath or shower on 9/26/2022. Review of the ADL-Bathing documentation for 10/1/2022-10/31/2022 for R195 documented in part, "ADL-Bathing (Prefers: Shower)..." It documented a bed bath given on 10/5/2022, 10/6/2022, 10/7/2022, and 10/10/2022. It failed to evidence documentation of a bath or shower on 10/3/2022.	F 561	5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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On 10/17/2022 at 12:35 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that showers were given three times a week and documented by the CNA's (certified nursing assistants) in the computer. LPN #8 stated that they had a shower schedule that they followed for the CNA's to know which residents were scheduled for showers on their assigned days. LPN #8 stated that all residents were offered a shower and a bed bath if they refused the shower. LPN #8 stated that if a resident refused the shower and the bed bath it was documented in the medical record.

On 10/17/2022 at 1:40 p.m., an interview was conducted with LPN #11. LPN #11 stated that showers were given three times a week. LPN #11 stated that if a resident refused their shower the CNA let them know and they talked to the resident. LPN #11 stated that a bed bath was offered if the resident refused the shower. LPN #11 stated that all residents should be offered showers.

On 10/17/2022 at 4:05 p.m., an interview was conducted with CNA #1. CNA #1 stated that showers or bed baths were given to residents three days a week. CNA #1 stated that they had a shower schedule that they followed to know which residents were scheduled for their showers each day. CNA #1 stated that all residents were offered a shower first unless they were unable to tolerate the shower. CNA #1 stated that some residents preferred a bed bath due to pain and refused the shower. CNA #1 stated that residents who refused their showers were offered a bed bath and the nurse was made aware. CNA #1 stated that they only had one resident that they

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cared for who did not like to take showers and it was not R195.

The facility policy, "Resident Rights" dated December 2016 documented in part, "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ...self-determination...be informed of, and participate in, his or her care planning and treatment..."

On 10/17/2022 at approximately 4:59 p.m., ASM #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern.

No further information was presented prior to exit.

2. For Resident #140 (R140), the facility staff failed to provide showers as per their preference.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/16/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. Section G documented R140 being totally dependent on two or more staff member for bathing.

On 10/12/2022 at 9:21 a.m., an interview was conducted with R140 in their room. R140 stated that they preferred to receive a shower rather than a bed bath. R140 stated that they had received two showers since being admitted to the

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facility and bed baths the other days. R140 stated that the staff who gave them the bed baths did not offer a shower on those days.

The comprehensive care plan for R140 dated 9/13/2022 documented in part, "ADL's (activities of daily living): [R140] has an ADL self-care performance deficit r/t (related to) Activity Intolerance, left femur fracture, generalized weakness, difficulty in walking, OA (osteoarthritis), abnormalities of gain and mobility arthropathies in other diseases, muscle wasting and atrophy, multiple health issues. Created on: 09/13/2022. Revision on: 09/21/2022." Under "Interventions" it documented in part, "BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. Created on: 09/13/2022."

Review of the ADL-Bathing documentation for 9/1/2022-9/30/2022 for R140 documented in part, "ADL-Bathing (Prefers: Shower)..." It documented a bed bath given on 9/12/2022, 9/15/2022, 9/22/2022, 9/29/2022 and 9/30/2022. It failed to evidence documentation of a bath or shower on 9/19/2022 and 9/26/2022.

Review of the ADL-Bathing documentation for 10/1/2022-10/31/2022 for R140 documented in part, "ADL-Bathing (Prefers: Shower)..." It documented a bed bath given on 10/5/2022, 10/6/2022, 10/7/2022, and 10/10/2022. It failed to evidence documentation of a bath or shower on 10/3/2022.

On 10/17/2022 at 12:35 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that showers were given three times a week and documented by the CNA's

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(certified nursing assistants) in the computer. LPN #8 stated that they had a shower schedule that they followed for the CNA's to know which residents were scheduled for showers on their assigned days. LPN #8 stated that all residents were offered a shower and a bed bath if they refused the shower. LPN #8 stated that if a resident refused the shower and the bed bath it was documented in the medical record.

On 10/17/2022 at 1:40 p.m., an interview was conducted with LPN #11. LPN #11 stated that showers were given three times a week. LPN #11 stated that if a resident refused their shower the CNA let them know and they talked to the resident. LPN #11 stated that a bed bath was offered if the resident refused the shower. LPN #11 stated that all residents should be offered showers.

On 10/17/2022 at 4:05 p.m., an interview was conducted with CNA #1. CNA #1 stated that showers or bed baths were given to residents three days a week. CNA #1 stated that they had a shower schedule that they followed to know which residents were scheduled for their showers each day. CNA #1 stated that all residents were offered a shower first unless they were unable to tolerate the shower. CNA #1 stated that some residents preferred a bed bath due to pain and refused the shower. CNA #1 stated that residents who refused their showers were offered a bed bath and the nurse was made aware. CNA #1 stated that they only had one resident that they cared for who did not like to take showers and it was not R140.

On 10/17/2022 at approximately 4:59 p.m., ASM #1, the administrator, ASM #2, the regional

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F 561	Continued From page 13 director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern. No further information was presented prior to exit.	F 561		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		11/15/22

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F 580	Continued From page 14 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to notify the physician of a change in a resident's clinical condition for two of 78 residents in the survey sample, Residents #61 and #124. The findings include: 1. For Resident #61 (R61), the facility staff failed to notify the physician when the resident's systolic blood pressure (1) was greater than 160 (mm Hg-millimeters of mercury) eleven times during May 2022. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	F 580	F580 Notify of Changes (Injury/declined room etc.) 1. Physician notified for Resident # 61 of increase in B/P with no new orders. Physician for Resident #124 was notified of the omissions of the medication with no new orders. Medication for resident # 124 has since been discontinued. 2. A review of current residents in the center was conducted to ensure abnormal B/P(s) was reported to the medical provider and to ensure medications were given as per MD orders. 3. Staff Development Coordinator or designee will educate all licensed nurses on the process to notify physician regarding medications that are not within	

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reference date) of 8/12/22, R61 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R61 was coded as receiving dialysis services during the look back period. A review of R61's current diagnoses revealed the resident has high blood pressure.

A review of R61's clinical record revealed the following orders:

"Clonidine HCl (2) Tablet 0/1 MG. Give 1 tablet by mouth every 12 hours as needed for systolic B/P (blood pressure) greater than 160." This order was dated 4/22/22.

A review of R61's MARs (medication administration records) for May 2022 revealed the following blood pressures: 5/7/22 at 6:30 a.m. 183/100; 5/8/22 at 6:30 a.m. 178/82; 5/8/22 at 4:30 p.m. 178/84; 5/11/22 at 6:30 a.m. 188/100; 5/13/22 at 6:30 a.m. 169/110; 5/14/22 at 4:30 p.m. 161/91; 5/15/22 at 4:30 p.m. 185/90; 5/16/22 at 6:30 a.m. 177/98; 5/22/22 at 4:30 p.m. 180/100; 5/23/22 @ 4:30 p.m. 190/91; 5/29/22 at 6:30 a.m. 178/89. Further review of the May 2022 MARs revealed no evidence that Clonidine was given on any of these dates and times when R61's systolic blood pressure readings exceeded 160.

Further review of R61's clinical record revealed no evidence that the facility notified the physician of the resident's high blood pressure on these 11 occasions.

A review of R61's care plan dated 2/4/22 and revised 8/15/22 revealed, in part: "[R61] has basic nursing care needs r/t (related to) ...HTN

the parameters per physician order and to notify the MD when medications are unavailable for administration with documentation in the medical record of the notification. In addition, education included the facilities process for obtaining medications from the pharmacy.
4. The Unit Managers or designee will review weekly to ensure physician orders were followed for medications with parameters not within range and verify unavailable medications are available.
5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction.
6. Date of Compliance: 11/15/2022

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(hypertension) ...Administer medications ...as ordered...Notify MD/RP (responsible party) of significant changes of condition as appropriate."

On 10/18/22 at 9:23 a.m., LPN (licensed practical nurse) #16 was interviewed. She reviewed R61's Clonidine order, and the May 2022 blood pressures. She stated the Clonidine should have been given each and every time R61's systolic blood pressure was over 160. She stated if the Clonidine was not given, the physician should have been notified.

On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She reviewed R61's Clonidine order, and the May 2022 blood pressures. She stated the Clonidine should have been given every time R61's systolic blood pressure was over 160. She stated the physician should have been notified of the resident's high blood pressure if the Clonidine was not given.

On 10/18/22 at 2:55 p.m., LPN #7, R61's unit manager, was interviewed. She reviewed R61's Clonidine order, and the May 2022 blood pressures. She stated the Clonidine should have been given each time R61's systolic blood pressure was over 160. She stated this is a medication error, and stated the risk for R61's not receiving the medication was that the resident might have a stroke. She stated the physician should have been notified of the blood pressure readings if the nurse was not going to administer the Clonidine.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant

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director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "Change in a Resident's Condition or Status," revealed, in part: "The facility shall promptly notify the resident, his or her Attending Physician...pf changes in the resident/s medical/metal condition...The nurse will notify the resident's Attending Physician or physician on call when there has been a(n)...significant change in the resident's physical/emotional/mental condition...need to alter the resident's medical treatment significantly."

No further information was provided prior to exit.

NOTES
(1) "Systolic pressure is the pressure when the ventricles pump blood out of the heart. Diastolic pressure is the pressure between heartbeats when the heart is filling with blood...For most adults, a normal blood pressure is less than 120 over 80 millimeters of mercury (mm Hg), which is written as your systolic pressure reading over your diastolic pressure reading - 120/80 mm Hg. Your blood pressure is considered high when you have consistent systolic readings of 130 mm Hg or higher or diastolic readings of 80 mm Hg or higher." This information is taken from the website https://www.nhlbi.nih.gov/health/high-blood-pressure#:~:text=Systolic%20pressure%20is%20the%20pressure,day%20based%20on%20your%20activities.

(2) "Clonidine tablets (Catapres) are used alone

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or in combination with other medications to treat high blood pressure. Clonidine extended-release (long-acting) tablets are used alone or in combination with other medications as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in children. Clonidine is in a class of medications called centrally acting alpha-agonist hypotensive agents. Clonidine treats high blood pressure by decreasing your heart rate and relaxing the blood vessels so that blood can flow more easily through the body. Clonidine extended-release tablets may treat ADHD by affecting the part of the brain that controls attention and impulsivity." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682243.html.

COMPLAINT DEFICIENCY.

2. For Resident #124 (R124), the facility staff failed to notify the physician when a medication was not available for administration in August and September 2022.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/12/22, R124 was coded as being cognitively intact, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as having experienced pain frequently during the look back period.

On 10/13/22 at 9:05 a.m., R124 was sitting up in bed. R124 stated they have almost constant pain

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due to fibromyalgia. The resident stated the facility has not always administered fibromyalgia medication the way the doctor ordered.

A review of R124's clinical record revealed the following order dated 8/21/22: "Savella Tablet 25 mg (milligrams) (Milnacipran HCl) Give 1 tablet by mouth two times a day for fibromyalgia/depression."

A review of facility pharmacy receipts for R124 revealed the facility received six tablets on 8/25/22, and another six tablets on 8/28/22. The receipts review revealed only 12 total tablets were dispensed to the facility prior to when the medication was discontinued on 9/13/22.

A review of R124's progress notes revealed the following:

"8/23/2022 18:12 (6:12 p.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Not available,"

"8/24/2022 09:21 (9:21 a.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/depression. Not available."

"8/24/2022 19:42 (7:42 p.m.) Orders - Administration Note Text: Savella Tablet 25 MG Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Not available."

"8/25/2022 09:43(9:43 a.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Medications unavailable

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will follow up with pharmacy."

"8/25/2022 18:25 (6:25 p.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Spoke to pharmacy awaiting authorization from facility to send."

"8/29/2022 08:36 (8:36 a.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Ordered from pharmacy."

"9/2/2022 08:34 (8:34 a.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Medication unavailable awaiting pharm del. (delivery)."

A review of R124's September 2022 MAR (medication administration record) revealed Sarvella was documented as not available from the pharmacy twice on 9/3, 9/4, 9/11, and 9/12.

Further review of R124's progress notes and MARs failed to reveal evidence that the physician was notified on the above dates when the Sarvella was unavailable.

A review of R124's care plan dated 8/3/22 and updated 9/3/22 revealed, in part: [R124] is at risk for increased pain due to...chronic pain...Administer pain medication per physician orders."

On 10/18/22 at 9:23 a.m., LPN (licensed practical nurse) #16 was interviewed. She stated if a medication is not available for administration, she

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calls the pharmacy. She stated if the pharmacy tells her a preauthorization is needed, she will ask the pharmacy to fax the form right away. She said the pharmacy faxes the form to the facility, and she [or whomever is taking care of the resident that particular day] is responsible for contacting the physician and getting the form filled out. She stated she would notify her manager, and write a progress note detailing everything she had done, including filling out the form and contacting the physician.

On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She stated she is an agency employee and does not work regularly at the facility. She stated if a medication is not available for a resident, she selects a button the clinical software to reorder it, and then she writes a progress note saying it is not available. She stated she could not think of anything else to be done. She did not state she would notify the physician if a medication is unavailable.

On 10/18/22 at 10:41 a.m., OSM (other staff member) #14, a pharmacist, was interviewed. She stated Sarvella is an unusual medication, and is rarely ordered in the long term care setting. She stated this medication is expensive, and insurance companies frequently require a special authorization before they will pay for it. She stated Sarvella required this prior authorization. She stated the pharmacy billing team communicated to the pharmacists that they should not dispense the medication before getting the authorization. The pharmacy sends a fax to the facility, instructing them to have the attending physician fill out the authorization form. She stated it is up to the physician to make the prior authorization happen. If not, the facility has to give the

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pharmacy the assurance that the facility will pay for the medication if the pharmacy will not. She reviewed the pharmacy's records, and verified the pharmacy only dispensed a total of 12 tablets for R124. She stated the pharmacy dispensed these so the resident would have a minimal supply. She stated the facility never provided the pharmacy with the required special authorization for the Sarvella.

On 10/18/22 at 2:55 p.m., LPN #7, R124's unit manager, was interviewed. She stated if a medication is not available, the nurse should call the pharmacy, and should notify the physician that the medication is not available. She stated the nurse should find out where the drug is, and what is going on with the medication. She described the same process for preauthorization as OSM #14.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "Unavailable Medications," revealed, in part: "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to

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F 580	Continued From page 23 ensure that medications are available to meet the needs of each resident...Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction." No further information was provided prior to exit. NOTES (1) "Milnacipran (Sarvella) is used to treat fibromyalgia (a long-lasting condition that may cause pain, muscle stiffness and tenderness, tiredness, and difficulty falling asleep or staying asleep). Milnacipran is in a class of medications called selective serotonin and norepinephrine reuptake inhibitors (SNRIs). It works by increasing the amount of serotonin and norepinephrine, natural substances that help stop the movement of pain signals in the brain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a609016.html.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		11/15/22

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F 584	Continued From page 24 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to maintain a homelike environment for two of 78 residents in the survey sample, Residents #58 and #197.	F 584	F584 Maintain Home-Like Environment 1. The flooring for Resident # 58 was repaired. Resident #197 was discharged from facility repairs to door and bathroom with painting was completed.	

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F 584	Continued From page 25 The findings include: 1. For Resident #58 (R58), the facility staff failed to maintain the resident's floor in good repair. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/11/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. On 10/11/22 at approximately 12:00 p.m. and 10/12/22 at 3:52 p.m., an observation of R58's room was conducted. Three sections of vinyl composite were missing from the floor. One section measured approximately three inches in length by five inches in width. Two other sections measured approximately three feet in length by five inches in width. The missing sections were located between the bed and privacy curtain. On 10/17/22 at 3:23 p.m., an interview was conducted with OSM (other staff member) #5 (the maintenance director). OSM #5 stated the facility has flooring issues with the vinyl planks on wing four. OSM #5 stated the planks are almost like the old peel and stick tiles but he has proper adhesive to fix the floors. OSM #5 stated he fixes the flooring issues when he receives a work order or if he sees an issue while in the rooms. OSM #5 stated sometimes it is kind of hard to see flooring issues when residents and their belongings are in the rooms. On 10/17/22 at 3:45 p.m., R58's floor was observed with OSM #5. OSM #5 stated he was not aware of the missing vinyl composite. OSM	F 584	2. An audit of resident rooms was by the maintenance director or designee to identify areas in resident rooms in need of repair. 3. The Administrator or designee will educate all the maintenance staff regarding the process for environmental repairs and preventative maintenance. The Staff Development Coordinator or designee will educate the facility staff on the process of submitting work orders for identified environmental repair needs to the maintenance department. 4. Maintenance Director or designee will audit work orders for completion and audit 10 residents room weekly to ensure compliance with maintaining safe and clean environment. Work orders will be review in daily morning meeting 5x weekly to ensure completion. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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#5 stated the missing vinyl composite was an easy fix. OSM #5 stated the missing vinyl composite was not homelike but he was not going to say it was not common. R58 stated that a few months ago, another maintenance employee told the resident that the resident's wheelchair was causing the flooring problem. R58 stated the flooring on the roommate's side of the room was fixed a few months ago. R58 stated the resident thought it was sad and the resident felt left out because the resident's roommate's flooring had been fixed but the resident's flooring had not been fixed.

On 10/17/22 at 4:51 p.m., OSM #5 stated a work order for R58's floor was created this morning and the floor was now fixed.

On 10/17/22 at 5:03 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Quality of Life - Homelike Environment" documented, "2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment."

No further information was presented prior to exit.

2. The facility staff failed to maintain a clean and homelike environment for Resident #197.

During interview with Resident #197 on 10/12/22 at 9:40 AM, holes in the drywall were observed approximately six inches above baseboard on

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wall next to the door and wall the resident's bed was facing. In addition, the inside of the bathroom door (shared bathroom between two double rooms) had paint scraped off of the door approximately six to eight inches from the bottom of door and ran the length of the door.

Resident #197's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 10/1/22, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

An interview was conducted on 10/12/22 at 9:40 AM, with Resident #197. When asked about his room, Resident #197 stated, "Look at the walls and open the bathroom door and look at it. Both bathroom doors are the same on the inside. Does that look like a homelike environment to you?" When asked if any staff or maintenance had discussed room repairs with him, Resident #197 stated, "No, they have not."

An interview was conducted on 10/12/22 at 10:30 AM with OSM (other staff member) #5, the maintenance director. When asked about the process for room repairs, OSM #5 stated, "We are working through the building, doing the common areas first and the resident room doors. We've added a material to the resident doors to prevent scuffing of doors and peeling paint, it has made a difference. Then we are working on the inside of the resident rooms."

On 10/13/22 at 10:30 AM, OSM #5 visited the resident's room with surveyor and observed peeling paint on two walls and two bathroom

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F 584	Continued From page 28 doors. Closet door two hinges were not attached. OSM #5 stated, "I will make this room a priority." On 10/17/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the regional vice president of operations were made aware of the findings. According to the facility's "Quality of Life-Homelike Environment" policy dated 5/2017, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible." No further information was provided prior to exit.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		11/15/22

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§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and

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F 585	Continued From page 30 coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document	F 585	F585 Grievance 1. Resident #62 blanket was located and	

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review, it was determined that the facility staff failed to act upon a reported grievance for missing personal items for one of 78 residents in the survey sample, Resident #62.

The findings include:

For Resident #62 (R62), the facility staff failed to fully investigate a known grievance in a timely manner.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/11/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 10/13/2022 at 12:57 p.m., an interview was conducted with R62. R62 stated that they had ongoing concerns about missing personal belongings at the facility. R62 stated that they had recently had clothing that had not been returned from the laundry which had been replaced by the social worker. R62 stated that they had lost a gray and white quilt which had their name in all four corners a few months prior and had reported it missing to the social worker when the clothing was missing but it had not been found. R62 stated that the quilt was never found and they had not gotten any follow up from the facility regarding it. R62 stated that the quilt had sentimental value and they would like to have it back if possible.

A facility "Grievance/Concern Report" dated 4/12/2022 for R62 documented in part, "...Describe concern using factual terms: Resident returned from hospital and reported

returned.
2. A Review of all grievances submitted for the last 30 days was conducted to ensure follow-up and resolution of stated grievance were completed with communication to the resident/RP.
3. Staff Development Coordinator and or designee will educate the IDT (Administrator ,MDS staff, nursing management Social Service, Director of Activities , Dietitian, Rehab director) and the facility staff on the policy related to reporting of grievances and have completed resolution.
4. Social Service or designee will audit all grievances weekly to ensure follow-up and resolution completed. Any identified issues will be immediately corrected.
5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction.
6. Date of Compliance: 11/15/2022

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missing items (clothes, blanket, other personal belongings). Items not labeled, resident educated on labeling personal items for easier return in future. [Signature of OSM (other staff member) #3, social worker]...What other actions was taken to resolve concern (be specific)? Located and returned items to social services. [Signature of OSM #7, director of housekeeping and laundry]. How was grievance/concern resolved? Resolved..."

On 10/17/2022 at 9:01 a.m., an interview was conducted with OSM #7, the director of housekeeping and laundry. OSM #7 stated that the staff reported any missing personal belongings to them and they investigated and searched for them. OSM #7 stated that they did not keep a log of missing personal belongings that were reported to them but if they were unable to find the item they worked with the administrator to get approval to replace the items that were missing. OSM #7 stated that they were not aware of R62 missing a blanket and they would look into it.

On 10/17/2022 at 1:22 p.m., an interview was conducted with OSM #3, social worker. OSM #3 stated that R62 had reported missing items and they had followed up with housekeeping to find them. OSM #3 stated that they had returned what they had found to R62 and they had not heard anything about the blanket. OSM #3 stated that they were not sure whether the missing blanket was found or not. OSM #3 stated that the department responsible for the grievance would follow up with the administrator and make sure that it was resolved.

The facility policy "Grievances/Complaints, Filing"

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F 585	Continued From page 33 dated April 2017 documented in part, "...The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative...Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint..." On 10/17/2022 at approximately 4:59 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern No further information was presented prior to exit.	F 585		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622		11/15/22

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(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)

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F 622	Continued From page 35 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to evidence required documents were sent to the receiving facility at the time of transfer for one of 78 residents in the survey sample, Resident #96. The findings include:	F 622	F622 Transfer and Discharge Requirements 1. No action taken for Resident #96 due to the time frame had already passed. 2. A review of residents transferred to the hospital in the last 30 days was conducted to ensure there is documentation in the EHR that required	

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F 622	Continued From page 36 For Resident #96 (R96), the facility staff failed to provide evidence that required clinical documentation, pertaining to the continuity of care, was sent to the receiving hospital on 8/8/22 when R96 was transferred to the hospital. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 28/26/22, R96 was coded as being cognitively intact for making daily decisions, having scored 14 out of 15 on the BIMS (brief interview for mental status). A review of R96's clinical record revealed the following progress note: "8/8/2022 13:21 (1:21 p.m.)...Clinical Note Text: Resident has complaints of pain and 'just not feeling well. Res (Resident) also crying. Wound care in to do dressing change and informed this writer that 'there has been a significant change in wound; more drainage, peri-area of wound very warm to touch.' NP (nurse practitioner) was called by wound nurse and new orders received to send resident to ER (emergency room) for evaluation. This writer called [name of transport company] and EMS (emergency medical service) arrived shortly after. Resident taken to [name of local hospital] via stretcher." Further review of the clinical record failed to reveal evidence that the resident's face sheet, medication list, recent laboratory results, or care plan goals were sent to the receiving facility. On 10/17/22 at 10:09 a.m., OSM (other staff member) #8, the director of social services, was interviewed. She stated when a resident is discharged to the hospital, nurses are responsible	F 622	clinical documents was send to the hospital to ensure continuity of care. 3. The Staff Development Coordinator or designee will educate all licensed nurses on the requirement for providing the required documentation; transfer form, medication list, care plan goals, discharge instructions and bed hold policy with the resident when discharged to a receiving facility with documentation in the medical record. 4. The Unit Managers or designee will review weekly facility-initiated transfers to ensure that required documentation was sent to the receiving facility with supporting documentation in the medical record to support the information was sent. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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for sending clinical information to the receiving facility.

On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated when a resident is sent to the hospital, "we send a copy of everything to the hospital." She stated the nurse also scans the information that is sent to the hospital so that the facility can maintain a record of what is sent to the hospital. She said she sends the face sheet, order summary, history and physical, most recent provider's note, and care plan goals to the hospital.

On 10/17/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "Transfer or Discharge - Emergency," revealed, in part:
"Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures:
a. Notify the resident's Attending Physician;
b. Notify the receiving facility that the transfer is being made;
c. Prepare the resident for transfer;
d. Prepare a transfer form to send with the resident;
e. Notify the representative (sponsor) or other family member;
f. Assist in obtaining transportation; and
g. Others as appropriate or as necessary.

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F 622	Continued From page 38 No further information was provided prior to exit.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to comprehensively complete an MDS (minimum data set) assessment for one of 78 residents in the survey sample, Resident #29. The findings include: For Resident #29 (R29), the facility staff failed to complete the mood interview, section D, on the five day Medicare MDS assessment with an ARD (assessment reference date) of 8/24/22. On the most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 8/24/22, the resident scored 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions. Section B coded R29 as "understood". In Section D, the resident mood interview was coded with dashes, indicating the resident mood interview was not completed. On 10/17/22 at 11:27 a.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated the therapy staff completes residents' mood interview	F 641	F641 Accuracy of Assessment 1. Resident #29 ARD has passed and unable to be updated. A PHQ9 Mood Assessment has been completed. 2. A review of MDS(s) completed since 10/01/2022 was conducted to ensure completion of PHQ9 Mood Assessments. 3. All the Occupational Therapists will be educated by the Regional Director of Therapy or designee on the completion of PHQ9 Mood Assessment for required assessments scheduled for upcoming ARD. 4. The Director of Rehabilitation Services or designee will audit weekly MDS(s) completed to ensure PHQ9 Assessments scheduled were completed. 5. The results will be discussed at the monthly QAPI meeting for review. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	11/15/22

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assessments then she pulls that information from the assessments into the MDS assessments. RN #1 stated any kind of interview should always be attempted and the mood interview should be done unless a resident is rarely/never understood or if the resident does not provide a response. RN #1 stated she references the CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) when completing MDS assessments.

On 10/17/22 at 11:47 p.m., RN #1 stated the mood interview for R29's 8/24/22 MDS assessment just was not done and should have been.

On 10/17/22 at 5:03 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern.

The CMS RAI manual documented, "SECTION D: MOOD. Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable...
D0100: Should Resident Mood Interview Be Conducted?
Item Rationale
Health-related Quality of Life
Most residents who are capable of communicating can answer questions about how they feel.
Obtaining information about mood directly from the resident, sometimes called 'hearing the

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F 641	Continued From page 40 resident's voice,' is more reliable and accurate than observation alone for identifying a mood disorder... Code 0, no: if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available... Code 1, yes: if the resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available." No further information was presented prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		11/15/22

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F 655	Continued From page 41 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigations, the facility staff failed to provide residents with a summary of the baseline care plan for three of 78 residents in the survey sample, Residents #304, #195 and #140. The findings include: 1. For Resident #304 (R304), the facility staff failed to provide the resident with a summary of the baseline care plan. Resident #304 was admitted to the facility on	F 655	F655 Provide Baseline Care Plan 1. Resident #304 is no longer a resident of center. #195 and # 140 remain in center provided a written summary of the baseline care plan. 2. Current residents have the potential to be affected. 3. The Director of Nursing or designee will educate the IDT team (MDS staff, nursing management Social Service, Director of Activities, Dietitian, Rehab director) on the development of a baseline care plan and a copy of the baseline care plan summary provided to the resident and/or their responsible	

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F 655	Continued From page 42 3/27/22 and discharged on 5/15/22. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/1/22, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A review of R304's clinical record failed to reveal the facility staff provided R304 with a summary of the baseline care plan. On 10/18/22 at 9:21 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the admitting nurse creates a baseline care plan and everything on the care plan is discussed during the care plan meeting. LPN #1 stated she thought initial care plan meetings are completed three weeks after admission. LPN #1 stated she thought the social workers provide a copy of the baseline care plan or a written summary of the baseline care plan to residents and/or their representatives at the care plan meeting. On 10/18/22 at 9:40 a.m., an interview was conducted with OSM (other staff member) #8 (the director of social services). OSM #8 stated she would provide residents and/or their representatives a copy of the baseline care plan or a written summary of the baseline care plan upon request but she does not typically offer this. On 10/18/22 at 4:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plans - Baseline"	F 655	representative and documented to validate provided. 4. The DON or designee will review admissions weekly to ensure baseline care plans are completed with documentation in the medical record of providing a summary of the baseline care plans to the resident and/or responsible party. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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documented, "4. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary."

No further information was presented prior to exit.

COMPLAINT DEFICIENCY.
2. For Resident #195 (R195), the facility staff failed to provide a written summary of the baseline care plan.

Resident #195 was admitted to the facility on 9/18/2022. On the most recent MDS (minimum data set), a 5-day admission assessment with an ARD (assessment reference date) of 9/30/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 10/12/2022 at 9:18 a.m., an interview was conducted with R195 in their room. R195 stated that they were new to the facility. When asked if they had received a written summary of their care plan, R195 stated that they had not been given anything.

A review of R195's clinical record failed to reveal the facility staff provided R195 with a summary of the baseline care plan.

On 10/18/22 at 9:21 a.m., an interview was

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conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the admitting nurse created a baseline care plan and everything on the care plan was discussed during the care plan meeting. LPN #1 stated that they thought the initial care plan meeting was completed three weeks after admission. LPN #1 stated that they thought the social workers provided a copy of the baseline care plan or a written summary of the baseline care plan to residents and/or their representatives at the care plan meeting.

On 10/18/22 at 9:40 a.m., an interview was conducted with OSM (other staff member) #8, the director of social services. OSM #8 stated that they would offer residents and/or their representatives a copy of the baseline care plan or a written summary of the baseline care plan upon request but they did not typically provide this.

On 10/18/2022 at approximately 4:34 p.m., ASM #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern.

No further information was presented prior to exit.

3. For Resident #140 (R140), the facility staff failed to provide a written summary of the baseline care plan.

Resident #140 was admitted to the facility on 9/11/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/16/2022, the

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resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions.

On 10/12/2022 at 9:18 a.m., an interview was conducted with R140 in their room. R140 stated that they were new to the facility. When asked if they had received a written summary of their care plan, R140 stated that they did not remember receiving anything.

A review of R104's clinical record failed to reveal the facility staff provided R140 with a summary of the baseline care plan.

On 10/18/22 at 9:21 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the admitting nurse created a baseline care plan and everything on the care plan was discussed during the care plan meeting. LPN #1 stated that they thought the initial care plan meeting was completed three weeks after admission. LPN #1 stated that they thought the social workers provided a copy of the baseline care plan or a written summary of the baseline care plan to residents and/or their representatives at the care plan meeting.

On 10/18/22 at 9:40 a.m., an interview was conducted with OSM (other staff member) #8, the director of social services. OSM #8 stated that they would offer residents and/or their representatives a copy of the baseline care plan or a written summary of the baseline care plan upon request but they did not typically provide this.

On 10/18/2022 at approximately 4:34 p.m., ASM

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F 655	Continued From page 46 #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern. No further information was presented prior to exit.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		11/15/22

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F 656	Continued From page 47 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: 4. For Resident #304 (R304), the facility staff failed to implement the resident's comprehensive care plan for pressure injury treatments per the physician's orders. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/1/22, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. R304's comprehensive care plan dated 3/28/22 documented, "(R304) has actual skin breakdown present on admission: SACRUM- PRESSURE INJURY, LLE (left lower extremity) POSTERIOR...Administer treatment per physician order..." A wound care nurse practitioner note dated 3/31/22 documented an unstageable pressure injury (1) on R304's left posterior lower leg (present on admission).	F 656	F656 Develop/Implement Comprehensive Care Plan 1. Residents # 403 and #404 no longer resides in the center. No action taken for Resident #11 since the time frame had already passed. Resident #61 is receiving the PRN B/P medications when the B/P is outside the parameters. Resident #108 has been re-educated on the smoking policy and cigarettes are to be returned and kept under the control of the center staff when not in use. Resident verbalizes understanding. Resident #304 no longer a resident of facility. 2. A review of care plans for residents with pressure ulcers, requiring assistance with meals, assistance with incontinence care to ensure the areas were care planned. In addition, a review of resident□s who smoking, have physician	

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F 656	Continued From page 48 A review of R304's clinical record revealed the following physician's orders regarding the resident's left posterior lower leg pressure injury: -A physician's order dated 3/28/22 to cleanse the left posterior lower leg with Dakin's (cleansing solution), skin prep the periwound, paint the eschar (dead skin) with betadine (antiseptic solution), apply medihoney (medical grade honey) fiber to the proximal/medial aspect of the pressure injury, apply Dakin's soaked 4x4 to the distal aspect of the pressure injury, cover the pressure injury with a boarder foam dressing every day shift. This order was discontinued on 3/31/22. -A physician's order dated 3/31/22 to cleanse the left posterior lower leg with Dakin's, skin prep the periwound, paint the eschar with betadine, apply medihoney fiber to the distal aspect of the pressure injury, cover the pressure injury with a boarder foam dressing every day shift. This order was discontinued on 4/18/22. -A physician's order dated 4/18/22 to cleanse the left posterior lower leg with Dakin's, skin prep the periwound, apply medihoney fiber, cover the pressure injury with a boarder foam dressing every day shift. This order was discontinued on 5/16/22. A review of R304's March 2022, April 2022 and May 2022 TARs (treatment administration records) failed to reveal evidence that the above treatment orders were performed on 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/6/22 [as evidenced by blank spaces on the TARs]. A review of nurses' notes for 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/6/22 failed to reveal evidence that the treatments were completed. A wound care nurse practitioner note dated	F 656	orders for PRN B/P medications are outside documented parameters, and residents who have dialysis assess sites to ensure the plan of care is being followed. 3. The Regional Director of MDS or designee will educate the IDT team (MDS staff, nursing management Social Service, Director of Activities, Dietitian, Rehab director) on development a comprehensive care plan to reflect resident□s status. The Staff Development Coordinator or designee will educate all certified and licensed nurses on the process for CNAs completing ADL documentation to validate care was provided feeding and incontinent care. All the licensed nurses will be educated by the Staffing Coordinator or designee on the process for completing E-MAR, E-TAR documentation to validate wound care and blood pressure medications with parameters were administered and followed, obtaining a physician order for residents with dialysis site to validate monitoring and residents that smoke have a smoking assessment performed with accuracy and completion. 4. Regional Director of MDS/designee will review 5 comprehensive care plans weekly to ensure the care plan reflects the resident□s status. The DON or designee with audit weekly ADL documentation is complete for feeding and incontinent care, blood pressure medications with parameters were followed with completed documentation, dialysis site monitoring and wound care documentation is complete. Identified smokers have a	

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F 656	Continued From page 49 4/6/22 that documented a stage two pressure injury (2) on R304's sacrum (present on admission). A review of R304's clinical record revealed the following physician's orders regarding the resident's sacral pressure injury: -A physician's order dated 3/28/22 to cleanse the sacrum with normal saline, apply zinc to the periwound, apply medihoney to the pressure injury and cover with a boarder foam dressing every day shift. This order was discontinued on 4/23/22. -A physician's order dated 4/23/22 to apply zinc to the sacrum three times a day. A review of R304's March 2022, April 2022 and May 2022 TARs failed to reveal evidence that the above treatment orders were completed on 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/13/22 (as evidenced by blank spaces on the TARs). A review of nurses' notes for 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/13/22 failed to reveal evidence that the treatments were completed. On 10/17/22 at 12:13 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is to identify problems, goals, and interventions to reach the goals. LPN #4 stated a lot of nursing interventions on the care plan can be put in as a physician's order or on a daily report to ensure the interventions are implemented. On 10/17/22 at 12:36 p.m., an interview was conducted with LPN #8. LPN #8 stated that if there is a hole on the medication administration record or the treatment administration record then that the hole means the person did not document	F 656	smoking assessment completed and accurate. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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that the treatment was done that day and cannot say the treatment was done.

On 10/18/22 at 4:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Wound Care" documented, "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing." The policy documented the steps for providing wound care.

No further information was presented prior to exit.

COMPLAINT DEFICIENCY.

References:
(1) "Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue)." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf
(2) "Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf
5. For Resident #404 (R404), the facility staff failed to implement the care plan for assistance

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with meals, provide incontinence care and to provide pressure ulcer treatments as ordered.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/25/2021, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section G documented R404 being totally dependent on one staff member for eating and toileting. Section M documented R404 having one Stage 4 pressure ulcer (1).

The comprehensive care plan for R404 documented in part, "ADL (activities of daily living): [R404] is at self-care deficit related to disease process. [R404] requires assistance for all ADL's and mobility. Created on: 06/21/2021. Revision on: 11/02/2021..." Under "Interventions" it documented in part, "Feed meals, encourage po (by mouth) intake as tolerated. Created on: 06/30/2021. Revision on: 09/08/2022..." The care plan further documented, "Skin: [R404] with actual skin breakdown related to pressure ulcer sacrum and is at risk for alteration in skin integrity related to impaired mobility, incontinence, malnutrition, oxygen. Created on: 06/21/2021. Revision on: 11/02/2021..." Under "Interventions" it documented in part, "Incontinence care as needed. Created on: 07/01/2021. Revision on: 09/08/2022" and "Treatments as ordered. Created on: 09/28/2021. Revision on: 09/08/2022..."

Review of the "Bladder Continence and Toilet Use" ADL documentation for 6/1/2021-6/30/2021 and 7/1/2021-7/31/2021 failed to evidence incontinence care provided to R404 on 11 shifts.

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Review of the "Eating" ADL documentation for 6/1/2021-6/30/2021, 7/1/2021-7/31/2021, 8/1/2021-8/30/2021, 9/1/2021-9/30/2021 and 10/1/2021-10/31/2021 failed to evidence feeding assistance provided to R404 for 23 meals.

Review of the "Bedtime snack" ADL documentation for 6/1/2021-6/30/2021, 7/1/2021-7/31/2021, 8/1/2021-8/30/2021, 9/1/2021-9/30/2021 and 10/1/2021-10/31/2021 failed to evidence a snack was provided to R404 for 15 dates.

Review of the eTAR (electronic treatment administration record) for 7/1/2021-7/31/2021, 8/1/2021-8/30/2021, 9/1/2021-9/30/2021 and 10/1/2021-10/31/2021 failed to evidence pressure ulcer treatment was provided to R404 for 20 treatments scheduled.

On 10/13/2022 at 5:40 AM, an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that feeding and incontinence care were documented in the computer. CNA #3 stated that blanks spaces in the documentation could mean that staff did not document it or that the care was not provided. CNA #3 stated that they could not evidence that the care was provided if there were blank spaces and no documentation.

On 10/17/2022 at 4:06 p.m., an interview was conducted with CNA #1. CNA #1 stated that incontinence care and feeding were documented in the ADL's form in the computer. CNA #1 stated that the incontinence care documentation does not require them to say how many times the care was provided during the shift but they evidence

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that it was done by signing it off for the whole shift. CNA #1 stated that if the documentation was blank there was no evidence to support that the care was done.

On 10/17/2022 at 12:36 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that blanks on the ADL documentation and the eTAR meant that the staff member did not document that it was done that day and they could not say that the treatment was completed. LPN #8 reviewed the ADL documentation for R404 for incontinence care and eating and stated that there was no evidence to support that it was done with the blanks.

On 10/17/2022 at 1:12 p.m., an interview was conducted with LPN #10, wound nurse. LPN #10 stated that wound care was evidenced as completed by signing it off on the eTAR. LPN #10 reviewed R404's eTAR's and stated that they were not sure what blanks were on the eTAR but they could not say that the treatments were provided if there were no initials documenting that it was done.

On 10/17/2022 at 1:40 p.m., an interview was conducted with LPN #11. LPN #11 stated that the purpose of the care plan was to set up goals for the resident that were to improve the residents condition or to maintain their status. LPN #11 stated that the care plan was not being implemented if the interventions were not being followed.

On 10/19/2022 at approximately 9:29 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of

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nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern.

No further information was provided prior to exit.

(1) Pressure Ulcer
A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

Complaint deficiency.

6. For Resident #403 (R403), the facility staff failed to implement the care plan to provide incontinence care.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/25/2022, the resident scored 7 out of 15 on the BIMS (brief interview for mental

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status) assessment, indicating the resident was severely impaired for making daily decisions. Section G documented R403 requiring extensive assistance from one person for toileting.

The comprehensive care plan for R403 documented in part, "Incontinence: [R403] has Bowel/Urinary incontinence related to impaired mobility, dementia. Created on: 03/21/2022. Revision on: 04/13/2022." Under "Interventions" it documented in part, "Provide assistance with toileting or provide incontinent care as needed, to include prior to departure and upon return from dialysis. Created on: 03/21/2022. Revision on: 04/13/2022..."

Review of the "Bladder Continence and Toilet Use" ADL documentation for 3/1/2022-3/31/2022 and 4/1/2022-4/30/2022 failed to evidence incontinence care provided to R403 on 8 shifts.

On 10/13/2022 at 5:40 a.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that incontinence care was documented in the computer. CNA #3 stated that blanks spaces in the documentation could mean that staff did not document it or that the care was not provided. CNA #3 stated that they could not evidence that the care was provided if there were blank spaces and no documentation.

On 10/17/2022 at 12:36 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that blanks on the ADL documentation meant that the staff member did not document that it was done that day and they could not say that the treatment was completed.

On 10/17/2022 at 1:40 p.m., an interview was

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conducted with LPN #11. LPN #11 stated that the purpose of the care plan was to set up goals for the resident that were to improve the residents condition or to maintain their status. LPN #11 stated that the care plan was not being implemented if the interventions were not being followed.

On 10/17/2022 at 4:06 p.m., an interview was conducted with CNA #1. CNA #1 stated that incontinence care was documented in the ADL's form in the computer. CNA #1 stated that the incontinence care documentation does not require them to say how many times the care was provided during the shift but they evidence that it was done by signing it off for the whole shift. CNA #1 stated that if the documentation was blank there was no evidence to support that the care was done.

On 10/19/2022 at approximately 9:29 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern.

No further information was provided prior to exit.

Complaint deficiency.

Based on observation, resident interview, staff interview, facility document review, clinical record

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review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement the care plan for six of 78 residents in the survey sample, Residents #61, #11, #108, #304, #404, and #403.

The findings include:

1. a. For Resident #61 (R61), the facility staff failed to follow the resident's care plan to administer Clonidine (1) as ordered when the resident's systolic blood pressure (2) was greater than 160 mm Hg (millimeters per mercury), eleven times during May 2022.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/12/22, R61 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R61 was coded as receiving dialysis services during the look back period. R61 was coded as having high blood pressure.

A review of R61's clinical record revealed the following orders:

"Clonidine HCl Tablet 0/1 MG. Give 1 tablet by mouth every 12 hours as needed for systolic B/P (blood pressure) greater than 160." This order was dated 4/22/22.

A review of R61's MARs (medication administration records) for May 2022 revealed 11 instances when R61's systolic blood pressure was greater than 160. Further review of the May 2022 MARs revealed no evidence that Clonidine was given on any of these dates and times when

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R61's systolic blood pressure readings exceeded 160.

A review of R61's care plan dated 2/4/22 and revised 8/15/22 revealed, in part: "[R61] has basic nursing care needs r/t (related to) ...HTN (hypertension) ...Administer medications ...as ordered."

On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated the purpose of a resident's care plan is to identify problems/goals for each individual resident, and to implement interventions to help the resident meet those goals. She stated CNAs and nurses, as well as the whole team, are responsible for implementing the care plan.

On 10/18/22 at 9:23 a.m., LPN #16 was interviewed. She reviewed R61's Clonidine order, the May 2022 blood pressures, and the care plan. She stated R61's care plan was not being followed.

On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She reviewed R61's Clonidine order, the May 2022 blood pressures, and the care plan. She stated R61's care plan was not being followed.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

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A review of the facility policy, "Care Plans, Comprehensive Person-Centered," revealed, in part: "The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident."

(1) "Clonidine tablets (Catapres) are used alone or in combination with other medications to treat high blood pressure...Clonidine is in a class of medications called centrally acting alpha-agonist hypotensive agents. Clonidine treats high blood pressure by decreasing your heart rate and relaxing the blood vessels so that blood can flow more easily through the body. Clonidine extended-release tablets may treat ADHD by affecting the part of the brain that controls attention and impulsivity." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682243.html.

(2) "Systolic pressure is the pressure when the ventricles pump blood out of the heart. Diastolic pressure is the pressure between heartbeats when the heart is filling with blood...For most adults, a normal blood pressure is less than 120 over 80 millimeters of mercury (mm Hg), which is written as your systolic pressure reading over your diastolic pressure reading - 120/80 mm Hg. Your blood pressure is considered high when you have consistent systolic readings of 130 mm Hg or higher or diastolic readings of 80 mm Hg or higher." This information is taken from the website https://www.nhlbi.nih.gov/health/high-blood-pressure#:~:text=Systolic%20pressure%20is%20the%20pressure,day%20based%20on%20your%20act

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ivities.

COMPLAINT DEFICIENCY.

1. b. For R61, the facility staff failed to follow the resident's care plan to administer the physician ordered medication, Hydralazine, from 6/1/22 through 6/5/22.

A review of R61's clinical record revealed the following order dated 4/13/22: "Hydralazine HCl Tablet 50 mg (milligrams. Give 2 tablets by mouth three times a day for HTN (hypertension). Last dose before 6PM (6:00 p.m.) as recommended for multiple doses/day."

A review of R61's June 2022 MARs (medication administration records) revealed that on 6/1, 6/2, 6/3, 6/4, and 6/5/22, R61 received the third (last of the day) dose of Hydralazine at 10:00 p.m., as evidenced by nurse initials in the block for Hydralazine and the time of 2200 (10:00 p.m.) on all five dates.

A review of R61's care plan dated 2/4/22 and revised 8/15/22 revealed, in part: "[R61] has basic nursing care needs r/t (related to) ...HTN (hypertension) ...Administer medications ...as ordered."

On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated the purpose of a resident's care plan is to identify problems/goals for each individual resident, and to implement interventions to help the resident meet those goals. She stated CNAs and nurses, as well as the whole team, are responsible for implementing the care plan.

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On 10/18/22 at 9:23 a.m., LPN #16 was interviewed. She reviewed R61's Hydralazine order, the June 2022 MAR, and the care plan. She stated R61's care plan was not being followed.

On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She reviewed R61's Hydralazine order, the June 2022 MAR, and the care plan. She stated R61's care plan was not being followed.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

No further information was provided prior to exit.

Resource:

(1) "Hydralazine is used to treat high blood pressure. Hydralazine is in a class of medications called vasodilators. It works by relaxing the blood vessels so that blood can flow more easily through the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682246.html.

COMPLAINT DEFICIENCY.

2. For Resident #11 (R11), the facility staff failed to follow the care plan to assess the resident's dialysis access site in March 2022, and from

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4/1/22 through 4/12/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/11/22, R11 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). R11 was coded as receiving dialysis services during the look back period.

A review of R11's clinical record revealed the following order: "Hemodialysis Diagnosis: ESRD (end stage renal disease) Dialysis Days and Time: Tues (Tuesday) -Thurs (Thursday) -Sat (Saturday)." This order was dated 5/7/21.

A review of R11's clinical record failed to reveal a physician's order to assess R11's dialysis access site from 3/1/22 through 4/12/22. The review failed to reveal any evidence that the staff were assessing R11's access site on those days, and failed to obtain a physician's order for assessing the dialysis access site per the care plan.

A review of R11's care plan dated 10/4/21 and revised 6/15/22 revealed, in part: [R11] has renal insufficiency related to chronic kidney disease on HD (hemodialysis)...check bruit and thrill q shift (every shift) as ordered."

On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated the purpose of a resident's care plan is to identify problems/goals for each individual resident, and to implement interventions to help the resident meet those goals. She stated CNAs and nurses, as well as the whole team, are responsible for implementing the care plan.

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On 10/17/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

No further information was provided prior to exit.

COMPLAINT DEFICIENCY.

3. For Resident #108 (R108), the facility staff failed to follow the resident's care plan for safe smoking.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 9/1/22, R108 was coded as being cognitively intact making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). The resident was coded as needing oversight for locomotion off the unit.

On 10/11/22 at 11:35 a.m., ASM (administrative staff member) #1, the administrator, was asked to provide a list of residents who smoke. ASM #1 stated the facility is smoke-free. He provided a list of residents who smoke off facility property. This list did not include R108.

On 10/12/22 at 10:54 a.m., R108 was sitting at a picnic table in an area between the facility and an adjacent building. The picnic table was surrounded by trees and bushes. The dirt path leading from the facility to the picnic table was

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cleared of debris, and contained a few rocks and uneven segments. R108 was smoking a cigarette. R108 stated: "It's good to see you again. We were out here last year together talking last year, weren't we?" R108 stated they smoke multiple cigarettes every day and evening, and spend a great deal of time at the picnic table. R108 pulled cigarettes out of their pocket, and stated they keep the cigarettes hidden in their room.

A review of R108's clinical record revealed a Smoking - Safety Screen dated 10/30/21; the most recent smoking safety screening prior to entrance. A review of this assessment revealed the following:

"Patient demonstrates safe smoking techniques: holding cigarette, lighting cigarette, extinguishing matches, lighter and cigarette after use and disposal of ashes: No

Patient remains alert [while] smoking: No

Patient understands that smoking accessories (cigarettes, lighters, matches, etc.) must be returned to and kept under the control of the center staff when not in use: Yes

Determination: At risk smoker: Requires staff, family or friend for physical support or supervision to smoke

Additional comments/information: Resident has heart issues and non-compliant and does smoke outside of facility, resident smells of smoke. Resident aware facility is smoke free."

A review of R108's care plan dated 1/13/20 and

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F 656	Continued From page 65 updated 9/30/22, revealed, in part: "Safe smoking...Educate to interventions and center smoking policy and procedures...Offer/encourage smoking cessation...Secure smoking materials (cigarettes, matches, lighters) at nursing station." On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated the purpose of a resident's care plan is to identify problems/goals for each individual resident, and to implement interventions to help the resident meet those goals. She stated CNAs and nurses, as well as the whole team, are responsible for implementing the care plan. On 10/17/22 at 12:36 p.m., LPN (licensed practical nurse) #8, R108's unit manager, was interviewed. He stated he had not been aware that R108 was going outside to smoke until a few days before. He stated he did not know where R108 keeps cigarettes, and had not asked the resident this question. He stated he needs to become more familiar with R108's care plan, and that if the resident had cigarettes in their room or on their person, the care plan was not being followed. LPN #108 stated residents should store cigarettes with the nurse. On 10/17/22 at 5:00 p.m., ASM #1, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns. No further information was provided prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		11/15/22

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F 657	Continued From page 66 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of 78 residents in the survey sample, Resident #304. The findings include:	F 657	F657 Care plan timing and revision 1. Resident #304 is no longer a resident of center. 2. A review of current residents in the center with wounds will be reviewed to ensure these areas are care planned. 3. The Regional Director of MDS/designee will educate the IDT team	

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F 657	Continued From page 67 For Resident #304 (R304), the facility staff failed to review and revise the resident's comprehensive care plan when the resident developed a new left medial leg arterial wound on 5/3/22 which required treatment. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/1/22, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A review of R304's clinical record revealed a wound care nurse practitioner note dated 5/3/22 that documented a new arterial wound on R304's left medial lower leg. Review of R304's clinical record revealed a physician's order dated 4/30/22 to paint a small area of eschar (dead skin) with betadine and leave the area open to air every day shift. Review of R304's comprehensive care plan dated 3/28/22 failed to reveal the care plan was reviewed and revised to include the new arterial wound on R304's left medial lower leg. On 10/19/22 at 7:47 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated the purpose of the care plan is for the whole interdisciplinary team to have their section to "Do what we are going to do, what approach we are going to take to treat the patient holistically." LPN #8 stated a resident's care plan should be reviewed and revised to include a new wound because, "If they have an actual wound that is being treated, we are taking measures to treat and heal." LPN #8 reviewed R304's comprehensive care plan and stated he did not see that the care plan was reviewed and revised for R304's arterial left medial lower leg wound.	F 657	(MDS staff, nursing management Social Service, Director of Activities, Dietitian, Rehab director) on the development of the comprehensive care plan to reflect resident□s current status to include revisions and updates on the care plan with change in conditions. 4. Regional Director of MDS/designee will review 5 comprehensive care plans weekly to ensure the care plan reflects the resident□s current status including revision/updates on the care plan. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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F 657	Continued From page 68 On 10/19/22 at 9:36 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plans, Comprehensive Person-Centered" documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition..." No further information was presented prior to exit.	F 657		
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, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of nursing for medication administration documentation for one of 78 residents in the survey sample, Resident #124. The findings include:	F 658	F658 Services Provided Meet Professional Standards 1. Resident #124 the physician was notified of medication not administered. The medication was discontinued on 9/13/2022. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate all	11/15/22

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F 658	Continued From page 69 For Resident #124 (R124) the facility staff falsely documented the administration of Sarvella (1) five times in September 2022. The facility staff documented the medication was administered when it was not available from the pharmacy for administration. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/12/22, R124 was coded as being cognitively intact, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as having experienced pain frequently during the look back period. On 10/13/22 at 9:05 a.m., R124 was sitting up in bed. R124 stated they have almost constant pain due to fibromyalgia. The resident stated the facility has not always administered fibromyalgia medication the way the doctor ordered. A review of R124's clinical record revealed the following order dated 8/21/22: "Savella Tablet 25 mg (milligrams) (Milnacipran HCl) Give 1 tablet by mouth two times a day for fibromyalgia/depression." A review of facility pharmacy receipts for R124 revealed the facility received six tablets on 8/25/22, and another six tablets on 8/28/22. Prior to the evening dose on 8/28/22, only six tablets had been dispensed to the facility from the pharmacy. The medication was documented as administered per the physician's order. A review of R124's MAR for September 2022 revealed nurses' initials, indicating Sarvella was administered at 5:00 p.m. on 9/21, at 8:00 a.m. and 5:00 p.m. on 9/22, at 8:00 a.m. on 9/23, and	F 658	licensed nurses on the process for accuracy of documentation in the medical record and process to secure or manage process when medications are not available. 4. The Unit Managers or designee will complete a weekly review of documentation on new medications were initiated and verify available with accurate documentation. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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at 8:00 a.m. on 9/25. However, no additional Savella was delivered to the facility after 8/28/22 or before 9/26/22.

A review of R124's care plan dated 8/3/22 and updated 9/3/22 revealed, in part: [R124] is at risk for increased pain due to...chronic pain...Administer pain medication per physician orders."

On 10/18/22 at 9:23 a.m., LPN (licensed practical nurse) #16 was interviewed. She stated when a nurse administers a medication, she (or he) initials the MAR to indicate the medication was given. She stated a nurse should never document that he/she administered in a medication when they did not. She stated: "It's not right, and it's not legal."

On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She stated she places her initials on the MAR to indicate a medication is given. She stated a nurse should not falsely document a medication as administered if it was not actually given to the resident.

On 10/18/22 at 10:41 a.m., OSM (other staff member) #14, a pharmacist, was interviewed. She reviewed the pharmacy's records, and verified the pharmacy only dispensed a total of six Sarvella tablets for R124 on 9/26/22 at 1:30 a.m. Prior to then, the facility had not received any additional Sarvella tablets after the 8/28/22 delivery.

On 10/18/22 at 2:55 p.m., LPN #7, R124's unit manager, was interviewed. She stated a nurse should not ever document a medication had been given unless the nurse had actually administered

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the medication, and witnessed the resident receiving the medication. LPN #7 reviewed R124's MAR and the pharmacy receipts. She stated: "I don't know how they could have administered a medication that was not here." She stated the nurses were not following professional standards of nursing practice, and R124's clinical record was not accurate.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

On 10/19/22 at 9:20 a.m., ASM #5 stated she would look for a standard of practice for documentation of medications not given and for the necessity of accurate nursing documentation for medication administration. She stated the facility standard of practice is the Lippincott Manual of Nursing Practice, 11th Edition. ASM #5 stated the facility defers to their policies if there is not a standard of practice.

According to the Lippincott Manual of Nursing Practice, 11th Edition: "Standards of practice...describe what nursing is, what nurses do, and the responsibilities for which nurses are accountable...professional nurses are to be guided by the generic standards applicable to all nurses in all areas of practice, as well as by specialty area standards..." A review of this section of manual revealed no specific information related to false documentation.

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F 658	Continued From page 72 A review of the facility policy, "Medication Administration - General Guidelines," revealed, in part: "The Medication Administration Record...is always employed during medication administration...If a dose of regularly scheduled medicine is...not available...documentation of the un-administered dose is done as instructed by the procedures for use of the eMAR system." No further information was provided prior to exit. NOTES (1) "Milnacipran (Sarvella) is used to treat fibromyalgia (a long-lasting condition that may cause pain, muscle stiffness and tenderness, tiredness, and difficulty falling asleep or staying asleep). Milnacipran is in a class of medications called selective serotonin and norepinephrine reuptake inhibitors (SNRIs). It works by increasing the amount of serotonin and norepinephrine, natural substances that help stop the movement of pain signals in the brain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a609016.html.	F 658		
F 677 SS=E	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 clinical record review, staff interview, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to provide ADL (activities of	F 677	F677 ADL Provided for Dependent Residents 1. Resident #404 ,# 403, # 305, #453 no longer a resident at the center.	11/15/22

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F 677	Continued From page 73 daily living) care to dependent residents for four of 78 residents in the survey sample, Resident #404, Resident #403, Resident #309 and Resident #453. The findings include: 1. For Resident #404 (R404), the facility staff failed to provide assistance with meals and incontinence care. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/25/2021, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section G documented R404 being totally dependent on one staff member for eating and toileting. Review of the "Bladder Continence and Toilet Use" ADL documentation for 6/1/2021-6/30/2021 and 7/1/2021-7/31/2021 failed to evidence incontinence care provided to R404 on the following dates. Day shift on 6/27/2021, 7/4/2021, 7/7/2021, 7/14/2021 and 7/29/2021. Evening shift on 6/23/2021, 7/14/2021 and 7/18/2021. Night shift on 7/17/2021, 7/23/2021 and 7/27/2021. . Review of the "Eating" ADL documentation for 6/1/2021-6/30/2021, 7/1/2021-7/31/2021, 8/1/2021-8/30/2021, 9/1/2021-9/30/2021 and 10/1/2021-10/31/2021 failed to evidence feeding assistance provided to R404 on the following dates. Breakfast on 6/19/2021, 6/27/2021, 7/4/2021, 7/14/2021, 7/16/2021, 7/29/2021, 8/17/2021 and 10/15/2021. Lunch on 6/19/2021,	F 677	2. Current residents in the center who are dependent on staff to provide ADL care have the potential to be affected. 3. The Staff Development Coordinator/designee will educate all certified and licensed nurses on providing and complete ADL documentation to validate care was provided including incontinence care, feeding assistance, bathing /showers. 4. The Unit Managers/designee will complete an audit on 10 residents weekly to ensure ADL records validate completion of feeding assistance and incontinence care. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022.	

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6/27/2021, 7/4/2021, 7/7/2021, 7/14/2021, 7/29/2021, 8/17/2021, 8/21/2021, 9/22/2021 and 10/15/2021. Dinner on 6/23/2021, 7/14/2021, 7/18/2021, 10/16/2021 and 10/18/2021.

Review of the "Bedtime snack" ADL documentation for 6/1/2021-6/30/2021, 7/1/2021-7/31/2021, 8/1/2021-8/30/2021, 9/1/2021-9/30/2021 and 10/1/2021-10/31/2021 failed to evidence a snack provided to R404 on the following dates. On 6/23/2021, 7/4/2021, 7/5/2021, 7/6/2021, 7/14/2021, 7/18/2021, 7/20/2021, 7/23/2021, 8/14/2021, 8/15/2021, 9/11/2021, 10/6/2021, 10/16/2021, 10/18/2021 and 10/20/2021.

The comprehensive care plan for R404 documented in part, "ADL (activities of daily living): [R404] is at self-care deficit related to disease process. [R404] requires assistance for all ADL's and mobility. Created on: 06/21/2021. Revision on: 11/02/2021..." Under "Interventions" it documented in part, "Feed meals, encourage po (by mouth) intake as tolerated. Created on: 06/30/2021. Revision on: 09/08/2022..." The care plan further documented, "[Skin: [R404] with actual skin breakdown related to pressure ulcer sacrum and is at risk for alteration in skin integrity related to impaired mobility, incontinence, malnutrition, oxygen. Created on: 06/21/2021. Revision on: 11/02/2021..." Under "Interventions" it documented in part, "Incontinence care as needed. Created on: 07/01/2021. Revision on: 09/08/2022."

On 10/13/2022 at 5:40 AM, an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that feeding and incontinence care were documented in the computer. CNA #3

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stated that blanks spaces in the documentation could mean that staff did not document it or that the care was not provided. CNA #3 stated that they could not evidence that the care was provided if there were blank spaces and no documentation.

On 10/17/2022 at 4:06 p.m., an interview was conducted with CNA #1. CNA #1 stated that incontinence care and feeding were documented in the ADL's form in the computer. CNA #1 stated that the incontinence care documentation does not require them to say how many times the care was provided during the shift but they evidence that it was done by signing it off for the whole shift. CNA #1 stated that if the documentation was blank there was no evidence to support that the care was done.

On 10/17/2022 at 12:36 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that blanks on the ADL documentation meant that the staff member did not document that it was done that day and they could not say that the treatment was completed. LPN #8 reviewed the ADL documentation for R404 for incontinence care and eating and stated that there was no evidence to support that it was done with the blanks.

The facility policy "Activities of Daily Living (ADLs), Supporting" dated March 2018 documented in part, "...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the

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resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems)..."

On 10/19/2022 at approximately 9:29 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern.

No further information was provided prior to exit.

Complaint deficiency.

2. For Resident #403 (R403), the facility staff failed to provide incontinence care.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/25/2022, the resident scored 7 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section G documented R403 requiring extensive assistance from one person for toileting.

Review of the "Bladder Continence and Toilet Use" ADL documentation for 3/1/2022-3/31/2022 and 4/1/2022-4/30/2022 failed to evidence incontinence care provided to R403 on the following dates. On day shift on 3/22/2022,

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4/8/2022, 4/9/2022 and 4/11/2022. On evening shift on 4/4/2022. On night shift on 3/23/2022, 3/28/2022 and 4/8/2022.

The comprehensive care plan for R403 documented in part, "Incontinence: [R403] has Bowel/Urinary incontinence related to impaired mobility, dementia. Created on: 03/21/2022. Revision on: 04/13/2022." Under "Interventions" it documented in part, "Provide assistance with toileting or provide incontinent care as needed, to include prior to departure and upon return from dialysis. Created on: 03/21/2022. Revision on: 04/13/2022..."

On 10/13/2022 at 5:40 AM, an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that incontinence care was documented in the computer. CNA #3 stated that blanks spaces in the documentation could mean that staff did not document it or that the care was not provided. CNA #3 stated that they could not evidence that the care was provided if there were blank spaces and no documentation.

On 10/17/2022 at 4:06 p.m., an interview was conducted with CNA #1. CNA #1 stated that incontinence care was documented in the ADL's form in the computer. CNA #1 stated that the incontinence care documentation does not require them to say how many times the care was provided during the shift but they evidence that it was done by signing it off for the whole shift. CNA #1 stated that if the documentation was blank there was no evidence to support that the care was done.

On 10/17/2022 at 12:36 p.m., an interview was conducted with LPN (licensed practical nurse) #8.

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LPN #8 stated that blanks on the ADL documentation meant that the staff member did not document that it was done that day and they could not say that the treatment was completed.

On 10/19/2022 at approximately 9:29 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern.

No further information was provided prior to exit.

Complaint deficiency.

3. The facility staff failed to provide complete documentation of ADL (activities of daily living) care for Resident #305.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/24/22, coded the resident as scoring a 02 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing; total dependence for locomotion, hygiene and bathing and supervision for eating.

A review of the comprehensive care plan with a revision date of 3/3/22, revealed, "FOCUS: INCONTINENCE: resident has urinary and bowel incontinence related to impaired mobility, CVA,

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history of dementia, generalized muscle weakness and difficulty in walking. INTERVENTIONS: Provide assistance with toileting or provide incontinent care as needed. Use absorbent products as needed (i.e. briefs). Report changes in skin integrity found during daily care."

A review of Resident #305's March 2022 ADL (activities of daily living) record for March 6, 2022, revealed no documentation of bowel continence care being provided on evening shift. There was evidence of bladder incontinence care being provided on 3/6/22 evening shift.

An interview was conducted on 10/17/22 at 2:18 PM with LPN (licensed practical nurse) #2. When asked what it meant if there was missing documentation for incontinence care, LPN #2 stated, it would mean that the care was not done.

An interview was conducted on 10/17/22 at 4:06 PM with CNA (certified nursing assistant) #1. When asked where incontinence care, baths and feeding of residents is documented, CNA #1 stated, they log onto ADL's (activities of daily living) form and it has incontinent or continent, the ADL's doesn't ask the number of times we change the resident, we evidence it by documenting on the ADL record. If there are blanks, there is no evidence.

On 10/17/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the regional vice president of operations were made aware of the findings.

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A review of the facility's "Urinary Continence and Incontinence-Assessment and Management" policy, dated 9/10, revealed, "As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. The staff will document the results of the toileting trial in the resident's medical record. If the resident responds well, the toileting program will be continued. A "check and change" strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin."

No further information was provided prior to exit.

4. For Resident #453, the facility staff failed to provide evidence of providing ADLs (activities of daily living) care regarding bathing.

Resident #453 was admitted to the facility on 1/26/22 with diagnoses that included but were not limited to: CHF (congestive heart failure), atrial fibrillation, pneumonia and respiratory failure.

The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an ARD (assessment reference date) of 1/31/22, coded the resident as scoring a 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately

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cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, eating, locomotion and hygiene; total dependence for bathing.

A review of the comprehensive care plan with a revision date of 1/28/22, revealed, "FOCUS: Resident has self-care deficit related to physical limitations, COVID 19, acute respiratory with hypoxia, generalized muscle weakness. Cognitive deficit, anxiety and multiple health issues. INTERVENTIONS: Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Assist to bathe/shower as needed. Assist with ADL's (activities of daily living).

A review of the ADL forms for January 2022, revealed bathing was performed on 6/6 (6 out of 6) days, and dressing was performed for 5/5 day shifts and 4/6 evening shifts. Personal hygiene (combing hair, brushing teeth, washing/drying face and hands) were performed 5/5 day shifts and 5/6 evening shifts. Bathing and dressing were coded as requiring limited/extensive assistance or total dependence. Personal hygiene was coded on day shift 3/5 shifts as independent.

A review of the ADL forms for February 2022, revealed bathing was performed 5/9 day shifts and 5/9 evening
shifts; dressing was performed for 5/9 day shifts and 8/9 evening shifts. Personal hygiene (combing hair, brushing teeth, washing/drying face and hands) were performed 5/9 day shifts and 7/9 evening shifts. Bathing, dressing and personal hygiene were coded as requiring limited/extensive assistance or total dependence.

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On 10/13/22 at 5:40 AM, an interview was conducted with CNA (certified nursing assistant) #3. When asked where CNA's document baths/showers and dressing, CNA #3 stated, we document it on the ADL (activities of daily living) forms in PCC (point click care-electronic charting system). When asked what it means if there are blank spaces in the documentation, CNA #3 stated, it could mean that they did not document or that it was not done. When asked how a CNA could evidence the care being provided if there were blanks, CNA #3 stated, they could not evidence it if there were blank spaces and no documentation.

An interview was conducted on 10/17/22 at 4:06 PM with CNA #1. When asked where bathing, dressing and hygiene of residents is documented, CNA #1 stated, we log onto ADL's (activities of daily living) form and it has bathing, dressing and hygiene places to document, we evidence it by documenting on the ADL record. If there are blanks, there is no evidence.

On 10/17/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the regional vice president of operations were made aware of the findings.

A review of the facility's "Urinary Continence and Incontinence-Assessment and Management" policy, dated 9/10, revealed, "As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. As appropriate, based on

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assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. The staff will document the results of the toileting trial in the resident's medical record. If the resident responds well, the toileting program will be continued. A "check and change" strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin."

4b. For Resident #453, the facility staff failed to provide evidence of providing ADLs (activities of daily living) care regarding feeding.

A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for eating.

A review of the ADL forms for January 2022, revealed the following:

Breakfast: resident refused 2/5 meals, ate 0% 2/5 meals and 51-75% of food for 1 meal. Of the 3 meals resident did not refuse to eat breakfast- feeding assistance was coded as set up for two meals and one person assist for one meal.
Lunch: resident refused 3/5 meals, ate 51-75% of food for 1 meal and 76-100% for one meal. Of the 2 meals resident did not refuse to eat lunch- feeding assistance was coded as set up for one meals and one person assist for one meal.
Supper: resident refused 2/6 meals, ate 51-75% of food for 2 meals and 76-100% for two meals. Of the 2 meals resident did not refuse to eat supper- feeding assistance was coded as set up

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for two meals and one person assist for two meals.

A review of the ADL forms for February 2022, revealed the following:

Breakfast: resident ate 1/9 meals, documented as not applicable 5/9 meals, no documentation for 2/9 meals and ate 51-75% of food for 2 meals. Of the 1 meals resident ate- feeding assistance was coded as set up for one meal.
Lunch: resident ate 2/9 meals, documented as not applicable 4/9 meals, no documentation for 3/9 meals and ate 51-75% of food for 1 meal. Of the 2 meals resident ate- feeding assistance was coded one person assist.
Supper: resident ate 2/8 meals, documented as not applicable 1/9 meals, resident refused for 5/8 meals and ate 51-75% of food for 2 meals. Of the 2 meals resident ate- feeding assistance was coded one person assist.

An interview was conducted on 10/17 at 11:50 AM, with LPN (licensed practical nurse) #7, the unit manager. When asked if she remembered Resident #453, LPN #7 stated, yes, she was not doing well at all. Her family asked us not to push her eating.

An interview was conducted on 10/17/22 at 4:06 PM with CNA (certified nursing assistant) #1. When asked about feeding residents, CNA #1 stated, if they cannot feed themselves, they are already assigned to someone to feed them. We pass out trays and then feed the residents. When asked about documenting amount eaten or assistance provided, CNA #1 stated, we log onto ADL's (activities of daily living) form and it has spaces for percent of meal eaten and assistance

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F 677	Continued From page 85 provided. We evidence it by documenting on the ADL record. If there are blanks, there is no evidence. When asked what not applicable would mean regarding eating, CNA #1 stated, that does not seem to apply to eating. No further information was provided prior to exit. Complaint deficiency.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow physicians' orders for five of 78 residents in the survey sample, Residents #61, #304, #116, #171, and #167. The findings include: 1. For Resident #61 (R61), the facility staff failed to follow the physician's orders for the administration of Hydralazine from 6/1/22 through 6/5/22. On the most recent MDS (minimum data set), a	F 684	F684 Quality of Care 1. Residents #61 no action taken due to time frame has already passed. Weights obtained for residents #116, #171, #167. Resident #304 no longer resides in center. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator/designee will educate all certified and licensed nurses on the process for obtaining weekly weights with documentation in clinical record. The	11/15/22

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F 684	Continued From page 86 quarterly assessment with an ARD (assessment reference date) of 8/12/22, R61 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R61 was coded as receiving dialysis services during the look back period. R61 was coded as having high blood pressure. A review of R61's clinical record revealed the following order dated 4/13/22: "Hydralazine HCl Tablet 50 mg (milligrams). Give 2 tablets by mouth three times a day for HTN (hypertension). Last dose before 6PM (6:00 p.m.) as recommended for multiple doses/day." A review of R61's June 2022 MARs (medication administration records) revealed that on 6/1, 6/2, 6/3, 6/4, and 6/5, R61 received the third dose of Hydralazine at 10:00 p.m., as evidenced by nurse initials in the block for Hydralazine and the time of 2200 (10:00 p.m.) on all five dates. A review of R61's care plan dated 2/4/22 and revised 8/15/22 revealed, in part: "[R61] has basic nursing care needs r/t (related to) ...HTN (hypertension) ...Administer medications ...as ordered." The physician who ordered R61's Hydralazine was not available for interview at the time of the survey. On 10/18/22 at 9:23 a.m., LPN (licensed practical nurse) #16 was interviewed. She reviewed R61's Hydralazine order and June 2022 MARs. She stated the Hydralazine was not given as ordered 6/1/22 through 6/5/22 for the evening dose.	F 684	Licensed nurse□s education will include medication administration of blood pressure medications, performing wound care and treatments with documentation completed in the E-MAR and E-TAR. 4. The DON or designee with audit weekly clinical record to validate blood pressure medication, wound care documentation is complete and weekly weights were obtained and documentation complete. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She reviewed R61's Hydralazine order and June 2022 MARs. She stated the Hydralazine was not given as ordered 6/1/22 through 6/5/22 for the evening dose.

On 10/18/22 at 10:41 a.m., OSM (other staff member) #14, a pharmacist, was interviewed. When asked about the scheduling of the final dose of Hydralazine before 6:00 p.m., OSM #14 stated there is a chance that a resident's blood pressure might drop drastically with multiple doses of this medication in one day. There could be a concern with a resident's blood pressure dropping too low, and potentially causing harmful side effects like dizziness or further kidney damage.

On 10/18/22 at 2:55 p.m., LPN #7, R61's unit manager, was interviewed. She reviewed R61's Hydralazine order and June 2022 MARs. She stated the Hydralazine was not given as ordered 6/1/22 through 6/5/22 for the evening dose.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "Administering Medications," revealed, in part: Medications must be administered in accordance with the orders, including any required time frame.

No further information was provided prior to exit.

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NOTES;
(1) "Hydralazine is used to treat high blood pressure. Hydralazine is in a class of medications called vasodilators. It works by relaxing the blood vessels so that blood can flow more easily through the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682246.html.

Complaint deficiency.
2. For Resident #304 (R304) the facility staff failed to apply physician ordered Nystatin (1) powder to the resident's groin on 4/9/22 and complete physician ordered treatment to the resident's left medial lower leg arterial wound on 5/6/22 and 5/7/22.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/1/22, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions.

R304's comprehensive care plan dated 3/28/22 documented, "(R304) has actual skin breakdown present on admission.
GROIN-IRRITATION/REDNESS...Administer treatment per physician order..."

A review of R304's clinical record revealed a physician's order dated 3/28/22 for Nystatin powder to be applied to the resident's groin every day and evening shift and a wound care nurse practitioner note dated 3/31/22 that documented erythema to R304's groin. Review of R304's April 2022 MAR (medication administration record)

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failed to reveal evidence Nystatin powder was applied to the resident's groin during the evening shift on 4/9/22 (as evidenced by a blank space on the MAR). A review of nurses' notes for 4/9/22 failed to reveal evidence that this treatment was completed.

Further review of R304's clinical record revealed a physician's order dated 4/30/22 to paint a small area of eschar (dead tissue) with betadine (2) and leave the area open to air every day shift. A wound care nurse practitioner note dated 5/3/22 documented an arterial wound on R304's left medial lower leg. Review of R304's May 2022 TAR (treatment administration record) failed to reveal evidence that R304's arterial wound was painted with betadine and left open to air on 5/6/22 and 5/7/22 (as evidenced by blank spaces on the TAR). A review of nurses' notes for 5/6/22 and 5/7/22 failed to reveal evidence that this treatment was completed.

On 10/17/22 at 12:36 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that if there is a hole on the medication administration record or the treatment administration record then the hole means the person did not document that the treatment was done that day and cannot say the treatment was done.

On 10/17/22 at 1:12 p.m., an interview was conducted with LPN #10. LPN #10 stated nurses evidence wound care is done by dating and initialing the dressing and marking the treatment off on the TAR. LPN #10 stated she was not sure what a blank space on the TAR meant but she could not say the treatment done if there were no initials on the TAR.

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On 10/18/22 at 4:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern.

On 10/19/22 at 9:15 a.m., ASM #5 stated the facility did not have a specific policy for following physician's orders except for the policy regarding the administration of medications. This policy titled, "Administering Medications" documented, "3. Medications must be administered in accordance with the orders, including any required time frame."

On 10/19/22 at 9:20 a.m., ASM #5 stated the facility did not have a standard of practice for following physician's orders.

No further information was presented prior to exit.

Complaint deficiency.

REFERENCES:
(1) Nystatin is used to treat fungal infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682758.html

(2) Betadine is an antiseptic solution. This information was obtained from the website: https://medlineplus.gov/ency/article/001958.htm

3. For Resident #116 (R116), the facility staff failed to obtain physician ordered weekly weights in September 2022 and October 2022.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment

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reference date) of 9/10/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions.

R116's comprehensive care plan dated 12/28/20 documented, "(R116) is at potential for nutritional risk r/t (related to) significant weight loss. Obtain weights as ordered..." A review of R116's clinical record revealed a physician's order dated 9/9/22 for weekly weights on Tuesday. A note signed by the dietician on 9/16/22 documented, "No significant weight change is noted x30/90/180 days; goal is to maintain weight stability. Monitoring: weights..." Further review of R116's clinical record, including the weight summary, progress notes, medication administration records and treatment administration records for September 2022 and October 2022, only revealed a weight on 9/13/22 (186.2 pounds) and a weight on 10/3/22 (180.6 pounds).

On 10/17/22 at 12:13 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated physician ordered weekly weights should show up as an order on the medication administration record. LPN #4 stated the nurses write the weights that are needed to be obtained on the CNA's (certified nursing assistants) assignment sheet and the CNAs obtain the weights. LPN #4 stated that if a weekly weight is missed, the CNAs or nurses can obtain the weight on the next shift.

On 10/17/22 at 5:03 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern.

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No further information was presented prior to exit.
4. The facility staff failed to follow physician orders for weekly weights x 3 for Resident #171.

Resident #171 was admitted to the facility on 9/22/22 with diagnoses that included but not limited to: ESRD (end stage renal disease).

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an ARD (assessment reference date) of 9/28/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

A review of the comprehensive care plan dated 9/23/22 documented in part, "DIALYSIS: the resident is at increased risk for complications secondary to requiring hemodialysis secondary to ESRD. INTERVENTIONS: Observe for signs and symptoms of complications related to ESRD including but not limited to fluid overload, hemorrhage, infection to the access site, hypotension, respiratory and / or cardiac distress and notify MD as indicated."

A review of the physician orders dated 9/22/22, revealed "Weekly weight x 3 after admission every day shift every Thursday for Baseline Admission for 3 Weeks." Per physician orders, weekly weights should have been obtained on 9/29/22, 10/6/22 and 10/13/22.

A review of weights showed admission a weight on 9/23/22=100 pounds, no weight on 9/29/22, a weight 10/6/22=101.2 pounds, and no weight on 10/13/22.

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An interview was conducted on 10/17/22 at 12:03 PM with LPN (licensed practical nurse) #4. When asked the process for obtaining weekly weights, LPN #4 stated, weekly weights are on the assignment for the CNA to obtain. If it is missed, then the next shift can get it. It comes up as an order on the MAR. When asked if the physician ordered weights are not done, are the physician orders followed, LPN #4 stated, "No, they are not."

On 10/17/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the regional vice president of operations were made aware of the findings.

On 10/19/22 at 9:15 a.m., ASM #5 stated the facility did not have a specific policy for following physician's orders.

On 10/19/22 at 9:20 a.m., ASM #5 stated the facility did not have a standard of practice for following physician's orders. ASM #5 stated the facility defers to their policies if there is not a standard of practice.

The facility standard of practice is the Lippincott Manual of Nursing Practice, 11th Edition.

No further information was provided prior to exit.

5. The facility staff failed to follow physician orders for weekly weights x 3 for Resident #167.

Resident #167 was admitted to the facility on 9/20/22 with diagnoses that included but were not

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limited to: malignant neoplasm of mouth and major salivary glands, and Parkinson's disease.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an ARD (assessment reference date) of 9/26/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

A review of the comprehensive care plan dated 9/20/22 documented in part, "The resident is at risk for complications related to the need for an enteral tube feeding secondary to tracheostomy with the inability to take in food by mouth. INTERVENTIONS: Weights per order."

A review of the physician orders dated 9/20/22 with a start date of 9/27/22, revealed "Weekly weight x 3 after admission every day shift every Tuesday for Baseline Admission for 3 Weeks." Per physician orders, weekly weights should have been obtained on 9/27/22, 10/4/22 and 10/11/22.

A review of weights showed admission weight on 9/26/22=203 pounds, no weight on 9/27/22, no weight on 10/4/22, and no weight on 10/11/22.

An interview was conducted on 10/17/22 at 12:03 PM with LPN (licensed practical nurse) #4. When asked the process for obtaining weekly weights, LPN #4 stated, weekly weights are on the assignment for the CNA to obtain. If it is missed, then the next shift can get it. It comes up as an order on the MAR. When asked if the physician ordered weights are not done, are the physician orders followed, LPN #4 stated, "No, they are not."

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F 684	Continued From page 95 On 10/17/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the regional vice president of operations were made aware of the findings. On 10/19/22 at 9:15 a.m., ASM #5 stated the facility did not have a specific policy for following physician's orders. On 10/19/22 at 9:20 a.m., ASM #5 stated the facility did not have a standard of practice for following physician's orders. ASM #5 stated the facility defers to their policies if there is not a standard of practice. The facility standard of practice is the Lippincott Manual of Nursing Practice, 11th Edition. No further information was provided prior to exit.	F 684		
F 686 SS=E	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	F 686		11/15/22

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F 686	Continued From page 96 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigations, the facility staff failed to provide care and services for the treatment of pressure injuries for two of 78 residents in the survey sample, Residents #304 and #404. The findings include 1. For Resident #304 (R304), the facility staff failed to perform physician ordered treatments to the resident's left posterior lower leg pressure injury on 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/6/22 and to the resident's sacral pressure injury on 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/13/22. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/1/22, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. R 304's comprehensive care plan dated 3/28/22 documented, "(R304) has actual skin breakdown present on admission: SACRUM- PRESSURE INJURY, LLE (left lower extremity) POSTERIOR...Administer treatment per physician order..." A wound care nurse practitioner note dated 3/31/22 documented an unstageable pressure injury (1) on R304's left posterior lower leg (present on admission).	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. Residents #304 and #404 no longer reside in center. 2. Current residents with wound care orders have the potential to be affected. 3. Staff Development Coordinator or designee will educate all licensed nurses on the process for performing wound care per physician orders for pressure ulcers includes complete documentation for validation. 4. DON or designee will audit weekly 10% of all residents with current pressure ulcers to ensure completion of wound treatments to validate wound care was prided and documentation is complete. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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A review of R304's clinical record revealed the following physician's orders regarding the resident's left posterior lower leg pressure injury:
-A physician's order dated 3/28/22 to cleanse the left posterior lower leg with Dakin's (cleansing solution), skin prep the periwound, paint the eschar (dead skin) with betadine (antiseptic solution), apply medihoney (medical grade honey) fiber to the proximal/medial aspect of the pressure injury, apply Dakin's soaked 4x4 to the distal aspect of the pressure injury, cover the pressure injury with a boarder foam dressing every day shift. This order was discontinued on 3/31/22.
-A physician's order dated 3/31/22 to cleanse the left posterior lower leg with Dakin's, skin prep the periwound, paint the eschar with betadine, apply medihoney fiber to the distal aspect of the pressure injury, cover the pressure injury with a boarder foam dressing every day shift. This order was discontinued on 4/18/22.
-A physician's order dated 4/18/22 to cleanse the left posterior lower leg with Dakin's, skin prep the periwound, apply medihoney fiber, cover the pressure injury with a boarder foam dressing every day shift. This order was discontinued on 5/16/22.

A review of R304's March 2022, April 2022 and May 2022 TARs (treatment administration records) failed to reveal evidence that the above treatment orders were completed on 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/6/22 (as evidenced by blank spaces on the TARs). A review of nurses' notes for 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/6/22 failed to reveal evidence that the treatments were completed.

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A wound care nurse practitioner note dated 4/6/22 that documented a stage two pressure injury (2) on R304's sacrum (present on admission).

A review of R304's clinical record revealed the following physician's orders regarding the resident's sacral pressure injury:
-A physician's order dated 3/28/22 to cleanse the sacrum with normal saline, apply zinc to the periwound, apply medihoney to the pressure injury and cover with a boarder foam dressing every day shift. This order was discontinued on 4/23/22.
-A physician's order dated 4/23/22 to apply zinc to the sacrum three times a day.
A review of R304's March 2022, April 2022 and May 2022 TARs failed to reveal evidence that the above treatment orders were completed on 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/13/22 (as evidenced by blank spaces on the TARs). A review of nurses' notes for 3/29/22, 3/30/22, 4/15/22, 4/16/22 and 5/13/22 failed to reveal evidence that the treatments were completed.

On 10/17/22 at 12:36 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that if there is a hole on the medication administration record or the treatment administration record then that the hole means the person did not document that the treatment was done that day and cannot say the treatment was done.

On 10/17/22 at 1:12 p.m., an interview was conducted with LPN #10. LPN #10 stated nurses evidence wound care is done by dating and initialing the dressing and marking the treatment off on the TAR (treatment administration record).

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LPN #10 stated she was not sure what a blank space on the TAR meant but she could not say the treatment done if there were no initials on the TAR.

On 10/18/22 at 4:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Wound Care" documented, "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing." The policy documented the steps for providing wound care.

No further information was presented prior to exit.

Complaint deficiency.

References:
(1) "Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue)." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf
(2) "Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

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2. For Resident #404 (R404), the facility staff failed to perform pressure ulcer treatments as ordered.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/25/2021, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section M documented R404 having one Stage 4 pressure ulcer (1).

The physician orders for R404 documented in part;
- "House Barrier Cream, Apply to Peri (perineal) area & Buttocks as needed for incontinent episodes. Order Date: 06/18/2021."
- "Consults: Wound Consult eval (evaluation) and treat. Order Date: 06/18/2021."
- "Right Buttock and Sacrum: cleanse with NS (normal saline), apply medihoney (2), and cover with border foam. Apply zinc to periwound. every day shift for wound care. Order Date: 06/24/2021."
- "SACRUM: cleanse with dakins (3), pack with dakins soaked roll gauze, apply medihoney to bilateral sides of the wound, apply zinc to the periwound, cover with a sacral foam one time only for wound care for 1 Day AND as needed for soilage AND every day shift for wound care. Order Date: 07/15/2021."
- "SACRUM: cleanse with dakins, pack with dakins soaked roll gauze, apply medihoney to bilateral sides of the wound, apply zinc to the periwound, cover with a sacral foam as needed for soilage AND one time only for wound care for 1 Day (ONE TIME ORDER FOR EVENING SHIFT FOR 8/3/2021) AND every day and

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evening shift for wound care. Order Date: 08/03/2021."

The progress notes for R404 documented in part; "6/26/2021 11:33 (11:33 a.m.) Skin note... Chief Complaint: Comprehensive skin and wound evaluation
for Right buttock-DTI (deep tissue injury) (4), sacrum-DTI...Factors Affecting Healing : Patient has frequent incontinence which can decrease healing rate of wound. Recommend providing incontinence care as needed, PRN (as needed). Increased moisture at wound site can promote poor prognosis of wound healing. Please keep wound site covered and avoid contamination with feces at all times..."

The wound evaluation dated 6/24/2021 for R404 documented in part, "...Sacrum...Pressure ulcer- Suspected DTI..." and "...Right buttock...Pressure ulcer- Suspected DTI..."
The wound evaluation dated 7/2/2021 for R404 documented in part, "...Right buttock ulcer and sacral ulcer have merged and is now one ulcer...worsening..."
The wound evaluation dated 7/21/2021 for R404 documented in part, "...Sacrum...worsening...Pressure ulcer- Stage 4..."
Additional wound evaluations were completed by the wound nurse practitioner on the following dates: 7/15/2021, 7/27/2021, 8/2/2021, 8/12/2021, 8/17/2021, 8/30/2021, 9/6/2021, 9/13/2021, 9/20/2021, 9/27/2021, 10/11/2021, 10/18/2021, and 10/25/2021.

The comprehensive care plan for R404 documented in part, "Skin: [R404] with actual skin breakdown related to pressure ulcer sacrum and

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is at risk for alteration in skin integrity related to impaired mobility, incontinence, malnutrition, oxygen. Created on: 06/21/2021. Revision on: 11/02/2021..." Under "Interventions" it documented in part, "Treatments as ordered. Created on: 09/28/2021. Revision on: 09/08/2022..."

Review of the eTAR (electronic treatment administration record) for 7/1/2021-7/31/2021 failed to evidence pressure ulcer treatment provided to R404 on the following dates. On day shift on 7/9/2021 and 7/25/2021. The treatment administration record was blank for these dates.

Review of the eTAR (electronic treatment administration record) for 8/1/2021-8/31/2021 failed to evidence pressure ulcer treatment provided to R404 on the following dates. On day shift on 8/12/2021, 8/25/2021, 8/28/2021, 8/29/2021 and 8/31/2021. On evening shift on 8/11/2021, 8/13/2021 and 8/28/2021. The treatment administration record was blank for these dates.

Review of the eTAR (electronic treatment administration record) for 9/1/2021-9/30/2021 failed to evidence pressure ulcer treatment provided to R404 on the following dates. On day shift on 9/1/2021, 9/17/2021, 9/25/2021 and 9/26/2021. The treatment administration record was blank for these dates.

Review of the eTAR (electronic treatment administration record) for 10/1/2021-10/31/2021 failed to evidence pressure ulcer treatment provided to R404 on the following dates. On day shift on 10/4/2021, 10/6/2021, and 10/10/2021. On evening shift on 10/10/2021, 10/12/2021 and

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10/23/2021. The treatment administration record was blank for these dates.

On 10/17/2022 at 12:36 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that treatment documentation was evidenced by signing off on the eTAR after completion. LPN #8 stated that blanks on the eTAR meant that the staff member did not document that it was done that day and they could not say that the treatment was completed. LPN #8 reviewed the ADL documentation for R404 for incontinence care and eating and stated that there was no evidence to support that it was done with the blanks.

On 10/17/2022 at 1:12 p.m., an interview was conducted with LPN #10, wound nurse. LPN #10 stated that wound care was evidenced as completed by signing it off on the eTAR. LPN #10 reviewed R404's eTAR's and stated that they were not sure what blanks were on the eTAR but they could not say that the treatments were provided if there were no initials documenting that it was done.

On 10/19/2022 at approximately 9:29 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern.

No further information was provided prior to exit.

Reference:
(1) Pressure Ulcer

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A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

(2) Medihoney
Applying honey preparations directly to wounds or using dressings containing honey seems to improve healing. Honey seems to reduce odors and pus, help clean the wound, reduce infection, reduce pain, and decrease time to healing. This information was obtained from the website: https://medlineplus.gov/druginfo/natural/738.html

(3) Dakin's solution
Dakin's solution is used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. This information was obtained from the website: https://www.webmd.com/drugs/2/drug-62261/dakins-solution/details

(4) DTI- deep tissue injury

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F 686	Continued From page 105 Pressure sores that develop in the tissue deep below the skin. This is called a deep tissue injury. The area may be dark purple or maroon. There may be a blood-filled blister under the skin. This type of skin injury can quickly become a stage III or IV pressure sore. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm Complaint deficiency.	F 686		
F 689 SS=E	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, resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide a safe environment for four of 78 residents in the survey sample, Residents #108, #60, #86, and #120. The findings include: 1. For Resident #108 (R108), the facility staff failed to provide smoking supervision per the safe smoking assessment, and failed to store the resident's cigarettes in a safe location.	F 689	F689 Free of Accident Hazards/Supervision/Devices 1. Resident #108 , #60 smoking assessments completed and indicates residents do not require assistance with smoking. Residents #108, #60, #86 cigarettes are stored with nursing department. Resident #86 had a smoking care plan initiated. Resident #120 and RP was educated and MVI was removed from bedside with order obtained for administration from nursing staff. 2. An audit was conducted of resident that smoke to review smoking	11/15/22

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F 689	Continued From page 106 On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 9/1/22, R108 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). The resident was coded as needing oversight for locomotion off the unit. On 10/12/22 at 10:54 a.m., R108 was observed sitting at a picnic table in an area between the facility and an adjacent building. The picnic table was surrounded by trees and bushes. The dirt path leading from the facility to the picnic table was cleared of debris, and contained a few rocks and uneven segments. R108 was smoking a cigarette. R108 stated: "It's good to see you again. We were out here last year together talking last year, weren't we?" R108 stated they smoke multiple cigarettes every day and evening, and spend a great deal of time at the picnic table. R108 pulled cigarettes out of their pocket, and stated they keep the cigarettes hidden in their room. On 10/11/22 at 11:35 a.m., ASM (administrative staff member) #1, the administrator, was asked to provide a list of residents who smoke. ASM #1 stated the facility is smoke-free. He provided a list of residents who smoke off facility property. This list did not include R108. A review of R108's clinical record revealed a Smoking - Safety Screen dated 10/30/21, the most recent smoking safety screening prior to entrance. A review of this assessment revealed the following: "Patient demonstrates safe smoking techniques:	F 689	assessments with education to the resident for storage of smoking materials in designated area. An observation audit was conducted for medications at bedside. 3. The Staff Development Coordinator/designee will educate all licensed nurses and the facility staff on the process for residents that smoke, smoking assessments performed by licensed nurse and care plan initiated or revised by MDS or licensed nurses and storage of smoking materials in designated area and staff will report any findings of medications in a resident room to the nurse. 4. The Unit Managers or designee will conduct a weekly audit to verify no medications are in the resident room and weekly audits will be conducted for new identified smokers to verify smoking assessment and care plan completed and smoking material are stored in designated area. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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holding cigarette, lighting cigarette, extinguishing matches, lighter and cigarette after use and disposal of ashes: No

Patient remains alert [while] smoking: No

Patient understands that smoking accessories (cigarettes, lighters, matches, etc.) must be returned to and kept under the control of the center staff when not in use: Yes

Determination: At risk smoker: Requires staff, family or friend for physical support or supervision to smoke

Additional comments/information: Resident has heart issues and non-compliant and does smoke outside of facility, resident smells of smoke. Resident aware facility is smoke free."

A review of R108's care plan dated 1/13/20 and updated 9/30/22, revealed, in part: "Safe smoking...Educate to interventions and center smoking policy and procedures...Offer/encourage smoking cessation...Secure smoking materials (cigarettes, matches, lighters) at nursing station."

On 10/17/22 at 12:36 p.m., LPN (licensed practical nurse) #8, R108's unit manager, was interviewed. He stated if resident wants to go off the facility property to smoke, the facility needs to complete a safe smoking assessment for that resident. He stated any nurse can complete this assessment. He stated residents were previously asked about smoking habits at the time of admission, but many times, the residents would not be truthful. He stated he had not been aware that R108 was going outside to smoke until a few days before. He stated he did not know where

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R108 keeps cigarettes, and had not asked the resident this question. He stated he needs to become more familiar with R108's care plan. LPN #108 stated residents should store cigarettes with the nurse.

On 10/17/22 at 12:50 p.m., LPN #12 was interviewed. She stated she took care of R108 in the past. She stated the whole time she worked with the resident, she was not aware the resident was smoking outside. She stated the resident would tell her when they were going outside. She stated if a resident expresses a desire to smoke, she informs the supervisor. She stated residents should not have any smoking materials in their rooms. She stated: "I used to do safe smoking assessments for residents, but we are now a non-smoking facility."

On 10/17/22 at 5:00 p.m., ASM #1, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "Smoking Policy - Residents," revealed, in part:

"This facility shall establish and maintain safe resident smoking practices...

Policy Interpretation and Implementation
1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non- smoking preferences.

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F 689	Continued From page 109 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Cigarettes may be permitted inside in designated areas only. Otherwise, smoking is not allowed inside the facility under any circumstances... 8. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues... 11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. 12. Residents who have independent smoking privileges are permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited. 13. Residents are not permitted to give smoking articles to other residents. 14. Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision." No further information was provided prior to exit. 2. For Resident #60 (R60), the facility staff failed to provide smoking supervision per the safe smoking assessment, and failed to store the resident's cigarettes in a safe location.	F 689		

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On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/9/22, R60 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). The resident was coded as needing oversight for locomotion off the unit.

On 10/12/22 at 10:48 a.m., RN (registered nurse) #5 was asked the whereabouts of R60. She stated the resident had just left the unit a few minutes before. She stated the resident normally leaves independently, and spends a lot of time outside during the day.

On 10/12/22 at 10:50 a.m., R60 was walking up the sidewalk towards the front door of the facility. R60 stated he had been smoking with another resident off facility property. R60 walked back to a picnic table in an area between the facility and an adjacent building. The picnic table was surrounded by trees and bushes. The dirt path leading from the facility to the picnic table was cleared of debris, and contained a few rocks and uneven segments. R60 stated he comes to this area multiple times a day to smoke. R60 pulled cigarettes out of his pocket, and stated he keeps the cigarettes in his pocket, even when he is inside the facility.

On 10/11/22 at 11:35 a.m., ASM (administrative staff member) #1, the administrator, was asked to provide a list of residents who smoke. ASM #1 stated the facility is smoke-free. He provided a list of residents who smoke off facility property. This list included R60.

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A review of R60's clinical record revealed a Smoking - Safety Screen dated 6/16/22, the most recent smoking safety screening prior to entrance. A review of this assessment revealed the following:

"Patient is free of physical limitations interfering with the ability to perform safe smoking techniques...able to grasp and handle cigarette, lighter, or matches without assistance: No...Determination: At risk smoker: Requires staff, family or friend for physical support or supervision to smoke...Resident has long history of smoking."

A review of R60's care plan dated 9/28/21 and updated 5/4/22 revealed, in part: "Possession of cigarettes/lighter not allowed on premises. Has a history [of] tobacco abuse...Discuss coping strategies...Provide information on support groups or addiction treatment...Smoking assessment as indicated."

On 10/17/22 at 2:11 p.m., CNA (certified nursing assistant) #6 was interviewed. He stated R60 usually signs out, and he was aware that the resident goes out to smoke. CNA #6 stated R60 had been going out to smoke since the time the resident was admitted. CNA #6 stated he had "no idea" where R60 stores their cigarettes.

On 10/17/22 at 5:00 p.m., ASM #1, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

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On 10/18/22 at 9:23 a.m., LPN (licensed practical nurse) #16 was interviewed. She stated R60 usually signs out, and tells her when they leave the building. She stated she was not aware R60 smoked.

No further information was provided prior to exit.

3. For Resident #86 (R86), the facility staff failed to ensure safe storage of smoking materials used by the resident.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/20/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that the resident was cognitively intact for making daily decisions. Section J documented R86 using tobacco.

On 10/12/2022 at 9:58 a.m., an interview was conducted with R86. R86 stated that they were a smoker but was not allowed to smoke on the facility property. R86 stated that they went off of the property to the smoking area at the building behind the facility in their electric wheelchair. R86 stated that they always notified the nurse on duty when they were leaving the building and when they returned. R86 stated that they went out a couple of times a day depending on what type of day they were having. When asked where their cigarettes and lighter were stored, R86 stated that they were stored in their nightstand drawer in their room. R86 stated that the drawer was not locked.

The comprehensive care plan for R86 failed to evidence a smoking care plan.

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The Safe Smoking Evaluation for R86 dated 8/28/2022 documented in part, "...Patient understands that smoking accessories (cigarettes, lighters, matches, etc.) must be returned to and kept under the control of the center staff when not in use. Yes...Determination: Independent Smoker: Capable and independent, requires no supervision to smoke..."

On 10/17/2022 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that smoking assessments were completed quarterly for residents and care plans were updated at that time. LPN #7 stated that residents who smoked signed out on their units each time they left the property to smoke. LPN #7 stated that smoking supplies were supposed to be kept on the medication carts when they were not in use on the residents unit.

On 10/17/2022 at 12:35 p.m., an interview was conducted with LPN #8. LPN #8 stated that residents who smoked required a safe smoking assessment to be completed. LPN #8 stated that they were aware that R86 left the facility to smoke. LPN #8 stated that they were not sure where the smoking supplies were stored but thought that the residents should be giving their smoking materials to the nurse to store.

On 10/17/2022 at 1:40 p.m., an interview was conducted with LPN #11. LPN #11 stated that they cared for R86 often. LPN #11 stated that R86 always told them when they were leaving the building but never told them what they were doing when they left.

On 10/17/2022 at approximately 4:59 p.m., ASM (administrative staff member) #1, the

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administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern.

No further information was provided prior to exit.
4. For Resident #120 (R120), the facility staff failed to ensure a bottle of multivitamin gummies was not left at the resident's bedside; the resident had not been assessed for safe medication self-administration.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/30/22, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately cognitively impaired for making daily decisions.

On 10/11/22 at approximately 12:45 p.m., a plastic bottle of multivitamin gummies was observed on R120's over-bed table. R120 stated a friend brought the gummies a few days ago and the resident had been taking the gummies every day. On 10/12/22 at 8:37 a.m., the multivitamin gummies remained on R120's over-bed table.

A review of R120's clinical record revealed a physician's order dated 10/13/22 for multivitamin gummies- one gummy by mouth one time a day. Further review of R120's clinical record failed to reveal a medication self-administration assessment or a physician's order for medication self-administration. R120's comprehensive care plan dated 10/7/22 failed to reveal documentation regarding medication self-administration.

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On 10/17/22 at 12:13 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated a multivitamin is considered a medication and should be locked in the medication cart. LPN #4 stated a medication should not be left in a resident's room unless the physician has written an order to keep the medication at the bedside and the resident has demonstrated he or she is capable to self-administer the medication. LPN #4 the nurses have an assessment that should be completed.

On 10/17/22 at 5:03 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #5 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Self-Administration of Medications" documented, "1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's:
a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications."

No further information was presented prior to exit.

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide monitoring for strict intake and output (I & O) for one of 78 residents, Resident #171. The findings include: The facility failed to provide monitoring for strict I & O for Resident #171. Resident #171 was admitted to the facility on 9/22/22 with diagnoses that included but were not limited to: ESRD (end stage renal disease).	F 692	F692 Nutrition/Hydration Status Maintenance 1. Resident #171 is now having intake output monitored as per physician orders. 2. A review of residents in the center with physician orders for strict Intake and output was reviewed to ensure compliance with the order. 3. The Staff Development Coordinator/designee will educate all licensed nurses on the process for transcribing physician for intake and output and completion of documentation for intake and output monitoring per	11/15/22

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F 692	Continued From page 117 The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an ARD (assessment reference date) of 9/28/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating. A review of the comprehensive care plan dated 9/23/22 documented in part, "DIALYSIS: the resident is at increased risk for complications secondary to requiring hemodialysis secondary to ESRD. INTERVENTIONS: Observe for signs and symptoms of complications related to ESRD including but not limited to fluid overload, hemorrhage, infection to the access site, hypotension, respiratory and/or cardiac distress and notify MD as indicated." A review of the physician orders dated 10/7/22 revealed, "Strict I&O measurement one time only for ESRD for 14 Days to be measured each shift." A review of Resident #171's MAR (medication administration record), TAR (treatment administration record) and ADL (activities of daily living) records revealed no evidence of strict I&O being documented. A request was made on 10/17/22 at approximately 9:00 AM for evidence of strict I&O for Resident #171. On 10/17/22 at 4:40 PM, ASM (administrative staff member) #4, the assistant director of nursing, stated,"We have no evidence of strict	F 692	physician order. 4. The Unit Managers or designee will complete weekly audits to verify residents with physician orders for intake and output have documentation completed for intake and output monitoring. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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F 692	Continued From page 118 I&O being captured for this resident." On 10/17/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the regional vice president of operations were made aware of the findings. A review of the facility's "Intake Measuring and Recording" dated 10/10, reveals "The purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period. Documentation: The following information should be recorded in the resident's medical record, per facility guidelines: 1.The date and time the resident's fluid intake was measured and recorded. 2. The name and title of the individual who measured and recorded the resident's fluid intake. 3. The amount (in milliliters) of liquid consumed. 4. The type of liquid consumed (i.e., tea, milk, coffee, soup, etc.). 5. If the resident refused the treatment, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data." No further information was provided prior to exit.	F 692		
F 695 SS=E	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	F 695		11/15/22

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F 695	Continued From page 119 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, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice for four of 78 residents in the survey sample, Resident #89, #64, #50, and #167. The findings include: 1. For Resident #89 (R89), the facility staff failed to store a nebulizer (1) mask in a sanitary manner when not in use. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/25/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. On 10/11/2022 at 1:30 p.m., an observation was made of R89 in their room. A nebulizer medication delivery cup with a mask attached and tubing were observed to be sitting on top of an oxygen concentrator to the right of R89's bed. The nebulizer mask was observed to be uncovered. At that time an interview was conducted with R89. When asked if they received nebulizer treatments via the nebulizer mask located on the oxygen concentrator, R89 nodded their head and stated that they did.	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. Resident #89 nebulizer mask replace and stored in bag when not in use. Resident #64 oxygen cannula replaced and stored when not is use; the oxygen cannister was removed from room. Resident #50 nebulizer mask replaced and stored in bag when not is use and the oxygen rebreather discarded. Resident # 167 the ambu bag placed at bedside. 2. Current residents in the center receiving respiratory therapy including oxygen, nebulizer treatments or physician orders for ambu bag have the potential to be affected. 3. The Staff Development Coordinator/designee will educate all licensed nurses on the process for obtaining orders for use of oxygen, sanitary storage of oxygen and nebulizer supplies when not in use, and proper storage of oxygen cannisters are in a holder. A physician order for ambu bag at bedside must ensure the ambu is bag in the resident room at bedside. 4. The Unit Managers or designee will conduct weekly audits on residents receiving oxygen and nebulizer treatments to verify in storage bag when not in use, verify physician order for ambu bag is at bedside, 10 % audit of resident□s room to verify oxygen cannister are in a holder when in room.	

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F 695	Continued From page 120 Additional observations on 10/11/2022 at 3:45 p.m. and 4:12 p.m. revealed the same as described above. The physician's orders for R89 documented in part, - "Ipratropium-Albuterol Solution 0.5-2.5 (3) MG (milligram)/3 ML (milliliter). 1 vial via trach (tracheostomy) two times a day for COPD (chronic obstructive pulmonary disease). Document abnormal lung sounds. Order Date: 08/09/2022." - "Normal Saline Flush Solution (Sodium Chloride Flush) 3 ml via trach two times a day for Trachea moisture. Place nebulizer over trach stoma site. Order Date: 11/25/2020." The eMAR (electronic medication administration record) dated 10/1/2022-10/31/2022 for R89 documented the above medications administered at 9:00 a.m. on 10/11/2022. The comprehensive care plan for R89 dated 9/6/2020 documented in part, "Respiratory: [R89] is at risk for respiratory impairment related to COPD, chronic hypoxic respiratory failure, SOB (shortness of breath) on exertion and when lying flat, suctioning needed, neb (nebulizer) tx (treatment), humidified oxygen, with trach stoma. Created on: 09/06/2020. Revision on: 05/30/2022." On 10/17/2022 at 11:50 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that nebulizers were stored in dated plastic Ziploc bags when not in use. LPN #7 stated that the purpose of the bag was for sanitary reasons to keep the nebulizer clean.	F 695	5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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On 10/17/2022 at 12:35 p.m., an interview was conducted with LPN #8. LPN #8 stated that nebulizers were stored in Ziploc bags at the bedside with the residents name on them when not in use. LPN #8 stated that the bags were changed every Saturday. LPN #8 stated that the nebulizer's were stored in the bags for infection control purposes.

The facility policy "Departmental (Respiratory Therapy)- Prevention of Infection Level" dated November 2011 documented in part, "The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff...Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: ...5. Store the circuit in plastic bag, marked with date and resident's name, between uses..."

On 10/17/2022 at approximately 4:59 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the vice president of operations were made aware of the concern

No further information was provided prior to exit.

Reference:

(1) nebulizer
A nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece. This information was obtained from the website:

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https://medlineplus.gov/ency/patientinstructions/000006.htm

2. For Resident #64 (R64), the facility staff failed to store oxygen in a safe manner and failed to store respiratory equipment in a sanitary manner.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/12/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section O - Special Treatment, Procedures and Programs, R64 was not coded as receiving oxygen.

Observation was made of R64's room on 10/11/2022 at approximately 12:30 p.m. An unsecured oxygen tank was observed next to the resident's dresser, not in a stand. A second oxygen tank was observed under the window but was stored in a stand. This oxygen tank had oxygen tubing with a nasal cannula attached to the tank and not covered or stored in anything, just exposed to the air.

A second observation was made on 10/11/2022 at 4:17 p.m. accompanied by LPN (licensed practical nurse) #1, the unit manager. When asked what was wrong with the oxygen tank next to the dresser, LPN #1 stated it should be in a stand. When asked why, LPN #1 stated because it's a hazard. When asked about the oxygen tubing hanging off the other oxygen tank, under the window, LPN #1 stated the tubing should be stored in a bag when not in use. When asked why, LPN #1 stated for infection control reasons. R64 was asked how long the oxygen tanks have

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been in his room, they stated it's been about a month ago they were brought in. When asked if they still use it, R64 stated, no.

Review of the physician orders failed to evidence an order for oxygen.

Review of the comprehensive care plan dated 7/27/2022, failed to evidence the use of oxygen.

The facility policy, "Departmental (Respiratory Therapy) - Prevention of Infection Level," documented in part, "8. Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use."

The facility policy, "Oxygen Administration" documented in part, "1. Portable oxygen cylinder (secured in a stand)."

ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM # #3, regional nurse navigator, and ASM #4, the assistant director of nursing, were made aware of the above findings on 10/12/2022 at 3:53 p.m.

No further information was provided prior to exit.

3. For Resident #50 (R50), the facility staff failed to store nebulizer and oxygen mask equipment in a sanitary manner.

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/1/2022, the resident scored a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired

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F 695	Continued From page 124	F 695		

for making daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while in the facility.

Observation was made on 10/11/2022 at approximately 1:15 p.m. of R50's room. The resident was in bed with their oxygen on via a nasal cannula. Sitting on a chair next to the bed was a nebulizer machine, a nebulizer mask and an oxygen mask with a rebreather bag attached, sitting on an afghan. Neither of the masks were in any sort of bag or container.

An interview was conducted with LPN (licensed practical nurse) #1, on 11/12/2022 at 1:36 p.m. When asked how nebulizer masks and oxygen equipment are stored when not in use, LPN #1 stated they should be stored in a bag. The above observation was shared with LPN #1. LPN #1 stated she was aware of the resident being on oxygen and nebulizer treatments but was unsure as to why a mask with a rebreather bag was in the resident's room.

Review of the physician's order revealed documented an order for oxygen therapy and an order for nebulizer treatments.

The comprehensive care plan dated, 8/9/2022, documented in part, "Focus: RESPIRATORY: (R50) Has/At risk for respiratory impairment related to PNA (pneumonia), w (with)/COVID on admission w/respiratory failure. SOB (shortness of breath), nebulizers and Oxygen." The "Interventions" documented in part, "Administer medications/treatments as ordered. Administer oxygen per physician order."

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The facility policy, "Departmental (Respiratory Therapy) - Prevention of Infection Level," documented in part, "Infection Control Considerations Related to Mediation Nebulizer/Continuous Aerosol: Store the circuit (device used to administer nebulizer medications) in plastic bag, marked with date and resident's name, between uses."

ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM # #3, regional nurse navigator, and ASM #4, the assistant director of nursing, were made aware of the above findings on 10/12/2022 at 3:53 p.m.

No further information was provided prior to exit.

4. The facility staff failed to provide respiratory therapy as ordered for Resident #167. Resident #167 was observed without an ambu bag at bedside on 10/11/22 and 10/12/22.

Resident #167 was admitted to the facility on 9/20/22 with diagnoses that included but were not limited to: trach (tracheostomy), malignant neoplasm of mouth and major salivary glands, and Parkinson's disease.

The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an ARD (assessment reference date) of 9/26/22, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring total dependence for locomotion and bathing; extensive assistance for bed mobility,

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transfers, dressing/hygiene and eating.

A review of the comprehensive care plan dated 9/20/22 documented in part, "The resident is at risk for complications secondary to a tracheostomy. INTERVENTIONS: Suction as needed. Tracheostomy care per order. Tracheostomy tie change per order."

A review of the physician orders dated 9/20/22, revealed "Ambu-bag and trach collar to be kept at bedside."

On 10/12/22 at approximately 9:45 AM, trach care was observed being performed on Resident #167. After trach care was performed by LPN (licensed practical nurse) #2, the LPN was asked to show the trach collar, inner cannula's, trach ties and ambu bag. LPN #2 revealed the location of all of the above with the exception of the ambu bag. LPN #2 stated, "We do not keep an ambu bag in the room. We have it in the supply closet if we need it." When asked if the physician orders included "Ambu bag to be kept at bedside", were the physician orders being followed, LPN #2 stated, "No, they would not be followed. Let me check on the order." The order was identified to keep ambu bag at bedside.

On 10/17/22 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator and ASM #7, the regional vice president of operations were made aware of the findings.

No further information was provided prior to exit.

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F 698	Continued From page 127	F 698		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility failed to maintain a complete dialysis program for two of 78 residents in the survey sample, Residents #11 and #61. The findings include: 1. For Resident #11 (R11), the facility staff failed to provide evidence of the assessment of the resident's hemodialysis access site in March 2022, and from 4/1/22 through 4/12/22; and failed to maintain communication with the dialysis center on multiple dates between 6/2/22 and 10/10/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/11/22, R11 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). R11 was coded as receiving dialysis services during the look back period. A review of R11's clinical record revealed the following order dated 5/7/21: "Hemodialysis	F 698	F698 Dialysis 1. Residents #11 and #61 remain in center. Resident #11 new order for monitoring dialysis access site. New dialysis communication books established for resident #11 and #61. 2. Current residents in the center who receive dialysis services have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all licensed nurses on the process that residents receive dialysis as physician order to monitor dialysis access site and utilization of communication books for dialysis residents. 4. The Unit Managers/designees will complete a weekly audit of residents with orders for dialysis to verify physician order for monitoring dialysis access sites with completed documentation and utilization of dialysis communication books. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are	11/15/22

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F 698	Continued From page 128 Diagnosis: ESRD (end stage renal disease) Dialysis Days and Time: Tues (Tuesday) -Thurs (Thursday) -Sat (Saturday)." A review of R11's clinical record failed to reveal a physician's order to assess R11's dialysis access site from 3/1/22 through 4/12/22. The review failed to reveal any evidence that the staff was assessing R11's access site on those days. Additionally, the clinical record review failed to reveal evidence of any communication with the dialysis center via R11's dialysis communication book on the following dates in 2022: 6/2, 6/4, 6/7, 6/9, 6/11, 6/14, 6/16, 7/2, 7/4, 7/9, 7/14, 7/21, 7/23, 7/26, 8/9, 8/13, 8/16, 8/25, 8/27, 8/30; and 9/2/22 through 10/10/22. A review of R11's care plan dated 10/4/21 and revised 6/15/22 revealed, in part: [R11] has renal insufficiency related to chronic kidney disease on HD (hemodialysis)...check bruit and thrill q shift (every shift) as ordered...Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed." On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated that any assessment regarding dialysis would need to have an order from a physician. She stated that ordinarily, the physician will order an assessment of the resident's dialysis site each shift. She stated the site should be monitored for bleeding, and for evidence that the site remains usable for dialysis. She stated the primary form of communication between the facility and the dialysis center is the dialysis communication book. She stated each resident's dialysis book	F 698	responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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contains a form for each dialysis day. Both the facility staff and the dialysis center staff document on the form, exchanging pertinent information regarding the resident's care with each other. She stated the information includes vital signs, medication administration, and any other important facts.

On 10/17/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "End-Stage Renal Disease, Care of a Resident with," revealed, in part: "Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care...Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes...the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis...the care of grafts and fistulas...Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including...how information will be exchanged between the facilities."

No further information was provided prior to exit.

2. For Resident #61 (R61), the facility staff failed

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F 698	Continued From page 130	F 698		

to maintain communication with the dialysis center on multiple dates between 6/28/22 and 10/10/22.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/12/22, R61 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R61 was coded as receiving dialysis services during the look back period.

A review of R61's clinical record revealed the following order dated 6/9/22: "Hemodialysis Diagnosis: CKD (chronic kidney disease) Stage V (five) Dialysis Days and Time: Tuesday, Thursday."

Additionally, the clinical record review failed to reveal evidence of any communication with the dialysis center via R61's dialysis communication book on the following dates in 2022: 6/28, 6/30, 7/2, 7/5, 7/7, 7/9, 7/12, 7/14, 7/16, 7/19, 7/21; and 7/30/22 through 10/10/22.

A review of R61's care plan dated 2/4/22 and revised 10/8/22 revealed, in part: "Dialysis: [R61] has renal insufficiency related to chronic renal failure...Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed."

On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated the primary form of communication between the facility and the dialysis center is the dialysis communication book. She stated each resident's

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F 698	Continued From page 131 dialysis book contains a form for each dialysis day. Both the facility staff and the dialysis center staff document on the form, exchanging pertinent information regarding the resident's care with each other. She stated the information includes vital signs, medication administration, and any other important facts. On 10/17/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns. No further information was provided prior to exit. Complaint deficiency.	F 698		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician,	F 712		11/15/22

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F 712	Continued From page 132 required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure required physician visits were conducted for one of 78 residents in the survey sample, Resident #94. The findings include: For Resident #94 (R94), the facility staff failed to ensure the resident was seen by a physician as required, since 5/25/22. R94 was admitted to the facility on 3/25/21. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/29/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. On 10/11/22 at approximately 12:30 p.m., an interview was conducted with R94. R94 stated the resident does not see a doctor that often. A review of R94's clinical record revealed the resident was seen by a nurse practitioner on 7/28/22, 8/5/22, 8/12/22, 8/15/22, 8/19/22, 9/23/22 and 10/2/22, however the resident was last seen by a physician on 5/25/22. On 10/18/22 at 10:45 a.m., an interview was conducted with ASM (administrative staff	F 712	F712 Physician Visits-Frequency/Timeliness/Alt NPP 1. Resident #94 was seen by physician on 10/19/2022. 2. Current residents have the potential to be affected. 3. The Administrator or designee will educate all Physicians and Nurse Practitioners on the centers policy regarding frequency of required physician visits. 4. The Director of Medical Records or designee will complete a weekly audit of residents to verify compliance with recertification and physician visits is maintained. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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F 712	Continued From page 133 member) #5 (the director of nursing). ASM #5 stated the physician should see a resident within the first 30 days of admission then monthly for 90 days then every 60 days with a 10 day grace period. ASM #5 stated the physician can alternate every other 60 day visit with a nurse practitioner if they deem that to be appropriate. On 10/18/22 at 12:26 p.m., ASM #5 stated she could not find evidence that a physician saw R94 since May 2022. On 10/18/22 at 4:36 p.m., ASM #1 (the administrator) and ASM #5 were made aware of the above concern. The facility policy titled, "Attending Physician Responsibilities" documented, "Resident Visits 1. The Attending Physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone. a. The visit schedule will be at least every 30 days for the first 90 days after admission, and then at least every 60 days thereafter. b. After the first 90 days, a Nurse Practitioner or other midlevel practitioner under the Physician's supervision can make alternate scheduled visits, unless otherwise restricted by regulations..." No further information was presented prior to exit.	F 712		
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	F 755		11/15/22

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F 755	Continued From page 134 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: Based on resident interview, facility staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide a medication as ordered by the physician for one of 78 residents, Resident #124. The findings include:	F 755	F755 Pharmacy 1 Resident #124 physician was notified of the documentation regarding the medication during the timeframe. The medication was discontinued on 9/13/2022. 2 All residents have the potential to be affected.	

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F 755	Continued From page 135 For Resident #124 (R124) the facility staff failed to provide Sarvella (1) for administration, as ordered by the physician, on multiple dates in September and October 2022. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/12/22, R124 was coded as being cognitively intact, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as having experienced pain frequently during the look back period. On 10/13/22 at 9:05 a.m., R124 was sitting up in bed. R124 stated they have almost constant pain due to fibromyalgia. The resident stated the facility has not always administered fibromyalgia medication the way the doctor ordered. A review of R124's clinical record revealed the following order dated 8/21/22: "Savella Tablet 25 mg (milligrams) (Milnacipran HCl) Give 1 tablet by mouth two times a day for fibromyalgia/depression." A review of facility pharmacy receipts for R124 revealed the facility received six tablets on 8/25/22, and another six tablets on 8/28/22. The receipts review revealed only 12 total tablets were dispensed to the facility prior to when the medication was discontinued on 9/13/22. A review of R124's progress notes revealed the following: "8/23/2022 18:12 (6:12 p.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for	F 755	3 The Staff Development Coordinator or designee will educate all licensed nurses on the process for accuracy of documentation and process to secure or manage process when medications are not available. 4 The Unit Managers or designee will complete a weekly audit of documentation on new medications initiated to verify available with accurate documentation. 5 The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6 Date of Compliance: 11/15/2022	

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fibromyalgia/ depression. Not available,"

"8/24/2022 09:21 (9:21 a.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/depression. Not available."

"8/24/2022 19:42 (7:42 p.m.) Orders - Administration Note Text: Savella Tablet 25 MG Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Not available."

"8/25/2022 09:43(9:43 a.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Medications unavailable will follow up with pharmacy."

"8/25/2022 18:25 (6:25 p.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Spoke to pharmacy awaiting authorization from facility to send."

"8/29/2022 08:36 (8:36 a.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Ordered from pharmacy."

"9/2/2022 08:34 (8:34 a.m.) Orders - Administration Note Text: Savella Tablet 25 MG. Give 1 tablet by mouth two times a day for fibromyalgia/ depression. Medication unavailable awaiting pharm del. (delivery)."

A review of R124's September 2022 MAR (medication administration record) revealed Sarvella was documented as not available from

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the pharmacy twice on 9/3, 9/4, 9/11, and 9/12.

A review of R124's care plan dated 8/3/22 and updated 9/3/22 revealed, in part: [R124] is at risk for increased pain due to...chronic pain...Administer pain medication per physician orders."

On 10/18/22 at 9:23 a.m., LPN (licensed practical nurse) #16 was interviewed. She stated if a medication is not available for administration, she calls the pharmacy. She stated if the pharmacy tells her a preauthorization is needed, she will ask the pharmacy to fax the form right away. She said the pharmacy faxes the form to the facility, and she (or whomever is taking care of the resident that particular day) is responsible for contacting the physician and getting the form filled out. She stated she would notify her manager, and write a progress note detailing everything she had done, including filling out the form and contacting the physician.

On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She stated she is an agency employee and does not work regularly at the facility. She stated if a medication is not available for a resident, she selects a button the clinical software to reorder it, and then she writes a progress note saying it is not available. She stated she could not think of anything else to be done.

On 10/18/22 at 10:41 a.m., OSM (other staff member) #14, a pharmacist, was interviewed. She stated Sarvella is an unusual medication, and is rarely ordered in the long term care setting. She stated this medication is expensive, and insurance companies frequently require a special

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authorization before they will pay for it. She stated Sarvella required this prior authorization. She stated the pharmacy billing team communicated to the pharmacists that they should not dispense the medication before getting the authorization. The pharmacy sends a fax to the facility, instructing them to have the attending physician fill out the authorization form. She stated it is up to the physician to make the prior authorization happen. If not, the facility has to give the pharmacy the assurance that the facility will pay for the medication if the pharmacy will not. She reviewed the pharmacy's records, and verified the pharmacy only dispensed a total of 12 tablets for R124. She stated the pharmacy dispensed these so the resident would have a minimal supply. She stated the facility never provided the pharmacy with the required special authorization for the Sarvella.

On 10/18/22 at 2:55 p.m., LPN #7, R124's unit manager, was interviewed. She stated if a medication is not available, the nurse should call the pharmacy, and should notify the physician that the medication is not available. She stated the nurse should find out where the drug is, and what is going on with the medication. She described the same process for preauthorization as OSM #14.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

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A review of the facility policy, "Unavailable Medications," revealed, in part: "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident...The pharmacy staff shall:
1) Call or notify nursing staff that the ordered product(s) is/are unavailable.
2) Notify nursing when it is anticipated that the drug(s) will become available.
3) Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available, which is covered by the resident's insurance.
B. Nursing staff shall:
1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available.
a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction.
2) Obtain a new order and cancel/discontinue the order for the non-available medication.
3) Notify the pharmacy of the replacement order."

No further information was provided prior to exit.

NOTES
(1) "Milnacipran (Sarvella) is used to treat fibromyalgia (a long-lasting condition that may

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F 755	Continued From page 140 cause pain, muscle stiffness and tenderness, tiredness, and difficulty falling asleep or staying asleep). Milnacipran is in a class of medications called selective serotonin and norepinephrine reuptake inhibitors (SNRIs). It works by increasing the amount of serotonin and norepinephrine, natural substances that help stop the movement of pain signals in the brain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a609016.html.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		11/15/22

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F 758	Continued From page 141 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to monitor a resident on psychoactive medication, in order to prevent unnecessary medication administration for one of 78 residents in the survey sample, Resident #96, The findings include: For Resident #96 (R96), the facility staff failed to monitor for the presence of targeted behaviors and adverse side effects while the resident was receiving a psychoactive medication.	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use 1. Resident #96 remains in center. The physician orders updated to include monitoring of side effect and behavior while on psychotropic medication. 2. Current residents receiving psychotropic medication have the potential to be affected. 3. The Staff Development Coordinator and designee will educate all licensed nurses on the process for the initiation of side effect and behavior monitoring for all resident orders receiving psychotropic medication utilization to support usage	

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F 758	Continued From page 142 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/26/22, R96 was coded as being cognitively intact for making daily decisions, having scored 14 out of 15 on the BIMS (brief interview for mental status). R96 was coded as receiving psychoactive medications during the look back period. A review of R96's clinical record revealed the following orders: "Buspirone HCl (1) Tablet 10 mg (milligrams) Give 1 tablet by mouth three times a day for anxiety." This order was dated 8/14/22. "Citalopram Hydrobromide (2) Tablet 20 mg Give 1 tablet by mouth in the morning." This order was dated 8/15/22. "Lorazepam (3) Tablet 0.5 MG Give 1 tablet by mouth every 6 hours as needed for Anxiety for 14 Days. May cause drowsiness. Avoid alcohol." This order was dated 9/15/22. A review of R96's MARs (medication administration records) for September 2022 and October 2022 revealed R96 received Buspirone and Citalopram as scheduled, and the resident received Lorazepam multiple times. Further review of these MARs failed to reveal any evidence R96 was being monitored for targeted behaviors and side effects of these psychoactive medications. A review of R96's care plan dated 4/22/22 revealed, in part: [R96] is at risk for adverse effects related to use of anti-depression medication, use of antianxiety/anxiolytic medication...Will show no side effects of	F 758	and prevent unnecessary psychotropic medication usage. 4. The Unit Mangers or designee will conduct weekly audits of all new psychotropic medication orders to ensure initiation of monitoring side effects and behaviors od psychotropic medication prescribed to prevent unnecessary medication utilization. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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medication use...Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs."

On 10/17/22 at 12:15 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated sometimes nurses had orders to monitor residents for side effects of medications. She stated she was not aware of specific procedures to monitor residents' targeted behaviors. She stated she was aware that R96 received psychoactive medications. After checking the MAR, she stated she did not see any orders for or places to document regarding the resident's psychoactive medication targeted behaviors or side effects.

On 10/17/22 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns. ASM #5 stated she had recently entered orders for R96 to be monitored for targeted behaviors and side effects of psychoactive medications. When asked why she did this, she stated when R96 had recently been re-admitted from the hospital, these orders were not placed. She stated she put them in when the survey team requested evidence of the monitoring. She stated this monitoring is necessary to make sure the resident is being managed properly through these medications.

A review of the facility policy, "Administering Medications," revealed, in part: "As required or indicated for a medication, the individual

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administering the medication will record in the resident's medical record:
a. The date and time the medication was administered;
b. The dosage;
c. The route of administration;
d. The injection site (if applicable);
e. Any complaints or symptoms for which the drug was administered."

No further information was provided prior to exit.

NOTES
(1) "Buspirone is used to treat anxiety disorders or in the short-term treatment of symptoms of anxiety. Buspirone is in a class of medications called anxiolytics. It works by changing the amounts of certain natural substances in the brain." This information was obtained from the website https://medlineplus.gov/druginfo/meds/a688005.html.

(2) "Citalopram is used to treat depression. Citalopram is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance." This information is taken from the website https://medlineplus.gov/druginfo/meds/a699001.html.

(3) "Lorazepam (brand name Ativan) is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation." This information is taken from the website

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F 758	Continued From page 145 https://medlineplus.gov/druginfo/meds/a682053.html.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, it was determined the facility staff failed to maintain a medication error rate of less than five percent for one of four residents in the medication administration observation, Resident #87 (R87). There were two errors within 25 opportunities. The findings include: For R87, the facility staff failed to administer medications per the physician order and failed to check a blood sugar per physician order. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/24/2022, the resident scored a 9 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. Observation was made of LPN (licensed practical nurse) #2 administering medications to R87, on 10/12/2022 at 9:29 a.m. The resident was sitting in their room in a wheelchair with an empty	F 759	F759 Free of Medication Error Rts 5 Prcnt or More 1. Resident #87 remains in center. The physician notified of medications administered outside of scheduled time with no new orders. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all licensed nurses on the process for medications that have specific scheduled administration times before meals will be administered during the scheduled time and process for notifying physician when not administered to the scheduled time with documentation. 4. The Unit Managers or designees will review resident□s medication administration record to 3x weekly ensure before meals medications are administered within scheduled time per physician orders. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will	11/15/22

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breakfast tray in front of them. LPN #2 first checked the resident's blood pressure. She then proceeded to perform the blood sugar check on the resident. LPN #2 proceeded to administer Metoclopramide 5 mg (milligram) tablet (used to relieve heartburn and speed the healing of ulcers and sores in the esophagus) (1).

The physician orders dated 6/17/2022, documented in part, "Metoclopramide HCL (hydrochloride Tablet 5 mg; Give 1 tablet by mouth two times a day for Gerd. Take 30 minutes before eating. Check Blood Sugars AC (before meals) &HS (bedtime). Notify MD (medical doctor) if blood sugar is lower than 60, and greater than 300 before meals and at bedtime for Diabetes."

The comprehensive care plan dated, 7/21/2022, documented in part, "Focus: DIABETES MANAGEMENT: (R87) has endocrine system related to Insulin Dependent Diabetes Mellitus Type 2." The "Interventions" documented in part, "Obtain glucometer readings and report abnormalities as ordered. Focus: CARE NEEDS: (R87) has the following care needs: CVA (stroke), gaseous abdominal distension, recent SBO (small bowel obstruction) following cerebral infarction."

An interview was conducted with LPN #2 on 10/12/2022 at 1:22 p.m. When asked when are blood sugars to be done, LPN #2 stated, 7:30 a.m. When asked why wasn't it done until she was observed, LPN #2 stated she guessed she didn't know who needed a blood sugar until she pulled the resident's MAR (medication administration record). When asked what the physician order was for, LPN #2 stated before

be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction.
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meals. When asked if they did it as ordered, LPN #2 stated, "No, it was after the meal." When asked about the Metoclopramide, and the dispensing card documented 30 minutes before meals, LPN #2 stated it was not given before his meal. When asked if it was administered per the physician order, LPN #2 stated, she didn't think it was a 7:30 a.m. medication. It's scheduled for 8:00 a.m. When stated it was supposed to be given before meals, LPN #2 stated, "I don't know what to say, I have 30 residents to give medications to and I know I am out of my time window for administration. There isn't enough time to get it all done within the time. "

The facility policy, "Administering Medications" documented in part, "3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)."

ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM # #3, regional nurse navigator, and ASM #4, the assistant director of nursing, were made aware of the above findings on 10/12/2022 at 3:53 p.m.

No further information was provided prior to exit.

(1) (used to relieve heartburn and speed the healing of ulcers and sores in the esophagus [tube that connects the mouth to the stomach] in people who have gastroesophageal reflux disease [GERD]; condition in which backward flow of acid from the stomach causes heartburn and injury of the esophagus, that did not get

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F 759	Continued From page 148 better with other treatments.). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a684035.html	F 759		
F 760 SS=E	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 interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to administer medications in a manner free of significant errors for one of 78 residents in the survey sample, Resident #61. The findings include: For Resident #61 (R61), the facility staff failed to administer Clonidine (1) as ordered when the resident's systolic blood pressure (2) was greater than 160 mm Hg (millimeters of mercury) eleven times during May 2022. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/12/22, R61 was coded as being cognitively intact for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R61 was coded as having high blood pressure. A review of R61's clinical record revealed the following orders:	F 760	F760 Residents are Free of Significant Med Errors 1. Resident #61 remains in the center. The physician was notified of the medication and parameters during the timeframe. Medication discontinued per physician order. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all licensed nurses on the process for PRN medication orders with parameter orders must be followed and notify physician when not within the parameters with documentation. 4. The Unit Managers or designee will complete a weekly audit of residents with PRN orders with parameters to ensure compliance with administration when not within the parameters. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The	11/15/22

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F 760	Continued From page 149 "Clonidine HCl Tablet 0/1 MG. Give 1 tablet by mouth every 12 hours as needed for systolic B/P (blood pressure) greater than 160." This order was dated 4/22/22. A review of R61's MARs (medication administration records) for May 2022 revealed the following blood pressures: 5/7/22 at 6:30 a.m. 183/100; 5/8/22 at 6:30 a.m. 178/82; 5/8/22 at 4:30 p.m. 178/84; 5/11/22 at 6:30 a.m. 188/100; 5/13/22 at 6:30 a.m. 169/110; 5/14/22 at 4:30 p.m. 161/91; 5/15/22 at 4:30 p.m. 185/90; 5/16/22 at 6:30 a.m. 177/98; 5/22/22 at 4:30 p.m. 180/100; 5/23/22 @ 4:30 p.m. 190/91; 5/29/22 at 6:30 a.m. 178/89. Further review of the May 2022 MARs revealed no evidence that Clonidine was given on any of these dates and times when R61's systolic blood pressure readings exceeded 160. A review of R61's care plan dated 2/4/22 and revised 8/15/22 revealed, in part: "[R61] has basic nursing care needs r/t (related to) ...HTN (hypertension) ...Administer medications ...as ordered." On 10/18/22 at 9:23 a.m., LPN (licensed practical nurse) #16 was interviewed. She reviewed R61's Clonidine order, and the May 2022 blood pressures. She stated the Clonidine should have been given each and every time R61's systolic blood pressure was over 160. She stated the risk of such a high blood pressure is a stroke. On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She reviewed R61's Clonidine order, and the May 2022 blood pressures. She stated	F 760	Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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the Clonidine should have been given each and every time R61's systolic blood pressure was over 160.

On 10/18/22 at 2:55 p.m., LPN #7, R61's unit manager, was interviewed. She reviewed R61's Clonidine order, and the May 2022 blood pressures. She stated the Clonidine should have been given each and every time R61's systolic blood pressure was over 160. She stated this is a medication error, and stated the risk for R61's not receiving the medication was that the resident might have a stroke.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "Administering Medications," revealed, in part: Medications must be administered in accordance with the orders, including any required time frame.

(1) "Clonidine tablets (Catapres) are used alone or in combination with other medications to treat high blood pressure. Clonidine extended-release (long-acting) tablets are used alone or in combination with other medications as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in children. Clonidine is in a class of medications called centrally acting

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F 760	Continued From page 151 alpha-agonist hypotensive agents. Clonidine treats high blood pressure by decreasing your heart rate and relaxing the blood vessels so that blood can flow more easily through the body. Clonidine extended-release tablets may treat ADHD by affecting the part of the brain that controls attention and impulsivity." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682243.html. (2) "Systolic pressure is the pressure when the ventricles pump blood out of the heart. Diastolic pressure is the pressure between heartbeats when the heart is filling with blood...For most adults, a normal blood pressure is less than 120 over 80 millimeters of mercury (mm Hg), which is written as your systolic pressure reading over your diastolic pressure reading - 120/80 mm Hg. Your blood pressure is considered high when you have consistent systolic readings of 130 mm Hg or higher or diastolic readings of 80 mm Hg or higher." This information is taken from the website https://www.nhlbi.nih.gov/health/high-blood-pressure#:~:text=Systolic%20pressure%20is%20the%20pressure,day%20based%20on%20your%20activities. Complaint deficiency.	F 760		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities.	F 791		11/15/22

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F 791	Continued From page 152 The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical	F 791	F791 Routine/Emergency Dental Srvcs in	

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F 791	Continued From page 153 record review, and facility document review it was determined that the facility staff failed to provide routine dental services for one of 78 residents in the survey sample, Resident #54 (R54). The findings include: For R54, the facility staff failed to offer routine dental services. R54's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/9/2022, the resident scored 8 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section K documented a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and R54 receiving a mechanically altered diet. Section L documented no mouth pain or dentures. On 10/12/2022 at 8:38 a.m., an observation was made of R54 in their room. An attempt was made to interview R54, however due to their cognitive status the interview was not completed. Observation of R54 revealed a single visible tooth protruding from the mouth. The comprehensive care plan for R54 dated 11/16/2017 documented in part, "Dental: [R54] has Dental or oral cavity health problem related to several missing natural teeth, some difficulty chewing currently on pureed diet and supplements. Created on: 11/16/2017, Revision on: 08/23/2022." Under "Interventions" it documented in part, "...Refer to dentist/hygienist for evaluation/recommendations regarding teeth extraction, repair of carious teeth. Created on:	F 791	NFs 1. Resident #54 remains in the center. Resident #54 scheduled for dental services and has declined participation at this time. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator will educate all licensed nurses and social service staff on the process for notification to Social Services for scheduling of residents requiring dental services. 4. The Director of Social Service or designee will complete a weekly audit of residents to ensure scheduling of residents requiring dental care services. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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F 791	Continued From page 154 11/16/2017. Revision on: 09/08/2022..." The physician orders for R54 documented in part, "Consults: Dental care as needed. Order Date: 08/23/2022" and "Fortified Foods diet Pureed texture, Thin liquids consistency. Must drink by straw for Nutrition. Order Date: 08/23/2022." Review of R54's clinical record failed to evidence documentation of dental consults or notes regarding dental care provided. On 10/17/2022 at 8:33 a.m., a request was made to ASM (administrative staff member) #1, the administrator for R54's dental notes. On 10/18/2022 at 4:34 p.m., ASM #5, the director of nursing stated that they did not have evidence of any dental notes to provide for R54. On 10/18/2022 at 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #12. LPN #12 stated that they had a dentist who came into the facility to see residents. LPN #12 stated that they kept a list and they saw anyone who complained of tooth pain or needed dental care. LPN #12 stated that they were not sure of the process for routine dental exams and cleanings and could not remember if the dentist saw R54 when they were in the building the last time or not. On 10/19/2022 at 7:51 a.m., an interview was conducted with LPN #8. LPN #8 stated that staff assessed residents for dental pain or bleeding during oral care and referred them to the dentist as needed. LPN #8 stated that they had a dentist who came into the building to see residents for routine exams and the director of nursing set the	F 791		

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F 791	Continued From page 155	F 791		

schedule up. LPN #8 stated that all residents should have access to routine dental services.

On 10/19/2022 at 9:12 a.m., an interview was conducted with ASM (administrative staff member) #5, the director of nursing. ASM #5 stated that they have a dental provider who comes to the facility but there was not a set schedule yet. ASM #5 stated that the dentist came in August or September and plans to come back in December. ASM #5 stated that if a referral was needed prior to the dentist coming to the facility they would send residents out of the facility for a consult. ASM #5 stated that they also had a dental hygienist that does the routine cleaning and exams but there was not a set schedule yet. ASM #5 stated that the plan was for the dental hygienist to come every other month. ASM #5 stated that all the residents should have routine dental services offered to them.

The facility policy "Dental Services" dated December 2016 documented in part, "Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care...All dental services provided are recorded in the resident's medical record. A copy of the resident's dental record is provided to any facility to which the resident is transferred."

On 10/19/2022 at approximately 9:29 a.m., ASM #1, the administrator, ASM #2, the regional director of clinical services, ASM #4, the assistant director of nursing, ASM #5, the director of nursing and ASM #6, the assistant administrator were made aware of the concern.

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F 791	Continued From page 156 No further information was provided prior to exit.	F 791		
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; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		11/15/22

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F 842	Continued From page 157 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 resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for one of 78 residents in the survey sample, Resident #124. The findings include:	F 842	F842 Resident Records - Identifiable Information 7. Resident #124 the physician was notified of medication not administered. The medication was discontinued on 9/13/2022. 1. All residents have the potential to be affected.	

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F 842	Continued From page 158 For Resident #124 (R124), the facility staff failed to maintain an accurate MAR (medication administration record) in September 2022 for the administration of the medication, Sarvella (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/12/22, R124 was coded as being cognitively intact, having scored 15 out of 15 on the BIMS (brief interview for mental status). On 10/13/22 at 9:05 a.m., R124 was sitting up in bed. R124 stated they have almost constant pain due to fibromyalgia. The resident stated the facility has not always administered fibromyalgia medication the way the doctor ordered. A review of R124's clinical record revealed the following order dated 8/21/22: "Savella Tablet 25 mg (milligrams) (Milnacipran HCl) Give 1 tablet by mouth two times a day for fibromyalgia/depression." A review of facility pharmacy receipts for R124 revealed the facility received six tablets on 8/25/22, and another six tablets on 8/28/22. Prior to the evening dose on 8/28/22, only six tablets had been dispensed to the facility from the pharmacy. The medication was documented as administered as ordered. A review of R124's MAR for September 2022 revealed nurses' initials, indicating Sarvella was administered at 5:00 p.m. on 9/21, and at 8:00 a.m. and 5:00 p.m. on 9/22, at 8:00 a.m. on 9/23, and at 8:00 a.m. on 9/25. However, no additional Savella was delivered to the facility after 8/28/22 or before 9/26/22.	F 842	2. The Staff Development or will educate all licensed nurses on the process for accuracy of medication documentation of administration and process to secure or manage process when medications are not available. 3. The Unit Managers or designee will complete a weekly review of documentation on new medications initiated to verify available and accurate medication documentation of administration. 4. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of Compliance: 11/15/2022	

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On 10/18/22 at 9:23 a.m., LPN (licensed practical nurse) #16 was interviewed. She stated when a nurse administers a medication, she (or he) initials the MAR to indicate the medication was given. She stated a nurse should never document that he/she administered in a medication when they did not. When asked if R124's clinical record was accurate for the administration of Sarvella, she stated: "No. It isn't."

On 10/18/22 at 9:54 a.m., LPN #17 was interviewed. She stated she places her initials on the MAR to indicate a medication is given. She stated a nurse should not falsely document a medication as administered if it was not actually given to the resident. When asked if R124's clinical record was accurate for the administration of Sarvella, she stated it is not.

On 10/18/22 at 2:55 p.m., LPN #7, R124's unit manager, was interviewed. She stated a nurse should not ever document a medication had been given unless the nurse had actually administered the medication, and witnessed the resident receiving the medication. LPN #7 reviewed R124's MAR and the pharmacy receipts. She stated: "I don't know how they could have administered a medication that was not here." She stated the nurses were not following professional standards of nursing practice, and R124's clinical record was not accurate.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and

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F 842	Continued From page 160 ASM #7, the vice president of operations, were informed of these concerns. A review of the facility policy, "Charting and Documentation," revealed, in part: "Documentation in the medical record will be objective..., complete, and accurate." No further information was provided prior to exit. NOTES (1) "Milnacipran (Sarvella) is used to treat fibromyalgia (a long-lasting condition that may cause pain, muscle stiffness and tenderness, tiredness, and difficulty falling asleep or staying asleep). Milnacipran is in a class of medications called selective serotonin and norepinephrine reuptake inhibitors (SNRIs). It works by increasing the amount of serotonin and norepinephrine, natural substances that help stop the movement of pain signals in the brain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a609016.html.	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		11/15/22

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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

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F 880	Continued From page 162 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, facility document review, and clinical record review, it was determined that the facility staff failed to follow transmission based precautions for one of 78 residents in the survey sample, Resident #96. The findings include: For Resident #96 (R96), the facility staff failed to properly dispose of contaminated medical waste after providing wound care on 10/12/22. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 28/26/22, R96 was coded as being cognitively intact for making daily decisions, having scored 14 out of 15 on the BIMS (brief interview for mental status). On 10/12/22 at 8:39 a.m., RN (registered nurse) #6 provided wound care to R96. On R96's door was a sign stating that all who entered the room should follow contact precautions. RN #6 stated	F 880	F880 Infection Prevention & Control 1. RN #6 received education regarding proper removal and disposal of PPE and wound care supplies following completion of wound care prior to exiting room. 2. Current residents receiving wound care have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all licensed nurses on the processes for transmission-based precaution rooms to gather wound supplies, disposal of PPE and discarding contaminated wound dressing prior to exiting room. The Staff Development Coordinator will educate all certified, licensed nurses, housekeeping staff and Rehab staff on processes for placing receptacles in transmission-based precaution rooms for PPE and replacing plastic bag in a receptacle for additional waste and to call /ask for assistance as needed if additional items are required while in room.	

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F 880	Continued From page 163 R96 had a wound infected with an extremely contagious strep bacteria. RN #6 donned an isolation gown and gloves before entering R96's room. After the old dressings were removed, the wounds cleansed, and the new dressings applied, RN #6 removed her gown and gloves, and gathered the dirty dressings and contaminated gauze used to cleanse the wounds. She took all of the items outside the room and placed them in a red biohazard bag attached to the wound care treatment cart. A review of R96's clinical record revealed the following order dated 9/30/22: "Contact Precautions." A review of R96's care plan dated 4/22/22 revealed, in part: [R96] has actual skin breakdown and is at risk for skin breakdown related to sacrum...left ischium...anal fistula...right hip pressure area." On 10/17/22 at 10:52 a.m., RN #2, the infection preventionist, was interviewed. She stated if a resident is on contact precautions, the resident's room should contain receptacles in the room. There should be separate receptacles for trash, contaminated medical waste (with a red biohazard bag), and laundry. She stated no contaminated medical waste or PPE should leave the resident's room unless it is already bagged up. She stated nurses should dispose of PPE and contaminated medical waste in the resident's room to prevent the possibility of spreading the infectious organism. On 10/17/22 at 1:22 p.m., LPN (licensed practical nurse) #10, a wound nurse, was interviewed. She stated soiled, contaminated waste from a resident	F 880	4. The Infection Preventionist or designee will complete weekly audits of resident rooms on transmission-based precautions to observe licensed nurses disposed of PPE and discarded contaminated wound dressing in red bag or plastic bag to discard in a biohazard container prior to exiting room and will ensure receptacles are available in room for disposal of PPE and waste with plastic bag. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 6. Date of Compliance: 11/15/2022	

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who is on contact precautions should be placed in a biohazard bag in the resident's room. She stated no contaminated materials should leave the room to prevent the infection spreading.

On 10/18/22 at 4:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional director of clinical services, ASM #3, the regional nurse navigator, ASM #4, the assistant director of nursing, ASM #5, the director of nursing, ASM #6, the assistant administrator, and ASM #7, the vice president of operations, were informed of these concerns.

A review of the facility policy, "Isolation - Categories of Transmission-Based Precautions," revealed in part: "Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment...Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed...Staff and visitors will wear gloves (clean, non-sterile) when entering the room. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). Gloves will be removed and hand hygiene performed before leaving the room."

"Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment as

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described in I.B.3.a. The specific agents and circumstance for which Contact Precautions are indicated are found in Appendix A. The application of Contact Precautions for patients infected or colonized with MDROs is described in the 2006 HICPAC/CDC MDRO guideline.927 Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. A single-patient room is preferred for patients who require Contact Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). In multi-patient rooms, =3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient ' s environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., VRE, C. difficile, noroviruses and other intestinal tract pathogens; RSV)." This information is taken from the website https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html#IIIb.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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