STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER EDGE REHABILITATION AND NURSING	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 11/1/2022 through 11/3/2022. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 039	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or	E 039		12/5/22

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

Electronically Signed | 11/25/2022

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functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section

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is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed

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messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared

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questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions

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designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop

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exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises

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to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises

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E 039	Continued From page 8 to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to conduct exercises to test the emergency preparedness	E 039	1. The Administrator held tabletop exercise including a group discussion using a narrated, clinically relevant	

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E 039	Continued From page 9 plan. There was no documentation or evidence of an annual table-top exercise, mock disaster drill, attempts to participate in a full-scale community-based exercise or activation of the emergency plan. The findings include: The facility's current Emergency Preparedness Plan (09/2022) was reviewed on 11/3/22 at 8:00 a.m. The plan documented no evidence regarding an annual full-scale community-based emergency exercise, a table-top exercise, a mock disaster drill or documentation that the emergency plan had been activated due to an actual event. On 11/3/22 at 8:30 a.m., the administrator was interviewed about any disaster drills, emergency plan activations or exercises conducted to test and evaluate the emergency preparedness plan. The administrator stated he had worked at the facility for approximately three months and did not find anything about tests/drills of the emergency plan. The administrator stated he was not aware if and/or when a table-top or community-based exercise had been conducted. The administrator stated he did not find any information about the emergency preparedness exercises from the previous administrator. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 11/3/22 at 11:00 a.m.	E 039	emergency scenario, and a set of problem statements, directed messages, and prepared questions designed to challenge an emergency plan for Winter Weather Alert on 11/22/2022. 2. No other full-scale exercise that is a community based or facility based functional exercise is due at this time. 3. The Regional of Operation will conduct education with the Administrator, Maintenance Director and the Director of Nursing on Emergency preparedness and conducting tabletop exercises. 4. The administrator or designee will do a monthly audit to determine when the next full-scale exercise is due. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	
F 000	INITIAL COMMENTS An unannounced (Medicare/Medicaid) standard	F 000		

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F 000	Continued From page 10 survey was conducted 11/01/2022 through 11/03/2022. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey: VA00054201 with three allegations was unsubstantiated. VA00056045 with three allegations was substantiated with deficient practice cited at F580 and F684. VA00054405 with one allegation was unsubstantiated. The census in this 109 certified bed facility was 84 at the time of the survey. The survey sample consisted of eighteen (18) current Resident reviews and three (3) closed record reviews.	F 000		
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	F 580		12/5/22

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F 580	Continued From page 11 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- (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: 2. The facility staff failed to notify the physician of a delay in the treatment of a UTI (urinary tract infection) for Resident #28. Findings were:	F 580	1. Facility staff notified resident #34's RP of wound on 8/8/2022. Facility staff notified resident #78's NP of resident's pain and/or that the resident's pain medication was not administered as	

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F 580	Continued From page 12 Resident #28 was admitted to the facility with the following diagnoses including but not limited to: Diabetes mellitus, quadriplegia, contracture of the left hand, UTI, and chronic kidney disease. An annual MDS (minimum data set - a cms assessment tool), dated 09/02/2022, documented the BIMS (Brief Interview for Mental Status) score of "15" (out of 15), indicating intact cognitive function for daily decision making. The clinical record was reviewed on 11/01/2022 beginning at approximately 3:00 p.m, noting the progress notes with the following entries: "10/29/2022 22:20 (10:22 p.m.) Positive for UTI. Spoke with (Name); place PICC line begin ertapenem 1 GM (gram) q (every) 24 hours." "10/31/2022 (Note from nurse practitioner signed 10/31/2022 at 7:51 p.m.)...Infection and inflammatory reaction due to indwelling urethral catheter...urine culture came back with E. Coli and Pseudomonas. She is on trimethoprim 50 mg daily for UTI prophylaxis, however, she has developed a UTI again. She should continue ertapenem 1 g daily until 11/4/2022. Foley care should be performed every shift and the catheter should be changed every 28 days..." "11/01/2022 01:27 (a.m.) Ertapenem Sodium Reconstituted 1 GM Use 1 gram intravenously one time a day for UTI over 4 days. IV therapy to begin tomorrow 11-1 @1700 per MD order, noted change in (computer system) as well." Written by the unit manager, RN (registered nurse) #1, a change in condition note was observed in the clinical record at approximately 9:10 a.m. on 11/02/2022. It contained the following:	F 580	ordered on 11/2/2022 and resident was seen by provider. Facility staff notified resident #28's NP of a delay in the treatment of a UTI (urinary tract infection). 2. The wound care nurse will complete a 100% audit of all RP notification of all non-pressure areas. The DON/designee will complete a 100% audit of MD/NP notification of pain medications not administered as ordered. The DON/designee will complete a 100% audit of MD/NP notification for delay of treatments for current antibiotic orders to treat UTI's. 3. The ADON will complete education with licensed nursing staff in regard to RP notification of wounds, MD/NP notification of pain medication not administered as ordered and MD/NP notification of delay in treatment for UTI's. 4. The DON/designee will do an audit two times weekly times six weeks then monthly times two months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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"11/02/2022 08:56 (a.m.) ..Change in Condition...nursing observations, evaluation, and recommendations are: Resident presents with UTI, Foley catheter in place. Treatment with Ertapenem 1 Gm IV X (times) 4 days..."

On 11/02/2022 at approximately 9:30 a.m., RN #1 was interviewed. In reference to the 11/02/2022 change in condition note, written earlier that day, RN #1 was asked if she was aware that the antibiotics for Resident #28 had not yet been started. She looked at the physician orders and stated, "Yes, it starts this evening." She was referred back to the progress notes from 10/29/2022, 10/31/2022, and 11/01/2022 regarding Resident #28's orders for an IV antibiotic.

At approximately 11:30 a.m., RN #1 came to the conference room and stated, "The antibiotic order was written by the on-call physician over weekend. It looks like the original order was written on October 29 to place a PICC line and discontinue it when the antibiotics were complete. That order was discontinued. There was also an order written on October 29 for the antibiotics to be given for four days...that was discontinued and rewritten to start on November first...that order was discontinued on November 1st, the reason on the order was waiting on IV supplies from the pharmacy and they were suppose to be here today...I don't know what happened...some of the notes say we were waiting on the medicine, some say waiting on IV supplies. It looks like we ordered the medicine from the pharmacy...we have that antibiotic here so it could have been started...I spoke with the nurse practitioner and we got the order clarified so we can give it IM starting today at noon." She was asked if the

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physician or nurse practitioner had been notified that the medication had not been given before today. She stated, "There isn't any documentation that notification occurred, I don't feel like that happened." She was asked if the nurses had changed/canceled the orders and the start dates of the antibiotic without speaking with the physician or the nurse practitioner. She stated, "Yes, that is what I think happened...the physician should have been notified."

On 11/02/2022 at approximately 3:30 p.m., the nurse practitioner was interviewed. She was asked if she was aware that Resident #28 had not received any doses of her antibiotics prior to the IM injection earlier on 11/02/2022. She stated, "I was told on Monday (10/31/2022) that she had an IV and that it had infiltrated...I can't tell you the nurses name who told me that, but she said there weren't any needles here to restart it and they would have to come from the pharmacy...I thought she had gotten one dose and it would resume the next day (11/01/2022). I found out today that none had been given, we changed the route to IM so it could start as soon as possible."

On 11/02/2022 at approximately 4:00 p.m., RN #1 was asked if other than the clinical record there was any place the nurses could have documented that the antibiotic was not given and the physician/nurse practitioner were notified. She stated, "There is a physician book." She went to the nurse's station and looked in the book. She stated, "There's not any documentation in here about that."

The above information was discussed with the DON, the administrator, the ADON (assistant director of nursing) and three members of the

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corporate staff. Concerns were voiced that an IV antibiotic had been ordered on 10/29/2022 for four doses and the medication was not started until 11/02/2022. The DON was asked if the physician or Nurse practitioner had been notified of the delay in treatment. She stated she would see what she could find out.

On 11/03/2022 at 9:30 a.m., the DON came to the conference room. She was asked if she could clarify if the physician had been notified of the delay in treatment for Resident #28. She stated, "I've not been able to get in touch with the nurses...I don't know if the physician was notified or not, or if the problem was they didn't know we had the meds or if they thought the IV supplies weren't available...either way the physician should have been notified....I don't see any record of that."

The facility policy "Unavailable Medications" contained the following information:
"Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable:...Notify physician of inability to obtain medication upon notification or awareness that medication is not available...If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification..."

No further information was obtained prior to the exit conference on 11/03/2022.

Based on resident interview, staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to

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notify the physician and/or RP (responsible party) of a change in condition for three of 21 residents in the survey sample (Resident #34, Resident #78 and Resident #28).

1. The facility staff failed to notify Resident #34's RP of a wound.

2. The facility staff failed to notify Resident #78's physician of the resident being in pain and/or that the resident's pain medication was not available for administration.

3. The facility staff failed to notify the physician of a delay in the treatment of a UTI (urinary tract infection) for Resident #28.

Findings include:

1. Resident #34's diagnoses included, but were not limited to: HTN (high blood pressure), CHF (congestive heart failure), schizophrenia, asthma, Parkinson's disease, anxiety disorder, polyneuropathy, obesity, and depression.

The most current MDS (minimum data set) was a quarterly review (this MDS was prior to the discovery of the resident's wound). This MDS assessed the resident with a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive to full assistance with ADL's (activities of daily living) with assistance of two staff.

The resident's most recent full MDS assessment with CAAS (care area assessment summary)

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(prior to the wound discovery) was an annual assessment dated 12/20/21. The MDS assessed the resident with a cognitive score of 14, indicating the resident was intact for daily decision making skills. The resident triggered in the CAAS section of this MDS for pressure ulcers.

A complaint investigation was completed on 11/01/22 through 11/03/22. An allegation within the complaint alleged that the RP/family of Resident #34 was not notified of the discovery of the resident's wound on 07/29/22.

The resident's clinical records were reviewed.

According to the resident's clinical records, the resident was found with bilateral 'friction' wounds to the dorsal area of both feet on 07/29/22 per the resident's weekly skin assessment (dated 07/29/22).

The resident's records were further reviewed and did not evidence that the resident's RP/family had been notified of the above information.

On 11/02/22 at approximately 6:15 PM, the administrator, DON (director of nursing), and corporate nurse were made aware of the above complaint allegation in a meeting with the survey team. The DON and staff were made aware that no information was found regarding notification of this incident to the resident's RP/family in the resident's records and was asked for assistance in locating any information.

The DON stated that it was true, the facility staff did not notify the resident's RP/family of the resident's wounds and/or the progression of the

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resident's wounds that were discovered on 07/29/22.

The DON stated that they had recognized notification as problem. According to the facility policy on wound care, the policy states, "...notification to physician and/or responsible party regarding wound or treatment changes..."

No further information and/or documentation was presented prior to the exit conference on 11/03/22 at 11:30 AM to evidence that Resident #34's RP/family was notified of a change in condition regarding the resident's skin.

This is a complaint deficiency.

2. Resident #78's diagnoses included, but were not limited: diverticulitis, atrial fibrillation, depression, muscle weakness, dysphagia, abnormal gait, polyneuropathy, history of falls, and musculoskeletal mastoid bone pain.

The resident's most recent MDS (minimum data set) was an admission assessment dated 08/23/22. This MDS assessed the resident with a cognitive score of 15, indicating the resident was intact for daily decision making skills.

The resident was assessed as requiring supervision with limited assistance of one staff person for ADL's (activities of daily living).

On 11/02/22 at approximately 7:55 AM, Resident

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#78 was interviewed in her room. The resident was sitting on the side of the bed. The resident stated that she had a rough night, was in pain and had not slept due to the pain. The resident stated that she had asked the night nurse for her ordered pain medication (hydrocodone) and stated that the nurse told her that they (the facility) didn't have any. The resident stated the nurse told her they didn't have it. The resident was asked what her pain was at the present moment and the resident stated that her pain was a 7 on a scale of 1-10 (one being minimal pain and 10 being the worst pain). The resident stated that they were supposed to change the medication order from a pill form to liquid form and that the nurse told her that it was still on order and had not arrived from the pharmacy. The resident stated that she was hurting and stated that she hoped she wouldn't start crying from it.

At approximately 8:05 AM, LPN (Licensed Practical Nurse) #1 (the resident's day nurse) was made aware of Resident #78's complaints of pain and not getting any pain medication the night before, as the night shift nurse had told her the medication was not available.

LPN #1 looked in the system and confirmed that the resident had an order for: "...[order date: 10/31/22 10:32 am]
Hydrocodone-Acetaminophen solution 2.5 -108 mg/5 ml (milligrams/milliliter) Give 5 ml by mouth at bedtime for mastoid bone pain Start Date: 10/31/22..."

The LPN looked further and stated that the resident did not get the medication the night before (11/01/22 at 10 PM) and and that it looked

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like the medication was on order according to the nursing/EMAR (electronic medication administration record) note written by the night nurse.

The LPN stated that it shouldn't take that long for a medication to get here and stated, "it was ordered on 10/31/22."

The LPN was asked to look on the medication cart to see if the medication was there. The LPN began looking for the ordered medication and found the bottle of medication. The LPN looked at the bottle and stated, "this is it." The bottle had the resident's name and the date dispensed as 10/31/22. The LPN stated, "that doesn't make sense" and went on to say that the she didn't understand why the medication was not given if the medication was here. The LPN was asked to look at the narcotic sheet for this medication to see if any had been signed out. The LPN pulled the narcotic sheet for this medication. The sheet documented the date the medication was received as 10/31/22. No doses were signed off as administered. The LPN was then asked to look to see if the resident had received pain medication at bedtime on 10/31/22. The LPN looked and stated that the resident had not received pain medication on that night either.

At approximately 9:30 AM, Resident #78's clinical records were reviewed. The resident's MAR (medication administration records) for October and November 2022 were reviewed. On 10/31/22 and 11/01/22 at 10:00 PM, the resident's MAR documented a '9' in the the slot for the above pain medication. The MAR legend for '9' means 'other/see nursing notes'.

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The resident's nursing notes were reviewed.

On 10/31/22 the nursing note documented, "10/31/2022 5:00 PM...Orders - General Note...you have entered HYDROcodone-Acetaminophen Solution 2.5-108 MG/5ML
Give 5 ml by mouth at bedtime for mastoid bone pain..."

On 11/1/2022 an EMAR note documented, "...1:35 AM - Medication Administration Note ...HYDROcodone-Acetaminophen Solution 2.5-108 MG/5ML Give 5 ml by mouth at bedtime for mastoid bone pain Pending pharmacy delivery @ this time. New mediation RX..."

On 11/2/2022 an EMAR note documented, "...12:17 AM - Medication Administration Note... HYDROcodone-Acetaminophen Solution 2.5-108 MG/5ML Give 5 ml by mouth at bedtime for mastoid bone pain Medication pending delivery @ this time. Res resting in bed w/ eyes closed..."

There were no notes found to evidence that the resident's physician was notified that the pain medication was not given or that the pain medication was not available.

On 11/02/22 at 3:10 PM, the NP (Nurse Practitioner) was made aware of the above information regarding Resident #78's interview about being in pain last night and not being able to sleep and stating that she had a rough night. The NP stated that the resident has mastoid bone arthritis and that this information was verified by the resident's daughter. The NP stated that they have tried several things to include, gabapentin -"which didn't really help" according to the NP.

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The NP stated that she did increase it that and that the resident is now on a low dose of Norco (the medication that was not administered on 10/31/22 and 11/01/22). The NP stated that other medications were tried, but stated that the Norco 2.5 mg seemed to do better for this resident.

The NP was asked what would the expectation be for a situation like Resident #78's, if the resident doesn't have pain medication or the medication is not available to administer. The NP stated that with someone like her (Resident #78) she would have told the nurse to give the resident a one time dose of an alternate medication that was actually on hand. The NP stated that she was not on call and that she was not made aware. The NP stated, "I do feel bad, I do think something is going on with her regarding this pain." The NP stated that the resident does have an upcoming appointment.

The NP stated that when any resident is in pain and their pain medication is not available or they don't have pain medication ordered her (the NP) expectation would be for the nurse to call the provider. The NP stated that for this resident the nurse could have contacted the provider and obtained an order to give an alternative pain medication of something preferably in house and stated that staff could have crushed a pill (after contacting the provider) and put it in applesauce to give, whatever they needed to do, in order to prevent a delay in treating the resident's pain. The NP again stated the nurse should have contacted the provider.

On 11/02/22 at approximately 6:15 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware that the

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F 580	Continued From page 23 resident's pain medication was on the medication cart and was found this morning by LPN #1 and that according to the label on the medication bottle and the narcotic sheet the medication was delivered on 10/31/22 and no medication doses had been administered from it. The facility staff were made aware that according to the above information and the resident's clinical records (MARs/TARs) the resident had not received the medication for two nights and the resident's provider had not been contacted either night. On 11/02/22 at 6:35 PM, the DON stated that the expectation would be and is for the nurse to notify the provider to get an order for something pain. No other information and/or documentation was provided prior to the exit conference on 11/03/22.	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- §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	F 584		12/5/22

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F 584	Continued From page 24 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 and facility document review, the facility staff failed to ensure a clean, comfortable and homelike environment in two resident rooms on a portion of B wing, specifically known as the B-Back hall. Findings include: On 11/01/22 at approximately 11:15 AM, Resident #34 was interviewed in his room, which had a bedside commode (used by Resident #34) sitting at the end of the bed. The bedside commode had a dry, smeared brown substance on the inside and around the sides of the bucket. The	F 584	1. Resident #34's bedside commode was cleaned immediately. CNA educated on emptying and cleaning the bedside commode after each use. Built-closet and cabinet has been painted. Resident #34's sink has been replaced due to stains in ceramic sink bowl and flange ring repaired. Top cabinet doors have been replaced resident #34's room. Resident #335's sink has replaced due to stains in ceramic sink bowl. The resident's floor around the heating unit (attached to the wall) has been cleaned. The power outlet has been repaired and cleaned as well. 2. DON/Designee will complete a 100%	

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F 584	Continued From page 25 toilet seat also had a dry, brown substance that was smeared on it. When asked if staff clean the bedside commode, Resident #34 replied, "Yes." Additional observations in the room included the following: The built in closet had paint chipped off with large scratches on the front and sides; the cabinet had some scraped, indented areas in the wood along the edges and sides; the resident's sink had a large brownish stain around the drain about 2-3 inches in diameter; the pipe under the sink had a flange ring detached from the wall and hanging on the pipe; and the top cabinet of the closet had an entire door missing. No hinges or even hardware were present. When asked how long the closet had been without a door, Resident #34 said that it had been like that for quite a while. When asked what happened to the door to the closet, Resident #34 stated, "It got gone." On 11/01/22 at approximately 11:40 AM, Resident #335's was interviewed in her room, along with her daughter, who was present. Resident #335's daughter stated that the resident's sink was dirty and she had asked someone to clean it, but it had not been done yet. The sink had some soiled areas that were dry. The resident's floor around the heating unit (attached to the wall) was soiled and had debris build up around the edges of the wall at the bottom of the heating unit and around the power outlet. The power outlet had dirt buildup and rust around the casing of the outlet. Resident # 335's daughter stated that it had been like that since the resident arrived on 10/12/22. Both resident rooms were observed in the same condition as described above multiple times each day during the survey process from November 1, 2022 through November 3, 2022.	F 584	audit of bedside commodes. The Maintenance Director will complete an 100% audit/inspection of built-in closets and cabinets, sinks with stains, sink flange rings, missing cabinet doors and rust around outlets in resident's rooms for repair. (Built-in closet/cabinet doors have been ordered for replacement.) Housekeeping Manager will complete an 100% inspection of resident's floors around the heating unit for cleaning. 3. ADON will conduct education with nursing staff on emptying and cleaning bedside commodes after each use. The Administrator will conduct education with the housekeeping director regarding cleaning the floors and walls around heating unit and maintenance director in regard to built-in closets/cabinets, sinks with stains, repairs to sink flange rings, replacement of cabinet doors, and cleaning/repairing outlets in resident's rooms. 4. Audits of resident's bedside commodes, room floors/walls around heating unit, sink stains, sink flanges, electrical outlets and built- closet cabinets needing paint and/or verification of door replacements will be conducted twice weekly times six weeks then monthly times two months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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On November 3, 2022 at approximately 7:30 AM, the resident rooms were again observed in the same manner as described above, except the sink in Resident #335's room had been wiped and/or cleaned.

On 11/03/22 at 7:45 AM, LPN (Licensed Practical Nurse) #6 was interviewed and asked who is responsible to clean bed side commodes. The LPN stated that it is the CNA's responsibility and that if it is the actual bathroom that housekeeping takes care of that.

On 11/03/22 at approximately 7:50 AM, CNA (certified nursing assistant) #4 was then interviewed and asked if she was working with Resident #34 today. The CNA stated that she was not, but had worked on that hall, with that resident/room the day before. The CNA was asked to go to the room with the soiled bedside commode. The CNA stated that they (CNA's) are supposed to clean them after each use. The CNA stated that the resident didn't use the bedside commode yesterday, he only used the urinal and stated that she didn't notice the day before that the bedside commode was soiled/dirty and therefore, didn't clean it.

On 11/03/22 at 8:03 AM, The Maintenance Supervisor (MS) was asked how does the maintenance department go about checking on resident rooms that may need repairs. The MS stated that it is a daily thing and that they (he and the assistant) will go and check on things. The MS stated that they are constantly painting and replacing things. The MS stated that they make their rounds daily and the nurse's should be reporting things too. The MS observed Resident #34's room that included the resident's stained

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sink, the pipe under the sink and the door missing from resident's closet. The MS stated, "Yea, that didn't just get like that." The MS did not provide any explanation and/or knowledge of why those items observed had not been fixed and/or addressed.

On 11/03/22 at approximately 8:50 AM, the MS was again asked how are maintenance issues/concerns logged and tracked for repair or replacement. The MS stated that he and his assistant make rounds every day, all day and are constantly looking for items in need of repair. The MS also stated that the nurse's have a log book at the nurse's station where they can write in items of concern for the maintenance department to check, repair or replace. The MS then stated that, a lot of times the facility staff will tell him in passing of concerns or things that need to be fixed and he will write it down, if he remembers and has time, or may try to fix at that time if possible, but stated that if he is busy sometimes those things could be missed. The MS looked in the log book for the B-wing and stated that he did not see anything in the book related to the issues pointed out regarding the two resident rooms above.

The MS was asked for a policy or procedure on how repairs are to be identified, logged and tracked for completion and what the expectation was for general resident room maintenance. The MS stated that he didn't really have anything in writing.

On 11/03/22 at approximately 9:30 AM, the administrator was made aware of the above information and asked for a policy/protocol on the maintenance expectations for resident rooms.

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F 584	Continued From page 28 The administrator presented a policy titled, "...Preventative Maintenance Program...shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff and the public...maintain a schedule of maintenance services...shall assess all aspects of the physical plant to determine if preventative maintenance is required...may be determined by maintenance request, grand rounds, life safety requirements, or experience...decide what tasks need to be completed and how often to complete them...develop a calendar to assist with keeping track of all tasks...documentation shall be completed for all tasks...Tels is the software...used to document and schedule preventative maintenance..." On 11/03/22 at approximately 10:30 AM, the administrator, DON (director of nursing), ADON (assistant director of nursing) and corporate nurse were made aware in a meeting with the survey team of the above findings. No further information and/or documentation was presented prior to the exit conference on 11/03/22 to evidence a clean, comfortable and homelike environment was maintained for the above residents and their rooms.	F 584		
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:	F 641		12/5/22

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F 641	Continued From page 29 Based on complaint investigation, clinical record review, and staff interview, the facility failed to ensure an accurate Minimum Data Set (MDS - a cms assessment tool) for one of 21 residents (Resident # 82) in the survey sample. Resident # 82, who was discharged to home, was incorrectly identified as being discharged to an acute care hospital on a Nursing Home Discharge Minimum Data Set. The findings include: Resident # 82 was admitted to the facility with diagnoses that included a left wrist fracture, cancer, hypertension, generalized muscle weakness, difficulty walking, right below the knee amputation, dysuria, bromhidrosis, frequency of micturition, and urinary urgency. According to a Nursing Home Discharge Minimum Data Set with an Assessment Reference Date of 8/19/2022, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Under Section A (Identification Information), at Item A2100, Discharge Status, Resident # 82 was identified as being discharged to an acute hospital. Review of the Progress Notes in Resident # 82's closed electronic health record revealed the following entry: 8/19/2022 - 11:45 a.m. - Discharge Note - "Resident discharged from facility to home. All personal items packed by resident. Resident walked out of facility on own...." At approximately 9:30 a.m. on 11/2/2022, the	F 641	1. Facility staff corrected MDS for resident #82 who was discharged home. 2. MDS Coordinator will complete 100% audit of MDS on residents discharged home in the past 30 days to assess accuracy. 3. The Administrator will complete education with MDS Coordinator on accuracy of MDS assessments of resident's discharged home. 4. The MDS Coordinator will do an audit of resident's discharge MDS two times weekly times six weeks then monthly times two months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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F 641	Continued From page 30 Social Worker, who also serves as the Discharge Planner, was interviewed. According to the Social Worker, the discharge of Resident # 82 was a planned discharge. Asked how the MDS Coordinator is made aware of discharges, the Social Worker explained that a Utilization Meeting is held daily that includes a discussion of discharges. "The MDS Coordinator is present at that meeting," the Social Worker said. The MDS Coordinator was unable to be interviewed due to an extended illness. During a meeting at 4:00 p.m. on 11/2/2022, that included the Administrator, Director of Nursing, Assistant Director of Nursing, Corporate Nurse Consultant, and the survey team, the inaccuracy of Resident # 82's discharge assessment was discussed. No additional documentation was provided prior to exit conference.	F 641		
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	F 656		12/5/22

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F 656	Continued From page 31 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 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: Based on staff interview, clinical record review and facility document review, the facility staff failed to develop a comprehensive care plan (CCP) for 4 of 21 residents in the survey sample (Resident #23, #78, #80, and #81). Resident #23 had no plan of care for anticoagulant (AC) medication and diabetic management, including insulin administration. Resident #78 had no plan of care developed/implemented for pain management. Resident #80 had no plan of care	F 656	1. Resident #23 Careplan entered for anticoagulant medication and DM management. Resident #78 Careplan entered for pain management. Resident #80 Careplan entered for anticoagulant medication. Resident #81 Careplan entered for anticoagulant medication. 2. The MDS coordinator will conduct an 100% audit of residents on Eliquis and insulin therapy. The MDS coordinator will	

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F 656	Continued From page 32 for anticoagulant (AC) medication. Resident #81 had no plan of care for anticoagulant (AC) medication. The findings include: 1. The facility staff failed to develop and implement a comprehensive care plan for anticoagulant therapy and diabetic management, including insulin therapy. Resident #23 was admitted to the facility with diagnoses that included COVID 19, hemiplegia/hemiparesis, chronic AFIB, DM2, cognitive communication deficit, and aphasia. The MDS (minimum data set -cms assessment tool) dated 09/05/22 was the 5 day admission assessment, which documented Resident #23 as moderately impaired cognitively for daily decision making with a score of 8 out of 15. Under Section N - Medications, the MDS documented that Resident #23 received insulin and anticoagulant medications, which are classified as high risk medications. Resident #23 clinical record was reviewed on 11/01/2022. Observed on the order summary report were the following orders: "Apixaban Tablet 5 mg (milligrams) Give 1 tablet by mouth two times a day for DVT prevention. Order Date 10/5/2022" "Insulin Glargine-yfgn 100 Unit/ML Solution Pen-injector. Inject 30 unit subcutaneously one time a day for DM 2. Order Date 10/12/2022." "Insulin Lispro (1 Unit Dial) Solution Pen-injector 100 Unit/ML. Inject 4 unit subcutaneously four times a day for Diabetes Order Date 10/25/2022." Resident #23's medication administration records (MAR) for October and November 2022 were	F 656	conduct an 100% audit of all residents for Pain management Careplan. 3. The Regional Director of Clinical Services will conduct education with the Director of Nursing, Unit Managers and the MDS coordinator on care planning residents who receives anticoagulated therapy, insulin, and pain management 4. Audits of Eliquis and Insulin therapy orders and Careplan for Anticoagulant therapy and DM will be conducted two times weekly times six weeks then monthly times two months. Audit of pain management will be conducted on all new and readmissions two times weekly times six weeks then monthly times two months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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reviewed and documented the resident received the anticoagulant, Apixaban and both insulin (Glargine-yfgn & Lispro) as ordered/scheduled.

Resident #23's comprehensive care plan (CCP) was reviewed, but had no individualized plan of care for anticoagulant (AC) medication or diabetic management, including insulin administration.

On 11/02/2022 at 11:25 a.m., the licensed practical nurse (LPN #2) who routinely provided care for Resident #23 was interviewed regarding the resident's medications and care plans. LPN #2 reviewed Resident #23's clinical record and stated the resident was currently receiving both the anticoagulant and insulin. When asked why these serious medications were not included in the care plan, LPN #2 stated that the unit manager was responsible for the care plans.

On 11/02/2022 at 11:30 a.m., the unit manager (LPN #3) was interviewed regarding the inclusion of high risk medications in the care plan. LPN #3 reviewed the clinical record and stated, "Yes, there should be care plans for both the anticoagulant and insulin medications. I'm not sure why they were not included."

On 11/02/2022 at 5:39 p.m., the above findings were reviewed during a meeting with the administrator, DON, ADON, and corporate staff. No further information was provided that indicated that the facility had provided care planning for either of the high risk medications or the diabetes management.

2. The facility failed to address the individualized need for anticoagulant medication in Resident #80's comprehensive care planning. Resident

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#80 was admitted to the facility with hypertension, DM2, hemiplegia/hemiparesis, AFIB, muscle weakness, and dysphagia. The minimum data set (MDS) dated 09/23/2022 was the 5-day admission assessment, which documented Resident #80 with severely impaired cognition for daily decision making, with a BIMS (Brief Interview for Mental Status) score of 6 out 15. Under Section N - Medications, the MDS documented Resident #80 received anticoagulant medication, which has increased risk of bleeding.

Resident #80's clinical record was reviewed on 11/01/022. Observed on the the order summary report was the following order: "Apixaban Tablet 5 MG (milligrams) Give 1 tablet via J-Tube two times a day for cva via peg tube. Order Date 09/16/2022."

Resident #80's medication administration records for September through November 2022 were reviewed and documented the resident received the anticoagulant medication, Apixaban as ordered/scheduled.

Resident #80's care plans were reviewed, but had no plan of care for anticoagulant (AC) medication.

On 11/02/2022 at 11:25 a.m., the licensed practical nurse (LPN #2) who routinely provided care for Resident #80 was interviewed regarding the resident's medications and care plans. LPN #2 reviewed Resident #80's clinical record and stated the resident was currently receiving the anticoagulant. LPN #2 stated the unit manager was responsible for the care plans.

On 11/02/2022 at 11:30 a.m., the unit manager (LPN #3) was interviewed regarding the care

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plans. LPN #3 reviewed the clinical record and stated, "Yes, there should be a care plan for the anticoagulant medications. I'm not sure why it was not included."

On 11/02/2022 at 5:39 p.m., the above findings were reviewed during a meeting with the administrator, DON, ADON, and corporate staff. No other information was provided that care planning had been developed/implemented, in accordance with the MDS, to address the resident-centered need for anticoagulant medication.

3. The facility staff failed to include the physician ordered anticoagulant medication in Resident #81's comprehensive care plan. Resident #81 was admitted to the facility with diagnoses that included pneumonia, hypoxia, acute kidney failure, DM2, perforation of intestine, congestive heart failure and hypertension. The minimum data set (MDS - cms assessment tool) dated 10/03/2022 was the 5-day admission assessment and assessed Resident #81 as cognitively intact for daily decision making with a score of 13 out of 15. Under Section N - Medications, the MDS documented Resident #81 received anticoagulant medication, which has increased risk of bleeding.

Resident #81's clinical record was reviewed on 11/01/022. Observed on the the order summary report was the following order: "Apixaban Tablet 2.5 MG (milligrams) Give 2.5 mg by mouth two times a day for a-fib. Order Date 10/20/2022."

Resident #81's medication administration records for October and November 2022 were reviewed and documented the resident received the

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anticoagulant medication, Apixaban as ordered/scheduled.

Resident #81's comprehensive care plans were reviewed, but had no plan of care to address the individualized need for anticoagulant (AC) medication or the associated risk factors of this physician ordered therapy.

On 11/02/2022 at 11:25 a.m., the licensed practical nurse (LPN #2) who routinely provided care for Resident #81 was interviewed regarding the resident's medications and care plans. LPN #2 reviewed Resident #81's clinical record and stated the resident was currently receiving the anticoagulant. When asked about care planning for this high risk medication, LPN #2 stated the unit manager was responsible for the care plans.

On 11/02/2022 at 11:30 a.m., the unit manager (LPN #3) was interviewed regarding the care plans for the high-risk medications. LPN #3 reviewed the clinical record and stated, "Yes, there should be a care plan for the anticoagulant medications. I'm not sure why it was not included."

On 11/02/2022 at 5:39 p.m., the above findings were reviewed during a meeting with the administrator, DON, ADON, and corporate staff. No other evidence was presented that a plan of care for anticoagulant medication had been developed or implemented for Resident #81.

4. The facility staff failed to develop and implement a CCP (comprehensive care plan) to include measurable objectives and timeframes for Resident #78 in the area of pain management.

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Resident #78's diagnoses included, but were not limited: diverticulitis, atrial fibrillation, depression, muscle weakness, dysphagia, abnormal gait, polyneuropathy, history of falls, and musculoskeletal mastoid bone pain.

The resident #78's most recent MDS (minimum data set - cms assessment tool) was an admission assessment dated 08/23/22. This MDS assessed the resident with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating the resident was intact for daily decision making skills.

This MDS did not assess the resident with having pain and pain was not triggered in the CAAS (care area assessment summary) section of this MDS.

Resident #78 was interviewed on 11/02/22 at approximately 7:55 AM. Observed grimacing, Resident #78 had stated that she was in pain and had not slept the night before due to pain. Resident #78 stated that she has been having pain and has scheduled pain medications, but did not get the pain medication as ordered.

Resident #78's clinical record was reviewed and included the following physician's order: "Observation: Pain- observe every shift...start date: 08/21/22..."

Further review of Resident #78's physician orders revealed that a lidocaine pain patch for hip pain was started on 10/11/22, Tylenol was started on 10/17/22, and the narcotic pain medication (indicated for moderate to severe pain) hydrocodone-acetaminophen 5-325 for mastoid

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F 656	Continued From page 38 bone pain was started on 10/17/22. Resident #78's current CCP (comprehensive care plan) was reviewed and revealed that the resident did not have a pain care plan developed until 11/01/22, although the resident was experiencing pain, receiving pain treatments, and had been admitted with pain diagnoses. The CCP documented, "...Pain Management Date initiated: 11/01/22 resident will demonstrate and verbalize knowledge of strategies for pain management: pain management date initiated: 11/01/22...Medication management date initiated: 1/01/22...Resident will be offered non-pharmacological interventions for pain including distraction, entertainment/activity, food and fluids offered and/or repositioning date initiated: 11/01/22..." There was no evidence in the resident's clinical record that Resident #78 had any other care plan related to pain prior to 11/01/22. On 11/02/22 at approximately 6:15 PM, the administrator, DON (director of nursing), ADON (assistant director of nursing) and the corporate nurse were made aware in a meeting with the survey team. The DON was asked why was Resident #78's pain care plan just added on 11/01/22. The DON replied that she did not update or review the care plan and wasn't sure. No further information and/or documentation was provided prior to the exit conference to evidence that a pain care plan was developed for Resident #78 prior to 11/01/22.	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		12/5/22

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F 657	Continued From page 39 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 observation, resident interview, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of twenty residents in the survey sample (Resident #17 & #62). Resident #17's Comprehensive Care Plan (CCP) was not revised regarding the provision of colostomy care. Resident #62's plan of care was	F 657	1. Careplan was updated for self-colostomy care on 11/2/22 for resident #17. Careplan was updated for physician ordered intervention of therapeutic support hose. 2. The MDS Coordinator will complete an 100% audit of all residents CP for self-care of the colostomy and physician	

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F 657	Continued From page 40 not updated to include the physician ordered intervention of therapeutic support hose (TED hose). The findings include: 1. The Comprehensive Care Plan for Resident #17 was not revised to address the provision of colostomy care by the resident. Resident #17 was admitted to the facility with diagnoses that included inflammatory bowel disease with colostomy, asthma, history of cerebral infarction, diverticulosis, atrial fibrillation, hypothyroidism, depression, anxiety, hypertension and chronic respiratory failure. The minimum data set (MDS - cms asssessment tool) dated 9/9/22 assessed Resident #17 as cognitively intact for daily decision making. On 11/1/22 at 12:06 p.m., Resident #17 was interviewed about quality of care in the facility. Resident #17 stated during this interview that she provided her own colostomy care that included twice weekly flange changes. Resident #17 stated the aides assisted her to clean around the colostomy site during showers. When asked further about the specifics of her colostomy care, Resident #17 stated that she emptied the colostomy bag daily, changed the bag/flange, made sure the skin around the site was clean, and notified the nurses of any problems. Resident #17's CCP (revised 7/6/22) documented that the resident had a colostomy but made no mention that the resident provided her own care. Interventions to maintain function of the colostomy and prevent skin breakdown included, "Assess daily to make sure ostomy is functioning	F 657	ordered intervention of TED hose. 3. The Regional Director of Clinical Services will conduct education with the Director of Nursing, Unit Managers and the MDS coordinator on care planning residents for self-care of the colostomy and physician ordered intervention of TED hose. 4. Audit of residents with new orders for colostomy care, TED hose and/or any changes in self-care two times weekly times six weeks then monthly times two months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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properly...Change Ostomy bag per MD [physician] orders and prn [as needed] if bag is leaking or bursts...Notify Charge nurse if no stool is passed each shift...skin will be inspected at ostomy site, around stoma for s/s [signs/symptoms] of irritation...respect [Resident #17's] dignity when providing ostomy care..." There were no revisions to the colostomy care part of the CCP since 9/24/20, but there was no documentation that the identified care interventions were being followed. Also, no problems, goals and/or interventions were listed regarding the resident #17's self-care of the colostomy.

On 11/2/22 at 2:37 p.m., the licensed practical nurse (LPN #2) caring for Resident #17 was interviewed. LPN #2 stated the resident performed her own colostomy care. LPN #2 stated Resident #17 was specific about how the care was done and used supplies provided by the facility. When questioned about the self-care not being included in the care plan, LPN #2 stated that the unit manager took care of updating care plans.

On 11/2/22 at 3:10 p.m., the unit manager (LPN #3) was interviewed about Resident #17. LPN #3 stated she was responsible for care plan updates/revisions. LPN #3 stated Resident #17 routinely performed her own colostomy care. LPN #3 reviewed the current plan of care and stated there was nothing on the plan about the resident performing colostomy self-care. LPN #3 stated, "It definitely should have been on there that she does her own care."

These findings were reviewed with the administrator, director of nursing and regional

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director of clinical services during a meeting on 11/2/22 at 5:40 p.m.

No further information was obtained prior to the exit conference on 11/03/2022 that indicated that the Comprehensive Care Plan had been developed and implemented to address the self-care of Resident #17's colostomy.

2. Resident #62's care plan was not reviewed and revised to include the physician orders for TED (thrombo- embolic deterrent/therapeutic support) hose to be applied daily for edema.

Resident #62 was admitted to the facility with hypertension, artherosclerotic heart disease, sick sinus syndrome, presence of cardiac pacemaker, diabetes mellitus, cognitive impairment, and a history of falls.

A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/07/2022, assessed Resident #62 with a BIMS (Brief Interview for Mental Status) score of 5/15, indicating moderate cognitive impairment for daily decision making.

Resident #62's clinical record was reviewed on 11/01/2022 at approximately 2:30 p.m. Review of the physician orders included the following orders, which were both written on 09/19/2022:
"Apply TED hose daily to BLE (bilateral lower extremities). Nursing staff to assist her with this task, one time a day for edema.
"Remove TED hose @ HS (hour of sleep) Nursing staff to assist with this task, one time a day for edema."

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On 11/02/2022 at approximately 9:30 a.m., Resident #62 was observed in her room, dressed for the day. No TED hose were observed. When asked if she had white stockings that staff helped her put on in the mornings and took off in the evening, Resident #62 stated, "No, I don't have that." When asked if she had any stockings in her drawers, Resident #62 opened her drawers and stated, "No, I don't have any."

CNA (certified nursing assistant) #1 was in the hallway and confirmed that she was assigned to Resident #62. When asked about the physician ordered TED hose, CNA #1 stated, "...I don't know if she is supposed to be wearing TED hose or not." When asked if she had reviewed Resident #62's kardex (daily care guide) prior to caring for her, CNA #1 stated, "I haven't looked at it recently...the nurses tell us what we are supposed to do..."

The CCP and the kardex were reviewed at approximately 10:15 a.m., the TED hose were not observed on either.

At approximately 11:30 a.m., RN #1 came to the conference room. She was asked how CNAs knew to apply TED hose if they were not on a resident's kardex. She stated, "It was on the nurse's MAR (medication administration record)...the nurse tells the CNA to assist the resident, but it should be on the care plan and the Kardex.

The above information was discussed with the administrator, the DON (director of nursing), the ADON (assistant director of nursing) and three corporate staff during an end of the day meeting

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F 657	Continued From page 44 on 11/02/2022 at approximately 5:30 p.m. No further information was obtained prior to the exit conference on 11/03/2022 that indicated that facility staff had addressed the individualized need for the physician ordered therapeutic hose in Resident #62's comprehensive care plan.	F 657		
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: 2. Facility staff failed to assist Resident #62 with wearing the physician ordered TED (thrombo-embolic deterrent) hose. On 11/02/2022 at approximately 9:30 a.m., Resident #62 was observed in her room. She was dressed for the day. No TED hose were observed. She was asked if she had white stockings that staff helped her put on in the mornings and took off in the evenings. She stated, "No, I don't have that." She was asked if she had any stockings in her drawers. She opened her drawers and stated, "No, I don't have any." CNA (certified nursing assistant) #1 was in the hallway. She confirmed that she was assigned to Resident #62. She was asked about the physician ordered TED hose. She stated, "I didn't help her	F 684	1. Resident #62's TED Hose are applied daily as resident will allow. Resident #62's Kardex has been updated for resident wearing TED hose. Resident #34's wound documentation was completed on return from the hospital and ongoing weekly until wound resolved. 2. DON/Designee will conduct 100% audit of all residents with TED hose to assure the resident is wearing TED Hose and the Kardex is accurate. The Wound Nurse will conduct 100% audit of all residents with non-pressure areas to assure a current weekly non-pressure tool is in place. 3. The Assistant Director of Nursing will conduct education with all license nurses	12/5/22

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F 684	Continued From page 45 get dressed today, the nurse did. I don't know if she is supposed to be wearing TED hose or not." She was asked if she had reviewed Resident #62's kardex (daily care guide) prior to caring for her. She stated, "I haven't looked at it recently...the nurses tell us what we are supposed to do...I think they put those on the residents anyway." Resident #62 was admitted to the facility with hypertension, artherosclerotic heart disease, sick sinus syndrome, presence of cardiac pacemaker, diabetes mellitus, cognitive impairment, and a history of falls. A quarterly MDS (minimum data set - cms assessment tool), with an ARD (assessment reference date) of 10/07/2022, assessed Resident #62 having a BIMS (Brief Interview for Mentals Status) score of 5/15, indicating moderately impaired cognition with daily decision making. Resident #62's clinical record was reviewed on 11/01/2022 at approximately 2:30 p.m. Review of the physician orders included the following orders written on 09/19/2022: "Apply TED hose daily to BLE (bilateral lower extremities). Nursing staff to assist her with this task, one time a day for edema. "Remove TED hose @ HS (hour of sleep) Nursing staff to assist with this task, one time a day for edema." The unit manager, RN (registered nurse) #1 was interviewed at approximately 9:45 a.m. When asked who was supposed to assist Resident #62 with her TED hose, RN #1 stated, "The CNAs do that." When told that Resident #62 did not have	F 684	on TED hose application, following the Kardex and completing non-pressure assessment tools on residents with newly identified areas. 4. The Director of Nursing or Designee will audit all residents with TED hose to assure the resident is wearing TED Hose, the Kardex is accurate and non-pressure assessment tools are completed two times weekly times six weeks then monthly times two months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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her TED hose on, nor were there any in her room that the resident could find, RN #1 stated, "They may be in the laundry, but there should be a spare pair in the room."

The comprehensive care plan and the kardex were reviewed at approximately 10:15 a.m., the TED hose were not observed on either.

At approximately 11:30 a.m., RN #1 came to the conference room and stated, "[Resident #62's] TED hose did go to the laundry this morning, but there should have been a spare in there for her." RN #1 was asked how the CNA would know to apply the TED hose since they were not on the resident's kardex. RN #1 stated, "It was on the nurse's MAR (medication administration record), it should have been on the TAR (treatment administration record)...the nurse tells the CNA to assist the resident, but it should be on the care plan and the Kardex."

The above information was discussed with the administrator, the DON (director of nursing), the ADON (assistant director of nursing) and three corporate staff during an end of the day meeting on 11/02/2022 at approximately 5:30 p.m.

No further information was obtained prior to the exit conference on 11/03/2022.

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Based on resident interview, staff interview, clinical record review, facility document review, the facility staff failed to provide ongoing wound assessments to monitor healing progress for one of 21 residents in the survey sample (Resident #34) and failed to follow physician's orders for applying TED hose for one of 21 residents in the survey sample (Resident #62).

The findings include:

1. A complaint investigation was conducted on 11/01/22 through 11/03/22. An allegation within the complaint alleged that the facility failed to monitor for appropriate wound healing. Resident #34's diagnoses included, but were not limited to: HTN (high blood pressure), CHF (congestive heart failure), schizophrenia, asthma, Parkinson's disease, anxiety disorder, polyneuropathy, obesity, and depression.

The most current MDS (minimum data set - cms assessment tool) was a quarterly review, dated prior to the discovery of the resident's wound on 07/29/22. This MDS documented the BIMS (brief Interview for Mental Status) score of 12 out of 15, indicating Resident #34 had moderate cognitive impairment in daily decision making skills. Resident #34's physical function was assessed as non-ambulatory and requiring extensive to full assistance of two staff for ADL's

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(activities of daily living).

Resident #34's most recent full MDS (minimum data set - cms assessment tool) assessment was an annual assessment dated 12/20/21, which triggered in the CAAS (care area assessment summary) section for pressure ulcers, indicating the need for care plan development in this area.

Resident #34's clinical records were reviewed and revealed that bilateral 'friction' wounds to the dorsal area of both feet (from shoes) were documented on a 07/29/22 weekly skin assessment.

A physician progress note documented the following: "...08/01/22...seeing the resident for reports that he has abrasions to the tops of both of his feet with odor. Over the weekend, nursing staff reports that his shoes were rubbing the tops of his feet...rubbed the first layer of skin off...nursing staff have been covering with nonstick piece of gauze and tape however nursing staff reports that today it is draining...and odorous. Resident denies pain or any other acute concerns regarding this today...wearing nonskid socks instead of shoes since these abrasions started...dorsal aspects of both feet with 1st layer of skin sloughed off due to friction from his shoes...underlying skin is pink and moist with small amount of drainage on dressing...I have ordered for nursing staff to cleanse the wounds with DWC (dermal wound cleanser), apply TAO (topical antibiotic ointment), cover with nonstick gauze, and tape/wrap until healed. Due to yellow drainage and odor, I have ordered cephalexin 500 mg (milligrams) 3 times daily for 7 days...continue to keep shoes off...until wounds heal...signature of NP (Nurse Practitioner)."

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A review of the physician's orders were revealed the following: "...Cleanse...with DWC, apply TAO, cover with nonstick gauze until healed (order date: 08/01/22)."

The above order was changed on 08/03/22 to the following: "...Cleanse...bilateral feet with DWC, apply collagen and calcium alginate, wrap with kerlix, Change QD [every day] every day shift for bilateral foot wounds...(start date: 08/03/22)."

The resident's MARs/TARs (medication/treatment administration records) for August 2022 were reviewed and revealed that the resident did receive the above treatments as ordered, but no documentation included wound monitoring or assessments.

On 11/01/22 at 12:01 PM, Resident #34 was interviewed regarding his foot/feet wound(s) and was asked what had happened to cause the wounds. Resident #34 stated that he didn't know what happened to either foot, then stated that he doesn't walk. When questioned about wound care, Resident #34 stated that staff was cleaning and dressing it once a day, adding that he dreaded them doing it, but he did let them do it. When asked if he refused care at times, Resident #34 stated that he did not refuse care to the wounds on his feet and that the staff was taking care of them. When questioned if he had any problems with his feet before going to the hospital in August, Resident #34 stated that he didn't know.

On 11/02/22 at 2:40 PM, an interview was conducted with the NP, regarding the wound development and treatment for Resident # 34.

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The NP stated that the resident started out with friction wounds from his shoes, for which she stated that she treated the resident with Keflex and wound care. The NP stated that the wounds seemed fine until one of the nurse's had notified another provider when maggots were found in the wound and the resident had been sent out to the hospital. The NP was then made aware that no wound assessments could be found or any evidence that the wound progress or treatment effective was being monitored. The NP was made aware that according to documentation, the wound treatments were completed, but there were no assessments documenting what the wounds looked like, during the dressing changes, on any of the days leading up to resident #34's transfer to the hospital on 08/08/22. The NP replied that she would expect them (nursing staff) to look at it and document what they saw, not necessarily measure each time, but would expect them to document wound drainage, odor, and to document specifically what they did and of what they saw during the dressing change each day.

On 11/02/22 at approximately 6:15 PM, the administrator, DON (director of nursing), and corporate nurse were made aware of the complaint allegations regarding Resident #34 and that no wound assessments to monitor wound progress could be found after the initial wound assessment by the NP, which was completed on 08/01/22. Their assistance was requested in locating any ongoing wound assessments, since that date. A policy on wound care and assessments was also requested at that time.

On 11/03/22 at approximately 8:15 AM, the DON presented wound policy and procedure documents. The policy documented,

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F 684	Continued From page 51 "...Documentation of Wound Treatments...the facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition and changes in treatment...type of wound...location...stage if pressure...if non-pressure (partial or full thickness)...measurements...description of wound characteristics...color...type of tissue...presence, amount, and characteristics of wound drainage...presence or absence of odor...presence or absence of pain...notification to physician and/or responsible party regarding wound or treatment changes..." The DON also presented a weekly wound assessment dated 07/29/22, which only documented that the resident had an open area that was abraded to both feet from shoes. The other wound assessment dated 08/08/22 only documented that the resident had an open area. No other information was on this assessment, now were any other wound assessments presented. No further information and/or documentation was presented prior to the exit conference on 11/03/22 at 11:30 AM to evidence that the facility staff completed ongoing wound assessments to appropriately monitor Resident #34's wound healing. This is a complaint deficiency.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		12/5/22

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F 689	Continued From page 52 §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 and staff interview the facility staff failed to ensure a safe room environment for one of 21 residents, Resident #62. Findings were: Resident #62 was admitted to the facility with hypertension, artherosclerotic heart disease, sick sinus syndrome, presence of cardiac pacemaker, diabetes mellitus, cognitive impairment, and a history of falls. A quarterly MDS (minimum data set - cms assedsment tool) with an ARD (assessment reference date) of 10/07/2022, assessed Resident #62 with a BIMS (Brief Interview for Mental Status) score of 5/15, indicating moderate cognitive impairment for daily decision making. Initial tour of the facility was conducted on 11/01/2022 at approximately 12:00 noon. Resident #62 was observed standing in the doorway of her room. An area of purple/blue discoloration was observed around her right eye. When asked what had happened to her eye, Resident #62 stated, "I fall." When asked how she fell, Resident #62 stated, "My mattress is slicky." Resident #62 then invited this surveyor into her room and stated, "See my mattress? I was getting up and slid off the blankets." When asked if she had called for help prior to the fall, Resident #62 stated, "When I falled I yelled, Help!	F 689	1. Resident #62 did not fall from the wet floor. Housekeeping corrected the wet floor immediately on 11/2/22 while surveyor standing there. 2. The Housekeeping Director will complete an audit of all housekeeping employees with an inspection of mopping floors. 3. The Housekeeping director will complete education with housekeeping employees on not applying large amounts of water to the floor while mopping, leaving the floors very visibly wet. 4. The Housekeeping director will conduct audit of wet floors for very visibly wet floors two times weekly times six weeks then monthly times three months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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Help!"

Review of the clinical record on 11/01/2022 at approximately 2:30 p.m., provided documentation that Resident #62 had recently fallen while getting up unassisted with the resulting fall and subsequent injury indicated by the discoloration around her eye. A review of the comprehensive care plan revealed new fall interventions that included the addition of a night light in her room.

On 11/02/2022 at approximately 9:00 a.m., a "Caution Wet Floor" sign was observed in the doorway to Resident #62's room. The floor in Resident #62's room had been recently mopped and was very visibly wet (indicating increased fall risk/hazard). Resident #62 was observed walking in her room between the bed and wall. The wetness of the floor and the need for caution was pointed out to Resident #62, who stated, "I'm being careful, I've got my shoes on." The housekeeper (other staff #1) who had mopped the floor was around the corner, on another hallway. When asked if she had mopped Resident #62's floor, other staff #1 stated, "Yes...I asked [name of Resident #62] to sit on the bed until it dried." Other staff #1 was then told that the resident was not sitting on her bed, that she was up walking in her room, and the floor was visibly very wet. When asked if there was a dry mop or something that could be run over the floor to get up the excess water, Other Staff #1 took a dry mop to the room and ran it over the floor to expedite the drying process.

Review of the care plan included the following information: "..high risk of falls r/t (related to) incontinence...[Name of Resident #62] needs a safe environment with even floors free from spills

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F 689	Continued From page 54 and/or clutter..." The above findings was discussed with the administrator, the DON (director of nursing), the ADON (assistant director of nursing), and three corporate staff during an end of the day meeting on 11/02/2022 at approximately 5:30 p.m. Concerns were voiced that the floor had been left visibly wet in a resident's room, especially a resident with a known fall history and interventions to reduce fall risk. The administrator stated, "I overheard you talking to her [OS #1] this morning. I went to the housekeeping director and he met with his staff." No further information was obtained prior to the exit conference on 11/03/2022.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		12/5/22

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F 690	Continued From page 55 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, and facility document review, the facility staff failed to provide timely treatment for an UTI (urinary tract infection) for one of twenty-one residents, Resident #28. The findings include: Resident #28 was admitted to the facility with the following diagnoses including but not limited to: Diabetes mellitus, quadriplegia, contracture of the left hand, UTI, and chronic kidney disease. An annual MDS (minimum data set -cms assessment tool) dated 09/02/2022 documented the BIMS (Brief Interview of Mental Status) score as 15 out of 15, indicating Resident #28 was cognitively intact for daily decision making. On 11/01/2022 beginning at approximately 3:00 p.m., a review of the clinical record included	F 690	1. Resident #28 received Ertapenem Sodium Solution Reconstituted 1 GM for UTI on 11/2/22 NP/RP made aware. 2. The Unit Managers will conduct an 100% audit of residents on antibiotic therapy to assure timely treatment is provided. 3. The Assistant Director of Nursing will conduct education with the Unit Managers and licensed nurses on clarification of antibiotic orders, notifying the MD when the medication is not available and obtaining unavailable medication. 4. DON/Designee will conduct an audit of antibiotic orders to assure medication availability and timely treatment is provided two times weekly times six weeks then monthly times three months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued	

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progress notes with the following entries:
"10/29/2022 22:20 (10:22 p.m.) Positive for UTI. Spoke with [Name redacted]; place PICC line begin ertapenem 1 GM (gram) q (every) 24 hours."
"10/31/2022 (Note from nurse practitioner signed 10/31/2022 at 7:51 p.m.)...Infection and inflammatory reaction due to indwelling urethral catheter...urine culture came back with E. Coli and Pseudomonas. She is on trimethoprim 50 mg daily for UTI prophylaxis, however, she has developed a UTI again. She should continue ertapenem 1 g daily until 11/4/2022. Foley care should be performed every shift and the catheter should be changed every 28 days..."
"11/01/2022 01:27 (a.m.) Ertapenem Sodium Reconstituted 1 GM Use 1 gram intravenously one time a day for UTI over 4 days. IV therapy to begin tomorrow 11-1 @1700 per MD order, noted change in (computer system) as well."

Resident #28 had been observed in her chair during initial tour on 11/01/2022 at approximately 12:00 p.m. No IV line was observed at that time. At approximately 5:00 p.m., Resident #28 was again observed sitting up in chair in her room. When asked if she was getting IV antibiotics for a urinary tract infection, Resident #28 stated, "I am supposed to be but I haven't gotten any yet...they said they don't have any needles...I had one, I think it was last week, it started bleeding and they took it out." When asked if she was having any lower abdominal discomfort or any symptoms related to her UTI, Resident #28 stated, "No, I'm okay right now."

On 11/01/2022 at approximately 5:10 p.m., LPN (licensed practical nurse) #7 was in the hallway preparing medications. When asked if she was

intervention or amendment of the plan.

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taking care of Resident #28, LPN #7 stated, "Yes." When asked about Resident #28's IV antibiotics for her urinary tract infection, LPN #7 looked at the MAR (medication administration record) and stated, "The order says to start that tomorrow (11/02/2022). When asked why it wasn't being started until 11/02/2022, when it was ordered on 10/29/2022, LPN #7 stated, "We are waiting for the pharmacy to send us the supplies to do it." When asked to explain what she meant by supplies, LPN #7 stated ,"We need the antibiotic and the supplies to start the IV."

On 11/02/2022 at approximately 9:10 a.m., a review of the clinical record included a change in condition note, which contained the following and was written by the unit manager, RN (registered nurse) #1:
"11/02/2022 08:56 (a.m.) ..Change in Condition...nursing observations, evaluation, and recommendations are: Resident presents with UTI, Foley catheter in place. Treatment with Ertapenem 1 Gm IV X (times) 4 days..."

On 11/02/2022 at approximately 9:30 a.m., RN #1 was interviewed. Referring to the change in condition note that she had written earlier that day, RN #1 was asked if she was aware that the antibiotics for Resident #28 had not yet been started. RN #1 looked at the physician orders and stated, "Yes, it starts this evening." She was referred back to the progress notes from 10/29/2022, 10/31/2022, and 11/01/2022, regarding Resident #28's orders for an IV antibiotic and the entry in the medical record for a PICC line insertion. RN #1 reviewed the record and stated, "We don't do PICC lines here...but for a four day course of antibiotics she wouldn't need a PICC. We could use a regular IV." When asked

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how long it took for a medication to arrive from the pharmacy, since the antibiotic had been ordered on 10/29/2022 and the resident had still not received a dose, RN #1 stated, "I don't know why she hasn't gotten her antibiotic. Ertapenem is something we have here in stock and we have everything we need to start an IV." RN #1 stated that she would look into a few things and get back to the survey team.

At approximately 11:30 a.m., RN #1 came to the conference room and stated, "The antibiotic order was written by the on-call physician over the weekend. It looks like the original order was written on October 29 to place a PICC line and discontinue it when the antibiotics were complete. That order was discontinued. There was also an order written on October 29 for the antibiotics to be given for four days...that was discontinued and rewritten to start on November first...that order was discontinued on November 1st, the reason on the order was 'waiting on IV supplies from the pharmacy', but they were suppose to be here today...I don't know what happened...some of the notes say we were waiting on the medicine, some say waiting on IV supplies. It looks like we ordered the medicine from the pharmacy...we have that antibiotic here so it could have been started...I spoke with the nurse practitioner and we got the order clarified so we can give it IM starting today at noon." When asked if the physician or nurse practitioner had been notified that the medication had not been given before today, RN #1 stated, "There isn't any documentation that notification occurred, I don't feel like that happened." When asked if the nurses had changed/canceled the orders and the start dates of the antibiotic without speaking with the physician or the nurse practitioner, RN #1

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stated, "Yes, that is what I think happened...the physician should have been notified."

On 11/02/2022 at approximately 3:30 p.m., the nurse practitioner (NP) was interviewed. When asked if she was aware that Resident #28 had not received any doses of her antibiotics prior to the IM injection ordered earlier on 11/02/2022, the NP stated, "I was told on Monday (10/31/2022) that she had an IV and that it had infiltrated...I can't tell you the nurses name who told me that, but she said there weren't any needles here to restart it and they would have to come from the pharmacy...I thought she had gotten one dose and it would resume the next day [11/01/2022]. I found out today that none had been given, so we changed the route to IM."

On 11/02/2022 at approximately 4:00 p.m., RN #1 was asked if other than the clinical record there was any place the nurses could have documented that the antibiotic was not given and the physician/nurse practitioner were notified. RN #1 stated, "There is a physician book." RN #1 went to the nurse's station and looked in the book, but stated, "There's not any documentation in here about that."

On 11/02/2022 at approximately 4:30 p.m., the DON (director of nursing) came to the conference room and stated, "Here is the packing slip from the pharmacy...the antibiotics have been here the whole time...they were ordered and the pharmacy dispensed them on the 30th [10/30/2022] and they were delivered on the 31st [10/31/2022]....As a matter of fact, the pharmacy delivered them twice. The bags are in the bottom drawer of the med cart." When asked why the nurse had documented that the meds were not available,

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F 690	Continued From page 60 the DON stated, "I don't know, she is not here and we have labeled her as DNR." When asked what DNR meant, the DON stated, "Do not rehire." The above information was discussed with the DON, the administrator, the ADON (assistant director of nursing) and three members of the corporate staff. Concerns were voiced that an IV antibiotic had been ordered on 10/29/2022 for four doses and the medication was not started until 11/02/2022. When asked if the physician or nurse practitioner had been notified of the delay in treatment, the DON stated that she would find out. When asked how the nurses know what meds were available in the "Stat" box, the DON stated that there was a list in each medication room. On 11/03/2022 at 9:30 a.m., the DON entered the conference room and was asked if she could clarify if the antibiotics were not started because the nurses thought the meds were in house or because they didn't know that IV supplies were in house. The DON responded, "I've not been able to get in touch with the nurses...I don't know if the physician was notified or not, or if the problem was they didn't know we had the meds or if they thought the IV supplies weren't available."The DON then presented a list of medications available in the "stat" box, on which Ertapenem 1 gram was listed. No further information was obtained prior to the exit conference on 11/03/2022.	F 690		
F 691 SS=E	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f)	F 691		12/5/22

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F 691	Continued From page 61 §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to obtain physician orders to provide ongoing assessment and care for a colostomy for one of twenty residents in the survey sample. Resident #17 had no current physician orders for care the colostomy and no evidence of daily colostomy site assessments as documented in the comprehensive care plan. The findings include: Resident #17 was admitted to the facility with diagnoses that included inflammatory bowel disease with colostomy, asthma, history of cerebral infarction, diverticulosis, atrial fibrillation, hypothyroidism, depression, anxiety, hypertension and chronic respiratory failure. The MDS (minimum data set - CMS assessment tool) assessment dated 9/9/22 documented the BIMS (Brief Interview of Mental Status) as indicating intact cognition for daily decision making. On 11/1/22 at 12:06 p.m., when interviewed about quality of care in the facility, Resident #17 stated that she provided care for her colostomy that included twice weekly flange changes. Resident #17 stated the aides assisted her to clean around the colostomy site during showers. Resident #17	F 691	1. A MD order for colostomy care was placed in PCC on 11/2/22 for the resident #17, documentation shows on the TAR. 2. The Unit Managers will complete 100% audits of all residents with MD orders for colostomy care and review sign offs on the TAR. 3. The Assistant Director of Nursing will complete education with the Unit Managers and all Licensed Nurses on placing MD orders for colostomy care. 4. Audits of residents with colostomy orders will be conducted two times weekly times six weeks then monthly times three months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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stated nurses did not routinely look at the colostomy and she informed the nurses if she had any problems with the site.

Resident #17's clinical record was reviewed and revealed no current physician orders regarding the care of the colostomy. The October 2022 treatment administration record (TAR) documented a previous order dated 11/4/20 for emptying of the colostomy bag once per shift with replacement as needed. This order was discontinued on 10/7/22. There were no current colostomy orders or treatments documented on the TAR from 10/8/22 through 10/31/22. There was no documentation regarding when the bag and/or flange were changed.

A nursing note dated 10/10/22 documented, "...PT [patient] needing assistance with stoma..." The remaining Nursing notes from 10/11/22 through 10/31/22 made no further mention of the resident's colostomy.

Resident #17's comprehensive care plan (revised 7/6/22) documented the resident had a colostomy, with goals to maintain proper function and prevent skin breakdown, along with interventions that included, "Assess daily to make sure ostomy is functioning properly and stool is being diverted through ostomy. Notify MD [physician] of any complications...Change Ostomy bag per MD orders..."

On 11/2/22 at 2:37 p.m., the licensed practical nurse (LPN #2) caring for Resident #17 was interviewed about colostomy care. LPN #2 stated that the resident performed her own colostomy care. LPN #2 stated that the resident was specific about how the care was done and used

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F 691	Continued From page 63 supplies provided by the facility. LPN #2 reviewed the clinical record and stated that she found no current orders about care of the colostomy. LPN #2 stated that the resident was readmitted to the facility on 10/10/22 and the orders may not have been restarted upon readmission. LPN #2 stated that there were no current entries on the TAR about the colostomy. On 11/2/22 at 3:10 p.m., the unit manager (LPN #3) was interviewed about Resident #17's colostomy care. LPN #3 reviewed the clinical record and stated that there were no current orders for colostomy care. LPN #3 stated that she did not know why colostomy care orders were not initiated when the resident was readmitted on 10/10/22. LPN #3 stated that the resident provided routine care of the colostomy and usually informed the nurses of any problems. LPN #3 stated that nurses should be monitoring the colostomy site for any complications. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 11/2/22 at 5:40 p.m. No further information was provided prior to facility exit.	F 691		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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:	F 697		12/5/22

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F 697	Continued From page 64 Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure pain management for one of 21 residents in the survey sample, Resident #78. Resident #78 was not administered scheduled pain medication as ordered by the physician; Resident #78 suffered unrelieved pain and was unable to sleep, which resulted in actual harm to the resident. Findings include: Resident #78's diagnoses included, but were not limited: diverticulitis, atrial fibrillation, depression, muscle weakness, dysphagia, abnormal gait, polyneuropathy, history of falls, and musculoskeletal mastoid bone pain. Resident #78's most recent MDS (minimum data set - CMS assessment tool) was an admission assessment dated 08/23/22. This MDS assessed the resident with a BIMS (Brief Interview for Mental Status) score of 15 (out of 15), indicating intact cognition function for daily decision making skills. Physical function was assessed as requiring supervision with limited assistance of one staff person for most ADL's (activities of daily living). On 11/02/22 at approximately 7:55 AM, Resident #78 was observed sitting on the side of bed with facial grimacing. Upon interview, Resident # 78 stated that she had a rough night, was in pain, and had not slept due to the pain. Having asked the night nurse for her ordered pain medication, Resident #78 states that the nurse had told her that they (the facility) didn't have any and that it was on order from the pharmacy. The resident stated that the nurse's name (identified as LPN	F 697	1. Resident #78 received Hydrocodone-Acetaminophen Solution 2.5 -108 MG/5ML pain medication on 11/2/22. Pain level decreased. 2. The DON/designee will complete an 100% audit of all residents with scheduled two controlled pain medication to assure medication is available and being administered as ordered. 3. The Assistant Director of Nursing will complete education with licensed nurses on controlling residents' pain, following MD orders, Unavailable medication policy, non-pharmacological interventions and location of medication on the medication carts. 4. The DON/designee will conduct an audit of residents with scheduled two controlled pain medication will be conducted two times a week for six weeks then monthly times 3 months. Audit findings will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of the plan.	

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#7) did not offer her anything else for her pain. When asked if the nurse had provided her with any non-pharmacological interventions, such a heat or ice packs or a back rub, etc., the resident stated, "No." When asked to rate her pain level, resident #78 responded that her pain was a 7 out of 10, indicating severe pain. In apparent distress, the resident expressed that she hoped she didn't start crying because of the pain, but stated, "...it hurts."

At approximately 8:05 AM, LPN (Licensed Practical Nurse) #1 (the day shift nurse) was informed of the above information and Resident #78's present complaint of pain.

LPN #1 looked in the system and confirmed that the resident had an order for Hydrocodone-Acetaminophen (a narcotic medication for moderate to severe pain) solution, scheduled at bedtime, for mastoid bone pain, with a Start Date of 10/31/22. Reviewing the EMAR (electronic medication administration record) further, LPN #1 stated that the resident #78 did not get the medication last night (11/01/22 at 10 PM) and that according to the nursing/note written by the LPN #7, the medication was on order. Stating that it shouldn't take that long for a medication to get here, LPN #1 added, "It was ordered on 10/31/22, it should be here." While observed, LPN #1 looked thru the medication cart until holding a bottle and said, "This is it." The bottle was labled with Resident # 78's name, medication name, and date dispensed as 10/31/22. When asked, LPN #1 pulled the narcotic count sheet and stated that none of the medication doses were documented or signed off as administered on 11/1/22. As requested, LPN #1 also checked 10/31/22 and stated that the

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resident had not received pain medication on that night either.

On 11/02/22 at approximately 8:45 AM, LPN #1 stated that she had obtained a one time order to administer the resident's pain medication. Observed preparing the medication, LPN #1 took the medication to the Resident #78's room. Holding her hand to side of her head & grimacing, Resident #78 appeared teary-eyed. When asked what her pain level was at the time. Resident #78 responded that her pain was now at 8.5 out of 10 (indicating very severe pain), took the medication, and stated that she hoped it helped.

At approximately 9:30 AM, Resident #78's clinical records were reviewed. The resident's physician's orders were reviewed and included an order for: "...[order date: 10/31/22 10:32 am] Hydrocodone-Acetaminophen solution 2.5 -108 mg/5 ml (milligrams/milliliter) Give 5 ml by mouth at bedtime for mastoid bone pain Start Date: 10/31/22..."

The Resident #78's MAR (medication administration records) for October and November 2022 were reviewed. On 10/31/22 and 11/01/22 at 10:00 PM, the MAR documented a '9' in the slot for the scheduled pain medication (Hydrocodone-Acetaminophen solution). According to the MAR legend, a '9' means 'Other/see nursing notes'.

The review of the nursing notes included the following entries:

On 10/31/22 the nursing note documented, "10/31/2022 5:00 PM...Orders - General Note...you have entered

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HYDROcodone-Acetaminophen Solution 2.5-108 MG/5ML
Give 5 ml by mouth at bedtime for mastoid bone pain..."

On 11/1/2022 an EMAR note documented, "...1:35 AM - Medication Administration Note ...HYDROcodone-Acetaminophen Solution 2.5-108 MG/5ML Give 5 ml by mouth at bedtime for mastoid bone pain Pending pharmacy delivery @ this time. New mediation [medication] RX [prescription]..."

On 11/2/2022 an EMAR note documented, "...12:17 AM - Medication Administration Note... HYDROcodone-Acetaminophen Solution 2.5-108 MG/5ML Give 5 ml by mouth at bedtime for mastoid bone pain Medication pending delivery @ this time. Res resting in bed w/ eyes closed..."

No progress notes were found to evidence that a physician was either notified that Resident #78 did not receive the physician ordered pain medication or that the ordered pain medication was not available for administration.

Upon review, Resident #78's current CCP (comprehensive care plan) was reviewed. The CCP documented, "...Pain Management Date initiated: 11/01/22 resident will demonstrate and verbalize knowledge of strategies for pain management...pain management date initiated: 11/01/22...Resident will be offered non-pharmacological interventions for pain...distraction, entertainment/activity, food and fluids...repositioning...date initiated: 11/01/22..." This care plan was developed on 11/01/22. There was no other information on the resident's care plan regarding pain, including resident

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preferences, pain assessment, guidelines for reporting pain, treatment effectiveness, or emerging issues. No documentation was found that the above pain management interventions had been implemented or even offered.

On 11/02/22 at 11:51 AM, Resident # 78 was observed laying calmly in bed, without any grimacing. When asked if she was feeling better, Resident #78 responded, 'some' and stated that her pain level was "...still at a level 5," which indicated moderate pain.

On 11/02/22 at 3:10 PM, the NP (Nurse Practitioner) was made aware of the above findings regarding the observation and interview with Resident #78 on 11/02/22. Adding that the resident's pain medication was found on the medication cart but had not been administered, which resulted in Resident stating that she had a rough night and was unable to sleep due to being in pain and was hoping that she didn't start crying due to the pain. In response, the NP stated that Resident #78 has mastoid bone arthritis, for which several meds had been tried, including gabapentin, "...which didn't really help." The NP stated that a low dose of Norco [hydrocodone-acetaminophen] had been started, "...which seemed to do better for her pain." When asked, the NP stated that when any resident is in pain and their pain medication is not available or they don't have pain medication ordered, "...my [the NP] expectation would be for the nurse to call the provider to obtain an order for an alternative pain medication of something preferably in house, to prevent a delay in treating the resident's pain." The NP then stated that she had not been on call, that she had not been made aware of this, and

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again stating the nurse should have contacted the provider.

On 11/02/22 at approximately 6:15 PM, the administrator, DON (director of nursing), ADON (assistant director of nursing) and the corporate nurse were made aware of the serious concerns with Resident #78 being observed in pain, after not receiving the scheduled pain medication as ordered, with complaints of inability to sleep and continued pain, when the medication was actually available for administration. A policy on pain management was requested at this time. At 6:35 PM, the DON stated that the expectation would be and is for the nurse to notify the provider to get an order for something for pain.

On 11/03/22, the facility policy titled "Pain-Clinical Protocol" was provided, which documented, "...staff will identify individuals who have pain...staff will evaluate how pain is affecting mood, activities of daily living, sleep...quality of life...the pain management program is based on...appropriate assessment...resident choices related to pain management...signs of pain...verbal expressions...groaning, crying...facial expressions...grimacing, frowning...limitations in her/her activity...insomnia...non pharmacological interventions may be appropriate alone or in conjunction with medications...ice packs, cool or warm compresses, baths,...relaxation...pharmacological interventions be prescribed to manage pain...administering medications around the clock rather than PRN [as needed]...implement the medication regimen as ordered..."

Another facility policy, which was titled

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F 697	Continued From page 70 "Unavailable Medications", documented that staff "...shall follow established procedures for ensuring residents have a sufficient supply of medications...may be unavailable for a number of reasons...Staff shall take immediate action when it is known that the medication is unavailable...Notify physician...obtain alternate treatment..." No further information and/or documentation was presented prior to the exit conference on 11/03/22 to evidence that facility staff provided timely pain management to Resident # 78 when experiencing pain, in accordance with the physician's orders and the CCP. This is a harm level deficiency.	F 697		