STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495121	A. BUILDING _____ B. WING _____	C 08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/16/2022 through 8/18/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/16/2022 through 8/18/2022. One complaint was investigated during the survey. Complaint VA00055523 was substantiated with deficient practice. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 174 at the time of the survey. The survey sample consisted of thirty-four (34) current resident reviews and three (3) closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure two of 37 residents were assessed for self administration of medications (Resident #99 and Resident #127).	F 554	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or	9/20/22

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

Electronically Signed | 09/07/2022

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F 554	Continued From page 1 1. Resident # 99 was not assessed to self administer eye drops. A bottle of eye drops were observed at the resident's bedside. 2. Resident #127 was not assessed to self administer eye drops (a bottle of betadine eye drops and a bottle of artificial tears were found at the resident's bedside). Findings include: 1. Resident #99's diagnoses included, but were not limited to: severe protein malnutrition, dysphagia following a stroke, high blood pressure, hemiplegia/hemiparesis, history of UTI (urinary tract infection), and atrial fibrillation. The resident's most recent MDS (minimum data set) was an admission assessment dated 08/13/22. This MDS assessed the resident with a cognitive score of 11, indicating the resident had moderate impairment of daily decision making skills. The resident was also assessed as requiring extensive assistance with at least one to two staff members for all ADL's (activities of daily living). On 08/16/22 at 8:39 AM, the resident was observed in bed. A bottle of prescription (with resident's name) Alcon (Isopto tears) hypromellose 0.5% 1 drop twice daily (dated 07/31/22) was observed on the resident's night stand. The resident was asked if she took eyes drops. The resident stated that she did not know. The resident was asked if she could put in eye drops on her own. The resident stated that she did not know.	F 554	will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F554 1. Resident #99 does not have an order for use of eye drops and the eye drops have been removed from the bedside. Resident #127□s eye drops were discontinued on 7/25/22 and the eye drops have been removed from the room. 2. Current Residents have the potential to be affected. 3. CNAs were educated by the SDC/designee to report any medications noted in the resident□s room to the charge nurse. Nurses were educated by the SDC/designee on physician notification of resident□s request to keep medications in the room for self-administration, completion of a Medication Self-Administration Safety Screen, and provision of a lock box for safe storage of the medication. 4. The Unit Managers will complete a weekly random review of residents to determine if the resident requests to self-administer medications and to ensure that the Medication Self-Administration Safety Screen has been completed indicating that the resident is able to safely administer medications and that a lock box has been provided. 5. The results of the review will be discussed at the monthly QAPI meeting.	

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F 554	Continued From page 2 The resident was observed multiple times throughout the day on 08/16/22, the bottle of eye drops remained on the resident's night stand. On 08/17/22 at 10:53 AM, Resident #99 was observed again in bed and again the bottle of eye drops were still on the resident's night stand beside the bed. The resident's physician's orders were reviewed and there were no current orders for any type of eye drops for this resident. The resident's current care plan was reviewed and documented, "Care Needs...administer medications as ordered..." There was no specific information on the care plan regarding eye drops/eye care for this resident. No information was found in the resident's clinical record regarding self administration of medications. On 08/17/22 at approximately 11:00 AM, the UM2 (unit 2 manager) was made aware that medications were at the resident's bedside and was asked if that was common practice to leave medications in the resident's room. The UM2 stated that they should not be left in the room. On 08/17/22 at approximately 11:30 AM in the corporate nurse was made aware of the above observations and was asked for assistance in locating any information regarding this resident for self administering medications. On 08/17/22 at approximately 4:30 PM, in a	F 554	Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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meeting with the survey team, the administrator and corporate consultants were again made aware of the above observations and information. The corporate consultant stated that there was no self administration assessment for medications for Resident #99 and stated that medications should not be left at the bedside.

No further information and/or documentation was provided prior to the exit conference regarding the eye drops observed at the bedside for Resident #99.

A policy was presented and reviewed titled, "...Self Administration of Medications at Bedside...patients may request to keep medications at bedside for self administration in a lock box...Verify physician's order...for self administration...complete self administration safety screen..."

2. Resident #127's diagnoses included, but not limited to: sepsis, HIV (human immunodeficiency virus) lymphedema, and cardiomyopathy.

On 08/16/22 at 8:54 AM, the resident was observed and interviewed in the resident's room. The resident had a medication bottle of betadine eye drops on the bedside table, along with a bottle of artificial tears (both bottles had the resident's name on them). The resident was asked if he puts in the eye drops, the resident stated that he did not.

The resident was observed multiple times throughout the day on 08/16/22 with the two bottles of eye drops at the bedside.

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On 08/17/22 at approximately 11:55 AM, the resident was observed again in bed. The medications were still on the bedside table.

On 08/17/22 at approximately 11:00 AM, the UM2 was made aware that medications were at the bedside and was asked if that was common practice to leave medications at the bedside. The UM2 stated that they should not be left in the room.

Resident #127's physician's orders were reviewed. The resident had an order for, "Ophthalmic Irrigation Solution Solution Instill 1 drop in both eyes four times a day for Eye irritation..." This was the only order found for eye drops.

The resident's care plan was reviewed and documented, "...Care Needs...administer medications as ordered..."

No assessment was found for Resident #127 regarding self administration of medications.

On 08/17/22 at approximately 11:30 AM in the corporate nurse was asked to help locate an assessment for the self administration of medications for Resident #127.

On 08/17/22 at approximately 4:30 PM, in a meeting with the survey team, the administrator and corporate consultants were again made aware of the above observations and information. The corporate consultant stated that there was no assessment for self administration of medications for Resident #127 and that medications should not be left at the bedside, unless the resident is assessed to do so.

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F 554	Continued From page 5 A policy was presented and reviewed titled, "...Self Administration of Medications at Bedside...patients may request to keep medications at bedside for self administration in a lock box...Verify physician's order...for self administration...complete self administration safety screen..." No further information and/or documentation was provided prior to the exit conference on 08/18/22 at noon.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		9/20/22

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F 561	Continued From page 6 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to allow two of 37 residents to have "private time" together. Resident #103 and Resident #105, both cognitively intact, and consenting, were not allowed by the facility staff to spend time together alone. Findings were: On 08/16/2022 at approximately 10:00 a.m., Resident #103 and Resident #105 were interviewed per their request. Both residents raised concern that they were not "allowed" to be in each others rooms. They were asked to explain. Resident #103 stated, "We are friends. They won't let us spend time together, we can't have innocent coffee without them separating us....they told us we can't be in each other's rooms...there is some rule about males and females being alone in a room...I got so upset the other day I thought I was going to have a stroke...they kept saying we had to stay away from each other...we want to be together and they won't let us." Resident #103 was asked who "They" were. He stated, "The nurses, the aids, all of them." Resident #105 nodded her head and stated, "That's right. We aren't bothering anybody. I don't know why it is a problem." At approximately 11:30 a.m. the clinical records	F 561	F561 1. Resident #103□s care plan has been revised to encourage self-directed activities of his choice. Resident #105□s care plan has been revised to encourage self-directed activities of her choice. 2. Current Residents have the potential to be affected. 3. Facility staff will be educated by the SDC/designee on resident rights to include private time between cognitively intact and consenting residents. 4. The Discharge Planner/Social Worker will complete a random weekly review of cognitively intact residents to ensure that the residents are able to have private time with other cognitively intact and consenting residents. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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for Resident #103 and Resident #105 were reviewed.

Resident #103 was admitted with the following diagnoses, including but not limited to: diplopia, depressive disorder, hypertension, and hemiplegia. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/08/2022, assessed Resident #103 as cognitively intact with a summary score of "14".

Resident #105 was admitted with the following diagnoses, including but not limited to: Encephalopathy, UTI (urinary tract infection), dementia, and shoulder pain. An admission MDS with an ARD of 07/18/2022 assessed Resident #105 as cognitively intact with a summary score of "14".

The progress notes were reviewed. Resident #103's clinical record contained the following:

"8/4/2022 22:48 (10:48 p.m.) Health Status Note...Resident has been going to room (Resident #105's room number).. He has been touching the resident inappropriately in the room and on (sic) the hallway. Writer redirect resident during the shift. Nurse will continue."
"8/12/2022 14:29 (2:29 p.m.) MEDICAL NOTE...Patient asking the staff about testosterone. He wants "pills" I checked his testosterone level recently. It was over 500. I don't believe there's any need to give him testosterone. I don't know where this is coming from?..."

Progress notes in Resident #103's clinical record contained the following:

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"8/4/2022 22:44 (10:44 p.m.) Health Status Note...Resident has been going to the room of (Resident #105's room number) during the shift advancing inappropriate behavior. Writer redirects the resident to her room, but she refuses. Nurse will continue to monitor."
"8/8/2022 19:37 (7:37 p.m.) Health Status Note...Resident is alert, oriented and verbally responsive...Resident has been in Room (Resident #105's room number) throughout the shift. She is sitting on resident's bed playing with the male resident of A bed. Writer requested the resident who is female in Room (Resident #103's room number) to leave room (Resident #105's room number), she refuses. Both residents in Room (Resident #105's room number) get angry. Supervisor was notified."
" 8/8/2022 22:54 (10:54 p.m.) Health Status Note...Resident is still in the room of (Resident #105's room number) in bed with the male resident at this time. Supervisor contact the daughter (name) of the resident in room (Resident #103's room number) and notify her about my mum's activities. She laughs about it and ask to be transfer to her mum. Continues to monitor."
"8/9/2022 07:45 (7:45 a.m.) Skilled Note Resident stayed in room (Resident #105's room number) even after encouragement from nurse. Resident was found sleeping in bed with male patient. family was called and arrived and spoke to resident. Resident eventually went to own right (sic should be room)."

The discharge planner/social worker, other staff #9. She was asked if she was aware that Resident #103 and Resident #105 were being told by staff that they could not be in each others rooms. She stated, "I know that they are friends,

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they like to sit together during meals." The interviews with Resident #103 and Resident #105, as well as the information in the clinical record were discussed. She was asked if anyone had discussed the resident's concerns and wishes with her. She stated, "No, I was not aware of that." She was asked if there was a rule that two cognitively intact, consenting adults, could not spend time alone. She stated, "No, that is their right." She presented a paper, "Resident Rights Annual Review" and stated, "This is a list of resident rights, we give it to each resident at admission and review it at least annually." She was asked which of the twenty rights listed would apply to the situation. She reviewed the list and stated, "There is a right for married couples to share a room, I know they aren't married, but that may be an option...also there is a right to have visitation rights and communicate privately...I will speak with them and get back to you.

On 08/17/2022 at approximately 9:00 a.m., the clinical records for Resident #103 and Resident #105 were reviewed. Notes were in both records that OS #9 had spoken with them individually and explained their rights. There was also a note from the physician written during the evening of 08/16/2022 which stated, "As far as I know physical relations are not allowed in the facility..."

OS #9 was interviewed at approximately 10:00 a.m. She stated, "I spoke to the residents yesterday, I told them they have some choices. We can move them into the same room, which (Name of Resident #105) is willing to do, but (Name of Resident #103) wants some time to think about it...I told them if we don't do that, we will have to find them a space to be together. They can't have intimate time while their other

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F 561	Continued From page 10 roommate is in the room and they can't ask the roommate to leave. We are limited on space but we will figure it out." She was asked if she had read the physician's note from the night before. She stated she had not. The contents of the note were discussed. She stated, "I will speak with him." The unit manager of the unit where Resident #103 and 105 resided was interviewed on 08/17/2022 at approximately 10:30 a.m. He was asked if he was aware of the relationship between the two residents and the actions of staff on the unit to keep them apart. He stated, "Yes, I am aware. She is new here, he is after her, it is not appropriate." He was asked why it was not appropriate since they were both cognitively intact and consenting. He stated, "They both have intermittent confusion." The above information was discussed during an end of the day meeting on 08/17/2022 with the administrator and the administrative staff. No further information was obtained prior to the exit conference on 08/18/2022.	F 561		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		9/20/22

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mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(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).

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F 580	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the physician of unavailable medications for one of thirty-seven residents in the survey sample. Resident #78's physician was not notified that the resident missed multiple doses of the medication epoetin alfa-epbx (Epogen) for treatment of anemia. After missing eight consecutive doses of the medication over a period of eight weeks, Resident #78 experienced critically low hemoglobin levels of 6.8 and 6.7 g/dL (grams per deciliter) requiring treatment with a blood transfusion. The findings include: Resident #78 was admitted to the facility with diagnoses that included anemia in chronic kidney disease, diabetes, osteomyelitis, multiple myeloma in remission, peripheral vascular disease, dysphagia, cerebrovascular disease, COPD (chronic obstructive pulmonary disease), hypertension, hyperlipidemia, major depressive disorder, gout and urinary retention. The minimum data set (MDS) date 6/27/22 assessed Resident #78 as cognitively intact. Resident #78's clinical record documented a physician's order dated 1/18/22 for epoetin alfa-epbx 4000 units/milliliter with instructions to administer 1 ml (milliliter) intramuscularly once every 7 days for treatment of anemia. Resident #78's medication administration record (MAR) documented no administration of the epoetin alfa-epbx during the next eight weeks following the order. The MAR documented doses	F 580	F580 1. The physician was notified of the missed doses of Epogen for Resident #78. The Epogen was discontinued on 4/18/22. 2. Current Residents have the potential to be affected. 3. Nurses will be educated by the SDC/designee on physician notification of medications which are not available for administration. 4. The Unit Managers/designees will complete a weekly review of medication administration to ensure that the physician has been notified of medication not available for administration. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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of epoetin alfa-epbx were scheduled but not administered on 1/27/22, 2/3/22, 2/10/22, 2/17/22, 2/24/22, 3/3/22, 3/10/22 and 3/14/22.

Nursing notes documented the epoetin alfa-epbx was not administered because the medication was not available from the pharmacy. Nursing notes documented the following regarding missed doses of the epoetin alfa-epbx.

2/3/22 - "...med [medication] is not available Epoetin Alfa-epbx Solution 4000 unit/ml..."
2/10/22 - "...non available labs to be faxed to pharmacy..."
2/17/22 - "Waiting for pharmacy to deliver Epoetin Alfa-epbx Solution 4000 unit/ml..."
2/24/22 - "non available"
3/10/22 - "awaiting delivery"
3/14/22 - "no available labs faxed..." (sic)
3/15/22 - "...Hg [hemoglobin] 6.8. Epoetin Alfa-epbx Solution 4000 unit/ml and order fax to pharmacy waiting for med..."

Prior to and during the weeks of missed epoetin alfa-epbx, Resident #78's hemoglobin was tested and documented as follows. The resident was identified with critically low hemoglobin on 3/14/22 after missing the ordered epoetin alfa-epbx injections for two months.

Lab reports listed the hemoglobin in g/dL and documented a reference/normal range of 11.0 to 15.3 g/dL.

11/19/21 - 8.6 (low)
12/16/21 - 11.2 (in range)
1/31/22 - 8.6 (low)
2/28/22 - 7.1 (low)
3/3/22 - 7.3 (low)

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3/7/22 - 7.4 (low)
3/14/22 - 6.8 (critically low)

A nurse practitioner (other staff #4) assessed Resident #78 two times prior to the critically low hemoglobin level of 3/14/22. The NP notes listed the resident was receiving epoetin alfa-epbx as treatment for anemia and made no mention of the resident not receiving the injections as ordered or that the medication was not available. The NP (other staff #4) documented the following assessments of Resident #78.

1/24/22 - "...Pt asked to be seen per nursing request for abnormal lab review...Assessment and Plan...Anemia Epoetin 1 ml [milliliter] IM [intramuscularly] inj [injection] Q 7D [every 7 days]..."

3/2/22 - "...Pt asked to be seen per nursing request for blood streaks in foley catheter, fever, and tachycardia...Assessment and Plan...Anemia Epoetin 1 ml IM inj Q 7D..."

A different NP (other staff #13) assessed the resident on 3/11/22 and diagnosed a urinary tract infection, started antibiotics and increased the frequency of the epoetin alfa-epbx from once per week to three times per week. There was no mention in the note that the resident had not received prescribed weekly doses of epoetin alfa-epbx or that the medicine had not been provided by the pharmacy.

The lab report listing the critically low hemoglobin of 6.8 on 3/14/22 documented the physician was notified of the abnormal value on 3/15/22. A nursing note dated 3/15/22 documented, "...Lab result received Hg [hemoglobin] 6.8. Epoetin

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Alfa-epbx 4000 unit/ml and order fax to pharmacy waiting for med. NP...notified. Continue Cefuroxime Axetil Tablet 500 mg...for UTI [urinary tract infection]..."

An additional dose of epoetin alfa-epbx scheduled for Wednesday 3/16/22 was not administered as ordered. A nursing note dated 3/16/22 at 10:22 a.m. documented, "Pending pharmacy delivery" and another note dated 3/16/22 at 10:55 p.m. documented, "Waiting for med Epoetin Alfa-epbx Solution 4000 unit/ml..."

There was no documented notification to the physician or NP about the unavailable epoetin alfa-epbx until 3/17/22. A nursing note dated 3/17/22 documented, "NP [nurse practitioner]...was notified of Epogen still pending deliver from pharmacy..." (sic) The NP ordered a repeat lab test for 3/18/22. The resident's hemoglobin was checked on 3/18/22 with results reported on 3/19/22 indicating another critically low value at 6.7 g/dL. A nursing note dated 3/19/22 documented, "...NP Notified of critical labs and order received to send pt [patient] out to... [hospital] for blood transfusion..."

The emergency department report dated 3/19/22 documented, "...presents from...nursing facility, after being found to have severe anemia, hemoglobin of 6.7. She reports no significant symptoms...upon being informed of her decreased hemoglobin, she was sent to the ER [emergency room] for transfusion..." The ER report documented the resident's hemoglobin at 6.8. The resident was administered one unit of packed red blood cells and transferred back to the facility on 3/20/22.

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NP (other staff #4) assessed Resident #78 on 3/21/22 after the blood transfusion. The NP note dated 3/21/22 documented, "...Assessment and Plan...Anemia critical lab hemoglobin 6.7, send out non-emergent for transfusion, 1 unit PRBCs [packed red blood cells] c/w [continue with] Epo [Epogen] 1 ml mon, wed, fri x 5 weeks..."

The resident continued to miss doses of the epoetin alfa-epbx following the blood transfusion because the medication was not available. Scheduled doses on 3/23/22, 3/25/22 and 3/28/22 were not administered because the medication was not provided by the pharmacy. There was no notification to the physician regarding these missed doses of epoetin alfa-epbx.

The record documented no notification to the physician regarding the missed doses of epoetin alfa-epbx from 1/24/22 until 3/17/22. Nurse practitioner assessments on 1/24/22 and 3/2/22 listed the epoetin alfa-epbx as treatment for anemia and made no mention the medication was not administered to the resident as ordered. Another NP assessment on 3/11/22 made no mention of missed/unavailable epoetin alfa-epbx and increased the frequency of the medication from once per week to three times per week.

On 8/17/22 at 10:06 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about Resident #78's missed doses of epoetin alfa-epbx. LPN #1 stated he did not work on Resident #78's unit until May 2022 and he did not know anything about the missed epoetin alfa-epbx or the critically low hemoglobin.

On 8/17/22 at 11:10 a.m., the regional director of

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clinical services (other staff #3) stated she reviewed Resident #78's medication records and the epoetin alfa-epbx was not administered as ordered and nursing should have notified the physician regarding the missed medication.

On 8/17/22 at 11:10 a.m., the unit manager (LPN #1) was interviewed again about the protocol when medications were not available. LPN #1 stated if medications were not available, the nurse should call pharmacy requesting delivery, notify the physician and seek alternate treatments if appropriate.

On 8/17/22 at 2:08 a.m., the nurse practitioner (other staff #4) that routinely cared for Resident #78 was interviewed about epoetin alfa-epbx and the missed doses prior to critically low hemoglobin values. The NP stated the Epogen (epoetin alfa-epbx) was a medication used to stimulate production of red blood cells for patients with anemia. The NP stated Resident #79 had anemia due to chronic kidney disease. The NP stated the resident's baseline hemoglobin was low and ran "in the high 7's." The NP stated she "got a couple of contacts from nursing" about the medication not available but she did not recall specific dates of the notifications.

The director of nursing was out on leave and not available for interview during the survey.

On 8/17/22 at 5:10 p.m., these findings were discussed with the administrator, regional director of clinical services and the corporate nursing consultant. The administrator stated at this time that nursing should contact the pharmacy when medicines were not available and notify the physician about any missed medicines.

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On 8/18/22 at 10:00 a.m., the regional nurse consultant (other staff #2) stated there was no notification documented regarding the unavailable Epogen for Resident #78. The nurse consultant stated she talked with the nurses and they reported some communication back and forth about the issue but there was nothing documented. The nurse consultant stated it was protocol to send a resident out for transfusion/treatment when hemoglobin dropped below 7.0.

On 8/18/22 at 10:03 a.m., the NP (other staff #13) that assessed Resident #78 on 3/11/22 and increased the Epogen dose to three times per week was interviewed. This NP stated she was on-call and nursing notified her about abnormal labs. This NP stated she was not aware the resident was not getting the prescribed weekly doses of Epogen. This NP stated she increased the dose to three times per week because, based on her calculations, the previous dose was not adequate for the resident's condition and weight. This NP stated again she was not aware the resident had missed weeks of the Epogen injections.

Resident #78's plan of care (revised 2/15/22) documented the resident had care needs and weakness due to conditions that included kidney failure, anemia and end stage kidney disease. Interventions to prevent complications included, "Monitor and notify MD/RP [responsible party] of any critical Lab...Notify MD/RP of any changes in condition...Administer medications as ordered..."

The Lippincott Manual of Nursing Practice 11th edition on pages 757 and 758 describes anemia

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as, "...the lack of sufficient circulating hemoglobin to deliver oxygen to tissues...Treatments for anemia include nutritional counseling, supplements, RBC [red blood cell] transfusions, and, for some patients, administration of exogenous erythropoietin (epoetin alfa or darbepoetin alfa), a growth factor stimulating production and maturation of erythrocytes...Severe compromise of the oxygen-carrying capacity of the blood may predispose to ischemic organ damage, such as myocardial infarction or stroke..." (1)

The Nursing 2022 Drug Handbook on page 49 describes epoetin alfa-epbx as a hematopoietic agent used for the treatment of anemia associated with chronic renal failure and cancer chemotherapy by stimulating red blood cell production in the bone marrow. Page 528 of this reference documents concerning epoetin alfa-epbx prescribed for anemia caused by chronic renal disease, "...Maintenance dosage is highly individualized. Give the lowest effective dose to gradually increase Hb [hemoglobin] to a level at which blood transfusion isn't necessary..." (2)

These findings were reviewed with the administrator, regional director of clinical services and corporate nursing consultant during a meeting on 8/17/22 at 4:15 p.m.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.

(2) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.

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F 607	Continued From page 20	F 607		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of employee files, staff interview, and review of facility policy and procedure, the facility failed to fully implement their policy for the screening of new employees. The facility filed to conduct a Criminal Background check for one of 24 employee files reviewed, and failed to ensure the Sworn Statement form was completed for two of 24 employee files reviewed. The findings were: During the review of 24 employee files, the following was found: A CNA (Certified Nursing Assistant) hired on 5/16/2022, did not have a Criminal Background Check completed. A CNA hired on 10/4/2021, did not have the Sworn Statement form completed. The Sworn Statement form, dated 10/3/2021, bore the	F 607	F607 1. The CNAs have completed screening as indicated by policy. 2. Current employees will be reviewed to ensure that criminal background checks and the sworn statement form has been completed. 3. The HR Manager will be educated by the Administrator/designee on obtaining criminal background checks and sworn statement forms at time of hire to ensure proper screening is completed. 4. The Administrator/designee will complete a review of newly hired employees to ensure that the criminal background check is complete that the sworn statement form is complete. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The	9/20/22

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F 607	Continued From page 21 employee's electronic signature. None of the barrier crimes listed on the form were responded to with either a Yes or No. A CNA hired on 6/20/2022, did not have the Sworn Statement form completed. The Sworn Statement form, dated 6/20/2022, bore the employee's electronic signature. None of the barrier crimes listed on the form were responded to with either a Yes or No. At approximately 3:30 p.m. on 8/16/2022, the Human Resources Manager (HR) was interviewed. After reviewing the three CNA employee files in question, the HR Manager said, "I missed them." The findings were discussed during a meeting at 4:00 p.m. on 8/16/2022 that included the Administrator, Director of Nursing, and the survey team.	F 607	Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure an accurate MDS (minimum data set) assessment for two of 37 resident's in the survey sample. Resident #167's discharge MDS assessment was coded as being discharged to the hospital instead of home. Resident #136 was not properly coded for infection in the foot.	F 641	F641 1. Resident #167□s MDS was modified to reflect the correct discharge destination. Resident #136□s MDS with was modified to include the foot infection. 2. Current Residents have the potential to be affected. 3. The MDSCs will be educated by the SDC/designee on correct coding of	9/20/22

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F 641	Continued From page 22 The Findings Include: 1. Diagnoses for Resident #167 included: Right femur fracture, right hip replacement, and anxiety. The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 4/25/22. Resident #167's cognitive score was a 15 indicating cognitively intact. During a closed record review, Resident #167 was added to the sample as a hospital discharge review. On 8/17/22 Resident #167's clinical record was reviewed. Section "A2100" of Resident #167's discharge MDS (dated 6/9/22) documented Resident #167 had been discharged to "Acute Hospital." Review of Resident #167's progress notes dated 6/9/22 read in part "Pt [patient] was discharged home today, all d/c [discharge] teaching was done." On 8/17/22 at 4:00 PM the MDS coordinator (registered nurse, RN #2) was interviewed regarding what she had documented on the MDS. RN #2 reviewed Resident #167's discharge MDS and then reviewed the discharge progress note. RN #2 verbalized that there was a mistake on the MDS and Resident #167 had actually went home. On 08/17/22 at 4:45 PM the above finding was presented to the administrator, and nurse consultant. No other information was presented prior to exit conference on 8/18/22.	F 641	discharge destination and presence of wounds. 4. The Unit Managers/designee will complete a random weekly review of MDS to ensure that coding for discharge destination and foot infection is accurate. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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2. The facility failed to ensure an accurate MDS assessment for Resident #136 regarding an infection in the resident's foot.

Resident #136's diagnoses included, but were not limited to: muscle weakness, high blood pressure, diabetes mellitus, and osteomyelitis of the left ankle/foot with partial amputation of the left foot.

Resident #136's most recent MDS (minimum data set) was an admission assessment dated 07/27/22. This MDS assessed the resident with a cognitive score of 14, indicating the resident was intact for daily decision making skills. The resident was also assessed as requiring extensive assistance with most ADL's (activities of daily living). In Section M1040. (Other Ulcers, Wounds and Skin Problems) Foot Problems (A. Infection of the foot (e.g., cellulitis, purulent drainage) B. Diabetic foot ulcer(s) C. Other open lesion(s) on the foot), none of the items were marked for Resident #136.

Resident #136's admission orders were reviewed and revealed the resident was admitted for the care and treatment of an infection in the resident's foot.

On 08/18/22 at approximately 9:00 AM, RN #8 (MDS coordinator) was interviewed regarding the above information and asked if the resident's admission MDS should have documented the resident's foot infection. The RN stated that she would check to be sure and it would depend if the resident was receiving treatments for the foot infection at that time.

At approximately 9:20 AM, RN #8 returned and

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F 641	Continued From page 24 stated that the resident's MDS assessment should have documented the resident's foot infection in Section M1040, since the resident had an infection upon admission to the facility. No further information and/or documentation was presented prior to the exit conference on 08/18/22 at noon.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph	F 655		9/20/22

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F 655	Continued From page 25 (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to develop and provide a summary of a baseline care plan to one of 37 residents, Resident #166. Findings were: Resident #166 was admitted to the facility with the following diagnoses, including but not limited to: hypothryoidism, pneumonia, acute kidney failure, hypertension, acute pulmonary edema, congestive heart failure. An admission MDS (minimum data set) with an ARD (assessment reference date) of 02/22/2022, assessed Resident #166 as cognitively intact with a summary score of 14. The clinical record was reviewed beginning on 08/17/2022 at approximately 3:15 p.m. Review of the clinical record did not reveal any	F 655	F655 1. Resident #166 no longer resides at the facility. 2. Current Residents have the potential to be affected. 3. Nurses will be educated by the SDC/designee on development and provision of the baseline care plan summary to the resident/RP. 4. Unit Managers/designees will complete a weekly review of newly admitted residents to ensure that the summary of the baseline care plan was provided to the resident/RP. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan	

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F 655	Continued From page 26 documentation regarding a base line care plan meeting with Resident #166 or her family. The Regional Director of Clinical Services was interviewed on 08/18/2022 at 9:10 a.m. She was asked if baseline care plans were completed at the facility and were the residents/family members involved in the development of the care plan and provided a summary. She stated, "We have a policy for baseline care plans...it has not been implemented here..." The facility policy, "Care Planning" was reviewed and contained the following: "The center will provide the patient and representative(s) with a summary of the baseline care plan that includes, but is not limited to: * Initial goals of the patient * Summary of the patient's medication list * Services and treatments to be administered by the Center... * Updated information based on the details of the comprehensive care plan ...at the care plan meeting the resident/RP will be provided the care plan goals, medication, and diet in writing..." No further information was obtained prior to the exit conference on 08/18/2022. This is a complaint deficiency.	F 655	of correction. 6. Date of compliance: 9/20/22	
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	F 656		9/20/22

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F 656	Continued From page 27 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the 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 observation, resident interview, staff	F 656	F656	

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F 656	Continued From page 28 interview, medical record review, and in the coarse of a complaint investigation the facility failed to develop a care plan for three of 37 resident's, and failed to meet with the resident and family regarding care plan goals for one of 37 resident's. A care plan was not developed for the care and monitoring of a Midline (A Intravenous line inserted into the upper arm, usually used for the treatment of antibiotics) for Resident #20. Resident #93 did not have a care plan for dialysis or shunt for dialysis. Resident #46 did not have a care plan for the care and monitoring of a forehead lesion/growth. Care plan goals were not discussed with Resident #166 or the family. This was a complaint deficiency. The Findings Include: 1. Diagnoses for Resident #20 included: Sepsis, stenosis of left carotid artery, depression, and urinary tract infection. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/30/22. Resident #20's cognitive score was a 15 indicating cognitively intact. On 08/16/22 at 8:54 AM during an interview, Resident #20 was asked about the Midline inserted into the left upper arm. Resident # 20 verbalized that he recently had an infection and was being given a antibiotics, but is no longer on antibiotics.	F 656	1. Resident #20 no longer has a midline and his care plan has been reviewed to ensure that his needs are addressed. Resident #93□s care plan has been revised to include dialysis and care of the shunt site. The care plan for Resident #46 was revised to address the atypical lesion to the forehead. Resident #166 no longer resides at the facility. 2. Current Residents have the potential to be affected. 3. Nurses will be educated by the SDC/designee on development of a care plan to address resident needs and discussion of care plan goals with the Resident/family. 4. Unit Managers/designees will complete a random weekly review of care plans to ensure that the care plan is comprehensive and meets the needs of the Resident and that care plan goals were discussed with the Resident/family. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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On 8/16/22 Resident #20's comprehensive care plan was reviewed for the care and monitoring of Resident #20's Midline and did not evidence a care plan had been completed.

On 8/17/22 at 8:36 AM the nurse consultant (administrative staff, AS #2) was interviewed. AS #2 reviewed Resident #20's care plan and verbalized a care plan should have been put in place with interventions regarding monitoring placement of the Midline.

On 8/17/22 at 4:45 PM the above information was presented to the administrator and nurse consultant.

No other information was presented prior to exit conference on 8/18/22.

2. Failed to develop a care plan for the care and monitoring regarding dialysis for Resident #93.

The Findings Include:

Diagnoses for Resident #93 Included: Chronic kidney disease, hemiplegia, diabetes, and anemia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/9/22. Resident #93's cognitive score was a 12 indicating cognitively intact.

On 8/17/22 Resident #93's medical chart was reviewed. A physician order (dated 4/18/22) read in part: "Dialysis every Monday, Wednesday, Friday."

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Resident #93's care plan was then reviewed and did not evidence a care plan had been developed for dialysis or the care and monitoring of Resident #93's shunt.

On 8/17/22 2:59 PM the facilities nurse consultant (administrative staff, AS #2) reviewed Resident #93's care plan for dialysis and verbalized a care plan was not developed and should have been.

On 8/17/22 at 4:45 PM the above information was presented to the administrator and nurse consultant.

No other information was presented prior to exit conference on 8/18/22.

3. Resident #46 was admitted to the facility with diagnoses that included atypical lesion of left eyebrow, hypertension, rheumatoid arthritis, chronic deep vein embolism, hyperlipidemia, cellulitis, peripheral vascular disease, major depressive disorder and GERD (gastroesophageal reflux disease). The minimum data set (MDS) dated 6/13/22 assessed Resident #46 as cognitively intact.

On 8/16/22 at 10:00 a.m., Resident #46 was observed in bed. The resident had an irregular shaped growth over the left eyebrow. The surface of the growth was red and moist with the lesion hanging partially over the upper portion of the left eyelid. Resident #46 stated the growth was supposed to have a dressing in place and the dressing was usually changed each day.

Resident #46's clinical record documented a physician's order dated 7/3/22 to cleanse the

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atypical lesion on the left eyebrow with wound cleanser, apply Xeroform, calcium alginate and cover with a border gauze every day shift and as needed for loose dressing. Treatment records documented dressing changes were done as ordered through 8/15/22.

Resident #46's plan of care (revised 3/18/22) included no problems, goals and/or interventions regarding the left eyebrow growth/lesion.

On 8/17/22 at 11:00 a.m., the licensed practical nurse (LPN #1) unit manager was interviewed about a plan of care regarding the eyebrow lesion. LPN #1 stated a care plan was supposed to be developed when new orders or new conditions occurred. LPN #1 stated a plan of care regarding the eyebrow lesion was "just missed."

This finding was reviewed with the administrator, regional director of clinical services and corporate nursing consultant during a meeting on 8/17/22 at 4:15 p.m.

4. Resident #166 was admitted to the facility with the following diagnoses, including but not limited to: hypothryoidism, pneumonia, acute kidney failure, hypertension, acute pulmonary edema, congestive heart failure.

An admission MDS (minimum data set) with an ARD (assessment reference date) of 02/22/2022, assessed Resident #166 as cognitively intact with a summary score of 14.

The clinical record was reviewed beginning on 08/17/2022 at approximately 3:15 p.m. Review of

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the clinical record did not reveal any documentation regarding care plan meetings or an invitation to care plan meetings with Resident #166 or her family.

The facility policy, "Care Planning" was reviewed and contained the following:
"The RN (registered nurse) MDS coordinator or designee will be responsible for inviting the patient and the family to the conference...Each patient's care plan will be discussed at the care plan conference by the IDT (interdisciplinary team) under the leadership of a licensed nurse. Notes will be kept for each patient's care plan discussed at the conference..."

One of the MDS (minimum data set) staff, RN #2 was interviewed on 08/18/2022 at 10:00 a.m. She was asked when care plan meeting were held. She stated, "We do them within fourteen days." She was asked why Resident #166 had not had a care plan meeting to discuss her goals and plan of treatment. She stated, "She was in and out...the clock resets with each admission to get the care plan completed...her last admission was March 16." She was asked why the care plan meeting had not been held on or before 03/30/2022, fourteen days later. She stated, "We do them on Thursdays." She looked at a calendar and stated the 30th was a Wednesday, we should have done it on the 31st." She was asked why the meeting had not occurred. She left the room and returned with a schedule of care plan meetings that included a meeting scheduled for Resident #166 on 03/30/2022. She was asked if the resident and her family had been invited to the meeting. She stated, "I can't find that form in her record or in medical records." She was asked why the meeting had not been held. She stated, "I

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F 656	Continued From page 33 think mostly because she was going to be discharged. There is no documentation about it...lesson learned, always document." The above information was discussed with the administrator and the administrative staff on 08/18/2022. No further information was obtained prior to the exit conference on 08/18/2022.	F 656		
F 657 SS=E	Care Plan Timing and Revision 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	F 657		9/20/22

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F 657	Continued From page 34 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to review and revise a comprehensive care plan (CCP) for 3 of 37 residents in the survey sample, Resident #135, Resident #42, and Resident #95. Resident #135's CCP was not reviewed and revised for the discontinuation and care of a PICC/Midline and for the change in discharge plans. Resident #42's CCP was not reviewed and revised for the discontinuation of anti-coagulant medication. Resident #95's CCP was not reviewed and revised for the discontinuation of tube-feeding and care of a gastrostomy tube. The findings include: 1a. Resident #135 was admitted to the facility with diagnoses that included urinary tract infection, difficulty walking, hyperlipidemia, anemia, hypertension, bacteremia, and COVID-19. The most recent minimum data set (MDS) dated 08/01/2022 was the 5-day admission assessment and assessed Resident #135 as moderately impaired for daily decision making with a score of 08 out of 15. Resident #135's clinical record was reviewed on 08/17/2022. Observed on the order summary report was the following order, "D/C (discontinue) PICC/Midline Order Date 08/10/2022. Observed on Resident #135's care plans was the following focus area including goals and interventions, "(Resident #135) has Midline catheter on left upper arm for Medication administration r/t	F 657	F657 1. Resident #135□s care plan has been revised to meet his current needs. Resident #42□s care plan was revised to discontinue the anticoagulant. Resident #95□s care plan has been revised to reflect the discontinuation of tube feeding and care of the gastrostomy tube 2. Current Residents have the potential to be affected. 3. Nurses will be educated by the SDC/designee on review and revision of the care plan to reflect current Resident needs. 4. The Unit Managers/designees will complete a random weekly review of care plans to ensure that the care plan was reviewed and revised to meet current Resident needs. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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(related to) UTI and ESBL in the urine."

On 08/17/2022 at 9:34 a.m., Resident #135 was observed eating breakfast in his room, the resident was not wearing a shirt at the time of the observation/interview. There was no PICC/Midline catheter observed on Resident #135's left upper arm. Resident #135 was asked if he had received medication through a PICC line in his arm. Resident #135 looked down and stated, "they took that thing out."

On 08/17/2022 at 4:00 p.m., the unit manager (LPN #3) who was responsible for Resident #135's care plans was interviewed. LPN #3 reviewed the clinical record and stated PICC/Midline care plan should have been resolved.

On 08/17/2022 at 4:15 p.m., the above findings were discussed during a meeting with the facility's administration team that included the administrator, staff development coordinator (RN #4), and corporate consultants. RN #4 stated the care plans were supposed to be reviewed and revised at the time of any change and every 90 days.

1b. Resident #135's clinical record was reviewed on 08/17/2022. Observed was the following process note:
"8/4/2022 11:42 DISCHARGE PLANNING PROGRESS NOTES Note Text: This dcp informed daughter on this date about insurance cut for LCD (last covered day) 8/6/22. Daughter informed me that his plan is LTC (long-term care) and that she has applied for Medicaid; she explained patient was previously at home and has declined significantly in terms of cognition and

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was at risk of burning things on the stove. This dcp explained medicaid process and medicaid pending status. This dcp informed BOM (business office manager), BOM to coordinate with daughter regarding medicaid."

Resident #135's care plans included a focus area with goals and interventions as "(Resident #125) preference for discharge is to return home. Created on 07/27/2022. Interventions Included: ..."Establish a pre-discharge plan with the resident/family/caregivers and evaluate progress and revise plan..."

On 08/17/2022 at 4:00 p.m, the unit manager (LPN #3) who was responsible for Resident #135's care plans was interviewed. LPN #3 stated, "sometimes the family changes their mind or there are other changes. For now I left the discharge location as home." LPN #3 was asked if there had been a recent change for the resident to return home and according to the note on 08/04/2022 the goal was for Resident #135 to remain at the facility for long-term care. LPN #3 stated, "no, but I was just leaving it in case the family changed their mind again."

On 08/17/2022 at 4:15 p.m., the above findings were discussed during a meeting with the facility's administration team that included the administrator, staff development coordinator (RN #4), and corporate consultants. RN #4 stated the care plans were supposed to be reviewed and revised at the time of any change and every 90 days.

2. Resident #42 was admitted to the facility with diagnoses that included wedge compression of lumbar vertebra, difficulty walking, muscle

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weakness, senile degeneration of brain, and, depression. The most recent MDS dated 06/13/2022 was the 5 day admission assessment and assessed Resident #42 moderately impaired for daily decision making with a score of 10 out of 15.

Resident #42's clinical record was reviewed on 08/16/2022. Observed on Resident #42's care plan was a focus area including goals and interventions: "ANTICOAGULANT: (Resident #42) is on anticoagulant therapy R/T (related to) DVT (deep vein thrombosis) prophylaxis. Created on 06/08/2022."

Resident #42's physician's orders were reviewed and documented orders for Eliquis (Apixaban) 2.5 mg ended on 06/15/2022. Resident #42's medication administration records (MAR) documented the Eliquis was discontinued on 06/15/2022.

On 08/17/2022 at 4:00 p.m., the unit manager (LPN #3) who was responsible for the care plans was interviewed. LPN #3 reviewed the clinical record and stated the anticoagulant care plan was overlooked and should have been resolved at the time ordered ended.

On 08/17/2022 at 4:15 p.m., the above findings were discussed during a meeting with the facility's administration team that included the administrator, staff development coordinator (RN #4), and corporate consultants. RN #4 stated the care plans were supposed to be reviewed and revised at the time of any change and every 90 days.

3. Resident #95 was admitted to the facility with

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the following diagnoses, including but not limited to: Encephalopathy, femur fracture, Alzheimer's, and hypertension.

A significant change MDS (minimum data set) with an ARD (assessment reference date) of 07/01/2022, assessed Resident #95 as severely impaired with a cognitive summary score of "00".

The clinical record was reviewed on 08/16/2022. The physician orders included: "Regular diet Level 4-Pureed texture, Level 2-Mildly thick consistency, fortified supplement with meal; Ensure plus two times a day for malnutrition prevention..."

The care plan was reviewed. The following focus areas with interventions were observed:
"(Name) has dehydration or potential fluid deficit r/t (related to) hx (history of infection and currently receiving enteral feed for nutrition and hydration."
"The resident requires tube feeding r/t dysphagia."
"NUTRITION: (NAME) is at nutrition risk r/t low BMI...NPO (nothing by mouth)d/t dysphagia, s/p (status post) PEG placement necessitating enteral feedings."

On 08/16/2022 during the lunchtime meal, Resident #95 was observed feeding himself a puree diet without difficulty.

The unit manager, RN (registered nurse) #4 was interviewed on 08/17/2022 at approximately 10:00 a.m. regarding Resident #95 and his diet. He stated, "He pulled the tube out. Speech looked at him and we started him on a puree diet last week." RN #4 was asked if the care plan should have been updated to remove the interventions

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F 657	Continued From page 39 for tube feeding and care of the feeding tube. He stated, "Yes, that should have been updated." The Regional Director of Clinical Services provided a copy of the facility policy for care plans on 08/18/2022 at approximately 9:00 a.m. The following was observed: "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur.." She was asked if Resident #95's care plan should have been updated. She stated, "Yes." No further information was obtained prior to the exit conference on 08/18/2022.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to obtain and/or follow physician orders for five of thirty-seven residents in the survey sample. 1. Resident #78 was not administered the medication epoetin alfa-epbx (Epogen) as ordered by the physician for treatment of anemia.	F 684	F684 1. The Epogen was discontinued for Resident #78. Resident #46 is receiving treatment to the forehead as ordered by the physician. Resident #136 no longer resides at the facility. Resident #92 is receiving Propranolol as ordered. Resident #20 is receiving care of the midline catheter as ordered by the	9/20/22

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F 684	Continued From page 40 After missing eight consecutive doses of the medication over a period of eight weeks, Resident #78 experienced critically low hemoglobin levels of 6.8 g/dL (grams per deciliter) and 6.7 g/dL and required treatment with a blood transfusion. 2. Resident #46 did not have a dressing applied to a forehead lesion as prescribed by the physician. 3. The facility failed to obtain a physician's order for the care and treatment of a midline (intravenous) catheter for Resident #136. 4. During the medication pass and pour observation physician orders were not followed for the administration of Propranolol (medication given for hypertension) for Resident #92. 5. There were no physician orders obtained for the care of a midline (an intravenous line inserted into the upper arm, usually used for the treatment of antibiotics) for Resident #20. The findings include: 1. Resident #78 was admitted to the facility with diagnoses that included anemia in chronic kidney disease, diabetes, osteomyelitis, multiple myeloma in remission, peripheral vascular disease, dysphagia, cerebrovascular disease, COPD (chronic obstructive pulmonary disease), hypertension, hyperlipidemia, major depressive disorder, gout and urinary retention. The minimum data set (MDS) date 6/27/22 assessed Resident #78 as cognitively intact. Resident #78's clinical record documented a	F 684	physician. 2. Current Residents have the potential to be affected. 3. Nurses will be educated by the SDC/designee on following of physician orders. 4. The Unit Managers/designees will complete a random weekly review of medication and treatment orders to ensure that orders are completed as ordered by the physician. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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physician's order dated 1/18/22 for epoetin alfa-epbx 4000 units/milliliter with instructions to administer 1 ml (milliliter) intramuscularly once every 7 days for treatment of anemia.

Resident #78's medication administration record (MAR) documented no administration of the epoetin alfa-epbx during the next eight weeks following the order. The MAR documented doses of epoetin alfa-epbx were scheduled but not administered on 1/27/22, 2/3/22, 2/10/22, 2/17/22, 2/24/22, 3/3/22, 3/10/22 and 3/14/22.

Nursing notes documented the epoetin alfa-epbx was not administered because the medication was not available from the pharmacy. Nursing notes documented the following regarding missed doses of the epoetin alfa-epbx.

2/3/22 - "...med [medication] is not available Epoetin Alfa-epbx Solution 4000 unit/ml..."
2/10/22 - "...non available labs to be faxed to pharmacy..."
2/17/22 - "Waiting for pharmacy to deliver Epoetin Alfa-epbx Solution 4000 unit/ml..."
2/24/22 - "non available"
3/10/22 - "awaiting delivery"
3/14/22 - "no available labs faxed..." (sic)
3/15/22 - "...Hg [hemoglobin] 6.8. Epoetin Alfa-epbx Solution 4000 unit/ml and order fax to pharmacy waiting for med..."

Prior to and during the weeks of missed epoetin alfa-epbx, Resident #78's hemoglobin was tested and documented as follows. The resident was identified with critically low hemoglobin on 3/14/22 after missing the ordered epoetin alfa-epbx injections for two months.

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Lab reports listed the hemoglobin in g/dL and documented a reference/normal range of 11.0 to 15.3 g/dL.

11/19/21 - 8.6 (low)
12/16/21 - 11.2 (in range)
1/31/22 - 8.6 (low)
2/28/22 - 7.1 (low)
3/3/22 - 7.3 (low)
3/7/22 - 7.4 (low)
3/14/22 - 6.8 (critically low)

A nurse practitioner (other staff #4) assessed Resident #78 two times prior to the critically low hemoglobin level of 3/14/22. The NP notes listed the resident was receiving epoetin alfa-epbx as treatment for anemia and made no mention of the resident not receiving the injections as ordered or that the medication was not available. The NP (other staff #4) documented the following assessments of Resident #78.

1/24/22 - "...Pt asked to be seen per nursing request for abnormal lab review...Assessment and Plan...Anemia Epoetin 1 ml IM [intramuscularly] inj [injection] Q 7D [every 7 days]..."

3/2/22 - "...Pt asked to be seen per nursing request for blood streaks in foley catheter, fever, and tachycardia...Assessment and Plan...Anemia Epoetin 1 ml IM inj Q 7D..."

A different NP (other staff #13) assessed the resident on 3/11/22 and diagnosed a urinary tract infection, started antibiotics and increased the frequency of the epoetin alfa-epbx from once per week to three times per week. There was no mention in the note that the resident had not

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received prescribed weekly doses of epoetin alfa-epbx or that the medicine had not been provided by the pharmacy.

The lab report listing the critically low hemoglobin of 6.8 on 3/14/22 documented the physician was notified of the abnormal value on 3/15/22. A nursing note dated 3/15/22 documented, "...Lab result received Hg [hemoglobin] 6.8. Epoetin Alfa-epbx 4000 unit/ml and order fax to pharmacy waiting for med. NP...notified. Continue Cefuroxime Axetil Tablet 500 mg...for UTI [urinary tract infection]..."

An additional dose of epoetin alfa-epbx scheduled for Wednesday 3/16/22 was not administered as ordered. A nursing note dated 3/16/22 at 10:22 a.m. documented, "Pending pharmacy delivery" and another note dated 3/16/22 at 10:55 p.m. documented, "Waiting for med Epoetin Alfa-epbx Solution 4000 unit/ml..."

There was no documented notification to the physician or NP about the unavailable epoetin alfa-epbx until 3/17/22. A nursing note dated 3/17/22 documented, "NP [nurse practitioner]...was notified of Epogen still pending deliver from pharmacy..." (sic) The NP ordered a repeat lab test for 3/18/22. The resident's hemoglobin was checked on 3/18/22 with results reported on 3/19/22 indicating another critically low value at 6.7 g/dL. A nursing note dated 3/19/22 documented, "...NP Notified of critical labs and order received to send pt [patient] out to... [hospital] for blood transfusion..."

The emergency department report dated 3/19/22 documented, "...presents from...nursing facility, after being found to have severe anemia,

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hemoglobin of 6.7. She reports no significant symptoms...upon being informed of her decreased hemoglobin, she was sent to the ER [emergency room] for transfusion..." The ER report documented the resident's hemoglobin at 6.8. The resident was administered one unit of packed red blood cells and transferred back to the facility on 3/20/22.

NP (other staff #4) assessed Resident #78 on 3/21/22 after the blood transfusion. The NP note dated 3/21/22 documented, "...Assessment and Plan...Anemia critical lab hemoglobin 6.7, send out non-emergent for transfusion, 1 unit PRBCs [packed red blood cells] c/w [continue with] Epo [Epogen] 1 ml mon, wed, fri x 5 weeks..."

After receiving the blood transfusion, Resident #78's hemoglobin on 3/21/22 was assessed at 8.0 g/dL.

The resident continued to miss doses of the epoetin alfa-epbx following the blood transfusion because the medication was not available. Scheduled doses on 3/23/22, 3/25/22 and 3/28/22 were not administered because the medication was not provided by the pharmacy. The first dose documented as administered was on 3/30/22.

The record documented no notification to the physician regarding the missed doses of epoetin alfa-epbx from 1/24/22 until 3/17/22. There were no documented attempts to determine the reason for the undelivered medicine, no communication to/from the provider or pharmacy about the medication or of any alternative treatments attempted to prevent the critically low hemoglobin that resulted in a blood transfusion. The resident

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was prescribed Vitron-C (iron-vitamin C) for anemia starting on 1/21/22 and this supplement was ongoing during the time with the critically low hemoglobin values. Nurse practitioner assessments on 1/24/22 and 3/2/22 listed the epoetin alfa-epbx as treatment for anemia and made no mention the medication was not administered to the resident as ordered. Another NP assessment on 3/11/22 made no mention of missed/unavailable epoetin alfa-epbx and increased the frequency of the medication from once per week to three times per week.

Monthly medication regimen reviews conducted by the consultant pharmacist on 2/22/22 and 3/20/22 documented no new irregularities with Resident #28's medicines and made no mention of the weeks of missed epoetin alfa-epbx injections.

On 8/17/22 at 10:06 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about Resident #78's missed doses of epoetin alfa-epbx. LPN #1 stated he did not work on Resident #78's unit until May 2022 and he did not know anything about the missed epoetin alfa-epbx or the critically low hemoglobin.

On 8/17/22 at 11:10 a.m., the regional director of clinical services (other staff #3) stated she reviewed Resident #78's medication records and the epoetin alfa-epbx was not administered as ordered and nursing should have notified the physician regarding the missed medication. The regional director stated nursing notes listed the medication had not been supplied by the pharmacy.

On 8/17/22 at 11:10 a.m., the unit manager (LPN

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#1) was interviewed again about the protocol when medications were not available. LPN #1 stated if medications were not available, the nurse should call pharmacy requesting delivery, notify the physician and seek alternate treatments if appropriate.

On 8/17/22 at 2:08 a.m., the nurse practitioner (other staff #4) that routinely cared for Resident #78 was interviewed about epoetin alfa-epbx and the missed doses prior to critically low hemoglobin values. The NP stated the Epogen (epoetin alfa-epbx) was a medication used to stimulate production of red blood cells for patients with anemia. The NP stated Resident #79 had anemia due to chronic kidney disease. The NP stated the resident's baseline hemoglobin was low and ran "in the high 7's." The NP stated she "got a couple of contacts from nursing" about the medication not available but she did not recall specific dates of the notifications. The NP stated patients with chronic kidney disease may have low hemoglobin readings even when taking Epogen. The NP stated sometimes there was no reason why something triggered a drop in hemoglobin. The NP stated her colleague (NP - other staff #13) increased the Epogen to three times per day so she was unable to comment on the increased dosage. The NP stated she had no information about why the epoetin alfa-epbx was not provided by the pharmacy and she had experienced problems getting Epogen for other residents in the facility. The NP stated there could be other reasons for the drop in hemoglobin such as dehydration or infection. When asked about any interventions implemented other than the Epogen to maintain the resident's hemoglobin, the NP stated the resident was already taking Vitron-C (iron-vitamin C).

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F 684	Continued From page 47 On 8/17/22 at 5:10 p.m., these findings were discussed with the administrator, regional director of clinical services and the corporate nursing consultant. The administrator stated at this time that nursing should contact the pharmacy when medicines were not available and notify the physician about any missed medicines. On 8/18/22 at 10:00 a.m., the regional nurse consultant (other staff #2) stated there was no notification documented regarding the unavailable Epogen for Resident #78. The nurse consultant stated she talked with the nurses and they reported some communication back and forth about the issue but there was nothing documented. The nurse consultant stated it was protocol to send a resident out for transfusion/treatment when hemoglobin dropped below 7.0. On 8/18/22 at 10:03 a.m., the NP (other staff #13) that assessed Resident #78 on 3/11/22 and increased the Epogen dose to three times per week was interviewed. This NP stated she was on-call and nursing notified her about abnormal labs. This NP stated she was not aware the resident was not getting the prescribed weekly doses of Epogen. This NP stated she increased the dose to three times per week because, based on her calculations, the previous dose was not adequate for the resident's condition and weight. This NP stated again she was not aware the resident had missed weeks of the Epogen injections. This NP stated she provided on-call coverage on 3/11/22 and did not assess the resident again after this visit. On 8/17/22 at 3:46 p.m., the registered	F 684		

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pharmacist/director of quality (other staff #5) was interviewed about why Resident #78's Epogen was not provided. The pharmacist director stated the order was received by the pharmacy on 1/18/22 with a start date assigned as 1/24/22. The pharmacist director stated at this time that Epogen required permission to send and an email was sent to a facility distribution on 1/20/22 requesting this permission/approval from the provider. The pharmacist director stated no response was received to the email so the medication was never released. The pharmacist director stated a second email was sent on 1/24/22 with no response received from the facility so the medication was not dispensed. The pharmacist director stated Epogen (epoetin alfa-epbx) was a medication that stimulated production of red blood cells and helped maintain and/or increase hemoglobin levels for patients with anemia. The pharmacist director stated Epogen typically took two to six weeks for effect and was not used for immediate treatment of low hemoglobin.

On 8/18/22 at 10:56 a.m., the consultant pharmacist (other staff #14) was interviewed about Resident #78's missed doses of Epogen due to unavailability from the pharmacy. The consultant pharmacist stated she performed "spot" checks of medications administered when she completed monthly medication reviews. The consultant pharmacist stated she did not pick up that Resident #78 missed the weekly Epogen during February and March (2022) reviews. The consultant pharmacist stated nobody from the facility notified her that the Epogen had not administered and/or provided. The consultant pharmacist stated Epogen was a medication that required additional approval before being

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dispensed.

The director of nursing was out on leave and not available for interview during the survey.

Resident #78's plan of care (revised 2/15/22) documented the resident had care needs and weakness due to conditions that included kidney failure, anemia and end stage kidney disease. Interventions to prevent complications included, "Monitor and notify MD/RP [responsible party] of any critical Lab...Notify MD/RP of any changes in condition...Administer medications as ordered..."

The Lippincott Manual of Nursing Practice 11th edition on pages 757 and 758 describes anemia as, "...the lack of sufficient circulating hemoglobin to deliver oxygen to tissues...Treatments for anemia include nutritional counseling, supplements, RBC [red blood cell] transfusions, and, for some patients, administration of exogenous erythropoietin (epoetin alfa or darbepoetin alfa), a growth factor stimulating production and maturation of erythrocytes...Severe compromise of the oxygen-carrying capacity of the blood may predispose to ischemic organ damage, such as myocardial infarction or stroke..." (1)

The Nursing 2022 Drug Handbook on page 49 describes epoetin alfa-epbx as a hematopoietic agent used for the treatment of anemia associated with chronic renal failure and cancer chemotherapy by stimulating red blood cell production in the bone marrow. Page 528 of this reference documents concerning epoetin alfa-epbx prescribed for anemia caused by chronic renal disease, "...Maintenance dosage is highly individualized. Give the lowest effective

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dose to gradually increase Hb [hemoglobin] to a level at which blood transfusion isn't necessary..." (2)

These findings were reviewed with the administrator, regional director of clinical services and corporate nursing consultant during a meeting on 8/17/22 at 4:15 p.m.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.

(2) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.

2. Resident #46 was admitted to the facility with diagnoses that included atypical lesion of left eyebrow, hypertension, rheumatoid arthritis, chronic deep vein embolism, hyperlipidemia, cellulitis, peripheral vascular disease, major depressive disorder and GERD (gastroesophageal reflux disease). The minimum data set (MDS) dated 6/13/22 assessed Resident #46 as cognitively intact.

On 8/16/22 at 10:00 a.m., Resident #46 was observed in bed. The resident had an irregular shaped growth over the left eyebrow. The surface of the growth was red and moist with the lesion hanging partially over the upper portion of the left eyelid. When asked about any concerns with her care, Resident #46 stated a dressing was supposed to be over the growth on her eyebrow. Resident #46 stated the dressing fell off earlier in the morning and she reported this to her nurse "around" 7:30 a.m. or 8:00 a.m.

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Resident #46 stated her nurse had been in the room and still had not replaced the dressing. Resident #46 stated she did not like having the lesion exposed to air.

On 8/16/22 at 11:08 a.m., Resident #46 was observed in bed with no dressing in place over the eyebrow growth. Resident #46 stated the nurse had not returned to replace the dressing yet.

On 8/16/22 at 12:00 p.m., Resident #46 was observed with a dressing in place over the eyebrow growth. Resident #46 stated a nurse had just applied the dressing. Resident #46 stated she was concerned that the dressing had been off all morning.

Resident #46's clinical record documented a physician's order dated 7/3/22 to cleanse the atypical lesion on the left eyebrow with wound cleanser, apply Xeroform, calcium alginate and cover with a border gauze every day shift and as needed for loose dressing.

On 8/16/22 at 12:03 p.m., the registered nurse (RN #3) caring for Resident #46 was interviewed about the eyebrow lesion without a dressing. RN #3 stated he was assigned to Resident #46 today and she told him earlier in the shift that the dressing was off. RN #3 stated he reported the missing dressing to the unit manager. RN #3 stated he did not know why the unit manager did not replace the dressing earlier.

On 8/16/22 at 12:05 p.m., the licensed practical nurse (LPN #1) unit manager was interviewed about Resident #46's lesion without a dressing. LPN #1 stated he had just reapplied the dressing

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to Resident #46's eyebrow growth. LPN #1 stated it had not been reported to him earlier that the dressing was off. LPN #1 stated, "No one told me the dressing was off." LPN #1 stated the lesion was supposed to have a dressing in place as ordered.

This finding was reviewed with the administrator, regional director of clinical services and corporate nursing consultant during a meeting on 8/17/22 at 4:15 p.m.

3. The facility failed to obtain a physician's orders for the care and treatment of a midline (intravenous) catheter for Resident #136.

Resident #136's diagnoses included, but were not limited to: muscle weakness, high blood pressure, diabetes mellitus, and osteomyelitis of the left ankle/foot with partial amputation of the left foot.

Resident #136's most recent MDS (minimum data set) was an admission assessment dated 07/27/22. This MDS assessed the resident with a cognitive score of 14, indicating the resident was intact for daily decision making skills. The resident was also assessed as requiring extensive assistance with most ADL's (activities of daily living).

Resident #136 was interviewed on 08/16/22 at approximately 10:00 AM. The resident stated that he had an infection in his foot and that staff were giving him IV (intravenous) medications for the treatment. An IV pump/pole was observed in the corner of the room. The resident had a midline catheter in the right upper arm, a clear occlusive dressing was covering the catheter.

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There was no date, no time and no initials on the dressing. The resident's clinical records were reviewed. The resident had an order to, "Insert midline one time only for IV abx [antibiotics]...order date: 08/03/22 start date: 08/03/2022..." There were no other orders found for the care and/or of the midline IV catheter.

The resident's CCP (comprehensive care plan) was then reviewed. The CCP documented, "...care needs related to osteomyelitis...meds as ordered..." There was no information on the resident's care plan regarding a midline or care interventions for an intravenous catheter.

The resident's MARs/TARs (medication administration/treatment administration records) were reviewed for July and August 2022. There was no information regarding the care and/or treatment of a midline IV catheter for Resident #136.

On 08/17/22 at approximately 1:30 PM, Resident #136 was again interviewed. The resident's midline IV catheter dressing was intact (as observed the day before) no date, no time, and no initials were on the dressing. The midline, single lumen IV catheter was observed without a protective cap.

RN #4 was in the room at the time and was interviewed. The RN stated that it should have a cap on the lumen hub and further stated that resident was no longer getting medication through the midline. The RN was asked how do the nurse's know how to care for a midline. The RN stated that they follow the physician's orders. The RN was made aware that there were no orders for the care of the midline. The RN stated

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that there should be orders.

On 08/17/22 at 2:19 PM, in a meeting with the survey team, the NP (nurse practitioner) and the administrator were interviewed regarding the residents midline catheter and made aware of concerns regarding no care orders and/or instructions on how to manage the midline. The NP stated, "I don't think I have specific orders for a midline, I think there is a standard, flush every 7 days, they [nurses] do the dressing change. You flush it everyday, with normal saline. I don't put in those orders, the nurses put them in and I would sign." The NP stated, that she thought it was a common practice for nurses to care for a midline and that she does review her orders. The NP was made aware that this resident did not have any care orders. The NP stated that when she was in nursing school that they had protocols they could use without physician's orders in the hospital. The NP was made aware that this is not a hospital and that resident's have to have specific care orders. The administrator nodded her head in agreement.

On 08/17/22 at approximately 4:30 PM, in a meeting with the survey team, the administrator and corporate consultants were again made aware of the concerns regarding the lack of physician's orders for the care and treatment of Resident #136's midline.

No further information and/or documentation was presented prior to the exit conference on 08/19/22 at noon.

4. During the medication pass and pour observation, physician orders were not followed for the administration of Propranolol (medication

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given for hypertension) for Resident #92.

Diagnoses for Resident #92 included: Hemiplegia, dementia, Hypertension, and hyperlipidemia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/7/22. Resident #92's cognitive score was a 6 indicating moderately cognitively intact.

On 08/16/22 at 8:26 AM a medication pass and pour was conducted with license practical nurse (LPN #3). LPN #3 began pulling Resident #92 's medications from the medication cart and handing them to the surveyor for review. One of the medications (Propranolol) instructed to give two 10 Mg (milligrams) tablets equaling 20 Mg. After reviewing the medications the surveyor handed the medication back to LPN #3 , and LPN #3 began popping the medications out into a medication cup.

LPN #3 picked up the Propranolol medication card and only popped one pill into the cup (equaling 10 MG). LPN #3 then put all the medication back into the medication cart, locked the cart, turned and started to go into Resident #92's room. Upon entering the resident's room, LPN #3 was asked to come back to the cart and review the instructions for the Propranolol. LPN #3 pulled the medication from the medication cart and reviewed the instructions on the medication with the instructions on the medication administration record (MAR) and was asked, what is the dosage of each Propranolol tablet and how much is supposed to be given. LPN #3 realized that 2 Propranolol pills should have been dispensed and said "You're right I will get another."

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Review of the physician's orders for Propranolol read: "Propranolol 10 MG tablet Give 20 mg orally two times a day [...]"

On 8/17/22 at 4:45 PM the above information was presented to the administrator and nurse consultant.

No other information was presented prior to exit conference on 8/18/22.

5. The facility staff failed to obtain physician orders for the care of a midline (an intravenous line inserted into the upper arm, usually used for the treatment of antibiotics) for Resident #20.

Diagnoses for Resident #20 included: Sepsis, stenosis of left carotid artery, depression, and urinary tract infection. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/30/22. Resident #20's cognitive score was a 15 indicating cognitively intact.

On 08/16/22 at 8:54 AM during an interview, Resident #20 was asked about the Midline inserted into the left upper arm. Resident # 20 verbalized that he recently had an infection and was being given a antibiotics, but is no longer on antibiotics.

On 8/16/22 Resident #20's medical record was reviewed. An order to insert a midline was dated 7/25/22, however there were no orders placed for care of the Midline (such as flushing to ensure patency).

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F 684	Continued From page 57 On 8/17/22 at 8:36 AM nurse consultant (administrative staff, AS #2) was interviewed. AS #2 reviewed Resident #20's physician orders and verbalized orders should have been placed for the care of the Midline. On 8/17/22 at 4:45 PM the above information was presented to the administrator and nurse consultant. On 8/18/22 at 8:30 AM AS #2 was asked if there are any nursing protocals regarding the care and treatment of a Midline. AS #2 said there is a protocol and those orders should have been placed on the medical chart. No other information was presented prior to exit conference on 8/18/22.	F 684		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		9/20/22

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F 725	Continued From page 58 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, facility document review and staff interview, the facility staff failed to respond to call bells in a timely manner. Facility staff failed to answer call bells in a timely manner as evidenced by resident interviews and as documented in the resident council meeting minutes. The findings include: On 08/16/2022, Resident Council minute minutes were reviewed for the months of May 2020 through July 2022. Observed on the July 29, 2022 minutes was the following statement, "...Residents are requesting that CNA's (certified nursing assistants) do better with answering the call lights...." On 08/17/2022 at 2:00 p.m., a group meeting was held with 17 residents. The group was asked about the call bell response time. Seven residents responded with the following statements regarding call bell response time. Resident #106 was admitted to the facility with diagnoses that included type 2 diabetes, long-term use of insulin, constipation, ileus,	F 725	F725 1. Residents #106, #40, #112, #149, #134, #108, and #124 were assessed to ensure that needs are being met. 2. Current Residents have the potential to be affected. 3. Facility staff will be educated by the SDC/designee on responding to call bells in a polite and timely manner. 4. The Director of Nursing/designee will complete a random interview with residents on a weekly basis to review call bell response. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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weakness, hyperlipidemia, obesity, depression, hypertension. The most recent minimum data set (MDS) dated 07/18/22 was a quarterly and assessed Resident #106 as cognitively intact for daily decision making with a score of 15 out of 15.

Resident #106 stated, "it takes them sometimes up to an hour and a half to respond to the call light. I've waited forever for them to only sometimes come and turn the light off and say they will return, but they seem to take their time and always say they are busy or overworked...."

Resident #40 was admitted to the facility with diagnoses that included multiple sclerosis, hypotension, hyperlipidemia, obesity, weakness, fibromyalgia, and GERD. The most recent MDS dated 06/08/2022 was a quarterly and assessed Resident #40 as cognitively intact with a score of 15 out 15.

Resident #40 stated, "I hate to even call them because all you hear is they are short staffed. It is stressful to think that when your ring you call light, sometimes you don't know if and when they will answer the light."

Resident #112 was admitted to the facility with diagnoses that included hypotension, hypothyroidism, type 2 diabetes, quadriplegia, spinal stenosis, cord compression, and weakness. The most recent MDS dated 07/22/2022 was a quarterly and assessed Resident #112 as cognitively intact for daily decision making with a score of 15 out of 15.

Resident #112 stated, "they are short staff and it shows. I ring my bell and some of the staff are rude and will ask, 'what do you want' or they will

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come to run turn off the bell, say they will return and you never see them again unless you ring the bell again."

Resident #149 was admitted with diagnoses that included dysphagia, hypertension, type 2 diabetes, cerebral infraction, dementia with behaviors, hyperlipidemia, and GERD. The most recent MDS dated 08/03/2022 was the admission assessment and assessed Resident #149 as cognitively intact for daily decision making with a score of 14 out of 15.

Resident #149 stated, "last night I waited over 45 minutes ringing the call light for my roommate. I time it by watching the clock last night. This happens all the time. When some of them come in they look at you so mean and bark, "what do you want now. No one needs to be treated like that."

Resident #134 was admitted to the facility with diagnoses that included hemiplegia, paraplegia, left hand contracture, depression, bipolar, and depression. The most recent MDS dated 07/28/2022 was the annual assessment and assessed Resident #134 as cognitively intact for daily decision making with a score of 15 out 15.

Resident #134 stated, "I've been here 10 years and staffing has always been a problem. We have agency staff now, but it doesn't matter it takes 30 or more minutes to answer the call bell. Sometimes I don't even want to ring because it seems we're bothering them."

Resident #108 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis, type 2 diabetes, hypertension,

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depression, lymphedema and CVA. The most recent MDS dated 07/20/2022 was a quarterly assessment and assessed Resident #108 as cognitively intact for daily decision making with a score of 15 out 15.

Resident #108 stated, "it takes about 35 minutes or more for someone to respond to the call light. Then some of them are quick to say they are busy or short staff."

Resident #124 was admitted to the facility with diagnoses that included lymphedema, cellulitis, depression, mood disorder, osteomyelitis, and peripheral vascular disease. The most recent MDS dated 07/28/2022 was a quarterly assessment and assessed Resident #124 as cognitively intact for daily decision making with a score of 15 out of 15.

On 08/17/2022 at 4:15 p.m., the above findings were reviewed with the facility's administrative team that included the administrator, staffing development coordinator, and corporate consultants. The facility's administrative team was asked what was the expectation regarding call bell response time. The administrator stated the expectation was for staff to answer the call bells within 5 to 15 minutes. The administrator was asked if staff were aware of this expectation. The administrator stated, "yes."

A review of the facility's policy titled, "Shift Responsibilities for CNA (revised 11/01/19) documented the following:
...Procedure 4. Perform shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call

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F 725	Continued From page 62 lights and notify the licensed nurse of any pertinent patient findings...." No other information was provided to the facility prior to exit on 08/18/2022.	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		9/20/22

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F 755	Continued From page 63 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for one of thirty-seven residents in the survey sample. Resident #78 missed twelve doses of the medication epoetin alfa-epbx (Epogen) for treatment of anemia. Following the eight consecutive weeks of the unavailable medication, the resident experienced critically low hemoglobin levels that required treatment with a blood transfusion. The findings include: Resident #78 was admitted to the facility with diagnoses that included anemia in chronic kidney disease, diabetes, osteomyelitis, multiple myeloma in remission, peripheral vascular disease, dysphagia, cerebrovascular disease, COPD (chronic obstructive pulmonary disease), hypertension, hyperlipidemia, major depressive disorder, gout and urinary retention. The minimum data set (MDS) date 6/27/22 assessed Resident #78 as cognitively intact. Resident #78's clinical record documented a physician's order dated 1/18/22 for epoetin alfa-epbx 4000 units/milliliter with instructions to administer 1 ml (milliliter) intramuscularly once every 7 days for treatment of anemia. Resident #78's medication administration record (MAR) documented no administration of the epoetin alfa-epbx during the next eight weeks following the order. The MAR documented doses	F 755	F755 1. Resident #78 is receiving medications as ordered. The Epogen was discontinued on 4/18/22. 2. Current Residents have the potential to be affected. 3. Nurses will be educated on ordering medications, physician notification of medication not available for administration, use of the Omnicell when indicated, pharmacy notification of medication not received, and timely response to approval to dispense requests. 4. The Unit Managers/designees will review availability of medications during the weekday clinical meeting to ensure that medications are available to administer as ordered. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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of epoetin alfa-epbx were scheduled but not administered on 1/27/22, 2/3/22, 2/10/22, 2/17/22, 2/24/22, 3/3/22, 3/10/22 and 3/14/22.

Nursing notes documented the epoetin alfa-epbx was not administered because the medication was not available from the pharmacy. Nursing notes documented the following regarding missed doses of the epoetin alfa-epbx.

2/3/22 - "...med [medication] is not available Epoetin Alfa-epbx Solution 4000 unit/ml..."
2/10/22 - "...non available labs to be faxed to pharmacy..."
2/17/22 - "Waiting for pharmacy to deliver Epoetin Alfa-epbx Solution 4000 unit/ml..."
2/24/22 - "non available"
3/10/22 - "awaiting delivery"
3/14/22 - "no available labs faxed..." (sic)
3/15/22 - "...Hg [hemoglobin] 6.8. Epoetin Alfa-epbx Solution 4000 unit/ml and order fax to pharmacy waiting for med..."

Prior to and during the weeks of missed epoetin alfa-epbx, Resident #78's hemoglobin was tested and documented as follows. The resident was identified with critically low hemoglobin on 3/14/22 after missing the ordered epoetin alfa-epbx injections for two months.

Lab reports listed the hemoglobin in g/dL and documented a reference/normal range of 11.0 to 15.3 g/dL.

11/19/21 - 8.6 (low)
12/16/21 - 11.2 (in range)
1/31/22 - 8.6 (low)
2/28/22 - 7.1 (low)
3/3/22 - 7.3 (low)

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3/7/22 - 7.4 (low)
3/14/22 - 6.8 (critically low)

A nurse practitioner (other staff #4) assessed Resident #78 two times prior to the critically low hemoglobin level of 3/14/22. The NP notes listed the resident was receiving epoetin alfa-epbx as treatment for anemia and made no mention of the resident not receiving the injections as ordered or that the medication was not available. The NP (other staff #4) documented the following assessments of Resident #78.

1/24/22 - "...Pt asked to be seen per nursing request for abnormal lab review...Assessment and Plan...Anemia Epoetin 1 ml [milliliter] IM [intramuscularly] inj [injection] Q 7D [every 7 days]..."

3/2/22 - "...Pt asked to be seen per nursing request for blood streaks in foley catheter, fever, and tachycardia...Assessment and Plan...Anemia Epoetin 1 ml IM inj Q 7D..."

A different NP (other staff #13) assessed the resident on 3/11/22 and diagnosed a urinary tract infection, started antibiotics and increased the frequency of the epoetin alfa-epbx from once per week to three times per week. There was no mention in the note that the resident had not received prescribed weekly doses of epoetin alfa-epbx or that the medicine had not been provided by the pharmacy.

The lab report listing the critically low hemoglobin of 6.8 on 3/14/22 documented the physician was notified of the abnormal value on 3/15/22. A nursing note dated 3/15/22 documented, "...Lab result received Hg [hemoglobin] 6.8. Epoetin

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Alfa-epbx 4000 unit/ml and order fax to pharmacy waiting for med. NP...notified. Continue Cefuroxime Axetil Tablet 500 mg...for UTI [urinary tract infection]..."

An additional dose of epoetin alfa-epbx scheduled for Wednesday 3/16/22 was not administered as ordered. A nursing note dated 3/16/22 at 10:22 a.m. documented, "Pending pharmacy delivery" and another note dated 3/16/22 at 10:55 p.m. documented, "Waiting for med Epoetin Alfa-epbx Solution 4000 unit/ml..."

There was no documented notification to the physician or NP about the unavailable epoetin alfa-epbx until 3/17/22. A nursing note dated 3/17/22 documented, "NP [nurse practitioner]...was notified of Epogen still pending deliver from pharmacy..." (sic) The NP ordered a repeat lab test for 3/18/22. The resident's hemoglobin was checked on 3/18/22 with results reported on 3/19/22 indicating another critically low value at 6.7 g/dL. A nursing note dated 3/19/22 documented, "...NP Notified of critical labs and order received to send pt [patient] out to... [hospital] for blood transfusion..."

The emergency department report dated 3/19/22 documented, "...presents from...nursing facility, after being found to have severe anemia, hemoglobin of 6.7. She reports no significant symptoms...upon being informed of her decreased hemoglobin, she was sent to the ER [emergency room] for transfusion..." The ER report documented the resident's hemoglobin at 6.8. The resident was administered one unit of packed red blood cells and transferred back to the facility on 3/20/22.

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NP (other staff #4) assessed Resident #78 on 3/21/22 after the blood transfusion. The NP note dated 3/21/22 documented, "...Assessment and Plan...Anemia critical lab hemoglobin 6.7, send out non-emergent for transfusion, 1 unit PRBCs [packed red blood cells] c/w [continue with] Epo [Epogen] 1 ml mon, wed, fri x 5 weeks..."

The resident continued to miss doses of the epoetin alfa-epbx following the blood transfusion because the medication was not available. Scheduled doses on 3/23/22, 3/25/22 and 3/28/22 were not administered because the medication was not provided by the pharmacy. The first dose documented as administered was on 3/30/22.

Monthly medication regimen reviews conducted by the consultant pharmacist on 2/22/22 and 3/20/22 documented no new irregularities with Resident #28's medicines and made no mention of the weeks of missed epoetin alfa-epbx injections.

On 8/17/22 at 10:06 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about Resident #78's missed doses of epoetin alfa-epbx. LPN #1 stated he did not work on Resident #78's unit until May 2022 and he did not know anything about the missed epoetin alfa-epbx or the critically low hemoglobin.

On 8/17/22 at 11:10 a.m., the regional director of clinical services (other staff #3) stated she reviewed Resident #78's medication records and the epoetin alfa-epbx was not administered as ordered and nursing should have notified the physician regarding the missed medication. The regional director stated nursing notes listed the

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medication had not been supplied by the pharmacy.

On 8/17/22 at 11:10 a.m., the unit manager (LPN #1) was interviewed again about the protocol when medications were not available. LPN #1 stated if medications were not available, the nurse should call pharmacy requesting delivery, notify the physician and seek alternate treatments if appropriate.

On 8/17/22 at 2:08 a.m., the nurse practitioner (other staff #4) that routinely cared for Resident #78 was interviewed about epoetin alfa-epbx and the missed doses prior to critically low hemoglobin values. The NP stated the Epogen (epoetin alfa-epbx) was a medication used to stimulate production of red blood cells for patients with anemia. The NP stated Resident #79 had anemia due to chronic kidney disease. The NP stated the resident's baseline hemoglobin was low and ran "in the high 7's." The NP stated she "got a couple of contacts from nursing" about the medication not available but she did not recall specific dates of the notifications. The NP stated patients with chronic kidney disease may have low hemoglobin readings even when taking Epogen. The NP stated sometimes there was no reason why something triggered a drop in hemoglobin. The NP stated her colleague (NP - other staff #13) increased the Epogen to three times per day so she was unable to comment on the increased dosage. The NP stated she had no information about why the epoetin alfa-epbx was not provided by the pharmacy and she had experienced problems getting Epogen for other residents in the facility. The NP stated there could be other reasons for the drop in hemoglobin such as dehydration or infection. When asked

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about any interventions implemented other than the Epogen to maintain the resident's hemoglobin, the NP stated the resident was already taking Vitron-C (iron-vitamin C).

On 8/17/22 at 5:10 p.m., these findings were discussed with the administrator, regional director of clinical services and the corporate nursing consultant. The administrator stated at this time that nursing should contact the pharmacy when medicines were not available and notify the physician about any missed medicines.

On 8/18/22 at 10:00 a.m., the regional nurse consultant (other staff #2) stated there was no notification documented regarding the unavailable Epogen for Resident #78. The nurse consultant stated she talked with the nurses and they reported some communication back and forth about the issue but there was nothing documented. The nurse consultant stated it was protocol to send a resident out for transfusion/treatment when hemoglobin dropped below 7.0.

On 8/18/22 at 10:03 a.m., the NP (other staff #13) that assessed Resident #78 on 3/11/22 and increased the Epogen dose to three times per week was interviewed. This NP stated she was on-call and nursing notified her about abnormal labs. This NP stated she was not aware the resident was not getting the prescribed weekly doses of Epogen. This NP stated she increased the dose to three times per week because, based on her calculations, the previous dose was not adequate for the resident's condition and weight. This NP stated again she was not aware the resident had missed weeks of the Epogen injections. This NP stated she provided on-call

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coverage on 3/11/22 and did not assess the resident again after this visit.

On 8/17/22 at 3:46 p.m., the registered pharmacist/director of quality (other staff #5) was interviewed about why Resident #78's Epogen was not provided. The pharmacist director stated the order was received by the pharmacy on 1/18/22 with a start date assigned as 1/24/22. The pharmacist director stated at this time that Epogen required permission to send and an email was sent to a facility distribution on 1/20/22 requesting this permission/approval from the provider. The pharmacist director stated no response was received to the email so the medication was never released. The pharmacist director stated a second email was sent on 1/24/22 with no response received from the facility so the medication was not dispensed. The pharmacist director stated Epogen (epoetin alfa-epbx) was a medication that stimulated production of red blood cells and helped maintain and/or increase hemoglobin levels for patients with anemia. The pharmacist director stated Epogen typically took two to six weeks for effect and was not used for immediate treatment of low hemoglobin.

On 8/18/22 at 10:56 a.m., the consultant pharmacist (other staff #14) was interviewed about Resident #78's missed doses of Epogen due to unavailability from the pharmacy. The consultant pharmacist stated she performed "spot" checks of medications administered when she completed monthly medication reviews. The consultant pharmacist stated she did not pick up that Resident #78 missed the weekly Epogen during February and March (2022) reviews. The consultant pharmacist stated nobody from the

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facility notified her that the Epogen had not administered and/or provided. The consultant pharmacist stated Epogen was a medication that required additional approval before being dispensed.

Resident #78's plan of care (revised 2/15/22) documented the resident had care needs and weakness due to conditions that included kidney failure, anemia and end stage kidney disease. Interventions to prevent complications included, "Monitor and notify MD/RP [responsible party] of any critical Lab...Notify MD/RP of any changes in condition...Administer medications as ordered..."

The Lippincott Manual of Nursing Practice 11th edition on pages 757 and 758 describes anemia as, "...the lack of sufficient circulating hemoglobin to deliver oxygen to tissues...Treatments for anemia include nutritional counseling, supplements, RBC [red blood cell] transfusions, and, for some patients, administration of exogenous erythropoietin (epoetin alfa or darbepoetin alfa), a growth factor stimulating production and maturation of erythrocytes...Severe compromise of the oxygen-carrying capacity of the blood may predispose to ischemic organ damage, such as myocardial infarction or stroke..." (1)

The Nursing 2022 Drug Handbook on page 49 describes epoetin alfa-epbx as a hematopoietic agent used for the treatment of anemia associated with chronic renal failure and cancer chemotherapy by stimulating red blood cell production in the bone marrow. Page 528 of this reference documents concerning epoetin alfa-epbx prescribed for anemia caused by chronic renal disease, "...Maintenance dosage is

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F 755	Continued From page 72 highly individualized. Give the lowest effective dose to gradually increase Hb [hemoglobin] to a level at which blood transfusion isn't necessary..." (2) These findings were reviewed with the administrator, regional director of clinical services and corporate nursing consultant during a meeting on 8/17/22 at 4:15 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019. (2) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		9/20/22

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F 756	Continued From page 73 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed recognize and report irregularities in the medication regimen review for one of thirty-seven residents in the survey sample. Two monthly pharmacist reviews failed to recognize and report that Resident #78 was not administered weekly injections of epoetin alfa-epbx (Epogen) as ordered by the physician for treatment of anemia. The findings include: Resident #78 was admitted to the facility with diagnoses that included anemia in chronic kidney disease, diabetes, osteomyelitis, multiple myeloma in remission, peripheral vascular disease, dysphagia, cerebrovascular disease, COPD (chronic obstructive pulmonary disease), hypertension, hyperlipidemia, major depressive	F 756	F756 1. Resident #78 is receiving medications as ordered. The Epogen was discontinued on 4/18/22. 2. Current Residents have the potential to be affected. 3. Nurses will be educated by the SDC/designee on physician notification of medications that are not available for administration. The Pharmacy Consultant will review administration of Epogen during the monthly medication regimen and clinical record review. 4. The Unit Managers/designees will review availability of medications during the weekday clinical meeting to ensure that medications are available to administer as ordered.	

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F 756	Continued From page 74 disorder, gout and urinary retention. The minimum data set (MDS) date 6/27/22 assessed Resident #78 as cognitively intact. Resident #78's clinical record documented a physician's order dated 1/18/22 for epoetin alfa-epbx 4000 units/milliliter with instructions to administered intramuscularly once every 7 days for treatment of anemia. Resident #78's medication administration record (MAR) documented no administration of the epoetin alfa-epbx during the next eight weeks following the order. The MAR documented doses of epoetin alfa-epbx were scheduled but not administered on 1/27/22, 2/3/22, 2/10/22, 2/17/22, 2/24/22, 3/3/22, 3/10/22 and 3/14/22. Nursing notes documented the epoetin alfa-epbx was not administered because the medication was not available from the pharmacy. Nursing notes documented the following regarding missed doses of the epoetin alfa-epbx. 2/3/22 - "...med [medication] is not available Epoetin Alfa-epbx Solution 4000 unit/ml..." 2/10/22 - "...non available labs to be faxed to pharmacy..." 2/17/22 - "Waiting for pharmacy to deliver Epoetin Alfa-epbx Solution 4000 unit/ml..." 2/24/22 - "non available" 3/10/22 - "awaiting delivery" 3/14/22 - "no available labs faxed..." (sic) 3/15/22 - "...Hg [hemoglobin] 6.8. Epoetin Alfa-epbx Solution 4000 unit/ml and order fax to pharmacy waiting for med..." An additional dose of epoetin alfa-epbx scheduled for Wednesday 3/16/22 was not	F 756	5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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administered as ordered. A nursing note dated 3/16/22 at 10:22 a.m. documented, "Pending pharmacy delivery" and another note dated 3/16/22 at 10:55 p.m. documented, "Waiting for med Epoetin Alfa-epbx Solution 4000 unit/ml..."

A nursing note dated 3/17/22 documented, "NP [nurse practitioner]...was notified of Epogen still pending deliver from pharmacy..." (sic) The NP ordered a repeat lab test for 3/18/22. The resident's hemoglobin was checked on 3/18/22 with results reported on 3/19/22 indicating another critically low value at 6.7 g/dL. A nursing note dated 3/19/22 documented, "...NP Notified of critical labs and order received to send pt [patient] out to... [hospital] for blood transfusion..."

The emergency department report dated 3/19/22 documented, "...presents from...nursing facility, after being found to have severe anemia, hemoglobin of 6.7. She reports no significant symptoms...upon being informed of her decreased hemoglobin, she was sent to the ER [emergency room] for transfusion..." The ER report documented the resident's hemoglobin at 6.8. The resident was administered one unit of packed red blood cells and transferred back to the facility on 3/20/22.

Monthly medication regimen reviews conducted by the consultant pharmacist on 2/22/22 and 3/20/22 documented no irregularities with Resident #28's medicines and made no mention of the weeks of missed epoetin alfa-epbx injections prior to 3/20/22.

On 8/18/22 at 10:56 a.m., the consultant pharmacist (other staff #14) was interviewed about Resident #78's missed doses of Epogen

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due to unavailability from the pharmacy. The consultant pharmacist stated she performed "spot" checks of medications administered when she completed monthly medication reviews. The consultant pharmacist stated she did not pick up that Resident #78 missed the weekly Epogen during February and March (2022) reviews. The consultant pharmacist stated nobody from the facility notified her that the Epogen had not been administered and/or provided.

The facility's policy titled Medication Regimen Review (8-2020) documented, "The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and minimizing adverse consequences related to medication therapy...MRR also involves reporting of findings with recommendations for improvement...Resident-specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate..."

The Lippincott Manual of Nursing Practice 11th edition on pages 757 and 758 describes anemia as, "...the lack of sufficient circulating hemoglobin to deliver oxygen to tissues...Treatments for anemia include nutritional counseling, supplements, RBC [red blood cell] transfusions, and, for some patients, administration of exogenous erythropoietin (epoetin alfa or darbepoetin alfa), a growth factor stimulating

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F 756	Continued From page 77 production and maturation of erythrocytes...Severe compromise of the oxygen-carrying capacity of the blood may predispose to ischemic organ damage, such as myocardial infarction or stroke..." (1) The Nursing 2022 Drug Handbook on page 49 describes epoetin alfa-epbx as a hematopoietic agent used for the treatment of anemia associated with chronic renal failure and cancer chemotherapy by stimulating red blood cell production in the bone marrow. Page 528 of this reference documents concerning epoetin alfa-epbx prescribed for anemia caused by chronic renal disease, "...Maintenance dosage is highly individualized. Give the lowest effective dose to gradually increase Hb [hemoglobin] to a level at which blood transfusion isn't necessary..." (2) These findings were reviewed with the administrator, regional director of clinical services and corporate nursing consultant during a meeting on 8/17/22 at 4:15 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019. (2) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		9/20/22

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F 757	Continued From page 78 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one of 37 residents (Resident #316) was free of unnecessary medications. Resident #316 had a physician's order to stop Lovenox injections when the resident's INR (international normalization rate) (measures the time for the blood to clot) reached above 2.0, the medication was not stopped at that time. Findings include: Resident #316 diagnoses included, but were not limited to: high blood pressure, seizure disorder, history of DVT (deep vein thrombosis), brain tumor and Factor V Leiden (an inherited blood clotting disorder, which can be life threatening).	F 757	F757 1. The Lovenox order for Resident #316 has been discontinued. 2. Current Residents receiving Lovenox with ordered parameters have the potential to be affected. 3. The SDC/designee will educate Nurses on monitoring ordered parameters for Lovenox to ensure that the medication is given as ordered. 4. The Unit Managers/designees will review administration of Lovenox on a weekly basis to ensure that the medication is given as ordered. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will	

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F 757	Continued From page 79 Resident #316's most recent full MDS (minimum data set) was an admission assessment dated 06/18/22. 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 extensive assistance of at least one staff person for all ADL's (activities of daily living). Section N0410. Medications Received in the last seven days, documented that the resident received an anticoagulant 7 days. Resident #316's clinical records were reviewed and revealed a discharge summary dated 06/12/22 (prior to admission to the facility on 06/12/22). The discharge summary documented, "...factor V Leiden on coumadin, DVT...His INR was subtherapeutic, therefore was bridging with heparin to coumadin...Neurosurgery is okay...to use Lovenox 1 mg/kg (milligram/per kilogram) twice daily to coumadin...Discharge Medications: ...Start taking...enoxaparin 120 mg/0.8 ml (milliliter) syringe commonly known as Lovenox Inject 0.77 mls (116 mg total)...every 12 hours...to bridge with coumadin while INR is below 2.0. Once INR is therapeutic above 2.0, lovenox can be discontinued..." The resident's admission orders documented, "... (06/12/22) Lovenox Solution Prefilled Syringe 120 MG/0.8ML (Enoxaparin Sodium) Inject 0.77 ml subcutaneously every 12 hours...to Bridge with coumadin while is INR is below 2.0, once INR is Therapeutic above 2.0 D/C Lovenox..." The resident also had an order dated 06/14/22 that documented, "...daily PT/INR checks while on lovenox and coumadin notify provider of results one time a day for INR management..."	F 757	be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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According to the resident's MARs (medication administration records) the resident received the lovenox injections starting on 06/14/22 and according to the resident's TARs (treatment administration records) the resident's PT/INR was only checked on the following days with the following results:

06/14/22 - 2.1
06/16/22 - 2.4
06/20/22 - 2.0

According to the physician's order, the lovenox should have been discontinued 06/14/22 as the INR was greater than 2.0 and again on 06/16/22 as the INR at that time was 2.4. The resident continued to receive lovenox injections twice daily through June 27th, although the resident's PT/INR was not being checked daily as ordered by the physician. There was no evidence of any additional labs (PT/INR results) until 06/29/22, at which time the resident's INR was 3.79.

The administrator and corporate consultants were made aware of the above concerns regarding not following physician's orders on 08/17/22 at approximately 4:30 PM, in a meeting with the survey team.

On 08/18/22 at approximately 9:00 AM, corporate consultant #1 stated that she could not follow what had happened regarding this resident's lovenox and/or PT/INR labs and was unsure why the resident continued to get the medication when the physician's orders had documented to stop the lovenox when the resident's INR was greater than 2.0.

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F 757	Continued From page 81 No further information and/or documentation was presented prior to the exit conference on 08/18/22 at noon.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		9/20/22

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F 758	Continued From page 82 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement a gradual dose reduction for one of thirty-seven residents in the survey sample. Resident #159 continued to receive a 75 mg (milligram) dose of the antipsychotic medication Seroquel for 15 weeks after the physician ordered for a dose reduction to 50 mg per day. The findings include: Resident #179 was admitted to the facility with diagnoses that included history of traumatic brain injury, transient ischemic attach, cerebral infarction, major depressive disorder, history of hip fracture, hypertension, psychosis, vascular dementia and acute respiratory failure. The minimum data set (MDS) dated 8/3/22 assessed Resident #179 as cognitively intact. Resident #179's clinical record documented a physician's order dated 8/24/22 for Seroquel 75 mg at bedtime each day for treatment of	F 758	F758 1. Resident #159 is receiving the Seroquel at the ordered dosage. 2. Current Residents have the potential to be affected. 3. Nurses will be educated by the SDC/designee on review of pharmacy recommendations to ensure that physician orders are noted and the medication is administered correctly. 4. The Unit Managers/designees will review pharmacy recommendations on a monthly basis to ensure that the recommendations were noted as indicated and medications were administered correctly. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are	

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F 758	Continued From page 83 psychosis. The clinical record documented a consultant pharmacist recommendation dated 2/22/22 stating, "This resident has been taking Quetiapine [Seroquel] 75 mg HS [at bedtime] since 8/24/22 without a GDR [gradual dose reduction]. Could we attempt a dose reduction to Quetiapine 50 mg HS at this time to verify this resident is on the lowest possible dose? The physician responded to the pharmacy recommendation for the Seroquel dose reduction on 3/9/22 documenting an order to reduce the dose to 50 mg at bedtime from 75 mg. Resident #179's medication administration records (MARs) for March, April, May and June (2022) documented the resident continued to receive the 75 mg dose at each bedtime from 3/9/22 until 6/23/22. The order to change from 75 mg dose to the 50 mg dose was not entered on the MAR until 6/23/22. On 8/17/22 at 11:06 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about not implementing the dose reduction for Resident #179's Seroquel. LPN #1 stated the physician usually entered their own orders for dose changes and if not, the nurses were supposed to enter and activate the order. LPN #1 stated he did not know why the dose reduction order was not entered when written. The director of nursing was out on leave and not available for interview during the survey. This finding was reviewed with the administrator, regional director of clinical serves and corporate	F 758	responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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F 758	Continued From page 84 nursing consultant during a meeting on 3/17/22 at 4:15 p.m. The Nursing 2022 Drug Handbook on pages 1250 through 1251 describes Seroquel (quetiapine fumurate) as an antipsychotic medication used for the treatment of schizophrenia, bipolar depression and as adjunctive therapy for manic episodes and major depressive disorder. Page 1253 of this reference documents Seroquel has a black box warning stating, "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection..." (1) (1) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview, staff interview and facility document review, the facility staff failed to ensure food was served at safe temperatures and meals were palatable and appetizing on one of four units. Fourth floor residents were served food items	F 804	F804 1. Residents residing on the fourth floor are receiving palatable food at an appropriate temperature, according to their preferences, and in a timely manner.	9/20/22

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F 804	Continued From page 85 below safe holding temperatures from the steam table. Residents stated food was not hot or appetizing. Findings were: On 08/16/2022 at approximately 10:45 a.m., Residents # 103, 105, and 112, assessed as cognitively intact, asked to speak with the surveyor. All three residents voiced concerns regarding food at the facility. Complaints included the food was cold, served late, not what was on the scheduled menu, and did not taste good. On 8/16/22 at 11:18 a.m., Resident #40, assessed by the facility as cognitively intact, was interviewed about quality care/life in the facility. Resident #40 stated her main problem was with food service. Resident #40 stated before COVID food was good but a new company ran the kitchen and now the food was worse. Resident #40 stated they rarely got fresh fruits/salads and when fruits like melons and/or cantaloupes were served, they were hard and not ripe. Resident #40 stated the food quantities at times were lacking as she had been served one chicken finger, one fish stick or a fish stick cut in half. Resident #40 stated there was an ongoing problem on fourth floor with toast that was brown only on one side. Resident #40 stated the menus posted were difficult to read and that 2nd and 5th floor residents were given options for food selections and residents on 3rd and 4th floor just got what was served. Resident #40 stated the food alternates for meals were never posted. Resident #108 was interviewed on 08/16/2022 at approximately 12:05 p.m. Resident #108 was	F 804	2. Current Residents have the potential to be affected. 3. Dietary staff will be educated by the Dietary Manager on serving food timely, at appropriate temperatures, appropriate portion size, according to the posted menu, and provision of alternate food items and snacks. Nursing staff will be educated on provision of alternate food items, provision of snacks, and reporting any Resident concerns with food to the Dietary Department at time of concern. 4. The Dietary Manager/designee will complete a random weekly review of provision of palatable food at appropriate temperature, resident preferences, and timely provision of meals. The Unit Managers/designee will complete a random weekly interview with Residents to ensure that the Residents are receiving food that is served timely, palatable, at appropriate temperatures, and according to Resident preference. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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assessed as cognitively intact. Resident #108 stated that she ate breakfast in her room every day, "It's a lot to get me up so I eat breakfast in here and then eat my other two meals in the dining room." She stated that breakfast was always late, sometimes as late as 9:30 a.m. She stated, "It's late and it is cold." When asked about meals in the dining room, the resident stated, "They are lukewarm at best on most days ...there is a microwave that we can use to warm it up." She was asked about alternates. She stated, "There are no alternates ....the only sandwiches are peanut butter and jelly or turkey and cheese ....we never have salads, just lots of carbs."

The four residents (#103, #105, 108, and #112) were asked if they had been asked about preferences, likes and dislikes. All four stated they had not. Resident #108 stated, "We used to get menus once a week to choose what we want for the week. We don't get those anymore."

The lunch meal on the 4th floor was observed on 08/16/2022. The steam table contained, creamed corn, crab cakes, beef steak with peppers, carrots, mashed potatoes, hush puppies, and corn bread. Observed beside the steam table was stainless steel container of soup that was not on a heat source. Also observed on the table behind the steam table was a stainless steel bowl of tossed salad.

The 4th floor lunch service was observed on 8/16/22 at 12:34 p.m. The menus were posted on the 4th floor bulletin board near entrance to the dining room. The menus were printed with a thin font with light colored ink and did not include the alternate food choices. Posted meal time for lunch was 12:00 p.m. until 1:00 p.m.

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The food cook temperatures measured in the kitchen on 8/16/22 prior to placement in the hot boxes were documented as follows:

regular meat = 165
pureed meat = 170
vegetable = 165
pureed vegetable = 165

On 8/16/22 at 12:41 p.m., dietary employee (other staff #7) checked the 4th floor food temperatures at the steam table prior to meal service with results as follows in degrees Fahrenheit (F).

crab cake = 127
cream corn = 148
hush puppies = 123
beef steaks with onions/peppers = 154
carrots = 124
mashed potatoes = 124
pureed crab cakes = 125
pureed broccoli = 125
mushroom soup = 125 (not held on a heat source)

The dietary employee proceeded to plate and serve the food to the twenty-five residents seated in the dining room and then the remaining residents on the unit eating in their rooms. No food was returned to the kitchen or was reheated prior to serving. The temperature log where the food temperatures were recorded documented hot food items were supposed to be maintained at 135 degrees or greater while on the steam table. Only two of the nine hot food items were above 135 degrees on the steam table. All plates, except those on a pureed diet, were served with one crab cake, a square of

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cornbread, two hush puppies and a scoop of cream corn. A fresh salad positioned on the table beside the steam table was not served to any residents. The alternate of beef steak with onions/peppers and the carrot coins were not served during the observation.

Resident #108 was in the dining room for lunch and was interviewed with her plate was in front of her. Her plate contained creamed corn, corn bread, hush puppies, and a breaded crab cake. Resident #108 had not eaten any of the food items. When asked about lunch Resident #108 stated, "Look at all of our plates. None of us are eating this." When asked if she preferred the alternate of the beef pepper steak or a salad, Resident #108 stated, "We have salad? No one told me that. I didn't know about the beef either." While walking around the dining room observing trays, no beef steak, salad or carrots were observed on any of the plates.

On 8/16/22 at 1:00 p.m.., Resident #40 and Resident #106 were eating at the same table and were interviewed about their lunch. Both residents had been served one crab cake, a scoop of cream corn, two hush puppies and a square of cornbread. Resident #106 stated, "I'm not eating this. I gave my crab cake away." Resident #106 stated the food was not hot even though it came right off the steam table. Resident #40 stated she did not know why they served "double" cornbread with hush puppies and cornbread square. Resident #40 stated the food was not hot. Both residents stated they were not aware of the fresh salad and were not aware of the beef steak alternate.

At the end of lunch, the bowl of tossed salad was

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still covered with plastic wrap and had not been served. CNA (certified nursing assistant) #1 was asked why the salad had not been served. CNA #1 stated, "We don't have any bowls for it or salad dressing." She looked in the condiment container and stated, "This is all the salad dressing we have." She was holding three individual packs of Italian salad dressing.

The resident council meeting minutes for the previous three months were requested and reviewed prior to the group meeting held on 08/17/2022 at 2:00 p.m. Per the minutes the residents requested more fruit and sandwich options in May, June, and July (2022). June 2022 notes documented residents wanted to choose from menu items and be aware of the alternates. Residents in July also requested better food portions and snacks on the floor at all times.

On 08/17/2022 at 2:00 p.m. a group meeting was conducted with seventeen residents that routinely participated in resident council. Comments about dietary and food concerns included, "...the food is cold. We don't have choices. The portions are small. The meals are never on time..." Resident #134 assessed as cognitively intact stated, "I've been here 10 years and food has always been a problem. The resident stated food service got worse last year when dietary was taken over by some new company and that residents had been promised for over a year that things would improve but they seem worse. Resident #134 stated there were no food selections, menus were difficult to read and the alternates were not posted. Resident #134 stated when you get served, often the food doesn't look, smell or taste good. The resident stated she had seen staff putting food in their pockets and personal work

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bags to take home. The portions are small and we rarely are offered second servings."

On 8/17/22 at 1:26 p.m., the administrator, dietary manager (other staff #6) and the regional director of culinary services (other staff 8) were interviewed by the survey team about the 4th floor food service and resident comments about food. The regional culinary director stated after a kitchen review yesterday (8/16/22), the hot boxes for transporting the food to the units were found not set appropriately for maximum heat retention. The regional culinary director stated the hot boxes were set for "proofing" to retain moisture and/or yeast activation and should have been set for hot foods. The dietary manager had no explanation of why the fresh salad, carrots or beef steak alternate were not served on the 4th floor and stated the soup was supposed to be held on the steam table for heat retention. The dietary manager stated the foods on the steam table below 145 degrees were supposed to be returned to the kitchen for reheating to 165 degrees. The regional culinary director stated the foods from the steam table were supposed to be at least 135 degrees. The regional culinary director stated menus were posted on each unit and he was not aware that the posted menus did not include the alternate. The regional culinary director stated "folders" with menu options were provided to each unit a day ahead so residents could choose their next meals. The dietary manager stated they currently allowed 2nd and 5th floor residents to choose meal/food items but that practice was not implemented on the 3rd and 4th floor. There was no explanation given as to why 2nd and 5th floor residents were allowed menu selections and 3rd and 4th residents were not. The regional culinary director stated meal

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F 804	Continued From page 91 service "got off track due to COVID" and there was a learning curve trying to get back to normal. The dietary manager stated he assessed food preferences for new admissions but preferences were not reassessed. The dietary manager stated the one-sided toast mentioned during a resident interview was due to a dysfunctional toaster. These findings were reviewed with the administrator, dietary manager and regional director of culinary services on 8/17/22 at 1:30 p.m. and with the administrator, regional director of clinical services and corporate nursing consultant on 8/17/22 at 4:15 p.m.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		9/20/22

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F 812	Continued From page 92 by: Based on observation, staff interview and facility document review, the facility staff failed to store, prepare and serve food in a sanitary manner. Dietary staff entered the kitchen without washing hands. Refrigerated foods were stored beyond use by dates and/or without labels indicating dates opened. Food temperatures were not checked on the steam tables prior to plating food. Hot foods were stored and served from the unit steam tables below the safe/recommended holding temperature of 135 degrees (F). The findings include: 1. On 8/16/22 at 8:38 a.m., a dietary employee (other staff #7) entered the kitchen. The dietary employee did not wash her hands upon entering the kitchen and proceeded to obtain a section of plastic wrap from a bulk dispenser and then left the kitchen area. On 8/16/22 at 8:40 a.m., the dietary manager entered the kitchen and failed to perform hand hygiene. On 8/16/22 at 8:44 a.m., accompanied by the dietary manager, food storage areas were inspected. Stored in the walk-in refrigerator was an unsealed plastic bag of ground sausage with no date opened or use by date indicated. There was sliced roast beef in plastic wrap with no label of the date opened. There was ground beef in a thaw pan wrapped in plastic wrap with no date opened or a use by date. There were one gallon containers of condiments with no manufacturing use by dates on the labels. The containers had handwritten use by dates as follows: mustard - use by 7/20; mayonnaise - no date opened and no use by date; Italian dressing - use by date of 8/4 and pickle relish - use by date of 7/18. Stored	F 812	F812 1. Food is being stored, prepared, and served in a sanitary manner. 2. Current Residents have the potential to be affected. 3. Dietary staff will be educated by the regional director of culinary services/designee on hand washing, labeling and storage of opened items, disposal of items beyond the use-by date, temperature checks of food, and cleanliness of the kitchen. 4. The Administrator/designee will complete a weekly review of the kitchen to ensure that staff are washing hands, food items are labeled when opened and discarded when beyond the use-by date, that temperature checks are completed and food served at appropriate temperatures, and the kitchen is clean. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance: 9/20/22	

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in the reach-in refrigerator was a plastic storage bag with ham sandwich meat with no date label indicating when opened or a use by date.

The dry storage room had a light yellow substance spilled in the floor in front of the rack holding the bananas. The spill had been tracked and the floor was sticky to your shoes as you entered the room. The floors in the foyer from the outside dumpster area prior to entrance to the kitchen were dirty with black stains and spills.

On 8/16/22 at 9:07 a.m., the dietary manager was interviewed about handwashing, refrigerated food storage and cleanliness of the storage/kitchen environment. The dietary manager stated employees were supposed to wash hands upon entrance to the kitchen and prior to handling any food prep items. The dietary manager stated stored food items were supposed to be labeled with the date opened and a use by date and that out of date foods should be discarded. The dietary manager stated floors were supposed to be cleaned and mopped daily.

The facility's policy titled Food Storage: Cold (October 2019) documented, "It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items will be appropriately stored in accordance with guidelines of the FDA Food Code...The Dining Services Director /Cook(s) insures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination..." The facility's policy titled Food: Preparation (October 2019) documented, "...The Dining Services Director insures that all staff practice proper hand washing technique...All Time/Temperature Control for

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Safety (TCS) foods that are to be held for more than 24 hours at a temperature of 41 [degrees] or less, will be labeled and dated with a 'prepared date' (Day 1) and a 'use by date' (Day 7)..."

The facility's policy titled Environment (October 2019) documented, "It is the center policy that all food preparation areas, food serve areas, and dining areas will be maintained in a clean and sanitary condition...The Dining Service Director will insure that the physical plant is maintained in a clean and sanitary manner, including floors, walls, ceilings..."

2. On 8/16/22 at 12:34 p.m., lunch service from the 4th floor steam table was observed. On 8/16/22 at 12:40 p.m. food was removed from a hot box and placed on the steam table. There was less than an inch of water in the steam table wells and the water was gray with floating food particles observed. The steam table knobs were set on 6 but there was no visible steam coming from the water in the wells.

On 8/16/22 at 12:41 p.m., dietary employee (other staff #7) checked the 4th floor food temperatures with results as follows in degrees Fahrenheit (F).

crab cake = 127
cream corn = 148
hush puppies = 123
beef steaks with onions/peppers = 154
carrots = 124
mashed potatoes = 124
pureed crab cakes = 125
pureed broccoli = 125

A stainless container of mushroom soup was positioned on the table near the condiment rack

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and was without a heat source. The soup temperature was 125.0 degrees F.

The dietary employee recorded only the temperature of the crab cakes and the carrots on the food log. The dietary employee proceeded to plate and serve the food to the twenty-five residents seated in the dining room and then the remaining residents on the unit eating in their rooms. No food was returned to the kitchen or was reheated prior to serving. The temperature log where the food temperatures were recorded documented hot food items were supposed to be maintained at 135 degrees or greater while on the steam table. Only two of the nine hot food items were above 135 degrees on the steam table.

On 8/16/22 at 1:20 p.m., the dietary employee (other staff #7) was interviewed about food temperatures. When asked what about the minimum safe temperature to hold food on the steam table, the dietary employee stated temperatures "could be anything" and stated temperatures were supposed to be written on the log. Asked again about what hold temperature was acceptable for food on the steam table, the dietary employee mumbled and then had no response. When asked what was required if food on the steam table was not hot enough, the dietary employee had no response.

On 8/16/22 at 1:19 p.m., the food temperatures on the 5th floor steam table were requested/observed. Foods stored on the steam table included crab cakes, carrots, beef steaks with onions/peppers, mashed potatoes, cream corn, hush puppies, pureed crab cakes, pureed vegetable. A stainless container of mushroom soup was positioned on the table beside the

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steam unit without a heat source. The steam table knobs were set on 3 with no steam observed coming from the water in the wells. Approximately twenty-five lunch trays were already plated on the food carts. The temperature log had approximately 20 pages, all of them blank. There were no recorded food temperatures on 8/16/22 prior to food service on the 5th floor.

On 8/16/22 at 1:23 p.m., the dietary employee (other staff #2) serving food from the 5th floor steam table was interviewed. When asked if food temperatures were supposed to be taken prior to or during food service, the dietary employee stated, "I don't know." When asked about the soup positioned without a heat source, the dietary employee stated, "They told me to just put it there because it won't fit on the steam table."

On 8/16/22 at 1:28 p.m., the dietary manager (other staff #6) came to the 5th floor dining service. The dietary manager stated, "Everyone knows to take food temperatures before plating the food." Food temperatures were requested at this time. The dietary manager checked food temperatures and they were as follows in degrees F.

crab cakes = 131
cream corn = 145
mashed potatoes = 152
carrots = 153
beef steaks with onions/peppers = 153
pureed crab cakes = 78
pureed vegetable = 136
mushroom soup = 78

The dietary manager stated the crab cakes and

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pureed meat and mushroom soup were below the recommended holding temperature of 135 degrees. The dietary manager stated that hot food not at least 135 degrees should be sent to the kitchen to be reheated. The dietary manager stated food was cooked, placed in serving pans and then stored/transported to the units in a hot box prior to placement on the unit steam tables. Concerning the steam table setting of 3, the dietary manager stated the table was usually set on 5 or 6 and "could be hotter." The dietary manager stated hot food items were supposed to be checked and temperatures recorded in the log book prior to service from the steam table.

On 8/16/22 at 1:16 p.m., the 2nd floor food service was completed and the food temperature log requested. The dietary employee (other staff #1) stated she took the hot food temperatures and recorded them in the log book. Review of the log book revealed only one page of food temperatures documented on 8/6/22. The dietary employee stated she checked the temperatures today (8/16/22) but did not write them down. The dietary employee stated she remembered the crab was 165, corn was 150, hush puppies were 163, beef steak was 159, carrots were 158 and mashed potatoes were 165. The dietary employee stated they were supposed to check food temperatures prior to each meal service. The dietary employee stated she did not record today because she was late. When asked if she knew the recommended holding temperature for the steam table items, the dietary employee stated she did not know what was being asked and stated, "It's in the book." When asked about the missing temperatures from previous days, the dietary employee stated, "I think people don't do it. We put it on the plate and serve it." The

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYDALE HEALTH AND REHABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207

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temperature log sheet documented hot food items were supposed to be held at 135 degrees or greater on the steam table.

On 8/16/22 at 1:21 p.m., the 3rd floor steam table was observed. Food temperature logs for the lunch service were requested and revealed no temperatures recorded. The dietary employee (other staff #3) was interviewed about the temperatures. The dietary employee stated the food temperatures were supposed to be taken before serving but she did not have time and the temperatures were not checked. The food temperatures were requested at this time for the foods held on the steam table. Food temperatures were measured on the following (in degrees F). The temperature of the other foods on the steam table were not taken.

crab cakes = 90
pureed vegetable = 122

The dietary employee stated the food was supposed to be held at 135 degrees or higher. When asked about the protocol for food less than 135 degrees, the dietary employee stated the heat should be turned up. The dietary employee continued to serve food including the crab cakes after measuring the temperature at 90 degrees.

The food cook temperatures measured in the kitchen on 8/16/22 prior to placement in the hot boxes were documented as follows: regular meat = 165, pureed meat = 170, vegetable = 165 and pureed vegetable = 165.

On 8/17/22 at 1:26 p.m., the survey team interviewed the administrator, dietary manager (other staff #6) and the regional director of

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culinary services (other staff #8) about the above kitchen and food service observations and interviews. The dietary manager stated it was standard practice to check temperatures and record them in the log book before service from the steam table for each meal. The dietary manager stated the minimum temperature for holding food on the steam table was 145 degrees (F) and if not up to that temperature, food was supposed to return to the kitchen for reheating to 165 degrees (F). The dietary manager stated the steam table knobs should be set on 5 or 6. The regional culinary director stated the minimum temperature for holding food on the steam table was 135 degrees (F). The regional culinary director stated the water in the steam table wells was supposed to be changed at least once per day. The dietary manager stated the soup was supposed to be stored and served from the steam table like other hot foods. The regional culinary director stated after a kitchen review yesterday (8/16/22), the hot boxes for transporting the food were found not set appropriately for maximum heat retention.

The facility's policy titled Food: Preparation (October 2019) documented, "It is the center policy that all foods are prepared in accordance with the guidelines of the FDA Food Code...The Dining Services Director of Cook(s) is responsible for food preparation techniques, which minimize the amount of time, that food items are exposed to temperatures greater than 41 [degrees F] and/or less than 135 [degrees F...The Cook(s) insures that all foods are held at appropriate temperatures, greater than 135 [degrees F]...for hot holding...Temperature for Time/Temperature Control for Safety (TCS) foods recorded at time of service, and monitored periodically during meal

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F 812	Continued From page 100 service periods as indicated..." These findings were reviewed with the administrator on 8/17/22 at 1:30 p.m. and during a meeting with the administrator, regional director of clinical services and corporate nursing consultant on 8/17/22 at 4:15 p.m.	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure proper functioning of the dishwasher and a functioning paper towel dispenser in the kitchen. The dishwasher was operated with water leaking from under the center stainless steel panel into the floor. A paper towel dispenser at the handwashing sink near the kitchen entrance was not functional. The findings include: 1. On 8/16/22 at 8:37 a.m., an initial tour of the kitchen was conducted accompanied by the dietary manager (other staff #6). Upon washing hands at the sink near the kitchen/dishwasher room entrance, the motorized paper towel dispenser was observed not working. The surveyor was directed by kitchen staff to another sink near the food prep area to obtain a paper towel to dry hands. On 8/16/22 at 8:40 a.m., accompanied by the dietary manager, the towel dispenser was	F 908	F908 1. The dishwasher and paper towel dispenser located in the kitchen have been repaired. 2. Current Residents have the potential to be affected. 3. Dietary staff were educated by the Dietary Manager/designee on prompt reporting of equipment that is not functioning properly. 4. The regional director of culinary services will complete a monthly review of equipment located in the kitchen to ensure that equipment remains functional. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction.	9/20/22

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F 908	Continued From page 101 observed not working and a red light was illuminated on the front of the dispenser. The dietary manager was interviewed at this time about the dispenser. The dietary manager stated he did not know why the dispenser was not working. On 8/16/22 at 10:28 a.m., the paper towel dispenser was observed non-functional with the red light still illuminated. 2. On 8/16/22 at 10:30 a.m., operation of the kitchen's dishwasher was observed. As dishes/racks went through the unit, water was steadily leaking from the bottom edge of the center stainless steel panel onto the floor. The floor in front and under the dishwasher was wet from the leaking water. The dietary employee (other staff #7) operating the dishwasher was interviewed at this time about the leaking water. The dietary employee stated sometimes the racks became stuck and caused the water to leak. On 8/16/22 at 10:35 a.m., the leaking dishwasher was observed accompanied by the dietary manager (other staff #6). The dietary manager opened the unit revealing four, perforated water pipes across the floor of the dishwasher for water distribution during the wash/rinse cycles. Caps were missing on three of the four pipes. The dietary manager stated water was leaking because the pipes did not have the caps in place. The dietary manager stated he thought the caps just came off. There were no caps observed inside or around the dishwasher. These findings were reviewed with the administrator, dietary manager and regional	F 908	6. Date of compliance: 9/20/22	

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F 908	Continued From page 102 director of culinary services on 8/17/22 at 1:30 p.m. and during a meeting on 8/17/22 at 4:15 p.m. with the administrator, regional director of clinical services and corporate nursing consultant.	F 908		