STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495244	A. BUILDING _____ B. WING _____	C 02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MADISON	NUMBER ONE AUTUMN COURT MADISON, VA 22727

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced emergency preparedness survey was conducted on 02/21/2023 through 02/23/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/21/2023 through 2/23/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey (VA00057803-substantiated with deficiency). The Life Safety Code survey/report will follow. The census in this 92 certified bed facility was 71 at the time of the survey. The survey sample consisted of 24 current resident reviews and four closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		3/28/23

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

Electronically Signed | 03/09/2023

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

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F 580	Continued From page 1 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). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed	F 580	F-580 (1) Corrective Action(s): Resident # 223 is no longer a	

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F 580	Continued From page 2 to notify a resident's responsible party of a change in condition for one of 28 residents in the survey sample, Resident #223. The findings include: For Resident #223 (R223), the facility staff failed to notify the resident's RP (responsible party) of a new physician's order for melatonin. A review of R223's clinical record revealed a note signed by the nurse practitioner on 1/27/23 that documented, "4) Insomnia - Acute. New recommendations given..." A physician's order dated 1/27/23 documented an order for melatonin 5 milligrams by mouth at bedtime for insomnia. Further review of R223's clinical record failed to reveal the resident's RP was made aware of the resident's insomnia and new medication order. On 2/23/23 at 8:52 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated a resident's RP should be notified regarding any change in condition and new medication order. LPN #8 stated, "You want the RP to know a change was made and this is a reason for what the doctor is doing." On 2/23/23 at approximately 11:15 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Resident Change in Condition Policy" documented, "5. The Resident/Physician or Provider/Family/Responsible Party will be notified when there has been...e. A need to alter the resident's medical treatment, including a change	F 580	resident in the facility. (2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident has the potential to be affected. DON and or designee will conduct an audit of new physician's orders and change of condition for the past 30 days to ensure RP notifications were complete. Any variances or deficient practices will be addressed at that time. (3) Systemic Change(s): The Director of Nursing (DON) or designee will educate licensed nurses on their responsibility of notifications in change in conditions to RP and MD and change in physicians' orders to the RP. Education will be Included in new hire orientation. (4) Monitoring: The DON or designee will audit 24 hours reports and new physicians' orders during Clinical Morning meeting weekly x 4 weeks then monthly x 2 months to verify RP and/or Physician have been notified of any change in conditions or change in physicians' orders; any variances will be addressed. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 580	Continued From page 3 in provider orders."	F 580		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		3/28/23

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F 623	Continued From page 4 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623		

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F 623	Continued From page 5 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide the required written documentation for a facility-initiated transfer, for one of 28 residents in the survey sample, Resident # 64 (R64). The findings include: For (R64), the facility staff failed to evidence that written notification was provided to (R64) and (R64's) responsible party for a facility-initiated transfer on 02/10/2023. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/20/2023, (R64) scored three out of 15 on the BIMS (brief interview for	F 623	F-623 (1) Corrective Action(s): The Director of Social Services has sent written notification to Responsible Party for Resident # 64 regarding transfers to hospital. (2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident has the potential to be affected. A 100% audit of residents who have been discharged for past 30 days will be completed to verify written notification has been provided to the Responsible Party. Any variances will be addressed and corrected. (3) Systemic Change(s): The Director of Nursing or designee will educate Social Services staff on the requirements for written notification to	

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F 623	Continued From page 6 mental status), indicating the resident was severely impaired of cognition for making daily decisions. The facility's progress noted for (R64) dated 2/10/2023 at 7:35 a.m., documented in part, "Situation: The Change In Condition/s reported on this CIC (change in condition) Evaluation are/were: Nausea/Vomiting ... A. Recommendations: If resident has additional n/v (Nausea/Vomiting) please send to hospital for evaluation." The facility's progress noted for (R64) dated 2/10/2023 at 10:05 a.m., documented. "RT (Resident) sent to (Name of Hospital) at 0700 (7:00 a.m.) for vomiting and abnormal VS (vital signs)." Review of the clinical record and the EHR (electronic health record) for (R64) failed to evidence written notification of the discharge was provided to (R64) and (R64's) representative for the facility-initiated transfer on 02/10/2023. On 02/22/2023 at approximately 3:58 p.m., an interview was conducted with OSM (other staff member) #1, director of social services. When asked about providing a written notification to the resident and the resident's RP regarding the transfer, OSM stated they mail a copy of the letter and scan it into the resident's electronic health record. On 02/22/2023 at approximately 4:49 p.m., ASM (administrative staff member) #1, administrator, stated that they did not have evidence of providing written notification provided to (R64) and (R64's) responsible party for a	F 623	Responsible Party (RP) of discharge. (4) Monitoring: The Director of Nursing or designee will audit all transfers/discharges weekly x 4 weeks then monthly x 2 months to verify required written notification has been provided to the Responsible Party. Audit findings will be reported to the QAPI committee monthly x 3 for further review and recommendations.	

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F 623	Continued From page 7 facility-initiated transfer on 02/10/2023. The facility's policy "Resident Discharge / Transfer Letter Policy" documented in part, "E) Social Services or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, id applicable. 1. Copies will be sent to Department of Health, Ombudsman Office, and filed in the business file and/or scanned into PCC (point click care - electronic health record) documents tab with administrator/designee signature, with certified receipt if applicable." On 02/23/2023 at approximately 11:10 a.m., ASM #1, administrator, and ASM #2, director of nursing, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625		3/28/23

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F 625	Continued From page 8 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed provide a bed hold policy notice to the resident or the resident's representative, for a facility-initiated transfer of one of 28 residents in the survey sample, Resident #64 (R64). The findings include: For (R64), the facility staff failed to evidence that a bed hold policy notice was provided to (R64) and (R64's) responsible party for a facility-initiated transfer on 02/10/2023. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/20/2023, (R64) scored three out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired of cognition for making daily decisions. The facility's progress noted for (R64) dated	F 625	F-625 (1) Corrective Action(s): The Director of Social Services has sent written notification to Responsible Party for Resident # 64 regarding bed hold policy. (2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident has the potential to be affected. A 100% audit of residents who have been discharged for past 30 days will be completed to verify written bed hold policy notification has been provided to the Resident and/or Responsible Party. Any variances will be addressed and corrected. (3) Systemic Change(s): The Director of Nursing or designee will educate licensed nurses and Social Services staff on the requirements for bed hold policy to be sent upon transfer and/or discharge to the Responsible Party (RP) and/or resident on the day of discharge. Education will be included in new hire orientation.	

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F 625	Continued From page 9 2/10/2023 at 10:05 a.m., documented. "RT (Resident) sent to (Name of Hospital) at 0700 (7:00 a.m.) for vomiting and abnormal VS (vital signs)." Review of the clinical record and the EHR (electronic health record) for (R64) failed to evidence a bed hold policy was provided to (R64) and (R64's) representative for the facility-initiated transfer on 02/10/2023. On 02/22/2023 at approximately 3:58 p.m., an interview was conducted with OSM (other staff member) #1, director of social services. When asked about the procedure to provide a bed hold policy for a facility-initiated transfer, OSM #1 stated the hold policy is given to the resident when they to go to emergency room and then it is scanned into the resident's electronic health record. On 02/22/2023 at approximately 4:49 p.m., ASM (administrative staff member) #1, administrator, stated that they did not have evidence of providing a bed hold policy to (R64) and (R64's) responsible party for a facility-initiated transfer on 02/10/2023. The facility's policy "Resident Discharge / Transfer Letter Policy" documented in part, "G) The resident or responsible party will receive a bed hold policy notice along with the discharge / transfer letter, when applicable. Bed hold notices can be found within PCC (point click care - electronic health record) under Document Manager ..." On 02/23/2023 at approximately 11:10 a.m., ASM #1, administrator, and ASM #2, director of	F 625	(4) Monitoring: The Director of Nursing or designee will audit all transfers/discharges weekly x 4 weeks then monthly x 2 months to verify required bed hold policy has been provided to the Resident and/or Responsible Party. Audit findings will be reported to the QAPI committee monthly x 3 for further review and recommendations.	

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F 625	Continued From page 10 nursing, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit	F 625		
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 clinical record review and staff interview it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 28 residents in the survey sample, Resident #38. The findings include: For Resident #38 (R38), the facility staff failed to code the quarterly MDS assessment with an ARD (assessment reference date) of 1/2/2023 for hospice services received during the assessment period. Review of the clinical record for R38 revealed the most recent MDS assessment to be a quarterly MDS with an ARD of 1/2/2023. Section O of the assessment failed to document R38 receiving hospice services during the assessment period. The physician orders for R38 documented in part, "Admit to [Name of hospice] - Do Not Give Antibiotics, No Vital Signs or Weights, Do Not Send To ER (emergency room) or Hospital, Do Not Draw Blood, Collect Urine or XR (x-ray) Testing, Do Not Give Tube Feedings. Order	F 641	F-641 (1) Corrective Action(s): MDS for Resident #38 has been modified and transmitted to the state. (2) Identification of Deficient Practice(s) and Corrective Action(s): All hospice residents have the potential to be affected. 100% audit of Hospice residents' MDS will be audited for accuracy. All variance will be corrected immediately with medications and transmissions. (3) Systemic Change(s): MDS staff will be reeducated by the Regional Clinical Reimbursement Specialist or designee on coding accuracy of MDS with emphasis on Hospice coding (4) Monitoring: DON or designee will Audit 5 hospice resident□s MDS per the quarterly calendar weekly x 12 weeks for MDS accuracy of coding the MDS. DON or designee will share audits with the QAPI committee for further review and recommendations	3/28/23

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F 641	Continued From page 11 Date: 06/28/2021." The comprehensive care plan for R38 documented in part, "HOSPICE SERVICES: Resident is on Hospice services, (Name of hospice) (phone number]) Date Initiated: 06/28/2021..." On 2/22/2023 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #1, MDS coordinator. LPN #1 stated that they used the RAI (resident assessment instrument) manual as their guide when completing the MDS assessments. LPN #1 stated that R38 received hospice services and the MDS should be coded for the services. LPN #1 reviewed the quarterly MDS with the ARD of 1/2/2023 and stated that it was not coded for hospice and should have been and it would be corrected. According to the RAI Manual, Version 1.16, dated October 2018, section O0100 documented in the steps for assessment, "1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days...O0100K, Hospice Care, Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider..." On 2/22/2023 at 4:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing/infection preventionist, ASM #4, the	F 641		

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F 641	Continued From page 12 business office manager/administrator in training and ASM #5, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		3/28/23

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F 656	Continued From page 13 (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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility policy review, and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for two of 28 residents in the survey sample, Residents #33 and #49. The findings include: 1. The facility staff failed to implement the care plan for obtaining weights per the physician orders for Resident #33 (R33). On the most recent MDS (minimum data set) assessment, a quarterly/Medicare five-day assessment, with an assessment reference date of 1/2/2023, the resident scored an eight out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. R33 has a diagnosis of congestive heart failure (CHF).	F 656	F-656 (1) Corrective Action(s): The nurses caring for Resident #33 and #49 have been educated on following comprehensive care plan. MD had been notified of resident missing daily weights. Resident #49 pain monitoring orders were revised to include non-pharmacological interventions every shift and care plan to match. #49 PRN pain medication orders were updated to pain levels. (2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident has the potential to be affected. A 100% residents with daily weights will be audited to ensure completion of the daily weights, and an audit of pain management residents will be completed to ensure non-pharmacological interventions are in place and nurses are following care plan. Any residents with PRN pain medication orders be audited for pain levels. Any variances will be corrected immediately.	

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F 656	Continued From page 14 The comprehensive care plan dated, 9/14/2022 and revised on 10/13/2022, documented in part, "Focus: The resident has a potential nutritional problem r/t (related to) risk for malnutrition r/t depression, celiac disease, Vitamin deficiency, and duodenal ulcer." The "Interventions" documented in part, "Weights per orders/routine/prn (as needed)." The physician order dated, 11/17/2022, documented, "Daily Weight." The December 2022 and January 2023, MAR (medication administration record) documented the above order for daily weights. The following dates were blank: 12/29/2022, 12/20/2022, 1/3/2023, 1/4/2023, 1/29/2023. Review of the "Weights" tab in the electronic medical record failed to evidence documentation of weights obtained on the above dates. An interview was conducted with LPN (licensed practical nurse) #3 on 2/22/2023 at 3:30 p.m. When asked the purpose of the care plan, LPN #3 stated, "It is to make sure we are doing the right things for our folks. It should have new orders, falls, treatments, ADLs (activities of daily living), and code status." LPN #3 stated it is individualized [care plan] for each resident, as each resident is different in their care needs. When asked if it should be followed, LPN #3 stated, yes. The facility policy, "Comprehensive Care Planning Policy" documented in part, "POLICY: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on	F 656	(3) Systemic Change(s): The Director of Nursing or designee will educate licensed nurses on following physician's orders and care plan interventions ensuring all, daily weights are being completed in a timely manner and nonpharmacological interventions are being followed per care plan and physician's orders will have pain levels for PRN pain medications. Education will be included in new hire orientation. (4) Monitoring: The Director of Nursing or designee will conduct weekly audits of 5 residents chart and observation to verify care plan interventions are being followed for but not limited to management of pain, and daily weight orders x 4 weeks then monthly x 2 months. The DON will report audit findings to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 656	Continued From page 15 an as needed basis. In states where pre-admission screening applies, this will be coordinated with the facility assessment. Goals must be measurable and objective... D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM # 5, the regional director of clinical services, were made aware of the above finding on 2/23/2023 at 11:15 a.m. No further information was provided prior to exit. 2. For Resident #49 (R49) the facility staff failed to implement the comprehensive care plan for the use of non-pharmacological interventions prior to the administration of a prn (as needed) pain medications, (R49) was admitted to the facility with a diagnosis that included but was not limited to chronic pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/03/2023, (R49) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R49) was cognitively intact for making daily decisions. Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R49) was coded a "7 (seven)." The physician's order for (R49) documented in part, "Hydromorphone HCl Tablet 2 (two) MG (milligrams). Give 2 tablet by mouth every 6 (six) hours as needed for chronic pain (1). Order Date: 09/16/202," and "Tylenol Tablet 325 MG (Acetaminophen). Give 975 mg by mouth every 6 hours as needed for pain (2). Order date:	F 656		

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F 656	Continued From page 16	F 656		

08/29/2022." Further review of the physician's orders failed to evidence pain level parameters for the administration of the above prn pain medications.

The comprehensive care plan for (R49) dated 08/16/2022 documented in part, "The resident has pain r/t (related to) Neuropathy (3) and PVD (peripheral vascular disease) (4). Has hx (history) of chronic pain to lower back and legs. Date Initiated: 08/16/2022." Under "Interventions" it documented in part, "Staff to offer/implement non-pharmacological interventions for pain relief ...Date Initiated: 08/16/2022."

The eMAR (electronic medication administration record) for (R49) dated January 2023 documented the physician's orders as stated above. The eMAR revealed that (R49) received 2 mgs of hydromorphone on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 01/03/2023 at 10:16 a.m., 01/04/2023 at 10:53 a.m., 01/06/2023 at 2:47 p.m., 01/07/2023 at 10:17 a.m., 01/11/2023 at 8:28 a.m. and at 3:54 p.m., 01/12/2023 at 9:03 a.m. and at 4:29 p.m., 01/13/2023 at 8:31 a.m. and at 3:54 p.m., 01/14/2023 at 12:53 p.m., 01/17/2023 at 7:39 a.m., 01/20/2023 at 11:37 a.m., 01/21/2023 at 4:51 p.m., 01/22/2023 at 9:05 a.m., 01/26/2023 at 8:00 a.m. and at 3:54 p.m., 01/27/2023 at 1:01 p.m. and at 7:07 p.m., and on 01/31/2023 at 12:32 p.m. Further review of the eMAR revealed that (R49) received 975 mg of Tylenol on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 01/11/2023 at 8:28 a.m., 01/13/2023 at 10:18 a.m., 01/14/2023 at 12:55 p.m., 01/21/2023 at 4:52 p.m., 01/22/2023 at 9:06

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F 656	Continued From page 17 a.m., 01/24/2023 at 11:24 a.m., and on 01/26/2023 at 11:34 a.m. The eMAR for (R49) dated February 2023 documented the physician's orders as stated above. The eMAR revealed that (R49) received 2 mgs of hydromorphone on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 02/01/2023 at 7:38 a.m. and at 2:33 p.m., 02/10/2023 at 9:58 a.m. and at 4:32 p.m., and on 02/15/2023 at 2:09 p.m. Further review of the eMAR revealed that (R49) received 975 mg of Tylenol on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 02/08/2023 at 5:36 a.m. and on 02/15/2023 at 2:09 p.m. On 02/21/23 at approximately 11:45 a.m., an interview was conducted with (R49). When if they have pain (R49) stated they have chronic pain. When asked if they receive as needed pain medication, does the staff try to alleviate their pain before administering their pain medication (R49) stated no. On 02/22/2023 at approximately 1:15 p.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 was asked to review the dates and times stated above on the eMARS to determine if there was documentation of non-pharmacological interventions attempted prior to the administration of (R49's) prn pain medications. At approximately 2:05 p.m., ASM #2 stated that there was no documentation of non-pharmacological interventions attempted for the dates and times stated above.	F 656		

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F 656	Continued From page 18 On 02/23/2023 at approximately 8:55 a.m., an interview was conducted with ASM #2. After reviewing (R49's) comprehensive care plan as stated above, ASM #2 was asked if the care plan was being implemented if there was no evidence of non-pharmacological interventions attempted. ASM # 2 stated no. The facility's policy "Comprehensive Care Planning Policy" documented in part, "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented." On 02/23/2023 at approximately 9:00 a.m., ASM #2, director of nursing, was made aware of the above findings. No further information was provided prior to exit. References: (1) Used to relieve severe pain. This information was obtained from the website: Hydromorphone: MedlinePlus Drug Information. (2) Used to relieve mild to moderate pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html. (3) Nerve damage. This information was obtained from the website: https://www.google.com/#q=neuropathy+nih. (4) Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website:	F 656		

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F 656	Continued From page 19 https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.	F 656		
F 657 SS=D	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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to revise the comprehensive care plan for one of 28 residents	F 657	F-657 (1) Corrective Action(s): #49s care plan has been updated to include being able to go outside when the weather is good.	3/28/23

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F 657	Continued From page 20 in the survey sample, Resident #49. The findings include: For Resident #49 (R49) the facility staff failed to update the comprehensive care plan for activities to include (R49's) preference of being outside when the weather is good. (R49's) most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/12/2023, coded (R49) as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0-15, with 15 being cognitively intact for making daily decisions. Under "F0500. Interview for Activity Preferences" it coded (R49) as it being "Very important to go outside to get fresh air when the weather is good." The comprehensive care plan for (R49) dated 08/22/2022 documented in part, "Focus: Activities: Resident prefers/enjoys the following activities: watching tv, spending time on social media and phone. Date Initiated: 08/22/2022. Under "Interventions" it documented, "Engage resident in group activities Date Initiated: 08/22/2022. Monitor independent activities prn (as needed). Date Initiated: 08/22/2022." On 02/23/2023 at approximately 8:45 a.m., an interview was conducted with LPN (licensed practical nurse) #6, MDS assistant coordinator. After reviewing section F0500 of (R49's) significant change MDS and their comprehensive care plan for activities, LPN #6 stated that (R49's) care plan was revised to include their activity preference of being outside when the weather is good. When asked to describe the procedure for	F 657	(2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident has the potential to be affected. The Activity Director or designee will conduct 100% audit of current residents who have the capability to go outside und NP to verify any changes were made and care plans have been updated. (3) Systemic Change(s): The RCRS or designee will educate the MDS staff, Social Services, Activities, Dietary manager, and Unit Managers on facility protocol to ensure care plans have been reviewed and revised to reflect resident's current status. (4) Monitoring: MDS or designee will audit 5 resident□s activities care plan weekly x 4 weeks then monthly x 2 months to verify residents care plans have been reviewed and revised to reflect resident's current status. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months	

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F 657	Continued From page 21 ensuring the care plan reflects the resident's preferences for activities LPN #6 stated that they follow the RAI (resident assessment instrument) manual. On 02/23/2023 at approximately 11:10 a.m., ASM #1, administrator, and ASM #2, director of nursing, and ASM #5, regional director of clinical services, were made aware of the above findings. No further information was provided prior to exit	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed follow the physician's order for obtaining daily weights for one of 28 residents in the survey sample, Resident #33. The findings include: For Resident #33 (R33), the facility staff failed to obtain daily weights twice in December 2022 and three times in January 2023. On the most recent MDS (minimum data set)	F 684	F-684 (1) Corrective Action(s): Resident #33 physician has been notified of the facility not obtaining daily weights as ordered. No new orders at this time (2) Identification of Deficient Practice(s) and Corrective Action(s): DON or designee will conduct an audit of all residents with daily weights to ensure completion of the weights. Any variance will be addressed immediately and MD notified. (3) Systemic Change(s): The DON or designee will educate	3/28/23

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F 684	Continued From page 22 assessment, a quarterly/Medicare five day assessment, with an assessment reference date of 1/2/2023, the resident scored an eight out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. R33 has a diagnosis of congestive heart failure (CHF). The physician order dated, 11/17/2022, documented, "Daily Weight." The December 2022 and January 2023, MAR (medication administration record) documented the above order for daily weights. The following dates were blank: 12/29/2022, 12/20/2022, 1/3/2023, 1/4/2023, 1/29/2023. Review of the "Weights" tab in the electronic medical record failed to evidence documentation of weights obtained on the above dates. The comprehensive care plan dated, 9/14/2022 and revised on 10/13/2022, documented in part, "Focus: The resident has a potential nutritional problem r/t (related to) risk for malnutrition r/t depression, celiac disease, Vitamin deficiency, and duodenal ulcer." The "Interventions" documented in part, "Weights per orders/routine/prn (as needed)." An interview was conducted with LPN (licensed practical nurse) #5 on 2/23/2023 at 9:26 a.m. When asked where daily weights are documented and why they are done, LPN #5 stated they are documented on the MAR and typically done for residents with CHF. When asked if there is a blank on the MAR for a day, what does that indicate, LPN #5 stated, if it's not	F 684	licensed nurses on their responsibility in ensuring daily weight orders are transcribed and carried out according to physicians orders. Education will be included in new hire orientation. (4) Monitoring: The DON or designee will audit daily weight orders weekly x 4 weeks then monthly x 2 months to verify daily weight orders have been carried out. The DON or designee will report the audit findings to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 684	Continued From page 23 documented it wasn't done. The facility policy, "Weights Policy" documented in part, "POLICY: Weights will be obtained routinely in order to monitor parameters of nutrition over time. Each individual's weight will be determined upon admission/readmission to the facility, weekly for the first four weeks after admission/readmission, and monthly or more often if risk is identified. Obtaining accurate weights is vital for the nutritional assessment of each resident and can be used as a basis for medical and nutritional intervention. Nursing is responsible for the determination of each individual's weight." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM # 5, the regional director of clinical services, were made aware of the above finding on 2/23/2023 at 11:15 a.m. No further information was provided prior to exit.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		3/28/23

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F 686	Continued From page 24 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure a new heel wound was assessed accurately, and a treatment was obtained and implemented timely, for one of 28 residents in the survey sample, Resident #33 (R33). The findings include: For R33, the facility staff failed to obtain a physician's order for a treatment to an opened heel blister, and, the heel blister was not assessed and staged as a pressure injury per the National Pressure Injury Advisory Panel (NPIAP) guidelines. On the most recent MDS (minimum data set) assessment, a quarterly/Medicare five-day assessment, with an assessment reference date of 1/2/2023, the resident scored an eight out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. In Section M - Skin Conditions, R33 was not coded as having any pressure ulcers. The "Weekly Wound Assessment" dated 2/10/2023, documented in part, "Wound type: other. Other wound type: open blister. Stage: N/A (not applicable). Wound location: right heel. Length: 5.0 cm (centimeters). Width: 6 cm. Depth: 0.2 cm. Location where wound was acquired: in house. Date wound identified: 2/10/2023. Wound status: New Wound.	F 686	F-686 (1) Corrective Action(s): Resident #33 physician was notified of the delay in treatment for a Right heel wound and a treatment has been ordered per the wound NP. (2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident has the potential to be affected. An audit of wound care practitioner's recommendations for past week has been reviewed to verify recommendations activated. Any variances will be addressed promptly. (3) Systemic Change(s): The DON or designee will educate licensed nurses on their responsibility in ensuring wound care treatment orders are transcribed and carried out according to physicians orders. Education will be included in new hire orientation. (4) Monitoring: The DON or designee will audit wound care provider treatment recommendations weekly x 12 weeks to verify wound care treatment recommendations have been transcribed and carried out. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 686	Continued From page 25 Treatment: area cleaned and dressing applied. Comments: Call placed to on call doctor, awaiting return call." The nurse who documented the wound was not available for interview. Per the NPIAP: "Stage 2 Pressure Injury: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel..." (1) The Wound Care Specialist Note dated, 2/14/2023, documented in part, "Wound: Right heel (+) full-thickness wound that measures 5.0 x 6.0 x 0.2 cm. Wound base 40% purple/maroon tissue, 60% granular, (+) surface induration, edges adherent to the wound base, moderate non-odorous serous drainage, Peri wound without erythema, induration or signs of cellulitis. Patient does not demonstrate evidence of pain when area palpated...Wound care to right heel as follows: Cleanse with normal saline or wound cleanser, pat dry. Apply Alginate to wound bed. Cover with gauze and kerlix dressing. Change dressing every day and as needed for saturation or soilage." Review of the physician orders failed to evidence documentation of the wound care specialist directions. Review of the TAR (treatment administration record) for February, failed to evidence	F 686		

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documentation of any dressing changes from 2/10/2023 through 2/14/2023 or 2/15/23 through 2/20/2023.

The physician order dated, 2/21/2023, documented, "Cleanse right heel with wound cleanser and apply xeroform and dressing daily to open blister."

The comprehensive care plan dated, 9/13/2022, documented in part, "Focus: Skin Integrity/Pressure Ulcer Development: The resident has potential for skin breakdown including pressure ulcer development r/t (related to) decrease in mobility. Resident refuses treatments at times. 2/20/2023 - Left heel wound (area is on his right heel)." The "Interventions" dated 9/13/2022, documented in part, "Administer treatments as ordered and monitor for effectiveness. Assess/document/report to MD (medical doctor) PRN (as needed) changes in skin status."

On 2/23/2023 at 9:15 a.m., ASM (administrative staff member) #2, the director of nursing, was asked if there was any documentation of any treatments between 2/10/2023 and 2/20/2023, ASM #2 stated there was no documentation of any wound treatment between 2/10/2023 and 2/20/2023. The Wound Care Specialist recommendations for wound care on 2/14/2023 was reviewed with ASM #2. ASM #2 stated the orders were never transferred over to the TAR.

On 2/23/2023 at 9:15 a.m., R33 was observed in bed with an air mattress in use on the bed. R33 was lifting both of his legs around in the bed. During the wound care observation at that time, the resident was able to lift his leg independently

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for the nurse to perform the dressing change. A dressing was observed on the heel prior to the dressing change.

An interview was conducted with LPN (licensed practical nurse) #5 on 2/23/2023 at 9:26 a.m. When asked the process for assessing and treating a new pressure wound, LPN #5 stated, the nurse should do a head-to-toe assessment, if any new areas are found, they complete the "Weekly Wound Assessment" form which documents the type of wound, location of wound, measurements and notification of the doctor and RP (responsible party), the new orders received from the doctor or nurse practitioner. When asked if there should be a treatment for an open blister, LPN #5 stated, yes. When asked what the process is for after the wound care specialist sees a resident with a pressure area, LPN #5 stated, typically the nurse practitioner will give a verbal order at the time she sees the resident. If she doesn't give a verbal order, her notes are faxed over to the facility in the evening after she was in the building. LPN #5 stated, typically the resident is reviewed the next day to ensure there are appropriate orders in place. The copy of the wound care specialist notes are printed and given to the nurse on the unit. The nurse is to transcribe the orders into the computer record. LPN #5 reviewed the February TAR. When asked if she saw any treatment documented between 2/10/2023 and 2/20/2023, LPN #5 stated, she didn't see anything

The facility policy, "Skin and Wound Care Best Practices" documented in part, Pressure Injury and Wound Treatment: steps initiated based on skin assessment findings: Pressure injuries and wounds will be treated with evidence-based

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F 686	Continued From page 28 interventions as ordered by the provider. See Wound Product Selection Guide for guidance on wound type/stage identification and suggested treatment approaches. Conduct comprehensive pain assessment for those with pressure injury. Communities may engage the services of a consulting wound care provider. Use of a consulting wound care provider for management of wounds is recommended for the following: A stage 3 or greater pressure injury, complicated vascular wounds, complicated diabetic wounds, wounds which are worsening, wounds which are not healing even with treatment changes, infected wounds, when assistance with correctly staging or categorizing a wound is needed." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM # 5, the regional director of clinical services, were made aware of the above finding on 2/23/2023 at 11:15 a.m. No further information was provided prior to exit. Reference obtained from: (1) https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's	F 687		3/28/23

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F 687	Continued From page 29 medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide foot care for two of 28 residents, Resident #43 and Resident #7. The findings include: 1. For Resident #43 (R43), the facility staff failed to provide foot care services. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/19/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section G documented R43 requiring extensive assistance of one staff member for personal hygiene. Section I documented R43 having diagnoses including but not limited to Diabetes Mellitus (1). On 2/21/2023 at 12:29 p.m., R43 was observed lying in bed asleep. R43's right foot was observed outside of the blanket uncovered. The toenail on the great toe was observed to be uneven with thick jagged edges which extended past the toe. The nails on the other toes were observed to be long but not jagged. Additional observations of R43 on 2/21/2023 at	F 687	F-687 (1) Corrective Action(s): Residents #43 and # 7 toe nails have been trimmed by a provider. The podiatrist is scheduled to come and round every 3 months. (2) Identification of Deficient Practice(s) and Corrective Action(s): All residents have the potential to be affected. DON and or designee will conduct a 100% audit of all residents toe nails to ensure they are not too long. All variance will be addressed and MD notified. (3) Systemic Change(s): The Director of Nursing or designee will educate all nursing staff on ensuring all residents toenails are trimmed per Saber Policy. Education will be conducted in orientation as well. (4) Monitoring: The Director of Nursing or designee will conduct random rounds of 5 residents weekly x 4 weeks then monthly x 2 months to verify resident's toe nails are trimmed. All audit findings will be reviewed and reported by the DON or designee to the QAPI committee for further review and recommendations monthly x 3 months.	

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2:50 p.m. revealed to same observation of the right foot uncovered outside of the blanket. An interview was attempted with R43 however due to their cognitive status it was not completed.

On 2/22/2023 at 9:29 a.m., an observation was made of R43 in bed with both of R43's uncovered and visible. Observation of the left foot revealed the great toenail to be thick and long with jagged edges which extended past the toe. The nails on the other toes were observed to be long but not jagged.

The comprehensive care plan for R43 documented in part, "ADL (activities of daily living) Functional Status: The resident has an ADL self care performance deficit r/t (related to) general weakness, morbid obesity, adult failure to thrive and neuropathy. Requires staff to assist with completing adl's daily. Date Initiated: 10/13/2022..."

On 2/22/2023 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the facility had a podiatrist that came in but they were not sure how often they came in the building or their schedule. LPN #3 stated that there was a podiatrist list kept at the nurses station and they could add residents to be seen as needed. LPN #3 stated that the CNA's (certified nursing assistants) could trim fingernails of residents unless they were diabetic and the nurses could trim the fingernails and toenails of all residents. LPN #3 stated that the nurses would trim or file the residents toenails and if they were too long, painful or too thick they would have the podiatrist see them because they did not have the proper equipment. LPN #3 observed R43's toenails and agreed that they were long

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F 687	Continued From page 31 and jagged and needed to be trimmed up. On 2/22/2023 at 4:33 p.m., an interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing, infection preventionist. ASM #3 stated that they were responsible for the podiatry schedule at the facility. ASM #3 stated that the podiatrist came to the facility every three months and more frequently if needed. ASM #3 stated that the nurses trimmed the toenails of diabetic residents. ASM #3 stated that the podiatrist preferred to have 10 to 15 residents to see when they came in the building but came in to see one resident if there was a need or a consult within 48-72 hours or they sent residents out to see a podiatrist. On 2/22/2023 at 4:47 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing/infection preventionist, ASM #4, the business office manager/administrator in training and ASM #5, the regional director of clinical services were made aware of the concern. On 2/23/2023 at 11:10 a.m., ASM #5, the regional director of clinical services stated that the facility did not have a policy regarding foot care or podiatry services and that they followed Lippincott as their nursing standard of practice. On 2/23/2023 at 11:41 a.m., ASM #5 provided the title page of "Lippincott Manual of Nursing Practice, Eleventh Edition." According to Lippincott Manual of Nursing Practice, 10th Edition, it documented in part, "Diabetes Mellitus and Related Disorders...Foot Care Guidelines...6. Go to a podiatrist on a	F 687		

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regular basis if corns, calluses, and ingrown toenails are present. 6.a. Trim toenails straight across to prevent ingrown toenails. b. File any rough corners with an emery board..."

No further information was provided prior to exit.

(1) Diabetes Mellitus
Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy. With type 1 diabetes, your body does not make insulin. With type 2 diabetes, the more common type, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood. You can also have prediabetes. This means that your blood sugar is higher than normal but not high enough to be called diabetes. Having prediabetes puts you at a higher risk of getting type 2 diabetes. Over time, having too much glucose in your blood can cause serious problems. It can damage your eyes, kidneys, and nerves. Diabetes can also cause heart disease, stroke and even the need to remove a limb. This information was obtained from the website: https://medlineplus.gov/diabetes.html

2. For Resident #7 (R7), the facility staff failed to provide foot care services.

On the most recent MDS (minimum data set), a five day admission assessment with an ARD (assessment reference date) of 1/4/2023, the resident scored 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section G

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F 687	Continued From page 33 documented R7 requiring extensive assistance of one staff member for personal hygiene. R7 was not documented as being a diabetic. On 2/21/2023 at 12:15 p.m., an interview was conducted with R7 in their room. R7 stated that they had a lot of pain in their left foot from their toenails. R7 stated that they had been having pain for "a long time." R7 stated that a nurse had looked at their toenails and told them the doctor was going to trim them but no one had been in. R7 stated that the nursing staff had told them that they were not allowed to trim their toenails. R7 stated that the toenails were so long that it was hurting their feet and they could not wear their shoes because it hurt. R7 was observed wearing non-slip socks on their feet. R7 stated that they were unable to trim their toenails themselves and required someone to do this for them. Additional observations of R7 on 2/21/2023 at 2:55 p.m. revealed R7 in the hallway in a wheelchair wearing non-slip socks. The comprehensive care plan for R7 documented in part, "ADL (activities of daily living) self care deficit: The resident has an ADL self care performance deficit r/t (related to) pain, BLE (bilateral lower extremity) edema (swelling), CHF (congestive heart failure), DJD/DDD (degenerative joint disease/degenerative disc disease), gen. (general) weakness. Date Initiated: 12/29/2022..." The progress notes for R7 documented in part, - "1/13/2023 10:38 (10:38 a.m.) Physician/PA (physician assistant)/NP (nurse practitioner) Progress note... History of Present Illness: Asked to see patient to evaluate pain. Nursing reports	F 687		

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F 687	Continued From page 34 patient complaining of left great toe pain. Patient interviewed. Reports having difficulty with her toes and needing them trimmed. Patient also reports pain and discomfort to left great toe...Skin: Warm and dry, normal color for ethnicity. **Hypertrophic thick and discolored toenails noted...Assessment/Plan (reviewed w/ (with) patient): 1) Left great toe pain- Acute. Most likely related to hypertropic [sic] nails. Patient placed on Podiatry list. 2) Hypertropic [sic] toenails- Acute. Consult Podiatry to evaluate and treat..." On 2/22/2023 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the facility had a podiatrist that came in but they were not sure how often they came in the building or their schedule. LPN #3 stated that there was a podiatrist list kept at the nurses station and they could add residents to be seen as needed. LPN #3 stated that the CNA's (certified nursing assistants) could trim fingernails of residents unless they were diabetic and the nurses could trim the fingernails and toenails of all residents. LPN #3 stated that the nurses would trim or file the residents toenails and if they were too long, painful or too thick they would have the podiatrist see them because they did not have the proper equipment. An observation of R7's toenails was requested with LPN #3. Observation of R7's toenails revealed the left and right great toenails to be long, thick and curved over growing towards the second toe. The additional toenails were observed to be long, thick and curved downward under the toes. LPN #3 agreed that they were long, thick, curved into the toes next to them and needed to be trimmed. LPN #3 stated that if R7 had been complaining of pain from the toenails they should have seen the	F 687		

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F 687	Continued From page 35 podiatrist at the facility or been sent out to see a podiatrist. On 2/22/2023 at 4:33 p.m., an interview was conducted with ASM (administrative staff member) #3, the assistant director of nursing, infection preventionist. ASM #3 stated that they were responsible for the podiatry schedule at the facility. ASM #3 stated that the podiatrist came to the facility every three months and more frequently if needed. ASM #3 stated that the CNA's could trim toenails of non-diabetic residents however the nurses preferred to do them to assess each residents feet. ASM #3 stated that the podiatrist preferred to have 10 to 15 residents to see when they came in the building but came in to see one resident if there was a need or a consult within 48-72 hours or they sent residents out to see a podiatrist. ASM #3 stated that the nurses were responsible for arranging the appointments for residents to go to a podiatrist outside of the facility. On 2/22/2023 at 4:47 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing/infection preventionist, ASM #4, the business office manager/administrator in training and ASM #5, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit.	F 687		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		3/28/23

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F 695	Continued From page 36 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice for two of 28 residents, Resident #43 and Resident #45. The findings include: 1. For Resident #43 (R43), the facility staff failed to properly store a BiPAP (1) mask in a sanitary manner when not in use. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/19/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section I documented R43 having diagnoses including but not limited to Obstructive Sleep Apnea. On 2/21/2023 at 12:29 p.m., an observation was made of R43 in their room. A BiPAP machine was observed on the nightstand to the right side of R43's bed. A mask with tubing was attached to the machine. The mask was observed to be uncovered and laying on the nightstand surface.	F 695	F-695 (1) Corrective Action(s): Resident #45s oxygen flowrate was adjusted to reflect physicians order upon discovery. Resident #43s Bipap mask was placed in a bag upon discovery. (2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident has the potential to be affected. A 100% audit of residents with Oxygen and BIPAP masks will be completed to verify oxygen is at prescribed flowrate and BIPAP masks are stored correctly. Any variances will be addressed. (3) Systemic Change(s): The Director of Nursing (DON) or designee will educate licensed nurses on their responsibility of following medical provider orders for prescribed oxygen flowrate and how to properly store unused respiratory equipment including BIPAP masks. Education will be included in new hire orientation. (4) Monitoring: The DON or designee will round on 3 residents weekly x 4 weeks then monthly x 2 months to verify oxygen flowrate is at prescribed rate and unused respiratory equipment such as BIPAP masks are stored appropriately. DON will report Audit findings to the QAPI committee for further	

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F 695	Continued From page 37 Additional observation of R43 on 2/21/2023 at 2:50 p.m. revealed the BiPAP mask uncovered on the nightstand surface. An interview was attempted with R43 however due to their cognitive status it was not completed. On 2/22/2023 at 9:29 a.m., the BiPAP mask was observed uncovered on the nightstand surface. The comprehensive care plan for R43 documented in part, "Respiratory Status: COPD (chronic obstructive pulmonary disease), OSA (obstructive sleep apnea). Resident has altered pulmonary status R/T (related to) COPD and Obstructive Sleep Apnea. Resident has use of BIPAP. Date Initiated: 10/13/2022..." The physician orders for R43 documented in part, "BIPAP q (every) HS (bedtime)...Order Date: 10/12/2022..." The eMAR (electronic medication administration record) dated 2/1/2023-2/28/2023 for R43 documented the use of the BiPAP each night at 8:00 p.m. from 2/1/2023 through 2/21/2023 with the exception of 2/2/2023, 2/3/2023 and 2/8/2023 when R43 refused to wear the BiPAP. On 2/22/2023 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that BiPAP masks should be washed with soap and water and stored in a bag after they were dried to keep them clean. LPN #3 stated that the bags were changed every week. LPN #3 observed R43's BiPAP mask uncovered on the nightstand and stated that at times R43 refused to wear it but it should be covered to keep it clean. The facility policy, "BiPAP/CPAP Policy" effective	F 695	review and recommendations monthly x 3 months.	

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1/24/2017 and revised 10/20/2021 documented in part, "...Mask: wash mask with soap and water or CPAP masks after each use, let air dry. Once dry store mask in a plastic bag to keep it clean..."

On 2/22/2023 at 4:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing/infection preventionist, ASM #4, the business office manager/administrator in training and ASM #5, the regional director of clinical services were made aware of the concern.

No further information was provided prior to exit.

Reference:
(1) Bi-Pap
Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems....Bilevel positive airway pressure (BiPAP or BIPAP) has a higher pressure when you breathe in and lower pressure when you breathe out. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm
2. The facility staff failed to provide oxygen per the physician order for Resident #45 (R45).

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/12/2022 the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making

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daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as using oxygen.

The physician order dated 2/10/2022 read: "Oxygen at 2 LPM for acute respiratory failure for 7 days."

Observation was made of R45 on 2/21/2023 at 1:30 p.m., 3:12 p.m. and 4:49 p.m., sitting in their bed with oxygen on via a nasal cannula. The oxygen concentrator was set at 3 LPM (liters per minute). On 2/21/2023 at 4:59 p.m. R45 was asked if they adjusted the oxygen rate on the concentrator, R45 stated, no, they can hardly reach where the machine is. Another observation was made on 2/22/2023 at 8:50 a.m. The resident was in bed with the oxygen on via the nasal cannula. The oxygen concentrator was set at 3 LPM.

On 2/22/2023 at 2:38 p.m. an observation of the concentrator was made with LPN (licensed practical nurse) #3. The oxygen concentrator was set at 2 LPM. LPN #3 stated she had adjusted it in the morning as it was set incorrectly at 3 LPM.

Review of the February MAR (medication administration record) and TAR (treatment administration record) failed to evidence documentation of the use of oxygen for February 21 - 22, 2023.

The comprehensive care plan dated 2/14/2023, documented in part, "Focus: Resident has infection R/T (related to) pneumonia, oxygen use as directed." The "Interventions" documented in part, "Oxygen as directed."

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F 695	Continued From page 40 An interview was conducted with LPN #3 on 2/22/2023 at 3:30 p.m. When asked where she signed off the resident is using oxygen, LPN #3 stated, on the TAR or MAR. When asked if R45 has a current order for oxygen, LPN #3 proceeded to review the physician orders for R45 in the computer. After reviewing the orders, LPN #3 stated, "She does not have a current order for oxygen at this time." When asked should there be an order, LPN #3 stated, yes. The facility policy, "Oxygen Administration Policy," documented in part, "POLICY: Licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider. In an emergency, clinicians may administer oxygen and obtain a provider's order as soon as practicably possible after patient stabilization or transfer...PROCEDURE: 1. Verify provider order." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, the business office manager/administrator in training, and ASM # 5, the regional director of clinical services, were made aware of the above finding on 2/22/2023 at 4:55 p.m. No further information was provided prior to exit	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 697		3/28/23

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F 697	Continued From page 41 and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for one of 28 residents in the survey sample, Resident # 49 (R49). The findings include: For (R49) the facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medications, hydromorphone (1) and Tylenol (2) and failed to clarify the physician's orders for the use of the PRN pain medications. (R49) was admitted to the facility with a diagnosis that included but was not limited to chronic pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/03/2023, (R49) scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R49) was cognitively intact for making daily decisions. Under "J0600. Pain Intensity" it documented, "A. Numeric Rating Scale (00-10)." (R49) was coded a "7 (seven)." The physician's order for (R49) documented in part, "Hydromorphone HCl Tablet 2 MG (milligrams). Give 2 tablet by mouth every 6 hours as needed for chronic pain. Order Date: 09/16/202 and Tylenol Tablet 325 MG (Acetaminophen). Give 975 mg by mouth every 6 hours as needed for pain. Order date: 08/29/2022." Further review of the physician's	F 697	F-697 (1) Corrective Action(s): Resident #49s POS and care plan has been updated to include nonpharmacological interventions. (2) Identification of Deficient Practice(s) and Corrective Action(s): All residents have the potential to be affected. 100% audit of pain medications and non □ pharmacological interventions will be conducted with any variances corrected immediately. (3) Systemic Change(s): The Director of Nursing (DON) or designee will educate licensed nurses on their responsibility of observing pain and pain management with non pharmacological interventions prior to administering pain medications. Education will be included in new hire orientation. (4) Monitoring: The DON or designee will round on 3 residents weekly x 4 weeks then monthly x 2 months to verify non pharmacological interventions are being utilized prior to pain medication administration. DON or designee will report audit findings to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 697	Continued From page 42 orders failed to evidence pain level parameters for the administration of the above prn pain medications. The eMAR (electronic medication administration record) for (R49) dated January 2023 documented the physician's orders as stated above. The eMAR revealed that (R49) received 2 mgs of hydromorphone on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 01/03/2023 at 10:16 a.m., 01/04/2023 at 10:53 a.m., 01/06/2023 at 2:47 p.m., 01/07/2023 at 10:17 a.m., 01/11/2023 at 8:28 a.m. and at 3:54 p.m., 01/12/2023 at 9:03 a.m. and at 4:29 p.m., 01/13/2023 at 8:31 a.m. and at 3:54 p.m., 01/14/2023 at 12:53 p.m., 01/17/2023 at 7:39 a.m., 01/20/2023 at 11:37 a.m., 01/21/2023 at 4:51 p.m., 01/22/2023 at 9:05 a.m., 01/26/2023 at 8:00 a.m. and at 3:54 p.m., 01/27/2023 at 1:01 p.m. and at 7:07 p.m., and on 01/31/2023 at 12:32 p.m. Further review of the eMAR revealed that (R49) received 975 mg of Tylenol on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 01/11/2023 at 8:28 a.m., 01/13/2023 at 10:18 a.m., 01/14/2023 at 12:55 p.m., 01/21/2023 at 4:52 p.m., 01/22/2023 at 9:06 a.m., 01/24/2023 at 11:24 a.m., and on 01/26/2023 at 11:34 a.m. The eMAR for (R49) dated February 2023 documented the physician's orders as stated above. The eMAR revealed that (R49) received 2 mgs of hydromorphone on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 02/01/2023 at 7:38 a.m. and at 2:33 p.m., 02/10/2023 at 9:58 a.m. and at 4:32 p.m.,	F 697		

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and on 02/15/2023 at 2:09 p.m. Further review of the eMAR revealed that (R49) received 975 mg of Tylenol on the following dates and times, with no evidence of non-pharmacological interventions being attempted on: 02/08/2023 at 5:36 a.m. and on 02/15/2023 at 2:09 p.m.

On 02/21/23 at approximately 11:45 a.m., an interview was conducted with (R49). When asked if they have pain (R49) stated they have chronic pain. When asked when they receive as needed pain medication, if the staff try to alleviate their pain before administering their pain medication, (R49) stated no.

The comprehensive care plan for (R49) dated 08/16/2022 documented in part, "The resident has pain r/t (related to) Neuropathy (3) and PVD (peripheral vascular disease) (4). Has hx (history) of chronic pain to lower back and legs. Date Initiated: 08/16/2022." Under "Interventions" it documented in part, "Staff to offer/implement non-pharmacological interventions for pain relief ...Date Initiated: 08/16/2022."

On 02/22/2023 at approximately 12:55 p.m., an interview was conducted with LPN (licensed practical nurse) #7. When asked to describe the procedure when administering as needed pain medication LPN #7 stated that the nurse assesses the resident's pain by obtaining the severity of the resident's pain on a scale of zero to ten, with ten being the worse pain, the location of the pain and the type of pain. LPN #7 stated that the nurse would start with non-pharmacological interventions such as repositioning and if that did not alleviate the resident's pain, they would administer the prescribe medication. When asked how often

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non-pharmacological interventions should be attempted, LPN #7 stated that it should be attempted each time before the as needed pain medication is administered. When asked to describe the procedure they follow when a resident is prescribed two prn pain medications without pain level parameters LPN #7 stated they would clarify the orders. After reviewing the physician's orders for the prn pain medications stated above, LPN #7 was asked how they determine which pain medication they administer when (R49) tells them they are in pain. LPN #7 stated that (R49) will tell them which pain medication the want.

On 02/22/2023 at approximately 1:15 p.m., an interview was conducted with ASM (administrative staff member #2, director of nursing. After reviewing the physician's orders for the prn pain medications stated above, ASM #2 was asked how they determine which pain medication they would administer when (R49) tells them they are in pain. ASM #2 stated that the physician's order should have been clarified. ASM #2 was asked to review the dates and times stated above on the eMARS to determine if there was documentation of non-pharmacological interventions attempted prior to the administration of (R49's) prn pain medications. At approximately 2:05 p.m., ASM #2 stated that there was no documentation of non-pharmacological interventions attempted for the dates and times stated above.

The facility's policy "Pain Management Protocol" documented in part, "Non-pharmacological intervention[s] will be attempted prior to the administration of PRN pain medications. When it is determined the resident's pain will need pharmacological interventions: a. Documentation

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F 697	Continued From page 45 of administration of medications will be located in the electronic medication record (eMAR). b. The effectiveness of the medication(s) will be identified on the eMAR." On 02/22/2023 at approximately 4:49 p.m., ASM #1, administrator, and ASM #2, director of nursing, ASM #3, assistant director of nursing, and ASM #4, business office manager/administrator in training, were made aware of the above findings. No further information was provided prior to exit. References: (1) Used to relieve severe pain. This information was obtained from the website: Hydromorphone: MedlinePlus Drug Information. (2) Used to relieve mild to moderate pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html. (3) Nerve damage. This information was obtained from the website: https://www.google.com/#q=neuropathy+nih. (4) Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		3/28/23

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F 698	Continued From page 46 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, staff interview and facility document review, it was determined the facility staff failed to evidence consistent communication to the hemodialysis (1) center for one of 28 residents in the survey sample, Resident #35. The findings include: For Resident #35 (R35), the facility staff failed to evidence communication to the dialysis facility for nine of 32 dialysis appointments between 12/10/2022-2/23/2023. There was no evidence of dialysis communication from the facility to the dialysis center on 12/27/2022, 1/5/2023, 1/10/2023, 1/14/2023, 1/17/2023, 1/19/2023, 2/7/2023, 2/11/2023 and 2/16/2023. On the most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 12/17/2022 the resident scored 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section O documented R35 receiving dialysis services while a resident at the facility. On 2/22/2023 at 9:22 a.m., an interview was conducted with R35. R35 stated that the staff	F 698	F-698 (1) Corrective Action(s): Resident #35 30 days of visit summaries from dialysis were obtained and scanned into electronic medical record. (EMR) (2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident has the potential to be affected. A 100% audit of current residents receiving dialysis services will be audited to ensure facility is sending communication assessments to the dialysis center and to verify visit summary information has been obtained from dialysis provider each visit and scanned into the EMR. Any variances will be addressed. (3) Systemic Change(s): The Director of Nursing (DON) or designee will educate licensed nurses on their responsibility to communicate with dialysis provider pre/post treatments and ensuring communication is scanned into the EMR. Education will be included in new hire orientation. (4) Monitoring: The Director of Nursing (DON) or designee will audit all residents receiving dialysis services weekly x 4 weeks then monthly x 2 months to verify communication to dialysis provider	

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F 698	Continued From page 47 send a communication book with them when they go to dialysis. R35 stated that the book was kept at the nurses station. On 2/23/2023 at 8:07 a.m., a review of R35's dialysis communication book revealed printed facility dialysis communication forms dated 1/26/2023, 1/31/2023, 2/2/2023, 2/4/2023, 2/14/2023, 2/18/2023 and 2/23/2023. Review of R35's clinical record failed to evidence dialysis communication for the dialysis appointments on 12/27/2022, 1/5/2023, 1/10/2023, 1/14/2023, 1/17/2023, 1/19/2023, 2/7/2023, 2/11/2023 and 2/16/2023. The comprehensive care plan for R35 documented in part, "DIALYSIS: ESRD (end stage renal disease). Resident receives dialysis treatments 3 times weekly. ESRD. Dialysis at [Name of dialysis center] on TU-TH-SA...Date Initiated: 12/12/2022..." The physician orders for R35 documented in part, "May attend dialysis at [Name of dialysis center] on Tuesday/Thursday/Saturday. pick-up time 12:15pm for chair time 1:00pm [Name, address, phone number of dialysis center]. Order Date: 01/30/2023..." On 2/23/2023 at approximately 8:30 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for evidence of dialysis communication from the facility for the dialysis appointments on 12/27/2022, 1/5/2023, 1/10/2023, 1/14/2023, 1/17/2023, 1/19/2023, 2/7/2023, 2/11/2023 and 2/16/2023 for R35.	F 698	pre/post dialysis treatment. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 698	Continued From page 48 On 2/23/2023 at 9:52 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that they completed the dialysis communication forms in the electronic medical record prior to R35 leaving for dialysis with current vital signs and any pertinent information on it to send with the resident in the dialysis communication book. LPN #2 stated that after they completed the dialysis communication form they printed it out and placed it in the book so that it was ready when transport came to pick the resident up. LPN #2 stated that dialysis sent the book back with any communication to them each treatment. On 2/23/2023 at 11:11 a.m., ASM #2 stated that they did not have any evidence of dialysis communication for R35 for 12/27/2022, 1/5/2023, 1/10/2023, 1/14/2023, 1/17/2023, 1/19/2023, 2/7/2023, 2/11/2023 and 2/16/2023 to provide. The facility policy, "Hemodialysis Care Policy" effective 6/16/2017 with a revision date of 4/20/2022 documented in part, "Policy: Licensed staff with demonstrated competence will care for residents who require hemodialysis (via onsite third-party providers or who travel to an outpatient setting). Communication between the dialysis provider and facility staff will occur before and after each hemodialysis treatment and as needed..." The policy further documented, "Pre-dialysis process: ...Document assessment in the Dialysis Communication Tool. Assessment includes: - Vital signs. - Pre-treatment weight (unless performed at dialysis). - Medications administered before treatment. - Time of last meal.	F 698		

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F 698	Continued From page 49 - Fluid intake. - Any additional alerts or information. Print the Tool and send with resident to dialysis (if off-site)..." On 2/23/2023 at approximately 11:15 a.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. (1) hemodialysis When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water.: Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week. Peritoneal dialysis uses the lining of your abdomen, called the peritoneal membrane, to filter your blood. This information was obtained from the website: https://medlineplus.gov/dialysis.html	F 698		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		3/28/23

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F 880	Continued From page 50 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 51 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined the facility staff failed to maintain effective infection control for one of 28 residents in the survey sample, Resident #33. The findings include: For Resident #33 (R33), the facility staff failed to provide a treatment to a pressure ulcer in a manner to prevent infection. The physician order dated, 2/21/2023, documented, "Cleanse right heel with wound cleanser and apply xeroform and dressing daily to open blister."	F 880	F-880 (1) Corrective Action(s): LPN # 4 was individually educated on Infection Control during a treatment to a wound. (2) Identification of Deficient Practice(s) and Corrective Action(s): Any resident with a wound care treatment dressing has the potential to be affected. A 100% audit of all nurses conducting wound care conducted to verify all infection control practices are being maintained per facility policy. (3) Systemic Change(s): The DON or designee will educate licensed nurses on ensuring infection prevention and control measures to prevent potential spread of infection from	

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F 880	Continued From page 52 On 2/23/2023 at 9:15 a.m., LPN (licensed practical nurse) #4 was observed providing a treatment to R33's right heel. LPN #4 was at the treatment cart where she got a 4x4 gauze packet, opened the packet by tearing it across one corner, used her hands to pull the gauze out of the packet and placed in on the outside of the packet. She proceeded to spray the gauze pad with wound cleanser. LPN #4 gathered the rest of her supplies; a xeroform dressing, a bordered gauze dressing, a 4x4 gauze pad, a red plastic bag, and a sterile field packet. LPN #4 entered the room. She placed the supplies on the overbed table that contained a container of thickened liquids on it. LPN #4 did not clean the table. LPN #4 then washed her hands, put on clean gloves, then proceeded to remove the current dressing from the right heel and placed it in the red bag. She then took the gauze pad, that had the wound cleanser on it and wiped the wound. She did not change gloves or perform hand hygiene between the dirty dressing and clean dressings. She then opened the clean 4x4 gauze pad by tearing it open, not using the edges to open it up. Dried the wound. Opened the xeroform dressing according to package directions, took a pair of scissors out of her pocket and proceeded to cut the xeroform dressing. She did not clean her scissors after removing them from her pocket. She placed the xeroform dressing on the wound. LPN #4 took the bordered dressing packet and tour it open and placed it on the resident's right heel. She took a marker out of her pocket which was the same pocket where the scissors were, and wrote the date and her initials on the dressing. LPN #4 removed her gloves, washed her hands and gathered the sterile field packet and returned to the treatment cart.	F 880	wound care dressings. Education will be included in new hire orientation. (4) Monitoring: The Infection Control Nurse or designee will conduct 3 random infection control round during wound care weekly x 4 weeks then monthly 2 months. The DON or designee will review the audit findings and report to the QAPI committee for further review and recommendations monthly x 3 months.	

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F 880	Continued From page 53 The above observations were reviewed with LPN #4, she concurred that she did not set up a clean field or used the sterile field packet, failed to change her gloves between taking the dressing off and putting on the new dressing, failed to clean her scissors, and failed to write the date and her initials prior to placing the dressing on the resident's heel. A policy was requested for dressing application. The facility staff stated they did not have a policy; they follow standards of care. "Wound Care: Preventing Infection: Gather supplies (dressings, tape, scissors, sterile saline solution, cotton swabs, extra gauze and culture materials if indicated). Wash your hands thoroughly and don gloves. Ensure strict aseptic technique during dressing changes." Lippincott Manual of Nursing Practice, 11th Edition, Wolters and Kluwer, page 104. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM # 5, the regional director of clinical services, were made aware of the above finding on 2/23/2023 at 11:15 a.m.	F 880		