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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated standard survey was conducted 1/18/23 through 1/26/23. An extended survey was conducted 1/20/23 through 1/26/23. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.

Immediate Jeopardy was identified in the area of Freedom from Abuse, Neglect, and Exploitation at a Scope and Severity Level 4, pattern which constituted Substandard Quality of Care. After accepting and verifying the plan for removal of Immediate Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level of level two, pattern.

Fifteen complaints were investigated during the survey with findings as follows:

VA00057495=Substantiated with Deficiency
VA00057357=Substantiated with Deficiency
VA00057308=Substantiated with Deficiency
VA00057249=Substantiated without Deficiency
VA00057021=Substantiated without Deficiency
VA00056837=Substantiated with Deficiency
VA00056735=Substantiated with Deficiency
VA00056346=Substantiated without Deficiency
VA00056193=Substantiated with Deficiency
VA00055162=Substantiated with Deficiency
VA00055164=Substantiated with Deficiency
VA00054804=Substantiated without Deficiency
VA00054630=Substantiated with Deficiency
VA00054193=Substantiated with Deficiency
VA00054109=Unsubstantiated.

The census in this 120 certified bed facility was

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

Electronically Signed | 02/14/2023

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F 000	Continued From page 1 116 at the time of the survey. The survey sample consisted of 9 resident reviews. .	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, facility documentation review, the facility staff failed to protect 3 Residents (Resident #16, Resident #15, Resident #12) from abuse/neglect in a sample size of 9 Residents. The findings included: 1. For Resident #16, the Administrator issued a 30-day discharge notice with retaliatory intent for Resident #16. A review of Resident #16's quarterly Minimum	F 600	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F600 Free from Abuse and Neglect 1. Resident #16 the 30-day discharge notice was revoked, and the resident is	2/28/23

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F 600	Continued From page 2 Data Set with an Assessment Reference Date of 10/30/2022 coded the Brief Interview for Mental Status as "15" out of "15" indicative of intact cognition. On 01/20/2023 at approximately 10:40 A.M., Resident #16 was interviewed by Surveyor C and Surveyor F. When asked about concerns at the facility, Resident #16 explained that at one time, the Administrator yelled at her. When asked about this, Resident #16 stated that "they weren't happy I went to the Ombudsman" about concerns instead of notifying facility staff. Resident #16 stated that she told the Administrator she did notify facility staff but nothing was done. Resident #16 stated that the Administrator spoke loudly and firmly and told her since she wasn't happy at the facility, they were going to issue a 30-day notice. Resident #16 then stated that the Director of Nursing (DON) and the Discharge Planning Director [DDP](Employee L) issued the 30-day notice. Resident #16 stated that she told them she wouldn't accept it but "they laid it on my bed and said I was to leave within 30 days." When asked about how that affected her, Resident #16 stated, "I was a wreck!" Resident #16 explained that she didn't know what to do; calling her children for help because she needed to find another place to live. Resident #16 stated, "I was so upset!" "I didn't want to leave." Resident #16 stated that the Ombudsman assisted her to file an appeal and we "convinced them to rescind it [the 30-day discharge notice]." Resident #16 stated that she was scheduled to be discharged on 08/19/2022. Resident #16 stated that it was the Ombudsman that notified her the 30-day discharge was rescinded. Resident #16 went on to explain that she asked the Administrator for something in writing about it (the rescinded	F 600	aware. Resident #15 a facility reported incident was submitted on 1/26/2023. Resident #15 no longer resides in the facility. Resident #12 had a submission of a facility reported incident on 1/19/2023. Resident #12 no action taken due to the timeframe has passed. 2. Current residents in the center have the potential to be affected. An audit by Administrator or designee will be conducted on current residents to identify if a 30-day discharge letter submitted met the requirements per policy. It not it will be corrected. An audit by the DON or designee on current residents to verify the ADL documentation for incontinent care is completed. 5 residents interviewed to assess for care concerns. An audit of service concern reports and FRIs were reviewed from past year 2022 to current 1/20/2023 by regional staff (VPO, RDCS) to identify any allegation of abuse/neglect. Any findings a facility reported incident filed with the protection of the resident and the abuse/neglect policy followed. 3. The Staff Development Coordinator or designee will in-service all CNAs on providing incontinent care and complete incontinent care documentation in the clinical record. The Staff Development Coordinator or designee educated all facility staff on the abuse policy, neglect, protecting the resident, investigation, resident rights, and customer service. The Administrator will educate social service on the process for 30-day	

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notice) and never received anything. Resident #16 added that the Administrator was "just after me" because she said I had so much clutter in my room and didn't want the health department seeing all my clutter so she moved me to this room (out of the more visible hall). Resident #16 stated that she doesn't feel welcome at this facility; she feels "on guard"; she feels that "the powers that be don't want me here."

Resident #16's progress notes were reviewed. A discharge planning progress note dated 07/20/2022 at 11:03 A.M. documented, "On 7/19/22, DDP issued patient a 30-day notice along with DON present. Patient indicated that her [family member] needed to be notified by which DDP informed her that her [family member] would be contacted after the meeting. DDP returned to office shortly after the meeting and received a call from patient's [family member]. She was told that due to another crisis, DDP hadn't called her yet, but we were able to discuss the 30-day notice and [name] requested a meeting. She will contact DDP when [family member] able to come into the facility and we will schedule the meeting request accordingly."

A psychotherapy note dated 08/09/2022 at 1:00 A.M. documented the following excerpts: "She shared recent events and interactions that are contributing to a sense that people "don't really care about me." "She is particularly worried about finding another place to live if 'they are going to kick me out on the 19th.' She shared [Department of Medical Assistance Services] letter confirming her appeal was being processed." "She was interested in the possibility of accessing grants to help support moving to an ALF [assisted living facility] but 'I have friends here' and wasn't sure

discharge notice requirements per policy and must be approved of the Administrator prior to any submission.
4. The unit managers or designee will conduct weekly audits to verify residents are receiving incontinent care by conducting 5 interviews of the residents to verify incontinent care provided or by observation incontinent being provided, review of service concerns reports with care concerns with resolution, review of ADL documentation to verify incontinent care provided and completed weekly x 8 weeks then monthly x 2 months. The Administrator or designee will audit to verify the abuse/neglect policy was followed with the resident protected and will audit to verify any submission of a 30-day discharge notice met the requirements of the policy prior to submission weekly x 8 weeks then monthly x 2. The findings will be submitted to QAPI for review, discussed and plan revised if compliance is not met or sustained. The Administrator or Director of Nursing are responsible for implementation of the plan of correction.
5. Date of compliance 2/28/2023

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what about programming and supports exist in an ALF."

Under the "Misc" tab in Resident #16's electronic health record, there was a letter from the Department of Medical Assistance Services (DMAS) dated 07/27/2022 addressed to the Administrator. An excerpt of the letter documented, "[Resident #16] has filed an appeal regarding proposed discharge."

On 01/20/2023 at 11:20 A.M., the Vice President of Operations and the Regional Director of Clinical Services were notified of this allegation of abuse by the Administrator. The Vice President of Operations stated she knew about this 30-day discharge notice and notified the Administrator that "she couldn't do that" and so the Administrator rescinded it.

In the facility's document entitled, "Resident Handbook" under the header "Grievances", it was documented, "As a resident of our Health and Rehabilitation Center, you have the right to voice grievances/file complaints (orally, in writing, or anonymously) to Center Management, to State Survey and Certification Agencies as well as to any advocacy representative of your choice without fear of discrimination or reprisal."

The facility staff provided a copy of their policy manual section entitled, "Abuse/Neglect/Misappropriation/Crime and policy name entitled, "Patient Protection." In Section 1, an excerpt documented, "Patients of the Center have the legal right to be free from ...mental ...abuse ..."

On 01/26/2023 by the end of survey, the Vice

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President of Operations and the Regional Director of Clinical Services stated there was no further information or documentation to submit.

2a. For Resident #15 the facility staff failed to ensure the Resident was free from neglect.

It was noted that on 4/16/22, Resident #15 and/or family reported to facility staff that "On 4/15/22 3-11 PM shift, the resident asked her CNA [CNA B's name redacted] to assist her to bed, the CNA told her she would put her to bed at 9 PM. CNA eventually came back at 9:45 PM complaining that the resident interrupted her break, she deserves a break because she had been on her feet all day, at this time the resident stated the CNA hit her in the face with the O2 [oxygen] cord unintentionally and stated that she didn't need it so long".

The facility provided an investigation summary that indicated they conducted an investigation and substantiated that abuse/neglect occurred and notified CNA B's agency/employer that she was not able to return to the facility.

A review of the facility's abuse policy titled, "Abuse/Neglect/Misappropriation/Crime, Patient Protection" was conducted. This policy read, "Patients of the center have the legal right to be free from verbal, sexual, mental and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician...".

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2b. For Resident #15 the facility staff neglected to provide incontinence care resulting in moisture associated skin damage (MASD).

On 1/18/23-1/20/23, a closed record review was conducted of Resident #15's clinical chart. Resident #15's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 11/22/22, was reviewed. This assessment coded Resident #15 in section H as having been incontinence of bowel and bladder frequently. This same assessment coded Resident #15 in section G as having required extensive assistance from one staff member for toileting.

Review of the progress notes revealed a note written 12/7/22, that read, "Resident behind [buttocks] had some redness due to sitting up in chair for prolonged period of time on shift prior to nurse working, supervisor aware and resident family aware and on call md [medical doctor] notified. report noted and given to supervisor".

Review of facility grievances revealed that on several occasions Resident #15 and/or her family reported the Resident was neglected. On 12/6/22, the family reported to facility staff, "Resident and roommate stated she hadn't been changed. That prior to leaving CNA was told by nurse to put resident into bed and clean up/wash up. Apparently, resident said something, and CNA stated that resident could sit in her pee until 11-7 arrived since she had an attitude. Resident states she wasn't changed entire time- chair was wet. Spoke with daughter during 3rd shift states this is the 3rd time mother has sat in urine for

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long times and no one answering c/l [call light] ..."

On 12/13/22, Resident #15 was seen by a skin/wound specialist that provided notes that read as follows:
1. "Wound 2 evaluation (12/13/22) location: left upper thigh. length: 9.61 cm, width: 5.66 cm, depth: 0... Etiology: Moisture associated skin damage (MASD)".
2. "Wound 3 evaluation (12/13/22) location: Right posterior thigh. length: 14.66 cm, width: 4.68 cm, depth: 0... Etiology: Moisture associated skin damage (MASD)".

Review of the ADL (activities of daily living) documentation from December 2022, revealed multiple shifts where there was no documentation that care was provided. This included but was not limited to, 12/2/22- the evening shift, 12/3/22- the day shift, and on 12/10/22- all shifts.

On 1/24/22 at 11:07 AM, an interview was conducted with CNA D. CNA D was asked how often incontinence care is provided to a Resident. CNA D said, "within a regular shift I check my Residents at least twice. There are some that are heavy wetter's so it may be more for them". When asked about documentation, CNA D said, "I try to chart after I do something for a Resident, after meals and at the end of my shift". When asked if there is no documentation for a shift, what this means, CNA D said, "nothing was done, that's how we were taught".

On 1/24/22 at 11:12 AM, an interview was conducted with CNA E. CNA E was asked to explain the frequency of care to Residents. CNA E said, "I try to do every 2 hours but sometimes things happen". When asked about charting and

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what blanks mean, CNA E said, "If it's not charted, it's not done".

On 1/24/22 at 2:32 PM, the facility's Regional Director of Clinical Services/interim Director of Nursing defined neglect as "When you do not provide services that any other prudent person would do".

A review of the facility's abuse policy titled, "Abuse/Neglect/Misappropriation/Crime, Patient Protection" was conducted. This policy read, "Patients of the center have the legal right to be free from verbal, sexual, mental and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician...".

On 1/25/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above findings.

No further information was provided.

3. For Resident # 12, the facility staff failed to protect from abuse/neglect by staff members.

Resident # 12's most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of

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10/29/2022. The MDS coded Resident # 12 with a BIMS (Brief Interview for Mental Status) Score of 15 out of 15 indicating no cognitive impairment; required extensive to total assistance from one to two staff members for Activities of Daily Living (ADLs). Resident # 12 was alert and oriented and able to make needs known.

Review of the electronic clinical record was conducted during the survey.

On 1/19/2023 at 2:15 p.m., Surveyor B conducted an interview with Resident # 12 who stated some members of the facility staff was verbally abusive and rough. Resident # 12 reported calling the police on 1/17/2023 because of failure of the staff to answer the call bell for over 2 and a half hours while she was in pain.

Surveyor B asked about the frequency of this type of incident. Resident # 12 stated "quite honestly every other time, you have the hardest time in here getting help". Resident # 12 then stated " I was in pain so bad and nobody came, so I called the police non-emergent police number and asked them to please call over here and get someone up here. "

Resident # 12 stated the facility Administrator and Director of Nursing "jumped all over me" Resident # 12 further stated "They said there was no need for me to call the police, I told them I have been in pain for 2 ½ hours and no one has come, what do you expect me to do? Resident # 12 stated "She said 'Well you have to wait' . I said for 2 ½ hours give me a break."

Resident # 12 then stated "She got mad at me one other time and she made them get me out of

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F 600	Continued From page 10 bed in the chair and of course that makes it worse 01/19/2023 at 3:40 p.m., the corporate Clinical Nurse Consultant and Corporate Executive Director were informed of the allegations by Resident # 12. They stated "We will follow our abuse policy. We will go interview the resident first and get you the policy." The Corporate Consultants stated the two staff persons would be suspended pending the investigation. "Then continue the investigation ourselves. They will be suspended, we want to make sure ___ (Resident # 12) is immediately ok ." Review of the facility's Abuse/Neglect Policy effective 1/23/2020 revealed the statement that there was a "zero tolerance of mistreatment , abuse, neglect .....of any crime against any patient of the Health and Rehabilitation Center" No further information was provided.	F 600		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		2/28/23

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F 607	Continued From page 11 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review , the facility staff failed to implement their abuse policy for 2 Residents (Resident #15, and 13) in a survey sample 9 Residents. In addition, the facility staff permitted a known perpetrator of abuse (CNA B) to work in the facility having direct contact with Residents on 1 of 2 nursing units. Immediate Jeopardy (IJ) was identified on 1/20/23 at 3:55 PM, at which time the facility Administrator and Director of Nursing were made aware. Following verification of the removal of immediacy the facility abated IJ on 1/26/23 at 4:07 PM. The scope and severity was lowered to a level 2, pattern. The findings included: 1. The facility staff failed to implement their abuse policy with regards to employee screening and	F 607	F607 Development /Implement Abuse/Neglect Policies 1. Resident #15 no longer resides in the facility. Resident # 13 no longer resides in the facility. The employee was immediately suspended and is no longer employed with the facility on 1/20/2023. 2. Current residents in the center have the potential to be affected. A skin assessment was performed of the residents assigned to the employee with no negative findings. All employees files were reviewed to verify background checks and 2 references were completed by Regional Director of HR. Residents and family/RP interviews were conducted for concerns by designated department managers and	

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F 607	Continued From page 12 protection of Residents, by permitting a known perpetrator of abuse/neglect (CNA B) to work in the facility having direct contact with multiple Residents who resided on 1 of 2 nursing units within the facility. This resulted in Immediate Jeopardy. A closed clinical record review was conducted 1/18/23-1/20/23. Resident #15 discharged from the facility and therefore was unavailable for interview. Review of facility documentation to include, but not limited to grievances, revealed Resident #15 and her family had reported numerous concerns of neglect and being left for extended periods of time/hours without any staff assistance for incontinence care. Specifically, it was noted that on 4/16/22, Resident #15's family reported that "On 4/15/22, 3-11 PM shift the resident asked her CNA [CNA B's name redacted] to assist her to bed, the CNA told her she would put her to bed at 9 PM. CNA eventually came back at 9:45 PM complaining that the Resident interrupted her break. She deserves a break because she has been on her feet all day, at this time the Resident stated the CNA hit her in the face with the O2 [oxygen] cord unintentionally and stated that she didn't need it so long". The facility removed CNA B from the schedule and because the CNA was an agency staff member, the agency was contacted and notified of the allegation. Upon conclusion of the facility's investigation the Administrator had a "Summary" document which was typed and read, "...The agency staff, [CNA B's name redacted] was removed from the scheduled immediately until the facility completed their investigation. After	F 607	residents that could not be interviewed had skin assessments completed by the nurse. The service concern reports, and facility reported incidents reviewed to verify no employees were employed for any allegation or substantiated abuse/neglect by the regional staff. Any findings of abuse/neglect had the abuse policy followed. 3. The Staff Development Coordinator or designee educated all facility staff on the abuse policy, neglect, protecting the resident, investigation, resident rights, and customer service. The Regional Director of HR will educate HR and the Administrator on the hiring process, screening new and prior employees with review of prior employment and both have a VA background check and 2 references per policy. The Administrator will educate the staff involved in the hiring process and scheduling of staff Department managers and staffing coordinator to the hiring requirements to schedule a new hire or former employee to work. 4. The Administrator or designee will audit service concern reports , known or allegations of abuse/neglect to verify the abuse/neglect policy was followed with the resident protected, facility incident reported submitted and investigation completed conduct weekly x 8 weeks then monthly x 2 months. The HR or designee will audit to verify new hire or rehire employees have a VA background check and 2 references prior to working conduct weekly x 8 weeks then monthly x 2	

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F 607	Continued From page 13 completing interviews with residents and staff it was determined that the incidence [sic] was substantiated the facility could substantiate this was a willful intent of abuse [sic]." There was a statement from the facility's Director of Nursing (DON) who indicated CNA B was placed on a "DNR [do not return] status with this facility". On the afternoon of 1/20/23, Surveyor E met with the facility's scheduling coordinator/Employee P. The scheduling coordinator reviewed past records and confirmed that CNA B did not work any shifts following 4/15/22. However, a review of the facility's submitted as-worked schedules revealed that CNA B was listed as having been scheduled during the survey as recent as 1/19/23 and was scheduled to work on 1/20/23. On the afternoon of 1/20/23, Surveyor E met with the facility's human resources manager (HRM)/Employee E. The HRM was able to access and confirmed CNA B was hired by the facility on 6/27/22, as a full-time employee and remained so. The HRM also provided CNA B's timecard which revealed CNA B worked as recent as 1/19/23. The employee file for CNA B was requested and received. Upon review it was determined that CNA B disclosed a prior criminal charge of "misdemeanor assault" on her sworn statement completed 6/19/22. The facility Administrator and Director of Nursing who were involved in the investigation of and determination that CNA B had abused/neglected Resident #15 in April 2022, were the same	F 607	months. The findings will be submitted to QAPI for review, discussed and plan revised if compliance is not met or sustained. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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individuals in those positions when CNA B was hired on 6/27/22.

On 1/26/23, a review of CNA B's timecard was conducted and revealed the employee had worked a total of 90 days having direct Resident contact. Many of those days CNA B worked double shifts, therefore having access to and interaction with many Residents and potentially having an opportunity to abuse and/or neglect the Residents again.

On the mid-morning of 1/26/23, Surveyor E conducted an interview with the Regional Human Resources Director (RHRD)/Employee K. Employee K stated that the facility's Administrator and Director of Nursing have a role in approving applicants for hire and should not have permitted CNA B to have been hired since they had prior knowledge of the employee's history and findings of abuse/neglect.

The facility policy titled "Abuse/Neglect/Misappropriation/Crime: Prevention/Screening/Training" read, "The Administrator promotes the prevention of abuse ... and neglect and misappropriation of property by performing background checks on all employees and by advocating and enforcing patient rights ...". The policy also stated, "1. Criminal background and reference checks are performed on all employees ..."

Immediately Jeopardy was identified on 1/20/23 at 3:55 PM, at which time the facility Administrator and Director of Nursing were made aware. Following this notification, CNA B was removed from the facility and clocked out at 4:08 PM.

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On 1/24/23 at 1:37 PM, the facility submitted an accepted IJ removal plan and on 1/26/23, submitted a revised plan which read as follows:

"1. Certified Nursing Aide (CNA) B was escorted immediately to the Director of Nursing (DON) office, and the Interim Director of Nursing and Regional Director of Clinical Services (RDCS) informed CNA B regarding the incident of the substantiated allegation of abuse and that she is terminated based on history of substantiated abuse/neglect against a resident.

2. CNA B was escorted by the Interim DON to the time clock. She clocked out at 4:08pm, was escorted to her car and she was observed exiting the facility grounds.

3. The surveyors were informed of the above, and a copy given of her clock out time, on the time sheet prior to exit.

4. The Board of Nursing report completed regarding CNA B substantiated abuse/neglect allegation and the employee file reviewed with 2 other corrective actions based on care issues included on report 1/20/2023.

5. On 1/20/2023 a 100% audit of all Facility Reportable Incidents (FRIs) from past year, 2022, to current January 2023 was completed to ensure no employee is currently employed that was involved in any substantiated FRI.

6. On 1/26/2023 a 100% audit of all facility employees' files, to include agency and contracted staff, were reviewed to verify the screening process was completed by Regional Director of HR. For any employee found not in

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compliance, they will have direct supervision by another employee with an approved background and reference checks.

7. On 1/20/2023 interviews immediately were conducted of the residents assigned to CNA B by Social Service Director and skin checks were completed on the resident's that could not be interviewed.

8. On 1/20/2023 all current residents of the facility that have the ability to be interviewed were conducted by designated management team to identify any concerns with care and/or allegations of abuse/neglect with abuse/neglect process followed.

9. On 1/20/2023 there were 4 additional residents who were identified with allegations of abuse/neglect. The abuse policy was followed, a FRI was submitted, and the resident was protected with the identified employee(s) suspended pending investigation.

10. On 1/20/2023 residents' family members were interviewed for allegations of abuse/neglect or concerns that were associated with allegation of abuse/neglect, or grievance reports.

11. On 1/20/2023 Staff interviews were conducted for all identified/associated staff with any allegation of abuse/neglect.

12. On 1/24/2023 Staff interviews were conducted to identify concerns for abuse/neglect with any findings further investigated by the Interim Administrator, Interim DON or designee with the abuse/neglect policies followed.

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13. On 1/24/2023 all other residents of the facility that do not have the ability to be interviewed had skin checks completed.

14. On 1/23/2023 the grievance concern reports, and the resident council minutes were reviewed and any identified as an allegation of abuse/neglect were reported following the abuse/neglect policy.

15. On 1/23/2023 there were 3 additional residents identified with allegation of abuse/neglect from the review of the grievance concern reports. The abuse policy was followed, a FRI submitted, and the patient was protected with the identified employee suspended pending investigation.

16. Education will be provided to the Administrator and department managers to include human resources, staffing coordinator, dietary, nursing, rehab, housekeeping, social service, business office manager, maintenance, activities, and admissions will be by Regional Director of HR regarding the hiring, prevention, and screening process of anyone involved in a substantiated allegation of abuse/neglect to identify if eligible for hiring.

17. All Facility staff, to include agency staff, will be educated on the policies to include abuse/neglect for patient protection, abuse/neglect/misappropriation/crime prevention, screening/training process, reporting and investigating, and resident rights. All staff will be educated prior to working next facility shift.

18. Administrator and department managers educated on 1/23/2023.

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19. [Administrator name redacted], Administrator and [DON name redacted], DON were suspended pending investigation on 1/19/2023.

20. On 1/23/2023 [Administrator name redacted], Administrator and [DON name redacted], DON were terminated by the Vice President of Operations (VPO) and Regional Director of HR.

21. [VPO name redacted], VPO is the Interim Administrator and [RDCS name redacted] RN/RDCS is the Interim DON.

22. Compliance date for abatement plan 1/26/2023 at 2:51pm."

The survey team verified the IJ removal plan as evidenced by the following:

On 1/20/23, the survey team remained on-site until CNA B was removed from the facility and received evidence that she had clocked out and left the premises.

The survey team reviewed evidence that CNA B had been reported to the Board of Nursing/Department of Health professions.

The survey team reviewed the FRI's for the past year and identified any staff with a substantiated allegation of abuse/neglect and verified that they were not currently employed or working in the facility.

The survey team reviewed the 100% audits conducted by the facility staff with regards to the screening documents required per the facility's

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abuse policy (i.e. criminal background check and references). The survey team then reviewed the as-worked schedule for the day, 1/27/23, and ensured that any staff who had outstanding screening documents were being directly supervised during Resident interactions by a staff member who had an approved criminal background check and references on file.

The resident interviews conducted of the Residents assigned to CNA B on 1/20/23, were reviewed with no identified concerns noted.

The Resident interviews conducted of all interviewable Residents and skin checks of non-interviewable Residents was reviewed. Concerns that were identified were noted and corresponding FRI's were submitted, which indicated the facility was implementing their abuse policy.

Family interviews conducted by the facility staff were reviewed.

Grievance concerns and Resident council minutes were reviewed, and the survey team confirmed that any identified concerns were being addressed as per the facility abuse policy, (any involved employee removed while an investigation was being conducted, FRI submitted, and investigation initiated)

Staff interviews were conducted across all departments for line staff and management staff which included staff working off shifts (evening and nights) to ensure they had received education and knew the abuse policy.

Survey team observed the Administrator and

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Director of Nursing being escorted from the premises and reviewed supporting evidence that their employment had been terminated.

Survey team confirmed that an interim Administrator and Director of Nursing were in place and aware of and following the abuse policy as evidenced by their daily presence in the facility during the survey, as well as staff being suspending while investigations were being conducted and FRI's being submitted for identified abuse/neglect allegations

IJ was verified as removed on 1/26/23 at 4:07 PM.

2) For Resident #13, the facility staff failed operationalize their abuse policies to protect, report, and investigate an allegation of abuse on 10-14-2022.

Resident #13's first MDS document (a federal assessment instrument) dated 9-29-22, indicated that the Resident was alert and oriented with no cognitive impairments, no memory nor mood issues, and no aberrant behaviors.

Resident #13's progress notes were reviewed and revealed a fall on 10-4-22, and an incident on 10-15-22.

On 1-19-23 all incident reports for the Resident were reviewed. The review revealed that the only fall prior to the 10-14-22 incident, occurred on 10-4-22. The Resident had a fall in her room

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getting out of bed. The Resident was in a private room and the incident was unwitnessed. The Resident was assisted off of the floor by the nursing staff and the Resident was assessed to be alert, and oriented, to time person place and situation, with no injuries.

The second incident occurred ten days later on 10-14-22 a Certified Nursing Assistant (CNA) found the Resident sitting on the side of her bed at approximately 8:00 p.m. with a bloody face and "golf ball sized raised area in the center of the Resident's forehead", with a "moderate amount of blood on the Residents face, sheets, and floor." The document stated the physician was notified and ordered the Resident be sent to the emergency department for evaluation.

The Resident stated that on 10-14-22 she had been hit on the head and knocked to the floor where she was beaten by someone, and she stated that she could not identify who the perpetrator was as she had lost consciousness. She stated she thought it was a man. The Resident indicated she told the facility staff someone had hit her in the head and beat her and asked the facility "supervisor nurse" on 10-14-22 to call police immediately after the incident and they refused.

The Resident was discharged back to the facility on 10-24-22.

The Resident stated she was scared to return, however, she wanted to see if she could identify the person responsible and get therapy to strengthen herself before going home. After returning to the facility and having no help to find the perpetrator, she called police herself and

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made a report on 10-27-22. The Resident stated that three to four days after seeing the police on 10-28-22 and making a report, the Director of Nursing (DON) called the Resident to her office and wanted to know what the Resident had called the police about. The Resident stated she told the DON exactly what she said to the police.

Resident #13's clinical record was reviewed for Social Work notes, and none were found.

On 1-19-2023 an interview was conducted with the Administrator and Director of Nursing (DON) and asked what their policy was on allegations of abuse. They stated all persons alleging abuse must be protected, and an investigation started immediately, and the incident had to be reported per law. They were asked for the investigation and reporting completed for Resident #13, and they stated she alleged a man had attacked her, and there were no men working on the day of the incident according to their investigation. However, on 1-26-23 the time clock punches for all staff were requested for 11-14-22 and received. The documents revealed 7 males working on that day.

On 1-20-23, the facility staff provided a copy of their policy entitled, "Abuse/neglect/misappropriation/crime Reporting requirements/investigations #703".

In section 1".....The Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation (of abuse) is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result

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F 607	Continued From page 23 in serious bodily injury. In Section 2 ""The Administrator and/or DON will immediately initiate a thorough internal investigation of the alleged/suspected occurrence." In policy #704 of the abuse neglect policies, under procedure section 2, "injuries of unknown origin should be handled the same as an allegation of mistreatment, neglect or abuse, and must be reported to the state agency." On 1-24-23 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. Both agreed that this incident should have been reported and investigated as an allegation of abuse. No further information was provided by the facility.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		2/28/23

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(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
F 609	Continued From page 24 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to report allegations of abuse/neglect involving one Resident (Resident #15) in a survey sample of 9 Residents. The findings included: The facility staff failed to report allegations of abuse/neglect to Adult Protectives Services (APS) and the Department of Health Professions/Board of Nursing for allegations substantiating abuse. On 1/18/23-1/20/23, a closed record review of Resident #15's clinical record was conducted. This review revealed no entries with regards to Resident #15's allegations of abuse/neglect. A review of the facility's investigation files revealed that on 3 occasions reports of abuse or neglect had been reported to the facility staff. The allegations were as follows:	F 609	F609 Reporting of Alleged Violations 1. Resident #15 no longer resides in the facility. 2. Current residents in the center have the potential to be affected. An audit of service concern reports and FRIs were reviewed from past year 2022 to current 1/20/2023 by regional staff (VPO, RDCS) to identify any allegation of abuse/neglect. Any findings a facility reported incident filed with the protection of the resident and the abuse/neglect policy followed and reported the appropriate state agencies per policy. 3. The VPO or the RDCS will educate the Administrator and the DON on the process for completion of the facility reported incidents to include reports to state agencies APS, DHP and police when applicable. 4. The VPO or RDCS or designee will audit submissions of initial facility reported incidents to verify completed and includes all reporting requirement to state agencies prior to submitting x 30 days. The findings	

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	495193	A. BUILDING _____ B. WING _____	C 01/26/2023

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F 609	Continued From page 25 1. On 4/16/22, Resident #15's family reported an allegation of abuse/neglect. The facility staff failed to report this allegation to Adult Protective Services and the Department of Health professions. Upon review of the investigation documents submitted by the facility there was evidence that during the facility's investigation they determined abuse/neglect had occurred involving Resident #15 and CNA B. The facility failed to have evidence that the allegation or investigation findings were reported to Adult Protective Services or the Department of Health Professions. Additionally, there was no evidence that the result of the investigation was reported to the State Survey Agency. 2. On 10/3/22, the facility staff received notification from Adult Protective Services that they had conducted an investigation into an allegation of abuse. APS's letter to the facility indicated, "The agency has determined the report founded for neglect as a review of the facts did show a preponderance of evidence that neglect occurred". The facility in turn conducted an investigation. During the facilities' investigation a staff member was identified, CNA C. The facility staff failed to have evidence of this allegation being reported to the Department of Health Professions. 3. On 12/6/22, Resident #15 reported an allegation of neglect and verbal abuse to the facility staff. This allegation as not reported to the state survey agency or adult protective services until 12/12/22. This allegation was not reported to the department of health professions.	F 609	will be submitted to QAPI for review, discussed and plan revised if compliance is not met or sustained. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 609	Continued From page 26 Upon completion of the facility's investigation, the state survey agency and adult protective services were not notified of the investigation findings until 12/19/22, which is outside of the reporting requirements. Again, the department of health professions was not notified. Review of the facility policy titled; "Reporting Requirements/Investigations" was reviewed. It read, "...1. b. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medicals examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime. c. Notify within 24 hours the Department of Health Professions (DHP) for incidences involving nurse aides, RNs, LPNs, Physicians, or others licensed or certified by DHP...". On 1/24/23 at 2:32 PM, a meeting was held with the interim Administrator and interim Director of Nursing. During this meeting, both acknowledged they had identified concerns with reporting to required agencies and the timeliness of reporting. They were made aware of the above specifics of what was missing for the above noted allegations of abuse/neglect. No further information was provided. Complaint related deficiency.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		2/28/23

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F 610	Continued From page 27 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to investigate an incident of bruising with an unknown origin involving one Resident (Resident #15) in a survey sample of 9 Residents. The findings included: 1. For Resident #15 the facility staff failed to have evidence of an investigation being conducted following identification of bruises of unknown origin. In the course of a complaint investigation the clinical record for Resident #15 was reviewed. A "skin observation" form conducted 12/7/22, noted the following: "Site: Right gluteal fold, Type: Bruising, length: 19 cm, Width: 8 cm, Depth: 0	F 610	F610 Investigate/Prevent/Correct Alleged Violation 1. Resident #15 a facility reported incident submitted on 1/26/2023.The resident no longer resides in the facility. Current residents in the center have the potential to be affected. An audit of service concern reports and FRIs were reviewed from past year 2022 to current 1/20/2023 by regional staff (VPO, RDCS) to identify any allegation of abuse/neglect. Any findings a facility reported incident filed with the protection of the resident and the abuse/neglect policy followed and reported the appropriate state agencies per policy. Any identified employees were suspended pending investigation. The RDCS conducted an audit of incidents	

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F 610	Continued From page 28 cm" a second line on this same document noted, "Site: Left thigh (front), Type: Bruising, length: 12.5 cm, width: 8.4 cm, depth: 0 cm". There was no further documentation within the clinical record with regards to the bruising. The facility's investigation files were reviewed and there was no evidence of an investigation being conducted following the identification of the bruises. On 1/24/23, during an end of day meeting, the facility's interim Administrator and interim Director of Nursing (DON) were made aware of the bruising and asked to provide any additional information they may have with regards to this. A review of the facility policy titled, "Abuse/Neglect/Misappropriation/Crime, Reporting Requirements/Investigations" was conducted. This policy read, "1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property....2. The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigation protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations...". On 1/26/23 at 1PM, the interim DON stated the bruising should have been investigated as an injury of unknown origin and stated an investigation had been initiated.	F 610	reports on current residents for injury of unknow origin 1/20/2023. f 2. The Staff Development Coordinator or designee will educate the licensed nurses on the abuse policy , protecting the resident with suspension of identified employee during the investigation and reporting injuries of unknown origin with investigation to cause. 3. The DON or designee will audit clinical records for documentation on known or documented injuries of unknown and reported to the Administrator, the resident protected by any identified employee was suspended pending investigation, facility reported incident submitted and investigation initiated. 4. to verify the facility reported incident report process with investigation was followed and completed weekly x 8 weeks then monthly x 2. The findings will be submitted to QAPI for review, discussed and plan revised if compliance is not met or sustained. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 610	Continued From page 29 Complaint related deficiency.	F 610		
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 Resident interview, Staff interview, Ombudsman interview, Clinical record review, and facility document review, the facility staff failed review and revise a nutrition, hydration, and	F 657	F657 Care Plan Timing and Revision 1. Resident #13 no longer resides in the facility.	2/28/23

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F 657	Continued From page 30 seizure care plan for one Resident (Resident #13) in a sample of 9 residents. The findings included: For Resident #13, the facility staff did not review and revise the care plan for weight loss, dehydration, and seizures. Resident #13 was admitted to the facility with diagnoses including; acute gastrointestinal bleeding with resulting acute post hemorrhagic anemia and weakness. History included diabetes, congestive obstructive pulmonary disease (COPD), seizures. On 9-26-22 the Registered Dietician (RD) evaluated the Resident and documented "nutrition risk related to recent hospitalization", and "moderate protein calorie malnutrition" as a medical diagnosis. The document describes weight on 9-22-22 was 164 pounds hospital weight upon discharge to the facility. The plan was to "Monitor/Evaluation (M/E): Monitor weights, meal intake and provide follow up per protocol." Resident #13's nutrition care plan, completed on 9-26-22, was reviewed and revealed the only interventions were the following 5 items; 1. administer medications as ordered 2. labs as ordered 3. provide, serve diet as ordered 4. monitor intake and record every meal, offer substitute when intake less than 50% 5. weekly weights Activities of Daily Living records (ADL's) were	F 657	2. Current residents in the center have the potential to be affected. An audit of current residents with change in condition or new active diagnosis in the past 30 days from 1/31/2023 was conducted by the MDS staff or designee to verify care plan was initiated, revised/updated. 3. The Regional Director MDS or designee will educate the IDT team (MDS staff, nursing management, dietitian, activities, social service) on the process for care plans will be initiated, revised/updated for change in condition, medical diagnosis to reflect the resident□s current status. 4. The Director of MDS or designee will assess 10 residents weekly to verify care plan is current with change in condition or new diagnosis weekly x 8 weeks then monthly x 2 months. The findings will be submitted to QAPI for review, discussed and plan revised if compliance is not met or sustained. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 657	Continued From page 31	F 657		

reviewed and revealed the following;

September - 9-22-22 through 9-30-22 (8 days), the Resident did not eat, or ate 26-50 percent of meals for 6 of 24 meals (25% of meals).
October - 10-1-22 through 10-15-22 (15 days). the Resident did not eat, or ate 26-50 percent of meals for 23 of 45 meals (50% of meals).
October - 10-24-22 through 11-4-22 (12 days) the Resident did not eat, or ate 26-50 percent of meals for 19 of 36 meals (50% of meals).

It is unknown if substitutions were offered, however, the Resident was documented as consuming the above amounts irregardless of food served, at the end of each meal.

The Resident's weights were not taken for 2 weeks between 9-22-22, and 10-5-22, and then not taken for 9 more days from 10-5-22 to 10-14-22 when the Resident was sent out to the hospital for trauma evaluation. The admission weight in the hospital revealed a 16 pound (approximately 10 %) weight loss since admission to the nursing facility in 23 days. The following are weights which were taken in the facility, and in the hospital as documented in the clinical records.

1. 9-22-22 - 163.0 pounds
2. 10-5-22 - 163.7 pounds
3. 10-14-22 - went out to hospital, admission weight at the hospital was 137.0 pounds.
4. 10-24-22 - returned to the facility, and no weight taken at the facility on readmission.
5. 10-26-22 - 141.2 pounds (4 pound weight gain during hospitalization)
6. 10-28-22 - 139.6 pounds (weight loss begins again)

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F 657	Continued From page 32 7. 11-2-22 - 138.4 pounds (weight loss continues for a 3 pound weight loss since readmission in 8 days) Resident #13 did not have a dehydration care plan, nor seizure disorder care plan upon admit despite receiving diuretic medications which strip fluid from the body, and receiving antiseizure medications. A dehydration care plan, and seizure care plan were also not completed for the Resident upon readmission from the hospital on 10-24-22, even though dehydration and fluid resuscitation, as well as anti-seizure medication overdose were diagnosed and documented in the hospital discharge records. A dehydration care plan, and a seizure disorder care plan were completed on 11-4-22. The day of the Resident's discharge. On 1-19-2023 an interview was conducted with the Administrator and Director of Nursing (DON) and asked what their policy was on care plan revisions for weight loss and hydration, both answered that when weight loss or the possibility for dehydration were suspected an immediate care plan revision should be completed to intervene. On 1-24-23 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. No further information was provided by the facility.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		2/28/23

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F 658	Continued From page 33 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to provide care and services in accordance with professional standards of practice for one Resident (Resident #16) in a sample size of 9 Residents. The findings included: For Resident #16, the facility staff failed to: 1) administer medications as ordered by the physician 2) notify the physician when medications were not given as ordered 3) obtain/ monitor routine blood pressure measurements when Resident #16 had a known diagnosis of hypertension and received blood pressure medication daily. On 01/18/2023, Resident #16's medical diagnoses included but was not limited to hypertension. A review of the physician orders revealed that Resident #16 received an oral antihypertensive daily (Lisinopril). There were no physician orders to obtain blood pressures regularly. The Vital Signs flowsheet was reviewed. There were no blood pressure measurements from 05/31/2022 through 07/07/2022. On 01/18/2023 at approximately 2:30 P.M., Resident #16's Medication Administration Record	F 658	F658 Services Provided Meet Professional Standards 1. Resident #16 had no action taken due the timeframe has passed. The resident is receiving medications per physician order and blood pressure obtained. 2. Current residents in the center have the potential to be affected. An audit by the DON or designee on current residents conducted to review the clinical record to verify medication are available and administered. If not available, the process to obtain medications will be followed to obtain for administration. An audit by the DON or designee of blood pressure ordered by the physician are documented and if no physician order for obtaining a BP has a blood pressure documented monthly. 3. The Staff Development Coordinator will educate all licensed nurses on the process for medication administration per physician orders, notification to physician if not given or medication unavailable with documentation and obtaining blood pressure per physician order or monthly to monitor while receiving blood pressure medication. 4. The unit managers or designee will review clinical record for medication administration per physician order, physician notified if not given and process followed for unavailable medications and	

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F 658	Continued From page 34 for August 2022 was reviewed and revealed the following: 1) There was an 11-day lapse (08/01/2022, 08/12/2022) of the administration of one medication (Trulicity) which was supposed to be administered every 7 days. 2) Mirapex was not administered on 08/27/2023 as ordered by the physician. The progress notes for August 2022 were reviewed. An administration note associated with the Mirapex administration dated 08/27/2022 at 8:59 P.M. documented, "Not on hand." There was no evidence the physician was notified of the missed dose of Mirapex or the 11-day lapse in the Trulicity administration. On 01/26/2023 at 9:15 A.M., Licensed Practical Nurse D (LPN D) was interviewed. When asked about the Trulicity 11-day lapse in administration, LPN D referred to the clinical record and stated that there should have been a progress note written as to why the Trulicity was switched from Mondays to Fridays, and that the physician was notified. The facility staff provided a copy of their policy entitled, "Medication Administration." In Section 3, an excerpt documented, "If medications are determined to be unavailable for administration, licensed nurse will notify the provider of the unavailability." According to Lippincott "Nursing Procedures", Seventh Edition, 2016, under the section entitled, "Blood Pressure Assessment", an excerpt	F 658	a review of physician orders for blood pressure were obtained and/ or monthly and documented in the clinical record. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 658	Continued From page 35 documented, "Regular measurement is indicated for patients with a history of hypertension ..." On 01/24/2023 at approximately 2:30 P.M., the Vice President of Operations and Regional Director of Clinical Services were notified of findings.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 661		2/28/23

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(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
F 661	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to document a discharge summary/recapitulation of stay in the clinical record for one Resident (Resident #13) in a sample of 9 Residents. The findings included; The DON was asked for a copy of the Resident's discharge summary/recapitulation of stay from the physician as none was found in the clinical record. The DON supplied a copy of a discharge nursing assessment from a Licensed Practical Nurse (LPN), who had been caring for the Resident, and stated she could not find one from the doctor. On 1-24-23 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. No further information was provided by the facility.	F 661	F661 Discharge Summary 1. Resident #13 no longer resides in the facility. 2. Current residents in the center have the potential to be affected. An audit of discharge residents past 30 days from 1/31/2023 will be reviewed by Medical Records to verify the discharge summary/recapitulation of stay by the physician was completed and uploaded in the clinical record. 3. The DON will educate the physicians on the discharge summary/recapitulation of stay must be completed and educate medical records to verify the discharge summary /recapitulation of stay is completed by the physician and uploaded in the clinical record. 4. Medical Records or designee will audit weekly to verify the discharge summary /recapitulation of stay by the physician is completed and is uploaded in the clinical record. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		2/28/23

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	495193	A. BUILDING _____ B. WING _____	C 01/26/2023

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F 677	Continued From page 37 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide activities of daily living (ADL) care/assistance to 2 Residents (Resident #15 and #12) who were dependent upon facility staff for assistance, in a survey sample of 9 Residents. The findings included: 1. For Resident #15 the facility staff failed to provide assistance with activities of daily living, which included incontinence care. On 1/18/23-1/20/23, a closed record review was conducted of Resident #15's clinical chart. Resident #15's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 11/22/22, was reviewed. This assessment coded Resident #15 in section H as having been incontinence of bowel and bladder frequently. This same assessment coded Resident #15 in section G as having required extensive assistance from one staff member for toileting. Review of facility grievances and investigation documents revealed that on several occasions Resident #15 and/or her family reported on 12/6/22, "Resident and roommate stated she hadn't been changed. That prior to leaving CNA was told by nurse to put resident into bed and clean up/wash up. Apparently, resident said something, and CNA stated that resident could sit in her pee until 11-7 arrived since she had an attitude. Resident states she wasn't changed	F 677	F677 ADL Care Provided for Dependent Residents 1. Resident #15 no longer resides in the facility. Resident #12 the resident is receiving incontinent care. 2. Current residents in the center have the potential to be affected. An audit of ADL documentation for the past 30 days from 1/31/2023 incontinent care, baths and showers were provided and documented. 3. The Staff Development Coordinator will educate all CNAs on providing incontinent care timely, bath and/or shower with documentation in the clinical record. 4. The unit managers or designee will assess 10 residents weekly to verify incontinent care, bath/shower provided with completion of documentation in the clinical record. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 677	Continued From page 38	F 677		

entire time- chair was wet. Spoke with daughter during 3rd shift states this is the 3rd time mother has sat in urine for long times and no one answering c/l [call light] ..."

Review of the ADL (activities of daily living) documentation from December 2022, revealed multiple shifts where there was no documentation that care was provided. This included but was not limited to, 12/2/22- the evening shift, 12/3/22- the day shift, and on 12/10/22- all shifts.

On 1/24/22 at 11:07 AM, an interview was conducted with CNA D. CNA D was asked how often incontinence care is provided to a Resident. CNA D said, "within a regular shift I check my Residents at least twice. There are some that are heavy wetter's so it may be more for them". When asked about documentation, CNA D said, "I try to chart after I do something for a Resident, after meals and at the end of my shift". When asked if there is no documentation for a shift, what this means, CNA D said, "nothing was done, that's how we were taught".

On 1/24/22 at 11:12 AM, an interview was conducted with CNA E. CNA E was asked to explain the frequency of care to Residents. CNA E said, "I try to do every 2 hours but sometimes things happen". When asked about charting and what blanks mean, CNA E said, "If it's not charted, it's not done".

No additional information was received.

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F 677	Continued From page 39	F 677		

Findings included:

2. For Resident # 12, the facility staff failed to provide incontinence care timely and baths/showers twice a week as scheduled.

Resident # 12's most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 10/29/2022. The MDS coded Resident # 12 with a BIMS (Brief Interview for Mental Status) Score of 15 out of 15 indicating no cognitive impairment; required extensive to total assistance from one to two staff members for Activities of Daily Living (ADLs). Resident # 12 was alert and oriented and able to make needs known.

Review of the electronic clinical record was conducted.

An interview was conducted on 01/18/2023 at 03:18 PM via telephone with Resident # 12's family member who stated that Resident # 12 had experienced many problems with some of the facility staff. The family member stated Resident # 12 often complained of being left wet for extended periods of time. The family member reported noticing long periods of time before incontinence was given when visiting Resident #12. The family member stated baths were not given as scheduled. The family member stated it was upsetting and embarrassing to Resident # 12.

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F 677	Continued From page 40	F 677		

On 1/19/2023 at 2:15 p.m.,Surveyor B conducted an interview with Resident # 12 who stated incontinence care was not provided regularly. Resident # 12 stated "they do not change us, sometimes we will be laying here wet, you call and tell them you need to be changed and they say you have to wait, I ask wait until what? She [CNA] said until I get a chance. Happened today the [CNA] I usually have didn't have me today and she came in to tell me I would have to wait because she didn't have me today. I started calling them at 9 AM, because I wanted to get changed before breakfast but it (breakfast) didn't come until late and .....was 11 before I got changed."

Resident # 12 further stated "Last weekend (weekend that just passed 1/14/23-1/15/23) we had 2 [CNAs] all weekend on 7-3 shift that gives them 30 patients and the next day we had 1 [CNA] so she had all 60 of us, we got changed once and didn't get bathed, I felt so horrible for them, they don't care about people or their workers it just the money. The nurses didn't even get out and help her. We are supposed to get baths twice a week then they started giving them to us once per week, I think I've been given one bath since I've been over here."

On 1/25/2023 at approximately 4:15 p.m., an interview was conducted with CNA D who stated incontinence care should be provided every two hours or as needed by the resident. CNA D stated baths/showers should be given twice a week. CNA D stated they do the best they can to provide care.

Review of the ADL flow sheets revealed missing documentation of incontinence care being

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F 677	Continued From page 41 provided. Review of the bathing documentation revealed baths/showers were not given twice a week as scheduled. During the end of day debriefing, the Administrator and Director of Nursing were informed of the findings. No further information was provided.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and in the course of a complaint investigation, the facility staff failed to provide an ongoing program of activities to support Residents in their choice of activities on one unit (North Unit) of 2 Units. The findings included: 1) For the North unit, the Activity Room was consistently locked in the evenings and some weekends resulting in activities being inaccessible to Residents on the North Unit.	F 679	F679 Activities Meet Interest /Needs each Resident. 1. Resident #16 aware on 1/24/23 the activity room has remained unlocked and accessible. 2. Current residents in the center have the potential to be affected. Resident council meeting conducted to inform other residents. 3. The RDCS will educate The Director of Activities on resident rights and the activity rooms remain accessible for	2/28/23

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F 679	Continued From page 42 On 01/19/2023 at 1:45 P.M., Employee F, the Activities Assistant, was interviewed. The Activities Assistant confirmed her desk/office is located in the North Unit Activity Room. When asked about if it is accessible to Residents in the evenings and weekends, the Activities Assistant stated the room is locked in the evenings and on some weekends (inaccessible to Residents) because her laptop is in there. On 01/20/2023 at approximately 10:40 A.M., Resident #16 was interviewed. When asked about activities at the facility, Resident #16 indicated she would like to have access to the Activity Room in the evenings to be able to do a puzzle on the puzzle table at times. Resident #16 indicated the Activity Room was closed in the evenings because the Activity Assistant's office was in there. A review of Resident #16's quarterly Minimum Data Set with an Assessment Reference Date of 10/30/2022 coded the Brief Interview for Mental Status as "15" out of "15" indicative of intact cognition. On 01/24/2023 at approximately 2:30 P.M., the Vice President of Operations and the Regional Director of Clinical Services were notified of findings. At approximately 3:45 P.M., the Regional Director of Clinical Services notified surveyor that the Activity Room on the North Unit would now remain open and accessible to Residents. On 01/26/2023, the facility staff provided a copy of their "Resident Handbook." Under the Section entitled, "Resident Rights" in subpart 16, an excerpt documented, "To meet with and	F 679	residents. 4. The Director of Activities or designee will interview 5 residents weekly to assess if any concerns with activities or accessibility to activity room. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 679	Continued From page 43 participate in activities of social, religious, and community groups that do not interfere with the rights of others at his/her discretion ..."	F 679		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to ensure the environment remained free of accident hazards in one of one halls observed. The findings included: For the front hall on the south unit, an electrical cord plugged into a red outlet was observed on 01/23/2023 extending across the hall and into a Resident Room on the opposite side of the hall. The cord was not secured to the floor and looped around creating a trip hazard. The cord also prevented Residents in wheelchairs to freely travel the hall. On 01/23/2023 at 12:44 P.M., the power went out at the facility and the generator was activated. At 12:55 P.M., this surveyor, the Regional Director of Clinical Services, and Registered Nurse B (RN B) observed that a bed and air mattress for the Resident in Room 29B was not working. RN B	F 689	F689 Free of Accident Hazards/Supervision/Devices 1. The cord was taped on 1/23/23 to allow wheelchairs to cross over or staff assisted. 2. Current residents in the center have the potential to be affected. 3. The Administrator or designee will educate the maintenance staff and the facility staff on the process and procedure during power outages with securing cords with tape on the floor to prevent risk and allow accessibility in hallway for the residents and assist the resident as needed. Post of signs to alert residents to the change in plane on floor with cords. 4. The director of maintenance or designee will verify weekly x 4 supplies are available for a power outage on the units for securing cords in the hallways. Once the QAPI committee determines the	2/28/23

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F 689	Continued From page 44 then stated that there were no red plugs (which are plugs that receive power from the generator) in the rooms but they would have to get an extension cord to plug it into the hall outlet. Upon exiting room 29B at approximately 1:00 P.M., an electrical cord was observed plugged into a red outlet in the hall extending across the hall into a different Resident room on the opposite side of the hall. On 01/24/2023 at 2:00 P.M., RN B was interviewed. When asked about the availability of red plugs, RN B stated there are 2 red plug outlets in the front hall and they are located on the same side of the hall. RN B stated that they plug air mattresses into the red outlets in the hall when the power goes out. RN B also confirmed there are air mattresses in use on both sides of the hall which is why an electrical cord was observed extending across the hall. When asked how Residents in wheelchairs travel the hall when the electrical cord is across the entire hall, RN B stated it is challenging and staff would have to assist the Residents. When asked about safety concerns, RN B indicated that the cord should've been taped down, secured, and signs posted to mitigate a tripping hazard. On 01/24/2023 at approximately 3:45 P.M., the Vice President of Operations and the Regional Director of Clinical Services were notified of findings. On 01/26/2023 by the end of survey, the Vice President of Operations and the Regional Director of Clinical Services confirmed there was no other information or documentation to submit.	F 689	problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	
F 691	Colostomy, Urostomy, or Ileostomy Care	F 691		2/28/23

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F 691 SS=D	Continued From page 45 CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview,and clinical record review, the facility staff failed to ensure that one resident (Resident # 12) in the survey sample of 9 residents, received necessary care for a colostomy. Findings included: For Resident # 12, the facility staff failed to provide colostomy care to meet the resident's needs. Resident # 12's most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 10/29/2022. The MDS coded Resident # 102 with a BIMS (Brief Interview for Mental Status) Score of 15 out of 15 indicating no cognitive impairment; required extensive to total assistance from one to two staff members for Activities of Daily Living (ADLs). Resident # 12 was alert and oriented and able to make needs known. Review of the electronic clinical record was conducted.	F 691	F691 Colostomy, Urostomy or Ileostomy Care 1. Resident #12 colostomy care is being provided. 2. Current residents in the center have the potential to be affected. An audit by DON or designee of current residents with a colostomy to verify colostomy care provided and documented. 3. The Staff Development Coordinator or designee will educate all the licensed nurses and CNAs on colostomy care with changing of bag and emptying with documentation. 4. The unit manager or designee will assess weekly residents with a colostomy have colostomy care, emptied, and documented. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 691	Continued From page 46	F 691		

On 1/18/2023 at 3:18 p.m., an interview was conducted with the family member of Resident # 12 who stated the facility staff did not provide proper care of Resident # 12's colostomy. The family member stated the bag often overflowed, was not sealed properly and caused Resident # 12 to feel anxious because of fear of it overflowing.

Review of the Activities of Daily Living sheets revealed missing documentation of changes of the colostomy bag.

On 1/19/2023 at 2:15 p.m.,Surveyor B conducted an Interview with Resident # 12 who stated incontinence care was not done timely. Resident # 12 stated the colostomy bag was not changed as needed.

On 1/25/2023 at 459 p.m., an interview was conducted with LPN (Licensed Practical Nurse) C who stated the colostomy bags should be checked frequently "every couple of hours" to see if they need to be changed. LPN C stated the seal should be checked to prevent leakage. LPN C stated the staff should respond to requests from the residents to have the colostomy bag changed

During the end of day debriefing on 1/25/2023, the Regional Vice President and the Regional Director of Clinical Services functioning as the interim facility Administrator and interim Director of Nursing respectively were informed of the findings.

No further information was provided.
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F 755	Continued From page 47	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to have medications available for	F 755	F755 Pharmacy SRVS/Procedures/Pharmacist/Records	2/28/23

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(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
F 755	Continued From page 48 administration as per doctors orders for two Residents (Resident #14, Resident #2) in a sample of 9 residents. The findings included: 1) For Resident #14, the facility staff failed to have available pain medications and a post operative anticoagulants upon admission. Resident #14 was admitted to the facility on 3-2-22 with diagnoses including; acute fractured right elbow, and clavicle with surgical repair. Physician progress notes were reviewed and described the physician's evaluation of the Resident to be oriented to person place time and situation. The physician found no cognitive impairment nor behaviors, and the Resident was able to give her medical history and was appropriate. Resident #14's physician orders and Medication administration records were reviewed and revealed that on 3-2-22 the Resident was ordered to be given Enoxaparin Sodium 30 milligrams (mg) in 0.3 milliliters (ml) of solution by injection every 12 hours for 30 days post operatively to prevent blood clots after surgery. The Resident was also ordered to be given pain medication for chronic nerve pain Gabapentin 600 mg tablet 2 times per day, and a second medication for acute post operative pain Oxycodone hydrochloride tablets 5 mg every 4 hours as needed for pain. The Resident received a paper copy of the narcotic pain killer from the hospital on 3-1-22 before arriving in the facility on 3-2-22. The Resident supplied the paper prescription to the facility upon admission.	F 755	1. Resident # 14 no longer resides in the facility. Resident #12 is receiving mediations per physician orders. An audit by the DON or designee on current residents review the clinical record for unavailable medications to verify the process to obtain medications was followed and ensure medications obtained and available for administration. 2. Current residents in the center have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all the licensed nurses on the process for obtaining unavailable medications. 4. The unit manager or designee will review documentation of clinical record weekly to ensure the process for unavailable mediations process was followed to have medications available and administered per physician orders. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	C 01/26/2023

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F 755	Continued From page 49 On the following days and time those medications were unavailable for administration. Enoxaparin Sodium injection - blood thinner - 3-2-22 at 9:00 p.m., and 3-5-22 at 9:00 p.m. Gabapentin - chronic nerve pain medication - 3-2-22 at 5:00 p.m., 3-3-22 at 9:00 a.m., 3-4-22 at 5:00 p.m., and 3-5-22 at 5:00 p.m. Oxycodone tablets - pain medication - 3-2-22 none given on day of admission, 3-5-22 none given. Progress notes for the 5 day stay were reviewed and revealed documented entries of "medication unavailable", and "waiting on pharmacy" to deliver. There were also entries of Resident pain complaints with medication administration documented. Resident #14's care plan was reviewed and indicated pain as a focus and as an intervention "Administer medication as ordered." On 1-19-2023 an interview was conducted with the Administrator and Director of Nursing (DON) and asked why the medications were omitted/unavailable, and both answered they did not know. On 1-24-23 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. No further information was provided by the facility.	F 755		

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F 755	Continued From page 50	F 755		

2. For Resident # 12, the facility staff failed to ensure medications were available as ordered by the physician,

Review of the electronic clinical record was conducted.

Review of the clinical record revealed documentation of medications being unavailable on at least 3 scheduled times of administration as listed.

"1/17/2023 10:26 a.m.
Orders -Administration Note
Note Text: medication n/a [not available] MD [medical doctor] needs to sign new script"

"1/16/2023 22:50 (10:50 p.m.)
Orders -Administration Note
Note Text: new script needed in order to pull from pyxis [system to access in house medications for first dose] MD aware of new script being needed. resident denies having any pain/discomfort at this time"

"1/16/2023 22:48 (10:48 p.m.)
Orders -Administration Note
Note Text: new script needed in order to pull from pyxis MD aware of new script being needed. resident denies having any pain/discomfort at this time"

"1/16/2023 13:57 (1:57 p.m.)
Orders -Administration Note
Note Text: Tramadol HCl Tablet 50 MG [milligrams]
Give 1 tablet by mouth four times a day for pain Medication on order."

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F 755	Continued From page 51 Review of the OMNICELL (onsite first dose) inventory sheet revealed no documentation that the medication, Tramadol was available for administration. There was no documentation of an inventory of items in the "Pyxis" provided to the survey team. Interviews conducted with nursing staff revealed the expectation was for the pharmacy to provide medications to enable the facility staff to administer medications as ordered by the physician. During an interview on 1/20/2023 at 4:59 p.m., LPN (Licensed Practical Nurse) C stated medications were provided by the pharmacy. LPN C stated the staff should check the inventory to determine if the missing medications were available in the facility and notify the physician if medications were unavailable for administration. During the end of day debriefings on 1/24/2023 and 1/25/2023, the Regional Vice President and the Regional Director of Clinical Services functioning as the interim facility Administrator and interim Director of Nursing respectively were informed of the findings of medications being unavailable. No further information was provided.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		2/28/23

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F 757	Continued From page 52 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to prevent unnecessary medication for one Resident (Resident #13) in a sample of 9 residents. The findings included: For Resident #13, the facility staff administered unnecessary dosages of Dilantin anti-seizure medication, causing overdose. Resident #13 had diagnoses including; seizures. Resident #13's physician orders and Medication administration records were reviewed and revealed that on 9-22-22 the Resident was ordered to be given Dilantin 200 milligrams (mg) four times per day to equal 800 mg per day in the	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1. Resident #13 no longer resides in the facility. 2. Current residents in the center have the potential to be affected. An audit conducted by the DON or designee on current receiving Dilantin to verify within dosage range, monitoring of signs and symptom of toxicity and physician orders for Dilantin lab levels. 3. The Staff Development Coordinator or designee will educate all the licensed nurses on management of Dilantin, lab levels and ranges, s/s of toxicity with physician notification and documentation. 4. The unit manager or designee will review and verify Dilantin on admission	

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F 757	Continued From page 53 nursing facility. On 10-14-22 the Resident was sent to the hospital due to an injury. During the 9 day stay there, hospital admission records dated 10-22-22 documented by the physician, that the Dilantin dosage (800mg) was excessive. While in the hospital the Resident was being "weaned" down to Dilantin 400 mg per day (200 mg twice per day) at the time of discharge. Documents reference the Residents complaints of dizziness were most likely attributed to receiving too much Dilantin. All laboratory results were reviewed in the clinical record, and revealed no labs were drawn to evaluate Dilantin blood levels with which to base dosage. On 1-19-2023 an interview was conducted with the Administrator and Director of Nursing (DON) and asked why no care plan had been devised, nor labs had been scheduled for the Resident in regard to her seizure disorder, and both answered they did not know. On 1-24-23 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. No further information was provided by the facility.	F 757	and for new orders dosages are within range, lab Dilantin levels, s/s of toxicity the physician was notified. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		2/28/23

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F 759	Continued From page 54 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a medication error rate of less than 5% for one Resident (Resident #16) in a sample size of 9 Residents. For Resident #16, there were 12 opportunities and 5 omissions resulting in a medication error rate of 41% on 01/19/2023. The findings included: On 01/19/2023 at approximately 10:10 A.M., this surveyor observed LPN B administer medications to Resident #16. LPN B placed the following oral medications in a medicine cup: Cyanocobalamin 500 mcg (2 tablets) Gabapentin 400 mg tablet (1 tablet) Omeprazole 20 mg capsule (1 capsule) Tramadol 50 mg tablet (Give 0.5 tablet) Lisinopril 2.5 mg (1 tablet) Lipitor 20 mg (1 tablet) When LPN B handed Resident #16 the medication, Resident #16 counted the 7 pills and stated that there should be 9 pills in the cup. LPN B returned to the medication cart to review Resident #16's Medication Administration Record. LPN B stated that the low dose aspirin (81 mg) and the sertraline (50 mg) were missing and added those medications to the cup. LPN B also stated that Resident #16 should receive 40 mg of Omeprazole and added another 20 mg capsule to the cup. LPN B stated that Resident #16 should have 10 pills in the cup. LPN B then administered the medications to Resident #16 at approximately 10:20 A.M. (an hour and 20 minutes beyond the scheduled time).	F 759	F759 Free of Medication Error Rate 5 % or more 1. Resident #16 receiving medications per physician order. 2. Current residents in the center have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all the licensed nurses on the administration of medications per physician orders and following the rights of medication administration. 4. The Staff Development Coordinator or designee will conduct medication pass observation of 3 licensed nurse weekly. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 759	Continued From page 55 On 01/19/2023 at approximately 1:50 P.M., Resident #16's clinical record was reviewed. A review of the Medication Administration Record and Physician's orders for the 9:00 A.M. scheduled medication administration revealed that Resident #16 also had Metformin 500 mg (Give 2 tablets) scheduled for 9:00 A.M. as well. On 01/19/2023 at approximately 2:00 P.M., LPN B was interviewed. When asked about the 9:00 A.M. dose of Metformin, LPN B stated that the Metformin was administered during the medication administration observation at approximately 10:20 A.M. (which was not the case). LPN B showed where the Metformin had been signed off on the Medication Administration Record as administered. On 01/24/2023 at 2:30 P.M., the Vice President of Operations and Regional Director of Clinical Services were notified of findings.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: Wilburn, Joyce Based on Resident interview, staff interview, Ombudsman interview, clinical record review, and facility document review, the facility staff failed to prevent significant medication errors for two Residents (Resident #13, & #14) in a sample of 9 residents.	F 760	F760 Free of Significant Med Errors 1. Resident #13 no longer resides in the facility. Resident #14 no longer resides in the facility. 2. Current residents in the center have the potential to be affected. An audit by	2/28/23

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F 760	Continued From page 56 The findings included: 1. For Resident #13, the facility staff administered unnecessary dosages of Dilantin anti-seizure medication. 1. Resident #13 had diagnoses including; seizures. Resident #13's physician orders and Medication administration records were reviewed and revealed that on 9-22-22 the Resident was ordered to be given Dilantin 200 milligrams (mg) four times per day to equal 800 mg per day in the nursing facility. On 10-14-22 the Resident was sent to the hospital due to an injury. During the 9 day stay there, hospital admission records dated 10-22-22 documented by the physician, that the Dilantin dosage (800mg) was excessive. While in the hospital the Resident was being "weaned" down to Dilantin 400 mg per day (200 mg twice per day) at the time of discharge. Documents reference the Residents complaints of dizziness were most likely attributed receiving excessive Dilantin. All laboratory results were reviewed in the clinical record, and revealed no labs were drawn to evaluate Dilantin blood levels with which to base dosage. On 1-24-23 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. No further information was provided by the facility.	F 760	the DON or designee on current residents conducted to review the clinical record to verify unavailable medication process followed to obtain and medication are available to administered. 3. The Staff Development Coordinator or designee will educate all the licensed nurses on the administration of medications per physician orders and on the process for obtaining unavailable medications. 4. The Staff Development Coordinator or designee will review the clinical record documentation weekly to verify pain medications, anticoagulants are available and administered, process followed for unavailable medication and verify management of Dilantin was followed. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	

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F 760	Continued From page 57	F 760		

2. For Resident #14, the facility staff failed to administer pain medications, and post operative anticoagulant upon admission.

Resident #14 was admitted to the facility with diagnoses including; acute fractured right elbow, and clavicle with surgical repair.

Physician progress notes were reviewed and described the physician's evaluation of the Resident to be oriented to person place time and situation. The physician found no cognitive impairment nor behaviors, and the Resident was able to give her medical history and was appropriate.

Resident #14's physician orders and Medication administration records were reviewed and revealed that on 3-2-22 the Resident was ordered to be given Enoxaparin Sodium 30 milligrams (mg) in 0.3 milliliters (ml) of solution by injection every 12 hours for 30 days post operatively to prevent blood clots after surgery. The Resident was also ordered to be given pain medication for chronic nerve pain Gabapentin 600 mg tablet 2 times per day, and a second medication for acute post operative pain Oxycodone hydrochloride tablets 5 mg every 4 hours as needed for pain. The Resident received a paper copy of the narcotic pain killer from the hospital on 3-1-22 before arriving in the facility on 3-2-22. The Resident supplied the paper prescription to the facility upon admission.

On the following days and time those medications were unavailable for administration.

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F 760	Continued From page 58 Enoxaparin Sodium injection - blood thinner - 3-2-22 at 9:00 p.m., and 3-5-22 at 9:00 p.m. Gabapentin - chronic nerve pain medication - 3-2-22 at 5:00 p.m., 3-3-22 at 9:00 a.m., 3-4-22 at 5:00 p.m., and 3-5-22 at 5:00 p.m. Oxycodone tablets - pain medication - 3-2-22 none given on day of admission, 3-5-22 none given. Progress notes for the 5 day stay were reviewed and revealed documented entries of "medication unavailable", and "waiting on pharmacy" to deliver. There were also entries of Resident pain complaints with medication administration documented. Resident #14's care plan was reviewed and indicated pain as a focus and as an intervention "Administer medication as ordered." On 1-19-2023 an interview was conducted with the Administrator and Director of Nursing (DON) and asked why the medications were omitted/unavailable, and both answered they did not know. On 1-24-23 at approximately 3:30 P.M., the Corporate Nurse Consultant and Regional Director of Operations were notified of findings. No further information was provided by the facility.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804		2/28/23

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F 804	Continued From page 59 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide food that is palatable and at an appetizing temperature. Specifically, the ice cream in the freezer on 01/18/2023 was observed to be soft and nearly milkshake consistency. The findings included: On 01/18/2023 at 3:10 P.M., this surveyor and the Dietary Manager entered the walk-in freezer for an observation. The temperature gauge on the outside of the freezer read (-3) degrees Fahrenheit. The temperature gauge on the inside of the freezer read 40 degrees. When asked about the ice cream, the Dietary picked up a plastic cup labeled chocolate ice cream. When asked if the ice cream was frozen, the Dietary Manager stated "Yes." When asked if she could squeeze the cup to test the firmness, the Dietary Manager stated she could squeeze the cup only slightly and that the ice cream was frozen. This surveyor requested to hold the cup. The cup was easily pliable to demonstrate the ice cream was soft and nearly melted. The Dietary Manager went on to say that the ice cream leaves the freezer and gets put on resident food trays, which is then transported to the resident units in the tray	F 804	F804 Nutritive Value/Appear Palatable/Prefer Temp 1. The freezer was repaired by vendor on 1/18/2023 and the freezer temperatures remain with the temperature to maintain foods in a frozen consistency. All food identified not in a frozen consistency was discarded on 1/18/2023. 2. Current residents in the center have the potential to be affected. 3. The Administrator or designee will educate the dietary manager on the process for monitoring and maintaining the freezer temperature for the storage of food remains frozen to preserve a palatable appearance and consistency. The Administrator will be notified for services required from outside vendor for repairs. The Dietary Manager will educate the dietary staff on the process for maintaining the freezer temperatures for the storage of food remains frozen to preserve a palatable appearance and consistency and reporting to the dietary manager if frozen foods are affected by higher temperatures. 4. The Dietary Manager or designee will	

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F 804	Continued From page 60 warmer so by the time it get to residents, the ice cream is melted. When asked what has been done to fix this problem, the Dietary Manager did not answer. On 01/18/2023 at 4:30 P.M., the Administrator and Director of Nursing were notified of findings. On 01/19/2023 at 8:30 A.M., the Administrator stated that she spoke with the Dietary Manager and told staff not to transport ice cream in the tray warmer but keep ice cream stored in the unit refrigerators. The facility staff provided a copy of their policy entitled, "Quality and Palatability." Under the header "Policy Statement", it was documented, "It is the center policy that food is prepared by methods that conserve nutritive value, flavor, and appearance. Food is palatable, attractive, and served at safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs."	F 804	audit 5 x weekly the freezer temperatures, log and assess foods are frozen in the freezer. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		2/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 61 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility documentation review, the facility staff failed to store food in accordance with professional standards for food service safety. Specifically, the walk-in freezer was observed on 01/18/2023 to be filled with meat, vegetables, and dairy products and have a temperature range of 40 to 48 degrees Fahrenheit. The findings included: On 01/18/2023 at 3:10 P.M., this surveyor and the Dietary Manager entered the walk-in freezer for an observation. The temperature gauge on the outside of the freezer read (-3) degrees Fahrenheit. The temperature gauge on the inside of the freezer read 40 degrees. When asked about this, the Dietary Manager stated that staff have been going in and out of the freezer recently so that's why the freezer temperature is up. The Dietary Manager stated if we wait a few minutes and keep the door closed, the freezer temperature will go back down and get cold again. At 3:15 P.M., Surveyor E and Surveyor F returned and entered the walk-in freezer with the Dietary Manager and the Maintenance Assistant and closed the freezer door. The inside temperature gauge read 48 degrees Fahrenheit. The Maintenance Assistant had a thermometer probe which he stated was new and accurate.	F 812	F812 Food procurement, Store/Prepare/Serve/Sanitary 1. Food in the freezer was discarded and the freezer was repaired on 1/18/2023. The food in freezer that was affected with temperatures not frozen was discarded. 2. Current residents in the center have the potential to be affected. 3. The Administrator or designee will educate the dietary manager on the process for monitoring and maintaining the freezer temperature for the storage of food in the freezer remains frozen. Services required for repairs from outside vendor inform the Administrator. The Dietary Manger will educate the dietary staff on the process for storage of food in the freezer remains frozen and the freezer temperature is monitored and maintained. Notify the dietary manager if freezer temperature is not maintained or food storage is affected. 4. The Dietary Manager or designee will audit 5 x weekly the freezer temperatures, log and assess foods are frozen in the freezer. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a	

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F 812	Continued From page 62 After approximately 10 minutes in the freezer, the temperature probe read 35 degrees Fahrenheit. On 01/18/2023 at 4:30 P.M., the Administrator and Director of Nursing were notified of findings. On 01/19/2023 at 8:30 A.M., the Administrator stated that the freezer repair technician worked on the freezer last night and it is currently working. The Administrator provided a copy of the work order which documented the following excerpt: "Freezer not getting to temp. Unit was frozen across the evap coil." At 8:40 A.M., this surveyor entered the walk-in freezer with the Dietary Manager for an observation. The inside temperature gauge read 10 degrees Fahrenheit and the freezer felt cold. The freezer was empty. The Dietary Manager stated all the food was discarded and expecting a delivery this day.	F 812	random basis. The Administrator or Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 2/28/2023	