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	495085	A. BUILDING _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/28/2023 through 03/09/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/28/2023 through 03/09/2023. An extended survey was conducted 03/01/2023 through 03/09/2023. Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity Level 4, Pattern which constituted Substandard Quality of Care on 03/01/2023 and was removed on 03/09/2023. After removal, the scope and severity was lowered to a level 2 isolated due to deficiencies that remained. Immediate Jeopardy was identified in the area of Infection Control at a Scope and Severity Level 4, Isolated on 03/03/2023 and was removed on 03/06/2023. After removal, the scope and severity was lowered to a level 2 isolated due to deficiencies that remained. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 124 certified bed facility was 103 at the time of the survey. The survey sample	F 000		

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

Electronically Signed | 03/29/2023

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F 000	Continued From page 1 consisted of 71 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be	F 550		4/23/23

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F 550	Continued From page 2 free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure the Resident's right to a dignified existence for 1 Resident (Resident #47) in a survey sample of 71 Residents. The findings included: For Resident #47, the facility staff failed to maintain dignity and assist Resident #47 with a meal on 3-1-23 resulting in Resident #47 sitting at a table with 2 other Residents observing them eat breakfast as she was unable to feed herself. On 3-1-23 at 8:00 A.M., Surveyor B observed Resident #47 sitting in a communal area on the nursing unit at a table with 3 other residents who were able to feed themselves. The residents were being served breakfast and eating while Resident #47 watched them eat with no meal in front of her. This dining observation was conducted from 8:30 A.M., until 9:35 A.M., when all of the food had been eaten by the other three residents, and Resident #47 had not been served nor assisted with a meal. No staff stayed in the room until 9:34 A.M. On 3-2-23, Resident #47's clinical record was reviewed. Resident #47's most recent quarterly Minimum Data Set with an Assessment Reference Date of 1-28-23 coded the Resident's	F 550	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or 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. 1) Resident # 47 is currently being observed to ensure that resident is being assisted with meals while others are eating. 2) All residents will be observed during mealtime to ensure a dignified experience. Any issues identified will be corrected as necessary at the time of observation. 3) All staff will be re-educated on resident dignity to include meal set up and feeding resident while other residents are eating or being fed. 4) The DON or designee will review 10% of patients who require assistance with meal set up and eating to ensure that resident is eating at the same time as others to ensure dignity is maintained 2 x	

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F 550	Continued From page 3 functional status for eating as extensive assistance on 1 staff member for eating. The Brief Interview for Mental Status was coded as severe cognitive impairment. The Resident's care plan was reviewed. There was a focus, goals, and interventions on the care plan associated with The Resident's nutritional status, however, the interventions listed that the Resident would be encouraged to eat in the dining room for lunch. No mention of communal eating was included in the care plan for breakfast or dinner. On 3-3-23 at approximately 5:00 P.M., the Administrator and Regional Registered Nurse Consultant were notified of findings. When asked about the expectation for meal service to table mates, and they both agreed that the Resident should not have been left there for an hour to watch others eat.	F 550	weekly x 12 weeks and report findings to QAPI committee. 5) Date of compliance April 23,2023	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 553		4/23/23

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F 553	Continued From page 4 (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation the facility staff failed to ensure the Residents right to participate in care planning for 2 Residents (#26 & # 82) in a survey sample of 71 Residents. The findings included: 1. For Resident # 26 the facility staff did not inform of and offer opportunity for RR (Resident Representative) to attend the care plan meetings since February 2022. On 2/28/22 at approximately 9:00 AM, an interview was conducted with Resident #26 who stated that he did not participate in care plan meetings. When asked why he did not participate, he stated he did not know when they were.	F 553	1) Resident # 26 was invited and participated in care-plan meeting on 3/7/23. Resident #82 was invited and participated in care-plan meeting on 3/7/23. 2) All residents are at risk of not being invited to attend care-plan meetings. A review of the last 3 months of care-plan meetings will be reviewed to ensure resident was invited to attend care-plan meeting. Any variance noted will have care-plan meeting scheduled and the resident is invited to attend. 3) Discharge planning department and MDS department will be re-educated on comprehensive care-plan policy to include resident invitation to care-plan meeting. 4) Administrator or designee will audit care-plan meeting invitations to ensure	

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F 553	Continued From page 5 A review of the clinical record revealed that Resident #26 was not his own RR due to his diagnoses. On 3/2/23 at 2:15 PM an interview was conducted with Employee G who stated that Resident #26 has not attended a care plan meeting "in a while". When asked about his Representative attending the care plan meetings, she stated that the facility has been a little "lax" on getting invitations to care plan meetings out to Resident Representatives. Resident #26's last care plan meeting invite was sent to his Representative in February of 2022. On 3/3/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #82, the facility staff failed to provide the opportunity for her to participate in her own care planning. On 2/28/23 at approximately 9:00 AM, Surveyor C conducted an interview with Resident #82 and asked if she participated in planning her care at the facility, to which Resident #82 replied, "I have never been asked or invited to attend any meetings about my care here, I would like to be involved". On 3/1/23, a review of Resident #82's clinical record was performed and revealed the most	F 553	resident was invited to participate in plan of care meeting weekly x 12 weeks and report findings to QAPI committee. 5) Date of compliance April 23,2023	

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F 553	Continued From page 6 recent MDS (Minimum Data Set), a quarterly review with an ARD (Assessment Reference Date) of 2/1/23, coded Resident #82 with a BIMS (Brief Interview of Mental Status) score of 15 out of 15, indicating no cognitive impairment. Resident #82 was documented as her own Responsible Party. Review of the clinical record also revealed care plan reviews conducted on 4/22/22, 7/29/22, 10/26/22, and 2/1/23, however there was no documentation indicating that Resident #82 was invited to participate with care plan meetings. On 3/1/23, an interview was conducted with the Social Services Director (SSD), which included a review of Resident #82's clinical record. The SSD verified the care plan reviews were conducted without Resident #82 in attendance and verified there was no evidence that Resident #82 had been invited to participate in her care planning since her admission on 4/22/22. The SSD stated, "We have had some turnover in our department and in the facility and we are trying to get back on track with things". On 3/2/23, the Facility Administrator was made aware of the findings. No further information was provided.	F 553		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of	F 565		4/23/23

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F 565	Continued From page 7 upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure grievances voiced in Resident Council and by six of six residents (R76, R104, R59, R67, R98, and R72) interviewed in the resident group meeting were acted upon in a timely manner and the Grievance Official responded to the resident group's concerns.	F 565	1) Residents #76, #59, #98, #72 no untoward effects noted. Meeting held with residents individually to discuss concerns on 3/30/23. Center will address grievances that have been voiced with timely follow up by the grievance officer. Resident #104, #67 □ no longer reside in the center. 2) All residents are at risk if grievances	

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F 565	Continued From page 8 Findings include: 1. Review of the facility's September 2022 to February 2023 "Resident Council Meeting" minutes, provided on paper by the Administrator, revealed several concerns were voiced several times over the last six months without evidence of follow-up and/or resolution presented to the Resident Council. These concerns included call bell response time, rooms not being cleaned consistently, and disrespectful treatment by staff. A. The 09/21/22 minutes documented the Administrator and five additional staff attended the meeting along with the resident council president and 12 additional residents. The minutes documented, "Reviewed last month's minutes." There was no evidence a review of the prior grievances and their corrective actions was presented. The minutes documented, "Residents had concerns of call bell response time." B. The 10/26/22 minutes documented the Administrator and eight additional staff attended the meeting along with the resident council president and 15 additional residents. The minutes documented, "Reviewed last month's business" with no further explanation of the information reviewed or who presented the information. Under Housekeeping was documented, "Rooms need more frequent cleaning." C. The 11/30/22 minutes documented the Administrator and eight additional staff attended the meeting along with the resident council president and eight additional residents. The minutes documented, "Reviewed last month's business. All concerns were followed up on: Staff	F 565	voiced in resident council are not followed up on in a timely manner. Grievances received in the last 3 months will be reviewed. Any outstanding concerns will be immediately addressed with timely follow up. 3) The Regional Director of Operations will re-educate Administrator, and Department managers on grievance process and timely follow up of resident concerns. 4) The Regional Director of Operations or designee will audit grievances and resident council meeting minutes to ensure concerns have been addressed and follow up has occurred by the grievance officer weekly x 12 weeks and report findings to QAPI committee. 5) Date of compliance April 23,2023	

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were in-serviced on residents being bathed in a timely manner. Housekeeping has been in-serviced on room cleaning schedule." Under Housekeeping was documented, "Rooms need more frequent cleaning," confirming the in-service training of housekeeping staff was ineffective at addressing the residents' grievance.

D. The 12/28/22 minutes documented the Administrator, Activity Director, Social Service Director, Director of Nursing, and Housekeeping Supervisor attended the meeting in addition to the resident council president and nine additional residents. Under Nursing was documented, "Residents had concerns of staff being on cell phones. Over hearing staff talking about their personal concerns" and under Housekeeping was documented, "Rooms not always being cleaned on a consistent basis. [Housekeeping Supervisor] made residents aware that she hired 3 more staff, and they were to start on 12/29/2022." There was no follow-up documented regarding concerns from the previous meeting, including rooms not being cleaned consistently.

E. The 01/25/23 minutes documented the Regional Clinical Registered Nurse (employee F), the Activity Director, the resident council president, and 14 additional residents attended the meeting. Under nursing concerns was documented, "Residents' [sic] states call bells are not answered in a timely manner. Nursing staff on cell phones while giving care. Evening and night staff talking loudly in hallways." Under Housekeeping was documented, "Rooms are not being cleaned daily." There was no follow-up documented regarding concerns from the previous meeting, including disrespectful treatment by staff and rooms not being cleaned

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consistently.

F. The 02/21/23 minutes documented the Administrator was in attendance along with the resident council president, six additional residents, and two social services staff. Under nursing concerns was documented, "3-11 [evening shift] staff not always being respectful." Though the Administrator presented information regarding filing grievances, contacting the Ombudsman, and the corporate compliance line, there was no follow-up documented regarding concerns from the previous meeting, including call light response time, disrespectful treatment by staff, and rooms not being cleaned consistently.

2. A resident group interview was held on 03/02/23 from 11:00 AM to 12:30 PM with six alert and oriented Resident Council representatives in attendance, including the resident council president.

A. Review of R76's quarterly "Minimum Data Set (MDS)" assessment with an assessment reference date (ARD) of 12/23/22, located in the "MDS" tab of the electronic medical record, revealed she scored 15 out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating no cognitive impairment.

B. Review of R104's significant change in status "MDS" with an ARD of 01/03/23 revealed she scored a 15 out of 15 on the BIMS, indicating no cognitive impairment.

C. Review of R59's quarterly "MDS" with an ARD

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of 01/27/23 revealed she scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

D. Review of R67's admission "MDS" with an ARD of 12/06/22 revealed he scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

E. Review of R98's annual "MDS" with an ARD of 12/31/22 revealed he scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

F. Review of R72's quarterly "MDS" with an ARD of 12/05/22 revealed she scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

During the resident group interview, all six residents (R76, R104, R59, R67, R98, and R72) reported they felt the concerns they voiced in Resident Council meetings were not always addressed and resolved by staff. R76 stated, "We don't feel like anything has been done to address our concerns" and the other five residents agreed. R104 stated the Administrator was "good at talking in circles . . . but does not address our concerns or give us any report on any follow-up. She will say they are working on it but nothing ever happens." The additional five residents agreed, and R67 stated, "There is no real response in Resident Council."

During the resident group interview, when reviewing concerns related to disrespectful treatment by staff, R59 stated she had a recent experience where a certified nurse aide (CNA) got upset with her when she had an incontinent episode, and she felt the staff attitudes had not improved. R104 stated the staff would fuss at her for using a bedside commode rather than the toilet, but this was because she was physically

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unable to use the toilet. R104 felt the staff attitudes had not improved. R76 stated there were still problems with staff being on their phones while providing care. R76 explained that often, the staff would enter her room while talking into their cell phone via an earpiece, and she would mistakenly believe they were talking to her. R76 stated the staff attitudes had not improved. All six residents agreed they often heard staff complaining of being short-staffed and overworked or other personal issues. All six residents reiterated they felt the staff continued to treat residents disrespectfully and they were not aware of any follow-up done to their repeated resident council grievances.

During the resident group interview, when reviewing concerns related to call light response time, all six residents agreed response to call lights had not improved. All six residents agreed the staff would complain they were short-staffed or had staff that did not show up. R104 stated, "It can take up to 30 or 40 minutes to answer call lights at times. Sometimes they turn off and say they will be back, but then don't come for a long time." The five other residents agreed. R76 added, "I'll have to sit on the toilet for up to 40 minutes because they take so long to answer the light" and R104 stated, "I've waited 10 minutes after calling for help to get out of the shower and get dried off. It's cold to wait so long so I've gotten to where I keep the water running until they come in."

During the resident group interview, when reviewing concerns related to inconsistent cleaning of resident rooms, all six residents agreed the rooms were not cleaned well, and this has been an ongoing problem. All six residents

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stated this had come up repeatedly in Resident Council, but was still an issue.

3. In an interview with the Administrator on 03/02/23 at 6:00 PM, any follow-up to the Resident Council's repeated grievances was requested. On 03/03/23, the Administrator provided paper records of staff trainings, which included:

A. Call bell response for nursing staff on 02/07/23

B. "Patient [and] Employee Experience - customer service module 2" for department heads on 02/03/23

C. "Customer Service" for nursing staff on 01/25/23

D. "Service excellence" for all staff on 01/19/23

E. Cleaning and floor care in December 2022 for environmental services staff
The Administrator did not provide any additional follow-up, written resolution to Resident Council grievances, or monitoring to ensure the training was effective.

In a concurrent interview on 03/03/23 at 7:30 PM with employee F and the Administrator, the Administrator stated the facility had implemented changes to improve call light response time, including managers assigned to answer lights during lunch and dinner when most staff were busy with the meal. The Administrator stated there was no documentation of this resolution and may not have been presented to the Resident

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Council because there were several meetings where she was not invited to attend. The Administrator stated the facility had implemented a program with the department heads to talk about positive attitudes, and the department heads were to present this information to their staff. In addition, there was training on service excellence. The Administrator stated there was no documentation of this resolution and may not have been presented to the Resident Council because there were several meetings where she was not invited to attend. The Administrator added that the housekeeping department had implemented a new cleaning schedule, implemented training, and hired new employees to address the residents' concerns of lack of consistent room cleaning. The Administrator stated this resolution may not have been presented to the Resident Council because there were several meetings where she was not invited to attend.

Review of the facility's policy for Resident Council revealed the facility provided the Centers for Medicare and Medicaid Services (CMS) December 2017 "Resident Council Interview" pathway. The pathway documented, "Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations?" and "Does the Grievance Official respond to the resident or family group's concerns?"

Review of the facility's 03/17/22 "Grievance Policy" revealed, "The Administrator is the designated grievance official . . . If a grievance is received by a staff member, the staff member receiving the grievance will record the nature and specifics of the grievance on the designated

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F 565	Continued From page 15 grievance form . . . The Grievance Official, or designee, will take appropriate steps to resolve the grievance promptly but no more than 30 days from the time the grievance is reported to the Center . . . All information about the grievance and any resulting actions will be recorded on the Grievance/Concern Form . . . The Grievance Official, or designee, will keep the patient appropriately apprised of progress towards resolution of the grievance . . . the Grievance Official, or designee, will issue a written decision on the grievance to the patient or representative at the conclusion of the investigation if requested."	F 565		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in	F 577		4/23/23

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F 577	Continued From page 16 areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to have the most recent survey readily accessible. One of one survey report binder was missing the survey ending 12/08/2022. The findings include: On 03/02/2023 at approximately 5:15 PM, the survey report binder located in the front lobby of the facility was reviewed. The review showed that the survey binder was missing the survey ending 12/08/2022. The facility was informed during an end of day meeting on 03/02/2023 during which the administrator stated that the binder in the lobby was the only one in the building.	F 577	1) Survey book was updated on 3/3/23 to include the survey results from the 12/8/22 survey. 2) All residents are risk if they are not able to access survey results. 3) The Regional Director of Operations will re-educate administrator on keeping survey book up to date with most recent survey results. 4) The Regional Director of Operations or designee will audit survey book to ensure the book remains up to date with survey results weekly x 12 weeks and report findings to QAPI committee. 5) Date of compliance April 23,2023	
F 583 SS=F	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		4/23/23

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F 583	Continued From page 17 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to ensure 1) staff knocked and waited for permission to enter the rooms of one of two residents (Resident (R)56) reviewed for privacy and 2) six of six residents (R76, R104, R59, R67, R98, and R72) interviewed in the resident group meeting; and 3) that electronic medical records (EMRs) were only accessible by staff members based on their need to know for all 103 facility residents. Findings include: 1. Review of R76's quarterly "Minimum Data Set	F 583	1) A: Staff are currently entering Residents #56, #76, #59, #98, #72 rooms after knocking and after given permission to enter room. Certified nursing assistant D re-educated on knocking and that resident is to give permission prior to entering a resident room. Resident #104, #67- no longer reside in center. B: No untoward effects noted to 103 residents with regards to access of medical information; facility immediately eliminated the staffs□ ability to access resident information when there was no need to know on 3/8/23 by eliminating the ability to save and/or share within the	

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F 583	Continued From page 18 (MDS)" with an assessment reference date (ARD) of 12/23/22 revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Review of R104's significant change in status "MDS" with an ARD of 01/03/23 revealed she scored a 15 out of 15 on the BIMS, indicating no cognitive impairment. Review of R59's quarterly "MDS" with an ARD of 01/27/23 revealed she scored 15 out of 15 on the BIMS, indicating no cognitive impairment. Review of R67's admission "MDS" with an ARD of 12/06/22 revealed he scored 15 out of 15 on the BIMS, indicating no cognitive impairment. Review of R98's annual "MDS" with an ARD of 12/31/22 revealed he scored 15 out of 15 on the BIMS, indicating no cognitive impairment. Review of R72's quarterly "MDS" with an ARD of 12/05/22 revealed she scored 15 out of 15 on the BIMS, indicating no cognitive impairment. During a resident group interview on 03/02/23 from 11:00 AM to 12:30 PM with the above six Resident Council representatives in attendance, all six residents stated the staff frequently failed to knock and wait for permission to enter their rooms. The residents stated they felt they had little privacy in the facility. 2. During an observation on 02/28/23 at 11:02 AM in R56's room, the resident was lying in bed and unable to respond appropriately to	F 583	EMR. C.N.A. F was re-educated on not accessing resident information without being assigned to resident or needing to know medical information to perform job duties. 2) A: All residents are at risk of not being provided personal privacy if staff enter room without being given permission to enter the room. B: All residents are at risk of not having confidentiality if resident information is accessed by staff without needing to know medical information to perform job duties. 3) A: The DON or designee will re-educate current facility staff on knocking on resident doors and waiting to be being given permission prior to entering resident room. B: The Administrator or designee will re-educate current facility staff on confidentiality, specific to access to resident electronic health record. 4) A: The DON or designee will conduct random rounds to ensure staff are knocking prior to entering resident rooms 3x week for 2 weeks then weekly x 2 then monthly x 2. B: The HR manager/designee will review new employee files weekly x 12 weeks to ensure workforce confidentiality has been reviewed with employee and signed form placed in file and findings will be reported to the QAPI committee. 5) Date of compliance April 23,2023	

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questioning due to advanced dementia. Certified Nurse Aide (CNA) D entered the room to provide care to R56 without knocking or announcing her presence.

Review of R56's undated "Profile," found in the "Profile" tab of the EMR, revealed she was admitted to the facility on 10/24/22 with diagnoses including dementia, glaucoma, legal blindness, insomnia, and muscle weakness.

Review of R56's significant change in status MDS assessment with an ARD of 02/18/23, located in the "MDS" tab of the EMR, revealed she scored two out of 15 on the BIMS indicating severely impaired cognition. R56 had severely impaired vision and was sometimes able to understand others. She did not exhibit any behavioral symptoms.

Review of R56's comprehensive "Care Plan," located in the "Care Plan" tab of the EMR and dated 11/06/22, revealed, "Res. [resident] wears eyeglasses, but her vision is severely impaired . . . and is legally blind" and, "Res. requires assist with her ADLs [activities of daily living] d/t [due to] imp. [impaired] mobility, imp. cognition, generalized muscle weakness, anemia, dementia, glaucoma, legally blind, [and] osteoarthritis."

Review of email from the Regional Clinical Registered Nurse, Employee F, on 03/03/23 at 5:20 PM, revealed the facility did not have a policy addressing resident privacy.

During a concurrent interview with the Administrator and Employee F on 03/03/23 at 7:30 PM, Employee F stated she expected the

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staff to knock and introduce themselves before entering residents' rooms.

3. The facility staff failed to uphold the confidentiality of the electronic health record of all 103 Residents residing in the facility in a manner to limit staff access to only the Resident information needed to perform their job duties.

On 3/5/23 at 6:11 PM, an interview was conducted with CNA F. CNA F was questioned about some documentation he had made into the clinical record of a Resident. CNA F explained that he had not cared for the Resident in question. When told he had completed the documentation, CNA F said, "I didn't do that, let me show you, we can document under anyone's name". CNA F then took Surveyor C to the computer at the nursing station and demonstrated how he was able to log into the clinical record using numerous staff member's access information that had been saved on the computer. CNA F then proceeded to say that staff just choose anyone's name to complete documentation and chart on Residents. CNA F further demonstrated that he could log-in under the access of an LPN and had access to the entire clinical record of every Resident.

On 3/6/23 at approximately 9:30 AM, Surveyor B and Surveyor C went to the nursing station. The surveyors were able to access the electronic health record of all Residents using various staff members credentials that were saved in the computer system. The CNA's had limited access to the clinical record but if log-in was made under a nurses name the entire clinical record could be seen/accessed.

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F 583	Continued From page 21 The facility staff provided a document titled, "State of Resident Rights". This policy was reviewed, and the following was noted, "...Right to privacy. Each resident has a right to: Privacy regarding their personal, financial, and medical affairs...". On 3/7/23 at 2:40 PM, during an end of day meeting held with the facility Administrator, Director of Nursing and Corporate Staff, the above findings were discussed and all parties in attendance confirmed this should not be happening. On 3/8/23 at approximately 9 AM, the facility Administrator confirmed they had validated that facility staff's log-in credentials were saved on several computers and staff were able to access the electronic health record of all Residents without any restrictions. The Administrator further stated that their IT [information technology] staff had corrected the issue. No further information was provided.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		4/23/23

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F 584	Continued From page 22 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to maintain an effective housekeeping program to keep the floors free from debris and pests for one of 37 residents (Resident (R) 56) rooms observed in Initial Pool and six of six residents (R76, R104, R59, R67, R98, and R72) interviewed in the resident group meeting.	F 584	1) Resident #56□s room cleaned on 3-9-23 and room free of debris and pests; resident□s room is being observed to ensure room is free from debris and pests. Resident #76, #59, #98, #72, and #67s□ rooms were cleaned of debris on 3 -9-23; residents□ rooms are being observed to ensure rooms are free from	

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F 584	Continued From page 23 Findings include: 1. Review of R56's undated "Profile," found in the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on 10/24/22 with diagnoses including dementia, glaucoma, legal blindness, insomnia, and muscle weakness. Review of R56's significant change in status "Minimum Data Set (MDS)" assessment with an assessment reference date (ARD) of 02/18/23, located in the "MDS" tab of the EMR, revealed she scored two out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating severely impaired cognition. R56 had severely impaired vision and was sometimes able to understand others. She did not exhibit any behavioral symptoms. Review of R56's comprehensive "Care Plan," located in the "Care Plan" tab of the EMR and dated 11/06/22, revealed, "Res. [resident] wears eyeglasses, but her vision is severely impaired . . . and is legally blind" and, "Res. requires assist with her ADLs [activities of daily living] d/t [due to] imp. [impaired] mobility, imp. cognition, generalized muscle weakness, anemia, dementia, glaucoma, legally blind, [and] osteoarthritis. During an observation on 02/28/23 at 1:55 PM, R56 was observed lying in bed in her room. On the floor behind the head of the bed was a piece of candy with many small black ants swarming on it and crawling in a line on the floor along the baseboard behind R56's bed. R56 was unable to answer questions regarding the cleanliness of her	F 584	debris and pests. Resident #104- no longer resides in center. 2) All residents are at risk if room is not maintained with a clean and homelike environment. 3) Administrator or designee will re-educate housekeeping and maintenance on maintaining rooms to be a safe/clean/comfortable home like environment. 4) Administrator or designee will audit rooms to ensure rooms are kept free of debris and pests 3x week for 2 weeks then weekly x 2 then monthly x 2. Findings will be reported to the QAPI committee. 5) Date of compliance April 23, 2023	

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room, responding "help me" to any questioning.

During observations in R56's room on 03/01/23 at 9:00 AM, 10:11 AM, and 12:33 PM; on 03/02/23 at 10:32 AM and 3:50 PM; and on 03/03/23 at 9:21 AM, the candy was still present on the floor behind the head of R56's bed, with a swarm of ants on the candy and crawling along the wall in a line to and from the candy.

In an interview and concurrent observation in R56's room on 03/03/23 at 11:03 AM, the housekeeper assigned to R56's room, employee J, stated there was candy on the floor with ants on and around it. Employee J picked up the piece of candy and threw it away. Employee J stated the candy must have been dropped today, as he cleaned behind the beds every day. Employee J stated, "I get upset when things are on the floor like that . . . they need to keep it clean . . . The floors need to be kept very clean otherwise you get bugs."

In an interview with the Employee K, Housekeeping Supervisor, on 03/03/23 at 12:18 PM, she stated the floors in every room were to be cleaned daily and there was a deep cleaning schedule as well where furniture would be moved, and the entire floor cleaned. Employee K stated she did walk-throughs on each unit at the end of the day to verify daily cleaning was done. She was not aware of the candy with ants on the floor of R56's room from 02/28/23 to 03/03/23.

2. Review of R76's quarterly "MDS," with an ARD of 12/23/22, revealed she scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

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Review of R104's significant change in status "MDS," with an ARD of 01/03/23, revealed she scored a 15 out of 15 on the BIMS, indicating no cognitive impairment.

Review of R59's quarterly "MDS," with an ARD of 01/27/23, revealed she scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

Review of R67's admission "MDS," with an ARD of 12/06/22, revealed he scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

Review of R98's annual "MDS," with an ARD of 12/31/22, revealed he scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

Review of R72's quarterly "MDS," with an ARD of 12/05/22, revealed she scored 15 out of 15 on the BIMS, indicating no cognitive impairment.

During a resident group interview on 03/02/23 from 11:00 AM to 12:30 PM with the above six Resident Council representatives in attendance, all six residents stated their rooms were not cleaned well and often their floors remained dirty, and this a problem brought up by the resident council on several occasions but has not been corrected by the facility staff.

Review of the facility's undated "5-Step Daily Room Cleaning" policy revealed, "The entire floor must be dust mopped - especially behind dressers and beds . . . move all furniture to dust mop . . . all corners and along all baseboards must be dust mopped to prevent build up . . . The most important area of a patient's room to disinfect is the floor. This is where most air-borne

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F 584	Continued From page 26 bacteria will settle and so it needs to be sanitized daily . . . move all furniture necessary and run the mop along the edges first."	F 584		
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 observation, interview, clinical record review, the facility staff failed ensure freedom from neglect for 1 Resident (#16) in a survey sample of 71 Residents. The findings include: For Resident #16 the facility staff neglected to provide care which resulted in the Resident being left to sit in a Geri chair (medical style recliner) for a prolonged time, which exceeded 9 hours. As a result, Resident #16 developed a deep tissue injury. On 2/28/23 at approximately 9:00 AM, Resident	F 600	1) Resident #16, FRI submitted on 3/27/2023. LPN C no longer employed with the center. C.N.A F re-educated on resident care needs during a room transition. 2) All residents will be individually observed to ensure appropriate care needs and services are being provided. Any issues will be corrected at the time of observation. 3) Corporate Designee will re-educate current facility staff on process for room transitions to include communication to other departments and resident care needs during transition.	4/23/23

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F 600	Continued From page 27 #16 was observed to reside in room [number redacted] and was on droplet precautions as identified by signage on the door. Staff interviews confirmed that Resident #16 was under quarantine for COVID-19. On 2/28/23 at 10:12 AM, Resident #16 was noted to no longer be in room [number redacted] and the signage had been removed from the door alerting to droplet precautions. An interview was conducted with the unit manager/LPN D. The unit manager stated that Resident #16 was being moved back to the room he was in previously, due to his quarantine period had ended at mid-night. On 2/28/23 at approximately 1:00 PM, Resident #16 was observed in a Geri chair in the day room. The assigned room that Resident #16 was moving to was observed and it was noted there was not a bed in the room for Resident #16. Resident #16 was not able to be interviewed and didn't respond when spoken to. On 2/28/23 at approximately 3:30 PM, Resident #16 was observed to still be sitting in a Geri chair in the day room and again did not respond to questions. The observation revealed the assigned room did not have a bed in the room. LPN C was questioned about Resident #16 being in the Geri chair in the day room and no bed being in the room. LPN C responded that she would call to get them to bring the bed from the other unit. Review of the clinical record of Resident #16 revealed the following: Resident #16 had diagnoses of, but not limited to: Dementia and Hemiplegia and hemiparesis following	F 600	4) The DON or Designee will conduct 5 random patient interviews regarding abuse resident care needs and observe for neglect 3x a week for 2 weeks, then weekly x 2 then monthly x 2 and report findings to the QAPI committee. 5) Date compliance April 23, 2023	

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cerebrovascular disease affecting right non-dominant side. Resident #16's care plan indicated the Resident was incontinent of bowel and bladder. The care plan also identified that Resident #16 was "at risk for skin breakdown". Review of the interventions to prevent skin breakdown included but were not limited to: "Encourage frequent position changes for pressure relief, observe for moisture and incontinence issues that affect skin. Report for further assessment if noted and provide pressure reduction surfaces as ordered/indicated".

On 3/1/23 at approximately 10:00 AM, an interview was conducted with Resident #26, who was now Resident #16's roommate. Resident #26 presented to be alert and oriented. When asked what time Resident #16 got moved into the room, Resident #26 said, "It was real late". When asked several questions to elicit a time, Resident #26 said, he had eaten his supper, it was dark outside and then said it was around 9-10 PM.

On 3/1/23 during the late morning, an interview was conducted with LPN C, who was the nurse assigned to Resident #16 following the room change on 2/28/23. LPN C was asked about the room change process and said that the nursing staff move the Resident and their belongings. LPN C confirmed that she worked over on 2/28/23, and at the time she left around 5 PM, Resident #16's bed still had not been moved. Review of the timecard revealed LPN C left at 5:06 PM on 2/28/23.

On 3/1/23 at 10:31 AM, an interview was conducted with Employee M/Maintenance Associate. Employee M stated he had been asked by nursing staff to move a bed into a room

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for Resident #16 on 2/28/23. He indicated that it was not brought to his attention until about 6 PM that evening. He then moved a bed into the room and advised nursing that it was available and needed to have sheets put on it.

On 3/5/23 at approximately 4 PM, an interview was conducted with CNA F. CNA F confirmed that he was not the assigned CNA for Resident #16 on 2/28/23, that the assigned CNA had to leave mid-shift. CNA F said that when he went on break at 8 PM, Resident #16 was still sitting in the day room and had not been put to bed.

On 3/6/23 an interview was conducted with the Wound Care Physician (WCP). The WCP confirmed that Resident #16 had developed a deep tissue injury to the back of his calf.

On 3/7/23, an interview was conducted with the Corporate Nurse/Employee F. The corporate nurse consultant confirmed that Resident #16 had developed a deep tissue injury that was consistent with him being left sitting in a Geri-chair for an extended period.

A review of the facility policy titled; "Abuse Prevention" was conducted. This policy defined neglect as, "Neglect: the failure of the Center, its employees or any service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress".

On 3/3/23 and again on 3/7/23, during an end of day meeting, the facility Administrator and Corporate Nurse consultant were made aware of the above findings and reported this was unacceptable.

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F 600	Continued From page 30 No further information was provided.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		4/23/23

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F 656	Continued From page 31 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to develop a comprehensive dental care plan for one Resident (Resident #48) in a survey sample of 71 residents. The findings included; For Resident #48, the facility staff failed to include the problems, interventions and goals to address the Resident's ongoing dental care. Resident # 48's most resent MDS (Minimum Data Set) with an Assessment Reference Date of 2-2-23 was coded as a Quarterly assessment. The Brief Interview for Mental Status was coded as "12" out of possible "15" indicating very mild cognitive impairment. On 3-1-23 the Resident was interviewed by Surveyor B. The Resident complained of dental problems and stated he had seen the dentist, and was eating soft food, but wanted to start having regular dental care appointments. The Residents weight history was reviewed and	F 656	1) It is noted that facility staff failed to develop or implement a comprehensive care plan for Resident #48. Care plan has been updated to include a dental care plan. 2) MDS Nurse /Designee will audit current resident care plans to ensure a dental care plan is in place as indicated based on the most recent MDS assessment. 3) Clinical Reimbursement Specialist will educate MDS Nurses on completion of care plans associated with the completion of any comprehensive MDS assessment. Care plans will be completed within 7 days of Care Area Assessment completion for comprehensive assessments. 4) MDS Nurse / Designee will audit 10 resident care plans for accuracy based on MDS assessment and active care needs weekly x 4 weeks and then monthly x 2 months and report findings to the QAPI committee. 5) Date compliance April 23, 2023	

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F 656	Continued From page 32 in 6 months the Resident had experienced weight loss, however, not significant, and was stable for 5 months. Dental consult exam notes were reviewed and revealed a Dental doctors orders for; "brushing of teeth and tongue twice daily morning and evening due to plaque and calculus build up, with follow up dentist cleaning every 4 months, and exam every 6 months." The dentist also recommended fluoride varnish due to high risk for caries. On 3-2-23 the clinical record for Resident #48 was reviewed and no dental care plan could be found. The nursing progress notes, physician progress notes, as well as dental progress notes documented that the Resident had been seen by a dentist in January 2023, and needed to be scheduled to return on regular appointments, however, there was no dental care plan in the clinical record to guide daily dental care, nor to plan for continuity of care. On 3-2-23 at 3:10 p.m., Surveyor B conducted an interview with LPN (Licensed Practical Nurse) H who stated the facility staff should follow the care plans and that care plans should be individualized for each resident and updated as needed. On 3-3-23, during the end of day debriefing at 5:50 P.M., the Administrator and Corporate Registered Nurse Consultant were informed of the findings. No further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		4/23/23

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F 657	Continued From page 33 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation the facility staff failed to review and revise care plans to include changes in resident care for 2 Residents (#65 and #15) in a survey sample of 71 Residents. The findings included: 1. For Resident #65 the facility staff failed to revise the care plan after a verbal abuse	F 657	1) Resident #65□s comprehensive care plan was updated to include request not to have a particular nurse assigned to provide care. The nurse in question is no longer employed at the center. Resident #15 no longer resides in center. 2) a. All residents who have made allegations of abuse could be affected by lack of a related care plan to address the situation. All patients with wounds could	

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F 657	Continued From page 34 allegation, to include LPN C not being assigned to Resident #65. On 3/2/23 at 12:15 PM Resident #65 was again observed in bed with her privacy curtain closed, an interview was conducted with Resident #65 who stated that on LPN C was rude to her. The Resident explained the incident and stated that the facility had stated that she would not have LPN C as her nurse anymore, however she continued to pull her medications and give them to another nurse to administer, causing Resident #65 to be concerned about her "messing with" her medications. Resident #65 also stated that when she got a roommate, LPN C was assigned to the roommate. On 3/3/23 a review of the facility investigation revealed the following excerpts: "Based on an investigation including resident and staff statements, we were unable to substantiate that abuse occurred. Our center values service excellence, so in an abundance of caution the center provided customer service education to the staff member prior to her returning to the center. In addition [LPN C name redacted] will not provide care to [Resident 65 name redacted]. Her care plan has been updated and revised." On 3/3/23 a review of the Resident care plan did not reveal any revision related to this matter. On 3/3/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657	be affected by not having a wound care plan created and implemented in a timely manner. b. All residents are at risk and will be reviewed to determine the need for changes in care plan related to any voiced preferences or special requests. c. All residents who have wounds will be audited by the Wound Nurse to ensure they have an appropriate care plan in place and implemented. d. MDS Nurses or designee will review all residents identified as at risk for skin breakdown on their most recent MDS to ensure care plan has potential for skin breakdown in place. 3) The DON or designee will educate the Wound Nurse and Social Services on initiating, reviewing, and revising active wound or abuse care plans. The Clinical Reimbursement Specialist will educate MDS Nurses on identifying and care planning patients at risk for potential or actual skin breakdown/pressure ulcers at the time of completing a MDS assessment. 4) MDS Nurse / Designee will audit 10 resident care plans to ensure care plans have been revised on a timely basis weekly for 4 weeks, then monthly x 2 and report findings to the QAPI committee. 5) Date compliance April 23, 2023	

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2. For Resident #15 the facility staff failed to revise care plan to include interventions for pressure ulcer prevention and treatment.

On 2/28/23 a review of the clinical record revealed that Resident # 15 had a pressure area to her sacrum that was facility acquired. According to facility documentation entitled "Skin and Wound Assessment V5.0" dated 3/1/23 at 6:13 AM, Resident #15 had a stage IV pressure area to the sacrum that was in house acquired, first identified on 11/9/22.

On 3/1/23 at approximately 10 AM an observation was made of the stage IV pressure area to the sacrum

The wound doctor was consulted on 11/28/22 and measured the wound as 2.9 cm x 1.9 cm x 0.4 cm and described it as 100% necrotic devitalized tissue and performed surgical debridement at that time.

On 3/1/23 a review of the care plan revealed no mention of a wound or wound care or interventions to prevent pressure areas from developing.

On 3/1/23 at 9:00 AM, an interview was conducted with LPN F who stated that "Care plans should reflect anything that is required to care for the Resident." When asked if a newly discovered wound should be added to the care plan, she stated that it should. She stated that the care plans should be updated with any changes in care or condition of the Resident.

A review of the facility policy # CL.2105, entitled " Pressure Injury and Prevention Guidelines"

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revealed the following excerpts:

"1. Individualized interventions will address specific factors identified in the patient's risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics).
2. The goal and preferences of the patient and/or legal representative will be included in the plan of care.
3. Interventions will be implemented in accordance with physician/physician extender orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them."

On 3/3/23, during the end of day meeting, the acting DON was asked if the care plan should reflect the presence of a wound and associated wound care and interventions, she stated that it should. When asked why this information was not in Resident #15's care plan she stated that it was. She then showed the surveyor a care plan that read as follows:

"Focus"
"Is at risk for skin breakdown pressure injury to sacrum and right heel Date Initiated: 12/19/2022 Created on: 12/19/2022."

On this copy of the care plan, there were interventions entered for the same date. When the acting DON was questioned about why the copy of the care plan the survey team obtained did not mention the wound or interventions, she stated that it had been marked as "Resolved" in Jan and she (the DON) had just "Reactivated it in the system." However, the care plan focus and

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F 657	Continued From page 37 interventions were dated 12/19/22 and the wound was identified on 11/9/23 indicating that the care plan was not updated, until over a month later, and was discontinued too soon before the wound healed as evidence by the observation of the wound on 3/1/23 at 10 am. On 3/3/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to follow standards of nursing practice with regards to following physician orders for one Resident (Resident #16) in a survey sample of 71 Residents. The findings included: For Resident #16 the facility staff failed to provide daily treatment to a pressure wound as ordered by the physician for a period of 11 weeks. Review of the clinical record revealed that on 12/18/22, Resident #16 was seen by the wound care physician. This physician noted that Resident #16 had "... a stage 3 pressure wound of the left arm for at least 1 day	F 658	1) Resident #16□s physician orders updated to include current treatment order for stage 3 pressure ulcer to left antecubital space. 2) Current residents have the potential to be affected by this deficient practice. A 7-day look back review was completed to ensure proper transcription of new provider orders. 3) DON or Designee will re-educate current licensed nurses on proper transcription of provider orders. 4) DON or designee will randomly review 10 residents□ new provider orders to ensure accurate transcription 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee.	4/23/23

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F 658	Continued From page 38 duration...Dressing Treatment Plan: Primary Dressing(s) Leptospermum honey apply once daily for 30 days; Alginate calcium apply once daily for 30 days Secondary Dressing(s) Gauze Island w/ bdr [with border] apply once daily for 30 days...". However, review of the Treatment Administration Record revealed the order by the wound care physician was entered as "Cleanse left antecubital space skin tear with NS/WC [normal saline/wound cleanser], apply Medi honey, alginate and cover with a dry dressing. every day shift every other day for Skin Tear...". This treatment was performed every other day from 12/14/22-12/30/22, and on 1/1/23, for a total of 10 occurrences versus the daily treatment that the wound specialist ordered. On 1/2/23, the wound care physician saw Resident #16 and noted the following orders, "...Dressing treatment plan: Primary Dressing(s) Alginate calcium w/[with] silver apply once daily for 30 days Secondary Dressing(s) Gauze Island w/ bdr [with border] apply once daily for 15 days..." However, review of the Treatment Administration Record (TAR) for January revealed the above order from 1/2/23, was transcribed to the TAR as, "Cleanse left antecubital space skin tear with NS/WC. apply silver alginate and cover with a dry dressing every day shift every other day for Skin Tear". This treatment was administered every other day from 1/3/23-1/31/23, for a total of 15 treatments. In February 2023, the treatment continued every other day for a total of 15 Administrations/treatments.	F 658	5) Date of compliance April 23, 2023	

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F 658	Continued From page 39 This wound continued to deteriorate as evidenced by the wound care physician noting in a progress note dated 2/27/23, that the Resident had "... a stage 4 pressure wound of the left arm for at least 66 days duration. There is moderate serous exudate....". On 3/6/23, during the afternoon, an interview was conducted with the wound care physician. During the interview, when asked about his expectation regarding treatments ordered for wound care, the physician stated he expects them to be carried out as ordered with regards to frequency. When Resident #16 was discussed, the physician stated he was not aware that the facility staff had not been providing the treatments daily as ordered. The Corporate Nurse Consultant cited Lippincott as their nursing professional guidance used by the facility. "Fundamentals of Nursing, by Lippincott", stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." During an end of day meeting held, the facility Administration was made aware of the above findings. They responded that the notation of the wound being a skin tear was in error. No further information was provided.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an	F 660		4/23/23

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effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's

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F 660	Continued From page 41 comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to develop discharge plans for one Resident (Resident # 113) in a survey sample of 71 Residents. Findings included:	F 660	1) Resident #113 no longer resides in the facility. 2) Current residents have the potential to affected by this deficient practice. Review of the last 14 days of resident discharges will be reviewed to ensure discharge plans	

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F 660	Continued From page 42 Review of the clinical record was conducted on 3/2/2023. Review of the Progress Notes and care plans revealed no documentation of discharge plans for Resident # 113. Review of the Progress Notes revealed that Resident # 113 did not return to the facility after an outing with his wife. Review of the care plan revealed no documentation of discharge plans for Resident # 113. On 3/3/2023 at 12:24 p.m., an interview was conducted with the Social Services Director who stated # 113 did not return to the facility after going on leave with family. The Social Services Director stated that discharge plans should be developed for residents. During the end of day debriefing on 3/3/2023, the facility Administrator and Corporate Nurse Consultant were informed of there findings. No further information was provided.	F 660	were developed. 3) Administrator or designee will re-educate social work department regarding development of discharge plans per policy. 4) Administrator or designee will audit anticipated discharges to ensure discharge plans have been completed weekly x 12 weeks and report findings to QAPI committee. 5) Date compliance April 23, 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 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide services	F 677	1) Resident #98 nail care and shower provided on 3/28/23. 2) All residents will be observed to	4/23/23

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F 677	Continued From page 43 to maintain personal hygiene for 1 Resident (#98) in a survey sample of 71 Residents. The Findings included: For Resident #98, the Resident's fingernails were 1/2 inch long with brown hard debris under them. On 3-1-23 the Resident was interviewed, and complained that his nails were too long and stated no one would cut them for him. He stated that staff normally do it when he got bathed, but stated that bathing had not happened lately either. Resident #98 had an annual minimum data set assessment dated 12-31-22 which coded the Resident with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. The Resident was incontinent of bladder and bowel, and required one staff assistance for bathing. The document also denoted that the Resident had no aberrant behaviors and did not refuse care. On 3-3-23 Resident #98's activity of daily living care records were reviewed and indicated that the Resident had been bathed only twice in 20 days, (almost 3 weeks) from 2-12-23 through 3-3-23. The Resident was documented that his bathing shift was 7:00 A.M. to 3:00 P.M. shift. Resident #98's care plan was reviewed and revealed that the Resident was to receive assistance with bathing and hygiene care daily and as needed. The Administrator and Regional Registered Nurse were notified of the lack of hygiene nail care for	F 677	determine the need for nail care and if showers have been provided. Any issues will be addressed at the time of observation. 3) DON or designee will re-educate current licensed nurses and certified nursing assistants on nail care policy and ADL care policy related to showers. 4) DON or designee will randomly audit 10 residents to ensure nail care and showers provided 3x week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date of compliance April 23,2023	

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F 677	Continued From page 44 Resident #98 at the end of day meeting on 3-3-23. No further information was provided by the facility.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, the facility staff failed to provide needed care and services that are resident centered, according to resident's preferences, goals for care that meet the resident's physical, mental, and psychosocial needs for 2 Resident (#26 & 104) in a survey sample of 71 Residents. The findings include: 1. For Resident #26 the facility staff failed to coordinate care to include a neurology consult for a Resident with epilepsy and traumatic brain injury with a ventriculoperitoneal shunt (a device that drains excess cerebrospinal fluid from the brain to the stomach). Resident #26 has diagnoses that include but are not limited to Diffuse Traumatic Brain injury, concussion, post-concussion syndrome,	F 684	1) Resident #26, no untoward effects. Neurology appointment scheduled for 3/7/23 was rescheduled for 5/3/23 due to an insurance denial. Resident #104 no longer resides in center. 2) All residents admitted in the last 30 days will be reviewed to identify recommended consultations and to ensure an appointment has been scheduled. Any issues will be corrected at the time of identification. 3) The DON or designee will re-educate licensed nurses on process for scheduled resident appointments. 4) The DON or designee will audit 10% of resident medical records to ensure the follow up appointments are made per physician orders and report findings to the QAPI committee. 5) Date of compliance April 23,2023	4/23/23

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presence of cerebrospinal fluid drainage device (Ventriculoperitoneal shunt), epilepsy, post traumatic headache, cerebellar ataxia (poor muscle control causing spastic movements) from TBI (Traumatic brain injury) migraines and hypertension.

On 02/28/23 at 09:41 AM, an interview was conducted with Resident #26 who stated that he has a shunt in his head. He stated that he was assaulted. He stated that he is concerned that his shunt "may be clogged." When asked if he has headaches, nausea or vomiting or if he feels bad, he stated that he feels ok, but it's been a long time since it has been checked and I feel a lot of stuff draining at night." When asked if he remembers when the last time, he saw the neurologist he stated he felt it was at least a year.

02/28/23 at 01:47 PM a review of clinical record revealed a computerized tomography (CT) scan of Resident #26's head in 2021 that occurred while he was hospitalized for another issue. At that time there were changes in the scan from the previous year (May 2020), however the neurologist felt the changes were not consistent with clogged shunt.

On 3/2/23 a review of the clinical record revealed the only mention of Resident #26 having a shunt are in reference to behaviors. The following are excerpts from the care plan:

"FOCUS:"
"... Has dx- TBI, VP Shunt,...Date initiated 1/9/20 revisions 6/4/20."

INTERVENTIONS:
"Consult VCU Neurology as needed created

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5/20/20."

During the end of day meeting on 3/3/23 an interview was conducted with the Acting DON who stated that she was not aware of Resident #26's need of a follow up and would research it and get back to the team on Monday.

On 3/6/23 at approximately 10:00 AM an interview was conducted with the Acting DON who stated that she did not see any appointments with VCU or any neurology consults since 2021. She stated that she did call around and get him an appointment for the following day.

The following are excerpts from the progress notes for Resident #26:
"3/6-23 at 1:19 PM spoke with resident to today regarding him requesting neurology appointment to be set up resident states that he doesn't feel bad, but notices increased drainage down the back of his throat at night time. He also stated that he is scared that his shunt may be clogging. Resident is not having any nausea or vomiting no headaches and vital signs are stable at this time. Neurology appointment made for 3-7-23 at 3:30pm at [physician name redacted] resident made aware of appointment tomorrow."

3/7/23 at 12:06 PM Social Service Note: Spoke with [name redacted] at [Hospital name redacted] Neurology Dept who informed me that [Resident #26's name redacted] appt scheduled for today at 3:30 would have to be canceled because they are no longer in network with his insurance company. Social Services will continue to look for an in-network provider to reschedule appt with."

3/7/23 at 12:42 PM Resident has appointment

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related to Presence of Cerebrospinal Fluid Drainage Device with [neurology practice name and phone number redacted] on May 3, 2023."

On 3/8/23 at 2:39 PM an interview was conducted with the medical director who stated that he would expect the care plan to outline how often the shunt should be followed up, and signs and symptoms to look for if the shut were to clog. When asked about the frequency that the follow up appointments should be he stated that it would depend on the neurosurgical team and the family. He stated if it was a 65-year-old Resident, and they didn't want to follow up or the family didn't want to pursue care that the family and Resident's decision. When he was informed this was a 49-year-old Resident who expressed concern that something could be wrong with his shunt, he stated that the facility should have something in the documentation about how often it should be followed up on with neurology and neurosurgery. He stated that the risks involved with not following up is shunt clogging and infection increased intracranial pressure encephalopathy and even death.

On 3/8/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #104, the facility staff failed to coordinate care and arrange for a gynecology consultation in response to the identification of a cyst/mass and as ordered by the physician.

Review of the clinical record for Resident #104 revealed the Resident had been admitted to the

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facility following a hospitalization on 11/9/22. Review of the hospital records, that had been uploaded into Resident #104's clinical record, the discharge summary noted, "... Left ovarian mass/cyst. Tumor markers negative. Pelvis ultrasound demonstrating an 8.7 x 6.3 x 8.3 cm largely cystic lesion in the right adnexa. Follow-up with gynecology in the outpatient setting".

Resident #104 had frequent progress notes from the medical providers overseeing her medical care while a Resident of the facility. The encounters with the medical providers (doctor and/or nurse practitioner), progress notes were written in Resident #104 medical record on 26 occasions from 11/9/22-2/27/23. Each of these notes indicated that assessment of the genitourinary (GU) system, (which consists of kidneys, urinary tract, and reproductive tract) was deferred, which indicated it was not assessed. The notes further read, "Left ovarian mass/cyst, tumor markers done in hospital. She is supposed to follow-up with gynecology after discharge".

On 3/6/23, in the afternoon, an interview was conducted with Resident #104. Resident #104 stated she had not seen a gynecologist in over 20 years, since she had her hysterectomy. When asked about the ultrasound findings in the hospital, Resident #104 was unaware of the findings. Resident #104 verbalized to the surveyors that she would like to see someone to see what is going on and what her treatment options are.

On 3/6/23 at 3:52 PM, an interview was conducted with the nurse practitioner (NP), who was the author of over 20 of the progress notes in Resident #104's chart indicating gynecology

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follow-up was needed. The nurse practitioner said that she was more focused on the Resident's "issues that were more pressing, and we weren't focused on that". The NP went on to say that the Resident was supposed to be discharged and after she was not discharged, this follow-up had slipped through the crack. The NP also stated, when Resident #104 didn't discharge in December 2022, as planned, the facility should have proceeded with arranging for a gynecology appointment.

On 3/8/23 at 2:38 PM, an interview was conducted with the facility's medical director. The medical director was asked about Resident's being seen/followed-up by specialist and was given the details in Resident #104's hospital discharge summary. The Medical Director confirmed that Resident #104 needed to be seen so that they could determine what the mass/cyst is and determine treatment options.

A facility policy regarding outside appointments and/or physician consultations was requested. The facility stated they didn't have such a policy to provide.

On 3/3/23, during an end of day meeting, the facility Administrator and Corporate Clinical Consultant were made aware of the above findings. Following the above notification, the facility staff entered a nursing note that they had spoken with the NP and a gynecology appointment was not needed.

On 3/6/23, during the end of day meeting, the facility Administration was made aware of Resident #104's request for follow-up. On 3/7/23, the facility provided a nursing note that had been

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F 684	Continued From page 50 entered into Resident #104's clinical record that they had reached out to a gynecologist and were awaiting a return call. No additional information was received.	F 684		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to conduct timely assessment and identification of pressure wounds for four of four residents (Resident (R) 75, R39, R16, R15) reviewed for pressure sores until the wounds had progressed to advanced stages (stage III - full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia; stage IV - a deep wound reaching the muscles, ligaments, or bones which often causes extreme pain, infection, invasive surgeries, or even death). Immediate Jeopardy was called on 03/01/23 at	F 686	1) a. Resident #75 no longer resides in center. Resident #39□s body audit completed on 3/8/2023 and areas of current skin impairment assessed, treatment implemented per physician order, and care plan reviewed and revised. Resident #16□s body audit completed on 3/8/23 and areas of current skin impairment assessed, treatment implemented per physician order, and care plan reviewed and revised. Resident #15 no longer resides in the center. b. Resident #16□s pressure injury	4/23/23

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F 686	Continued From page 51 5:08 PM. The Immediate Jeopardy began on 11/11/22, when R15 was noted with an open area on the sacrum that was assessed on 11/28/22 with 100% necrotic tissue that required surgical debridement. The Immediate Jeopardy was removed on 03/09/23 at 12:02 PM. Deficiencies remain at a level 2 isolated including for Resident #16, the facility staff failed to provide care and position changes for an extended period (9 hours) which resulted in the development of a Deep Tissue Injury. Findings include: 1. R75 developed multiple avoidable pressure ulcers. Review of R75's undated "Profile," located in the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on 10/11/22 with diagnoses including encephalopathy, protein-calorie malnutrition, respiratory failure, anxiety, and muscle weakness and atrophy. Review of R75's significant change in status "Minimum Data Set (MDS)" assessment, with an assessment reference date (ARD) of 02/17/23, revealed she scored 6 of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. She did not exhibit any behavioral symptoms, including rejection of care. R75 required extensive assistance by two staff with bed mobility and was totally dependent on staff for personal hygiene, and bathing. R75 was at risk of developing pressure ulcers and had one stage II, one stage III, one stage IV, and one deep tissue injury. R75 was receiving hospice	F 686	resolved on 3/13/23. 2) a. All residents that need assistance with positioning will be observed to ensure appropriate positioning needs are being met. Any issues will be corrected at the time of observation. Skin observations were conducted on 3/8/23 to identify any additional new areas of impairment. A review of new admission skin impairments from 3/8/23 will be completed to ensure that appropriate identification of pressure ulcers occurred. 3) a. The DON or designee will re-educate current licensed nursing staff on timely identification of pressure injuries, body audit policy and admission skin observation process. b. The DON or designee will re-educate current facility staff in recognizing when residents have remained in one position for an extended time. 4) a. The DON or designee will randomly audit 10 body audits to ensure proper identification and staging of skin impairment weekly x 12 weeks and report findings to the QAPI committee. b. The DON or designee will randomly audit residents to ensure positions are being changed timely 3x week x 2 weeks, then weekly x 2, then monthly x 2 and report findings to QAPI committee. 5) Date of compliance April 23,2023	

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services.

Review of R75's 01/02/23 "Care Plan," found in the "Care Plan" tab of the EMR, revealed R75 was at risk for skin breakdown and currently had open areas to her right buttocks, sacrum, and right lateral heel and deep tissue injuries on her right ankle. The interventions included: "Air mattress to bed . . . Assess skin thoroughly and implement precautions and/or treatment as indicated . . . Consult wound MD [physician] as needed . . . Encourage frequent position changes for pressure relief . . . Encourage patient to allow heels to be floated while in bed . . . Observe for moisture and incontinence issues that affect skin. Report for further assessment if noted . . . Off-laoding [sic] boots while in bed . . . Provide pressure reduction surfaces as ordered/indicated . . . [and] Provide treatments as ordered. Report unusual change or decline in skin integrity."

Review of R75's 01/17/23 "Unavoidable Skin Breakdown" worksheet, provided in a "soft file" for R75 on paper by Employee F, revealed "Resident hospice [with] expected decline" and was completed by Licensed Practical Nurse (LPN) E. The form documented, "In reviewing this resident, I believe the pressure sore(s) meet the criteria to be unavoidable" and was signed by a physician. There was no evidence or rationale documented on the form to indicate why the resident's skin breakdown was unavoidable, other than she was receiving hospice care. Review of R75's physician "Progress Notes," located in the "Documents" tab of the EMR, revealed no indication the physician assessed the resident and determined her skin breakdown was unavoidable. NOTE: a soft file is a group of documents that are not part of the official clinical

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record.

Review of R75's 02/24/23 "Body Audit," located in the "Assessments" tab of the EMR, revealed she had a pressure ulcer to her right buttock, a pressure ulcer to her sacrum, and unidentified skin issues to her right heel and ankle.

Review of R75's 02/28/23 physician's "Orders," found in the "Orders" tab of the EMR, revealed she was receiving daily wound treatments to her right buttock, sacrum, right heel and was receiving application of skin prep (a liquid film-forming dressing that forms a protective film to help reduce friction during removal of tapes and bandages) to her bilateral outer ankles and bilateral heels.

Observation in R75's room on 02/28/23 at 11:46 AM revealed the resident was lying in bed. Though her eyes were open, she was unable to respond to questions or acknowledge the surveyor. She appeared thin and frail. There was a pressure-reducing air mattress on the bed and she had pressure-reducing boots on both feet.

A. Right Buttock

Review of a 12/06/22 "Health Status Note," found in the "Progress Notes" tab of the EMR, revealed, "CNA [Certified Nurse Aide] reported to charge nurse . . . resident has new area on buttocks. This nurse into assess and noted shearing to right buttock. Cleaned area and applied zinc, charge nurse to update NP [Nurse Practitioner] and treatment nurse.

Review of a 12/07/22 "Skin Note," located in the "Progress Notes" tab of the EMR, revealed, "This

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writer went in to assess area and an OA [open area] area [sic] was noted to the right buttocks that presents with characteristics of friction from resident sliding down in bed. Area was cleansed with WC [wound cleanser], Medihoney [an ointment containing active leptospermum (Manuka) Honey (ALH) that helps to promote a moist wound environment and aids autolytic debridement] applied, and covered with a foam dressing; pillow placed behind back and buttocks for offloading. Hospice aide in room and made aware, this writer also asked hospice nurse to [sic] for an air mattress. NP/RP [Responsible Party] updated."

Review of a 12/08/22 "Wound & Skin Evaluation," found in the "Assessments" tab of the EMR and completed by the facility's wound nurse (LPN E) revealed a pressure ulcer, stage II, on the right buttock that was in-house acquired on 12/06/22. The wound measured 2.9 centimeters (cm) long, 1.9 cm wide, and 0.1 cm deep. LPN E recommended cleansing the wound with wound cleanser, using Medihoney, and covering with a foam dressing.

Review of R75's 12/12/22 "Initial Wound Evaluation & Management Summary" from the contract wound physician, located in the "Documents" tab of the EMR, revealed R75 had a pressure ulcer to her right buttock, full thickness, that was unstageable due to necrosis. The summary documented the physician performed surgical debridement of the wound: "The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise devitalized tissue and necrotic subcutaneous level tissues were removed at a

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depth of 0.2 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 75 percent."

Review of R75's 02/22/23 "Skin & Wound Assessment," located in the "Assessments" tab of the EMR revealed a picture of the right buttock wound, which appeared as small, circular bright red area of denuded skin.

Review of R75's EMR revealed no evidence the right buttock wound was assessed for appropriate treatment and healing measures by a Registered Nurse, physician, or physician extender from 12/06/22 when the wound was first identified until 12/12/22, when the wound was assessed by the physician as unstageable due to necrosis and requiring surgical debridement.

B. Sacrum

Review of a 01/02/23 "Skin Note," located in the "Progress Notes" tab of the EMR, revealed, "Resident seen during wound rounds [by consultant wound physician] and new area was noted to the sacrum. Area presents with characteristics of a pressure injury stage 3. Area was cleansed with WC, Medihoney applied, alginate (alginic acid salts in hydrogel form to aid in wound healing) applied and covered with a foam dressing. NP/hospice and RP updated."

Review of a 01/02/23 "Wound & Skin Evaluation," found in the "Assessments" tab of the EMR and completed by LPN E revealed a new pressure ulcer, stage III, on the sacrum that was in-house acquired. The wound measured 1.1 cm long by

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0.5 cm wide by 0.2 cm deep.

Review of R75's 01/02/23 "Wound Evaluation & Management Summary" from the contract wound physician, located in the "Documents" tab of the EMR, revealed R75 had a stage IV, full thickness, pressure ulcer to the sacrum which measure 1.1 cm long by 0.5 cm wide by 0.8 cm deep. The summary documented the physician performed surgical debridement of the wound: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick-ups were used to surgically excise devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.9 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 35 percent."

Review of R75's 03/01/23 "Skin & Wound Assessment," located in the "Assessments" tab of the EMR revealed a picture of the sacral wound, which appeared as a very large and very deep crater exposing the fascia, bones, and tendon. The entire surrounding sacral and coccyx were dark red.

Review of R75's EMR revealed there was no information addressing the disparities between LPN E's "Wound & Skin Evaluation," which documented a stage III wound with a depth of 0.2 cm and the physician's "Wound Evaluation & Management Summary," which documented a stage IV wound with a depth of 0.8 cm.

C. Right Ankle

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Review of a 01/09/23 "Health Status Note," located in the "Progress Notes" tab of the EMR, revealed, "Hospice [nurse] stated that resident has 3 new wounds. She stated one on the heel and 1 each on lateral ankles."

Review of a 01/10/23 "Skin Note," located in the "Progress Notes" tab of the EMR, revealed, "This writer went in to assess new areas noted. The right . . . ankle present with characteristics of a DTI [deep tissue injury] . . . Treatment orders have been implemented. NP/RP updated."

Review of a 01/11/23 "Wound & Skin Evaluation," found in the "Assessments" tab of the EMR and completed by LPN E revealed a new right ankle pressure ulcer, presenting as a deep tissue injury, that was facility-acquired on 01/09/23 that measured 0.7 cm long by 0.4 cm wide.

Review of R75's 01/16/23 "Wound Evaluation & Management Summary" from the contract wound physician, located in the "Documents" tab of the EMR, revealed R75 had an unstageable deep tissue injury on the right ankle.

Though the wound physician had provided treatment to R75's sacral and buttock wounds on 01/09/23, there was no evidence the physician had been alerted to the right ankle wound for assessment and treatment on 01/09/23.

Review of R75's 03/01/23 "Skin & Wound Assessment," located in the "Assessments" tab of the EMR revealed a picture of the right ankle wound, which appeared as a small, circular, scabbed area that was dark purple/black and yellow. A large area of the surrounding skin appeared red.

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D. Left Ankle

Review of a 01/09/23 "Health Status Note," located in the "Progress Notes" tab of the EMR, revealed, "Hospice [nurse] stated that resident has 3 new wounds. She stated one on the heel and 1 each on lateral ankles."

Review of a 01/10/23 "Skin Note," located in the "Progress Notes" tab of the EMR, revealed, "This writer went in to assess new areas noted. The . . . left ankle present with characteristics of a DTI [deep tissue injury] . . . Treatment orders have been implemented. NP/RP updated."

Review of a 01/11/23 "Wound & Skin Evaluation," found in the "Assessments" tab of the EMR and completed by LPN E revealed a new left ankle pressure ulcer, presenting as a deep tissue injury, that was facility-acquired on 01/09/23 that measured 1.7 cm long by 0.8 cm wide.

Review of R75's 01/16/23 "Wound Evaluation & Management Summary" from the contract wound physician, located in the "Documents" tab of the EMR, revealed R75 had an unstageable left ankle pressure ulcer that presented as a deep tissue injury.

Though the wound physician had provided treatment to R75's sacral and buttock wounds on 01/09/23, there was no evidence the physician had been alerted to the left ankle wound for assessment and treatment on 01/09/23.

E. Right Heel

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Review of a 01/09/23 "Health Status Note," located in the "Progress Notes" tab of the EMR, revealed, "Hospice [nurse] stated that resident has 3 new wounds. She stated one on the heel and 1 each on lateral ankles."

Review of a 01/10/23 "Skin Note," located in the "Progress Notes" tab of the EMR, revealed, "This writer went in to assess new areas noted . . . The right lateral heel presents with characteristics of a pressure injury. Treatment orders have been implemented. NP/RP updated."

Review of a 01/11/23 "Wound & Skin Evaluation," found in the "Assessments" tab of the EMR and completed by LPN E revealed a new right heel pressure ulcer, presenting as a stage IV, that was facility-acquired on 01/09/23 and measured 0.7 cm long by 0.6 cm wide by 0.2 cm deep. LPN E documented a treatment of wound cleanser, Medihoney, calcium alginate, and a foam dressing.

Review of R75's 01/16/23 "Wound Evaluation & Management Summary" from the contract wound physician, located in the "Documents" tab of the EMR, revealed R75 had a stage IV, full thickness, pressure ulcer on her right heel that required surgical debridement: "The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.3 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 45 percent."

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Review of R75's 03/01/23 "Skin & Wound Assessment," located in the "Assessments" tab of the EMR revealed a picture of the right heel wound, which appeared as a large, black circular area that covered the entire back side of the heel. It appeared deep and covered with necrotic tissue. The edges of the wound appeared as whitish/yellow scabbed tissue.

Though the wound physician had provided treatment to R75's sacral and buttock wounds on 01/09/23, there was no evidence the physician had been alerted to the right heel wound for assessment and treatment on 01/09/23, until it had progressed to a stage IV and required surgical debridement.

In an interview on 03/01/23 at 11:41 AM, R75's hospice nurse stated the resident had declined rapidly in the past two weeks. The nurse stated, "Before, she could tell who she is or where she is; now, she can't do that anymore."

In an interview on 03/01/23 at 5:27 PM, LPN D, who served as the unit manager, stated R75 had been experiencing more of a decline in the last two weeks. LPN D added R75 had poor food intake recently. LPN D stated the facility had recently implemented shower sheets, where the CNAs could document new skin issues to communicate to the nurse. She stated, before the shower sheets were implemented at the end of January 2023, CNAs communicated new skin issues to the nursing staff verbally for follow up. LPN D stated she would expect the staff to report any new skin issue, from reddened or non-blanching areas to wounds. LPN D stated she would expect the staff to note a new skin

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issue before it becomes a stage 4 or unstageable necrotic wound. LPN D added, "I was told a wound can change within two hours, it can decline fast." LPN D added the shower sheets were implemented to help the staff identify skin issues earlier, rather than after decline to a stage 4 or unstageable necrotic wound.

On 03/02/23, the facility provided a paper "Body Audit" form for R75, which was undated and unsigned, that had been completed the evening of 03/01/23 or early morning of 03/02/23. It revealed a new pressure sore to the resident's left ear, a new pressure sore to the left heel, and a pressure sore to the right heel. The right buttock pressure ulcer, right sacrum pressure ulcer, and right and left ankle pressure ulcers were not included. On 03/02/23 at 10:23 AM, employee E confirmed the "Body Audit" was inaccurate and would be re-done.

F. Left Heel

Review of R75's 03/01/23 "Skin & Wound Assessment," located in the "Assessments" tab of the EMR, revealed a picture of both her heels. Though the picture focused on the right heel wound, a clear visual of a large, purplish-black scabbed area on R75's left heel with several smaller areas that appeared as suspected deep tissue injury.

Review of R75's EMR revealed there was no assessment or treatment order for the wound on her left heel.

During an observation in R75's room on 03/02/23 at 3:52 PM, LPN G uncovered R75's legs to reveal she had pressure-reducing boots on both

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feet and was lying with her ankles crossed. LPN G gently un-crossed R75's legs, causing her to moan and grimace. LPN G reported R75 only expressed pain with movement. LPN G removed the resident's boots to reveal a bandaged area on her right heel. Her left heel had no bandage or covering. There was a large purplish-black circular area on the left heel that looked as if scabbed, and two smaller circular areas that appeared as deep tissue injuries. LPN G stated she did not see an assessment of the left heel wounds in the EMR or treatments, other than skin prep.

In an interview on 03/02/23 at 4:00 PM, LPN D, who served as the Unit Manager, stated the picture of R75's left heel on 03/01/23 showed wounds on the heel. She stated she did not see any treatment orders for the left heel wounds or an assessment of the wounds. She stated she would expect the wound to be assessed and the physician notified for treatment orders of any newly identified wound.

In an interview on 03/02/23 at 4:31 PM, LPN E, who served as the facility's wound/treatment nurse, stated she had taken the picture of R75's heels on 03/01/23 but did not notice the wounds on the left heel at that time. LPN E was unable to explain why she did not see the left heel wound on 03/01/23, stating there was "no reason for it." LPN E stated she first noticed the left heel wound on 03/02/23 when she was providing wound care for R75's right heel.
LPN E stated the certified nurse aides (CNAs) and floor nurses were observing residents frequently, and if a staff member noticed a new area, they were to put in a skin alert on the EMR so the wound could be assessed, notifications

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could be made, and treatment could be started. LPN E stated she would expect nursing staff to identify areas when they were red, non-blanching areas or partial thickness loss, rather than at a full thickness tissue loss with or without necrosis. The LPN stated, "I kind of take it personally [when wounds are not reported until they reach full thickness] because this is what I do all day every day. It's heartbreaking sometimes when you see one that progressed that bad. If you saw some red areas or something, nobody reported." LPN E continued she would expect new wounds to be identified immediately, adding, "When it first starts, if you see redness, whether it blanches or not, it's important to know for progression of the wound to get ahead of it." LPN E explained risks of wounds included infections (osteomyelitis , sepsis), pain, surgical debridement, and potential amputation.

LPN E stated she performed all wound treatments during the week, and the LPNs on the floor would do the treatments on the weekend. She stated she completed the "Wound & Skin Evaluations" for all wounds and attended wound rounds weekly with the consultant wound physician. LPN E stated she performed the measurements and assessment of the type of tissue, wound bed, and other wound characteristics. She stated there was no Registered Nurse who participated in wound assessments.

2. R39 developed multiple avoidable pressure ulcers.

Review of R39's undated "Profile," located in the "Profile" tab of the EMR revealed he was initially

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admitted to the facility on 09/19/14 and readmitted on 05/22/20 with diagnoses including obstructive hydrocephalus, epilepsy, chronic respiratory failure, tracheostomy, and contracture.

Review of R39's annual "MDS" assessment with an ARD of 01/03/23, located in his EMR under the "MDS" tab, revealed the "Brief Interview for Mental Status (BIMS)" could not be conducted, and staff assessed R39 with severely impaired cognition. R39 was rarely/never able to make himself understood or understand others. He exhibited behavioral symptoms not directed toward others, but the behaviors did not impact the resident's care. R39 was totally dependent on staff for bed mobility and all activities of daily living. He was at risk for developing pressure sores but did not have any current pressure sores.

Review of R39's 01/16/23 "Care Plan," located in the "Care Plan" tab of the EMR, revealed, "[R39] has skin integrity problem r/t [related to] h/o [history of] skin breakdown and irritation r/t reduced mobility, incontinence of bowel and bladder, use of feeding tube, and trach. Pressure ulcer to right buttock resolved, scar and self-inflicted scratches noted to right inner thigh-resolved, and abrasion noted to right flank area-resolved, redness to sacrum." The goal was, "Wound will not demonstrate signs of deterioration, new complication, or new or increasing infection through the next review." The facility's interventions included: "Administer treatment per physician order. Report unusual change or decline in skin integrity or failure to improve within 2 weeks to MD [physician] for change in tx [treatment] if indicated . . . Air Mattress check placement and function Q [every]

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shift . . . Barrier cream as needed . . . Heel lift boots as tolerated . . . Larger briefs issued . . . MD addressed unavoidable risks . . . Observe for sporadic head movements and position resident to avoid injury to skin . . . [and] RD [registered dietician] available for dietary update/review PRN [as needed]."

A. Coccyx/Sacrum and Right Buttock Wounds

Review of R39's 12/21/22 "Body Audit," located in the "Assessments" tab of the EMR, revealed R39 did not have any red or open areas on his sacrum/coccyx or buttocks.

Review of R39's 12/28/22 "Body Audit," located in the "Assessments" tab of the EMR, revealed he had redness to the sacrum. The area to identify any new areas was left blank, as was the area to document notification of the physician and responsible party.

Review of 01/04/23, 01/11/23, 01/18/23, 01/25/23, 02/01/23, "Body Audit," located in the "Assessments" tab of the EMR, revealed redness was noted to R39's coccyx. The area to identify any new areas was left blank, as were the areas to document notification of the physician and responsible party.

Review of R39's 02/03/23 "Health Status Note" revealed, "Resident's father called and stated he would like for him to remain in the bed for the weekend, due to area on his buttocks."

Review of R39's 02/08/23 "Body Audit," located in the "Assessments" tab of the EMR, revealed the resident had a pressure ulcer to the right hip (ischium) and a pressure ulcer to the right

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buttock. The physician and responsible party were notified of these new pressure sores on 02/06/23.

Review of the 02/08/23 "Wound Evaluation & Management Summary," completed by the contract wound physician, documented an "Unstageable (due to necrosis), full thickness pressure ulcer of the right ischium measuring 4.1 cm long, 4.8 cm wide, and 0.2 cm deep. The summary indicated the wound required surgical debridement: "The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 2.95 cm2 of devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.3 cm and health bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 35 percent to 20 percent." The evaluation also documented MASD, full thickness, to the right buttock measuring 2.3 cm long, 2.7 cm wide, and 0.2 cm deep. The physician determined the wound required surgical debridement: "The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 1.55 cm2 of devitalized tissue including slough, biofilm and non-viable muscle-level tissues were removed at a depth of 0.3 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 75 percent."

Review of R39's 02/28/23 physician's "Orders" under "Orders" tab located in the EMR revealed an order for zinc paste to right buttock every shift

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to treat MASD, which originated on 02/08/23, and an order to clean the right ischium with saline, apply Medihoney, and cover with calcium alginate a foam dressing every day to treat a pressure ulcer, which originated on 02/09/23.

Review of R39's EMR revealed there was no indication the redness to the resident's sacrum/coccyx that had been identified weekly since 12/28/22 on the "Body Audits" and on the right buttock identified by the resident's responsible party on 02/03/23 had been reported to the physician, assessed by the wound nurse, and treated to prevent deterioration and promote healing prior to 02/08/23, when the wounds were assessed and identified as full thickness wounds by the contract wound physician which required surgical debridement.

In an interview on 03/02/23 at 4:31 PM, LPN E, who served as the facility's wound/treatment nurse, stated CNAs and floor nurses observed residents frequently, and if a staff member noticed a new area, even just new redness, they were to put in a skin alert on the EMR so the wound could be assessed, notifications could be made, and treatment could be started. LPN E stated she would expect nursing staff to identify areas when they were red, non-blanching areas or partial thickness loss, rather than at a full thickness tissue loss with or without necrosis.

Review of the facility's 05/27/22 "Body Audit" policy revealed, "A full body, or head to toe, body audit will be conducted by a licensed or registered nurse upon admission/readmission and weekly thereafter. The body audit may also be performed after a change of condition or after any newly identified pressure injury . . . Documentation of

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the body audit in the EHR [electronic health record] includes but it not limited to:
Include date and time of the assessment, your name, and position title.
Document observations (e.g. skin conditions, how the patient tolerated the procedure, etc.).
Document type of wound.
Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain).
Document if patient refused assessment and why.
Document other information as indicated or appropriate.

Review of the facility's 05/27/22 "Skin - Wound Mobile Application Documentation" policy revealed, "The Center will document wound evaluation using skin and wound mobile application through [the EMR]. Wound evaluation includes Pressure and vascular wounds, and other non-pressure wounds as indicated . . . Photograph measurements obtained by the skin-wound mobile application will be considered a part of the medical record . . . The frequency of wound documentation will be at least weekly or as determined by the DON or designated wound nurse . . . For capturing new wounds or re-evaluation of weekly wound measurements through the skin wound mobile application, techniques to ensure consistency will be utilized."

Review of the facility's 05/27/22 "Pressure Injury Prevention Guidelines" policy revealed, "The effectiveness of interventions will be monitored through ongoing assessment of the patient and/or wound. Considerations for needed modifications include:
Development of a new pressure injury.
Lack of progression towards healing or changes

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in wound characteristics.
Changes in the patient's goals and preferences, such as at end-of-life or in accordance with his/her rights.
Surveillance will be utilized as a method to prevent and to promote the early identification of pressure injuries, to the extent possible. RNs and LPNs participate in surveillance through the evaluation of patients and reporting changes in condition to the patient's physician/physician extender and other nursing management employees of new or worsened pressure injuries . . . Pressure injuries will be tracked, and a focused review completed on pressure injuries that develop or worsen in the Center."

3. For Resident #16, the resident developed an avoidable stage 3 pressure ulcer and the facility staff failed carry out wound physician orders.

On the afternoon of 2/28/23, Resident #16 was visited in the day room, where he was sitting in a Geri-chair. Resident #16 did not respond when spoken to. Observations revealed Resident #16 had a contracture of his left arm at the elbow.

Review of the clinical record of Resident #16 revealed the following: Resident #16 had diagnoses of, but not limited to: Dementia and Hemiplegia and hemiparesis following cerebrovascular disease affecting right non-dominant side. Resident #16's care plan indicated the Resident was incontinent of bowel and bladder. The care plan also identified that Resident #16 was "at risk for skin breakdown". Resident #16 was also noted as being totally dependent upon facility staff for all care needs.

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Resident #16 had a body audit completed 12/12/22, that noted, "left antecubital [of or relating to the inner or front surface of the forearm] skin tear".

On 12/14/22, a nurse entered a progress note that read, "CNA reported that resident has open area to his left arm. Resident has open area noted to his left AC [antecubital]. Wound bed is red with scant amount of serosanguinous drainage noted. Area is approximately 2 cm by 2 cm. Area cleaned with normal saline and Medi honey applied with dry dressing. RP [responsible party] and NP [nurse practitioner] aware. NP in to assess and new order to clean with normal saline (at dry and apply Medi honey to area daily until healed [sic]".

On 12/14/22, the nurse practitioner note indicated that Resident #16 was seen for "...Generalized weakness with constipation and dysphagia...". There was no mention of the Resident's skin being impaired.

On 12/16/22, a "Skin & Wound Evaluation" was completed by the facility staff that identified the wound on Resident #16's "Left antecubital space" as a Stage III pressure wound, which measured 1.0 cm x 1.2 cm x 0.3 cm.

On 12/18/22, Resident #16 was seen by the wound care physician/specialist that indicated, "...a thorough wound care assessment and evaluation was performed today. He has a stage 3 pressure wound of the left arm... there is moderate serous exudate...". A surgical excisional debridement procedure was performed to "remove necrotic tissue and establish the margins of viable tissue... 15 blade was used to

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surgically excise devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.4 cm...". The wound care physician then ordered, "Dressing and treatment plan: Leptospermum honey apply once daily for 30 days; Alginate calcium apply once daily for 30 days. Secondary dressing: Gauze Island with border apply once daily for 30 days".

Review of the December 2022 and January 2023, treatment administration record (TAR) revealed the order by the wound care physician was entered as "Cleanse left antecubital space skin tear with NS/WC [normal saline/wound cleanser], apply Medi honey, alginate and cover with a dry dressing. every day shift every other day for Skin Tear...". This treatment was performed every other day from 12/14/22-12/30/22, and on 1/1/23, for a total of 10 occurrences versus the daily treatment.

On 1/2/23, the wound care physician saw Resident #16 and noted the following orders, "...Dressing treatment plan: Primary Dressing(s) Alginate calcium w/[with] silver apply once daily for 30 days Secondary Dressing(s) Gauze Island w/ bdr [with border] apply once daily for 15 days..."

Review of the Treatment Administration Record (TAR) for January revealed the above order from 1/2/23, was transcribed to the TAR as, "Cleanse left antecubital space skin tear with NS/WC. apply silver alginate and cover with a dry dressing every day shift every other day for Skin Tear". This treatment was administered every other day from 1/3/23-1/31/23, for a total of 15 treatments. In February 2023, the treatment continued every other day for a total of 15

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Administrations/treatments.

This wound continued to deteriorate as evidenced by the wound care physician noting in a progress note dated 2/27/23, that the Resident had "... a stage 4 pressure wound of the left arm for at least 66 days duration. There is moderate serous exudate....".

On 3/6/23, during the afternoon, an interview was conducted with the wound care physician. During the interview, when asked about his expectation regarding treatments he orders for wound care, the physician stated he expects them to be carried out as ordered with regards to frequency. When Resident #16 was discussed, the physician stated he was not aware that the facility staff had not been providing the treatments daily as ordered. The wound care specialist physician also stated that he would expect facility staff to identify skin impairments and wounds prior to being at a stage III or greater.

The facility policy titled; "Pressure Injury Prevention Guidelines" was reviewed. The policy read, "Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this Center to implement evidence-based interventions for all patients who are assessed at risk or who have a pressure injury, and in accordance with physician/physician extender orders".

During an end of day meeting held, the facility Administration was made aware of the above findings.

No further information was provided.

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4. For Resident #15 the facility staff failed to provide care and services for the prevention of pressure ulcers and the worsening of pressure ulcers once they have developed.

On the morning of 2/28/22 a review of the facility Matrix submitted to the team revealed Resident #15 had a facility acquired state IV pressure ulcer.

On 3/1/23 at approximately 10 AM, an observation was made of Resident #15 lying in bed family at bedside. Resident #15 is non communicative, mumbles at times but no meaningful conversation. Resident #15 had eyes open staring at the ceiling, she was dressed in a hospital gown and had a blanket over her.

On the afternoon of 3/2/23 an observation was made while CNA D was in the room providing care, CNA D was asked to remove the blanket from Resident # 15's feet. Both feet were flat on the bed and the Surveyor noted redness to right heel.

A review of the clinical record revealed that an MDS (Minimum Data Set) with an ARD of 10/19/22 was completed after admission excerpts are as follows:

M-0150 At risk of developing pressure ulcers / injury? 1. Yes
M-0210 - Unhealed pressure ulcers? 0 - No

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A review of the clinical record revealed that on 11/18/22 a body audit was conducted and described redness to coccyx. However, on 11/25/22 another body audit was done, and it stated that there was a treatment in place to the sacrum (a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis) not the coccyx (a triangular arrangement of bone that makes up the very bottom portion of the spine below the sacrum).

A review of the clinical record revealed that on 11/28/22 Resident # 15 was seen by the wound physician for her initial wound visit for the sacral wound . The wound specialist measured the wound at 2.9 cm. x 1.9 cm x 0.4 cm and performed surgical debridement at that time as the wound was described as "Full thickness 100 % necrotic." The wound physician documentation describes additional measurements and surgical debridement on the following dates:

Sacral wound 12/5/22 measuring 2.9 x 1.9 x 0.4 cm with surgical debridement performed.
Sacral wound 12/12/22 measuring 3.2 x 1.1 x 0.4 cm with surgical debridement performed.
Sacral wound 1/30/23 measuring 3.4 x 2.8 x 1.4 cm with surgical debridement performed.
Sacral wound 2/20/23 measuring 5.5 x 4.3 x 1 cm with surgical debridement performed.

On 3/2/23 at 4:30 PM an interview was conducted with the LPN E (Wound Nurse) who stated that the process for identifying wounds and skin issues starts with CNA's. She stated that CNA's document any skin issues noted such as redness or open areas or rashes, in the POC (Point of

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Care) electronic health record. She stated this flags on the nurse's dashboard and they are to go and assess the Resident and do a body audit notify the MD get treatment orders and interventions in place. Then notify the RP (Responsible Party) The nurses will then notify the wound nurse so that she can evaluate it further.

When asked about any training or certification she had in wound care LPN E stated that she had corporate training for 3 months. She did not have any documentation or proof of training to submit to team. When asked about initial assessments and staging of wounds she stated that she has an wound App that is on the phone and it measures wounds she takes a picture of a wound and the app does the measurements, however it does not measure depth of wounds. She stated that she uploads the information into the skin assessment and then confirms the accuracy with the wound doctor. She stated the wound doctor has access to PCC and can see what is uploaded into the system.

On 3/6/23 at 2:45 PM an interview was conducted with the wound physician who stated that he probably does have access to PCC (the electronic health record) however he has not ever used it. When asked if he has accessed the photos attached to PCC, he stated that he has not. He stated the facility has access to him through email and phone and text. When asked when he would expect wounds to be discovered he stated that it would depend on condition of the patient but usually it starts out with redness or irritation, and small area that gets bigger over time. When asked if you would expect wounds to be found before they reach Stage III, he stated

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that he would.

A review of Resident #15's current care plan obtained on 3/2/23 revealed that Resident #15 had no treatment or interventions for pressure ulcers in place and her care plan did not mention wounds actual or potential for pressure ulcers.

On 3/3/23 during the end of day meeting the acting DON was asked if the care plan should reflect the presence of a wound and associated wound care and interventions. The acting DON stated that it should. When asked why this information was not in Resident #15's care plan she stated that it was. She then presented a care plan that read as follows:

"Focus"
"Is at risk for skin breakdown pressure injury to sacrum and right heel Date Initiated: 12/19/2022 Created on: 12/19/2022."

There were interventions entered for the same date (12/19/22). When the acting DON was questioned about why the copy of the care plan that the survey team obtained did not mention the wound or interventions, she stated that it had been marked as "Resolved" in Jan. She stated that when she was reviewing the wound she noticed that there was no mention of wounds and she, (the DON) had just "Reactivated it in the system."

NOTE: the care plan focus and interventions were dated 12/19/22 and the wound was identified on 11/9/22 indicating that the care plan was not updated timely and was discontinued too soon before the wound healed.

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On 3/8/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

On 03/01/23 at 5:08 PM, the Administrator, the interim Director of Nursing, and the Regional Clinical Registered Nurse (employee F) were notified the failure to conduct timely assessment and identification of pressure wounds constituted Immediate Jeopardy to the health and safety of the residents.

The facility presented the following removal plan:

1. All residents have the potential for risk. One hundred percent completion of body audits were performed to determine residents current skin condition between 3/1/2023-3/8/2023. Any newly identified skin impairment will be assessed and have treatment initiated as ordered. Appropriate revisions will be made to the care plans to reflect all current skin impairment with preventive interventions.

On 3/1/2023 The Director of Nursing or designee conducted a body audit on Residents #75. Body audits newly identified unable to stage pressure ulcer noted to her left ear, stage 3 to right buttock, sacrum [a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis] deteriorated to an unable to stage, right heel deteriorated to unable to stage, right lateral malleolus [the bony prominence on the lateral side of the ankle joint] deteriorated to unable to stage, newly acquired left medial malleolus [the small prominent bone on the inner side of the ankle] unable to stage pressure ulcer, newly acquired left heel (1) deep tissue injury, newly acquired left heel (2) unable

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to stage pressure ulcer, newly acquired left heel (3) unable to stage (identified on 3/2/23, reassessed on 3/3/23), newly identified left lateral malleolus deep tissue injury (identified on 3/3/2023), newly identified left foot first digit (hallux) deep tissue injury (identified on 3/3/2023) were assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury prevention interventions. The treatment nurse reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023. As of 3/6/2023, Resident #75 no longer resides in the center.

On 3/1/2023 the Director of Nursing or designee conducted a body audit on Residents #16. Body audit identified stage 4 pressure area to the left antecubital space [triangular region on the anterior side of the elbow between the forearm and the anatomical arm], which was assessed, measured, an order was obtained for treatment, and treatment was initiated as ordered. Newly identified left hand lesion, not pressure related. Resident was re-assessed on 3/5/2023, newly identified DTI to right calf on 3/8/23 wound reclassified as a stage 2 pressure ulcer. At this time, the area was assessed, measured, an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury prevention interventions. The treatment nurse reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/1/2023 the Director of Nursing or designee conducted a body audit on Residents #15. Body

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audit identified stage 4 pressure area to the sacrum, which was assessed, measured, staged, and an order was obtained for treatment, and treatment was initiated as ordered. Newly identified DTI to the right heel. Resident was also noted with ingrown and decolorated right and left great toes. Mottling noted to bilateral feet. The wound was assessed, measure, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury prevention interventions. The treatment nurse reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023. As of 3/4/2023, resident no longer resides in facility.

On 3/1/2023 and 3/2/2023 the Director of Nursing or designee conducted a body audit on Resident #39. Body audit identified stage 4 wound to the right ischial tuberosity [where the adductor and hamstring muscles of the thigh, as well as the sacrotuberous ligaments, attach], Moisture associated dermatitis to right buttock and scrotum resident also has large amount defuses [sic] scar tissue noted on both right and left buttock which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/5/2023 the Director of Nursing or designee conducted a body audit on Resident #27. Body audit identified scar tissue to sacrum, re-classification of left lateral foot from opened

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wound to stage 4 pressure ulcer which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/4/2023 the Director of Nursing or designee conducted a body audit on Resident #101. Body audit identified previous diabetic wound to left heel. Newly identified stage 2 right lateral malleolus [the bone on the outside of the ankle joint], pressure ulcer which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/4/2023 the Director of Nursing or designee conducted a body audit on Resident #65. Body audit identified previous moisture associated dermatitis to left buttock. On 3/8/2023, the area was reclassified as a stage 2 pressure ulcer which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/5/2023 the Director of Nursing or designee

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conducted a body audit on Resident #29. Body audit newly identified unable to stage to right foot fifth digit which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/5/2023 the Director of Nursing or designee conducted a body audit on Resident #365. Body audit newly identified stage 2 left buttock pressure ulcer which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/5/2023 the Director of Nursing or designee conducted a body audit on Resident #371. Body audit newly identified DTI to sacrum noted protruding sacral bone no adipose tissue present which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/4/2023 the Director of Nursing or designee conducted a body audit on Resident #105. Body audit previously identified right ischium tuberosity

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moisture associated dermatitis, surgical wound to right BKA [below-the-knee amputation], diabetic left heel wound. Newly identified on 3/4/2023, right hip skin tear, fungal rash to abdominal fold. Newly identified on 3/8/2023 sacral split (stage 2) which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/5/2023 the Director of Nursing or designee conducted a body audit on Resident #36. Body audit newly identified stage one right malleolus which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/3/2023 the Director of Nursing or designee conducted a body audit on Resident #14. Body audit newly identified stage one to left and right heel which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/2/2023 the Director of Nursing or designee

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conducted a body audit on Resident #59. Body audit newly identified stage 3 to sacrum which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/3/2023 the Director of Nursing or designee conducted a body audit on Resident #47. Body audit newly identified stage one pressure ulcer to left great toe, fungal rash to left and right breast, which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/4/2023 the Director of Nursing or designee conducted a body audit on Resident #76. Body audit newly identified unable to stage pressure ulcer to left heel, which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/5/2023 the Director of Nursing or designee conducted a body audit on Resident #100. Body audit newly identified re-opened stage four to left

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heel that presents as a DTI [deep tissue injury- an injury to underlying tissue below the skin's surface that results from prolonged pressure] which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/1/2023 the Director of Nursing or designee conducted a body audit on Resident #9. Body audit newly identified DTI on right and left heel, which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Body audit on 3/8/2023 identified improvements of DTI on right and left heel to stage one on left heel and stage two on right heel. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/2/2023 the Director of Nursing or designee conducted a body audit on Resident #57. Body audit newly identified stage one right buttock which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. On 3/6/2023, stage one pressure ulcer was resolved. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

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On 3/5/2023 the Director of Nursing or designee conducted a body audit on Resident #22. Body audit newly identified right heel deep tissue injury, which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/3/2023 the Director of Nursing or designee conducted a body audit on Resident #117. Body audit newly identified stage three left sacrum cluster and stage three right sacrum cluster which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/1/23 the Director of Nursing or designee conducted a body audit on Resident #8. Body audit newly identified stage 3 to the sacrum. On 3/5/2023 re-classified pressure ulcer on sacrum to unable to stage, newly identified unable to stage to right lateral malleolus, stage two to the left dorsal foot. Wound rounds completed on 3/6/2023, pressure ulcer to left dorsal foot re-classified to stage three which was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised

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care plans with all staff involved in the care of the resident on 3/3/2023. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/8/2023 the Director of Nursing or designee conducted an admission body audit on Resident #369. Body audit previously identified left heel unable to stage unable to stage to the sacrum was assessed, measured, staged and an order was obtained for treatment, and treatment was initiated as ordered. On 3/8/2023, newly identified stage 2 to left ischium which was assessed, measured, staged, and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

On 3/4/2023 the Director of Nursing or designee conducted an admission body audit on Resident #66. Body audit previously identified stage four to sacrum. On 3/8/2023, newly identified stage two to the right malleolus, which was assessed, measured, staged, and an order was obtained for treatment, and treatment was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure injury preventive interventions. Reviewed the revised care plans with all staff involved in the care of the resident on 3/3/2023-3/8/2023.

2. A. All nurses re-educated on body audit policy, center process for skin observation on

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admission. Proper identification of new skin impairment. Implementation of treatment and process communication to wound care nurse completed by 3/8/2023. The remaining staff education is ongoing and will be completed prior to the start of their next assigned shift until all staff re-education requirement is met.

B. All certified nursing assistants will be re-educated on center process of reporting skin impairment to nurse immediately, and residents point of care documentation. This will be completed by 3/8/2023. The remaining staff education is ongoing and will be completed prior to the start of their next assigned shift until all staff re-education requirement is met.

3. To prevent reoccurrence direct care nurse will complete body audit at time of identification of skin impairment, will describe the wound in body audit, and immediately implement treatment and preventative measures. Within 24-48 hours of identification, wound nurse or designee will reassess skin impairment to identify staging, appropriate treatment, and preventative measures.

4. Completion date on 3/8/2023 at 3:00pm.

The survey team did the following to verify the facility's removal plan.

The survey team verified that all Residents in the IJ removal plan were assessed and had treatments in place. The survey team verified all residents in the facility had current body audits in the clinical record, and that those Residents

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identified with pressure wounds had wound assessments in their clinical record and treatments in place.

The survey team reviewed the education provided to facility staff and verified the education was provided to the CNAs and the nurses by interviewing the CNAs and nurses.

The CNAs were asked what they were expected to do if a wound or skin change is noticed. The CNAs were able to verbalize the expectation of entering it into the ADL computerized documentation and notifying the nurse.

The nurses were able to verbalize that they should assess the area, notify the Resident's representative, the MD, and implement any treatments ordered, and put in place any interventions to prevent worsening or further wound development, and to notify the wound nurse of the new area.

The survey team selected 10 percent of the Resident population (this included Residents who had pressure wounds and Residents who the facility identified as not having pressure wounds but were at high risk of developing pressure wounds) plus an additional six random Residents and, along with facility staff, compared the assessments and body audits with the actual wounds found on the Resident to verify the accuracy of wound description, measurements, staging, appropriateness of treatments and interventions orders.

Immediate Jeopardy was removed on 3/9/23 at 12:02 PM.

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5. For Resident #16 the facility staff failed to provide care and position changes for an extended period (9 hours) which resulted in the development of a Deep Tissue Injury.

Review of the clinical record of Resident #16 revealed the following: Resident #16 had diagnoses of, but not limited to: Dementia and Hemiplegia and hemiparesis following cerebrovascular disease affecting right non-dominant side. Resident #16's care plan indicated the Resident was incontinent of bowel and bladder.

The care plan also identified that Resident #16 was "at risk for skin breakdown". Review of the interventions to prevent skin breakdown included but were not limited to: "Encourage frequent position changes for pressure relief, observe for moisture and incontinence issues that affect skin. Report for further assessment if noted and Provide pressure reduction surfaces as ordered/indicated".

On 2/28/23 at approximately 9:00 AM, Resident #16 was observed to reside in room [redacted] and was on droplet precautions as identified by signage on the door. Staff interviews confirmed that Resident #16 was under quarantine for COVID-19.

On 2/28/23 at 10:12 AM, Resident #16 was noted to no longer be in room [redacted] and the signage had been removed from the door alerting to droplet precautions. An interview was conducted with the unit manager/LPN D. The unit manager stated that Resident #16 was being

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moved back to the room he was in previously, due to his quarantine period had ended at mid-night.

On 2/28/23 at approximately 1:00 PM, Resident #16 was observed in a Geri chair in the day room. The assigned room that Resident #16 was moving to was observed and it was noted there was not a bed in the room for Resident #16. Resident #16 was not able to be interviewed and didn't respond when spoken to.

On 2/28/23 at approximately 3:30 PM, Resident #16 was observed to still be sitting in a Geri chair in the day room and again did not respond to questions. The observation revealed the assigned room did not have a bed in the room. LPN C was questioned about Resident #16 being in the Geri chair in the day room and no bed being in the room. LPN C responded that she would call to get them to bring the bed from the other unit.

On 3/1/23 at approximately 10:00 AM, an interview was conducted with Resident #26, who was Resident #16's new roommate following the room change. Resident #26 presented to be alert and oriented. When asked what time Resident #16 got moved into the room, Resident #26 said, "It was real late". When asked several questions to determine time, Resident #26 said, he had eaten his supper, it was dark outside and then said it was around 9-10 PM.

On 3/1/23 during the late morning, an interview was conducted with LPN C, who was the nurse assigned to Resident #16 following the room change on 2/28/23. LPN C was asked about the room change process and said that the nursing

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staff move the Resident and their belongings. LPN C confirmed that she worked over on 2/28/23, and at the time she left around 5 PM, Resident #16's bed still had not been moved. Review of the timecard revealed LPN C left at 5:06 PM on 2/28/23.

On 3/1/23 at 10:31 AM, an interview was conducted with Employee M/Maintenance Associate. Employee M stated he had been asked by nursing staff to move a bed into a room for Resident #16 on 2/28/23. He indicated that it was not brought to his attention until about 6 PM that evening. He then moved a bed into the room and advised nursing that it was available and needed to have sheets put on it.

On 3/5/23 at approximately 4 PM, an interview was conducted with CNA F. CNA F confirmed that he was not the assigned CNA for Resident #16 on 2/28/23, that the assigned CNA had to leave mid-shift. CNA F said that when he went on break at 8 PM, Resident #16 was still sitting in the day room and had not been put to bed.

On 3/6/23 an interview was conducted with the Wound Care Physician (WCP). The WCP confirmed that Resident #16 had developed a Deep Tissue Injury to the back of his calf.

On 3/8/23, mid-morning the Corporate Nurse Consultant confirmed with the survey team that the development of the wound on Resident #16's leg was "consistent" with the findings the survey team had identified with regards to Resident #16 being left to sit in a Geri-chair for an excess of 9 hours.

The facility policy titled; "Pressure Injury

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F 686	Continued From page 92 Prevention Guidelines" was reviewed. The policy read, "Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this Center to implement evidence-based interventions for all patients who are assessed at risk or who have a pressure injury, and in accordance with physician/physician extender orders". The facility Administrator was made aware of the above findings during an end of day meeting. No further information was provided.	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review and facility policy review, the facility failed to ensure two residents of two residents (Resident (R) 43 and R15) reviewed for podiatry services received services. Findings include:	F 687	1) Resident #15 no longer resides in center. Podiatry care provided to Resident #43 on 3/27/2023. 2) All residents□ toenails will be observed to determine the need for podiatry care. Podiatry consultations will be scheduled for residents in need of	4/23/23

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F 687	Continued From page 93 1. Review of R43's undated "Admission Record" located on his electronic medical record (EMR) revealed he was initially admitted to the facility on 11/08/22 with multiple diagnosis to include diabetes mellitus and hemiplegia. Review of R43's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 02/13/23 located in the "MDS" tab of the EMR, revealed R43 scored seven out of 15 on the "Brief Interview for Mental Status (BIMS)," which indicated R43 was severely cognitively impaired. R43 used wheelchair and was totally dependent for bathing with one staff assistance required and extensive assistance with one staff for personal hygiene. Review of R43's "Physician's Orders" dated 01/03/23 under "Orders" tab located on his EMR revealed resident had active orders for "podiatrist screen and treat as indicated." Review of R43's 01/23/23 comprehensive "Care Plan" under "Care Plan" tab located on his EMR revealed, "Observe for and report changes in sensation and/or skin integrity of feet for further assessment." Review of R43's "Body Audit" dated 02/23/23 and 03/02/23 under "Assessment" tab located on his EMR revealed that there was no mention of toe issue or nail care included. On 03/01/23 at 12:10 PM, R43 was observed in bed. His toenails were long and yellow in color. Resident revealed that his feet hurt sometimes. Observations conducted on 03/02/23 at 12:10	F 687	toenail care. 3) The DON or designee will re-educate current licensed nurses on nail care policy. 4) The DON or designee will audit 10% of residents to ensure foot care provided weekly x 12 weeks and report findings to QAPI committee. 5) Date of compliance April 23,2023	

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PM, 1:24 PM and on 03/02/23 at 2:15 AM, 3:45 PM, and 7:57 PM revealed long and yellowing toenails digging into the skin. The big toenail was longer than two inches over bed of the nail and was thick, yellow, and curved. The second to fifth toes approximately one inch over bed of nail, thick, and straight.

During an interview on 03/03/23 at 3:33 PM, Certified Nurse Aide (CNA) E was asked to show R43's toenails, CNA E stated, "I think I remember him saying that they [toenails] were bothering him." When asked if he saw them he stated, "Yes they are long, but that needs a specialist. I think we have someone coming in to do that. They need to professionally cut them because there can be infection. Especially if he is diabetic, if he isn't then we can do it."

During an interview on 03/03/23 at 4:45 PM, Licensed Practical Nurse (LPN) F was asked to show R43's toenails, the LPN F stated, "that needs to be seen by the podiatrist. I can't mess with that." She stated, "a referral would be needed to see the podiatrist and the social worker handles that. He is currently on the list. I would like to see a turnaround with how fast these referrals get taken care of so people can be seen." LPN stated that she has submitted the referral for Podiatrist Visit for R43 to the social worker and that she does not know when the podiatrist is to come until the day of their visit.

On 03/03/23 at 4:20 PM, Surveyor H asked the Social Worker if they had a Podiatry referral for R43. She stated, "I was looking for those before. Let me see. I do not see one."

On 03/03/23 at 04:49 PM, the Social Worker said

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that the Podiatrist had not seen R43 and that he was not on the list for Podiatry Visits.

2. For Resident #15 the facility staff failed to provide proper treatment to maintain good foot health.

On 3/1/23 at approximately 10 AM an observation was made of Resident #15 lying in bed family at bedside. Resident #15 is non communicative, mumbles at times but no meaningful conversation. Resident #15 had eyes open staring at the ceiling, she was dressed in a hospital gown and had a blanket over her. Resident #15 was noted to be moving her feet under the blankets. At that time an interview was conducted with Resident #15's family member who was asked if Resident #15 always moves her feet like that and the resident has ingrown toenails.

On the afternoon of 3/2/23 an observation was made while CNA D was in the room providing care, CNA D was asked to remove the blanket from Resident # 15's feet. Both feet were flat on the bed. Resident # 15 was observed to have extremely long toenails, extending at least half an inch over the tip of the toe, as well as discoloration to both left, and right great toes (black/blue) caused by ingrown toenails. CNA D was asked who is responsible for routine nail care and she stated that the nurses do nails, and the podiatrist does toenails. When asked when the nail care is done, she stated that it is done on the Resident's bath day.

On 3/2/23 at approximately 2:15 PM an interview was conducted with the Social Worker who was

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F 687	Continued From page 96 asked who schedules Residents for the Podiatrist, and she indicated that she did. She was then asked when the last time Resident #15 had seen the podiatrist she stated that Resident #15 had not had any podiatry services since admission in October of 2022. A review of the clinical record revealed no podiatry notes or progress notes related to foot care, or nail care or condition of toenails since admission. On 3/8/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 687		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		4/23/23

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F 700	Continued From page 97 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, Food and Drug Administration's (FDA) guidance and facility policy review, the facility failed to demonstrate an indication for use and attempt alternatives prior to installing bed rails (siderails) for one of six residents (Resident (R) 464) reviewed for accidents. Findings include: Review of the FDA's "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued 03/10/06, indicated, "For 20 years, FDA has received reports in which vulnerable patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities . . . Patient entrapments may result in deaths and serious injuries . . . The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement . . . Long-term care facilities reported the majority of the entrapments." Review of R464's undated "Profile," located in the "Profile" tab of the electronic medical record (EMR) revealed she was admitted to the facility on 02/25/23 with diagnoses of metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood that can lead to personality changes, delirium, and acute confusion), gastrostomy (an opening into the stomach from the abdominal wall made surgically), muscle weakness, and unsteadiness.	F 700	1) Resident # 464 no longer resides in center. 2) All residents are at risk and will be individually observed to ensure bed rails are in use per plan of care. 3) The DON or designee will re-educate current Licensed nurses on bed rail policy. 4) The DON or designee will audit 10% of residents with bed rails to ensure bed rail policy is being followed weekly x 12 weeks and report findings to QAPI committee. 5) Date of compliance April 23, 2023	

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Because R464 had only been in the facility since 02/25/23, she did not have a "Minimum Data Set (MDS)" assessment yet completed.

Review of R464's 02/25/23 admission "Bed Rail Evaluation," found in the "Assessments" tab of the EMR, revealed, a Bed Rail evaluation was completed, and it was determined: "NO bedrail(s) required."

Review of R464's 02/25/23 "Bed Rail Evaluation" note, located in the "Progress Notes" tab of the EMR, documented, "[R464] was evaluated and observed for bed rail(s) needs/requirement and was determined that NO bed rail(s) required."

Review of R464's 02/25/23 baseline "Care Plan," located in the "Care Plan" tab of the EMR, revealed, "Demonstrates the need for ADL [activities of daily living] assistance." The interventions included, "Provide assistance for bed mobility as needed." The baseline "Care Plan" did not address the use of siderails.

Review of R464's 02/28/23 "Physician's Orders," located in the "Orders" tab of the EMR, revealed there was no order for the use of siderails.

Review of R464's EMR revealed no documentation of consent for the use of siderails from R464's representative.

In an observation on 02/28/23 at 7:59 AM, R464 was observed in her room, lying in bed with bilateral 1/2-siderails (rails that ran from the head of the bed to the midline on both sides of the bed). R464 was unable to answer questions related to her use and need of the siderails. When questioned, she stated, "These aren't

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mine, they belong to that girl over there [while pointing out the window]."

During observations in R464's room on 03/01/23 at 9:08 AM, 10:06 AM, and 12:30 PM; on 03/02/23 at 10:38 AM and 3:40 PM; and on 03/03/23 at 9:20 AM, R464 was again observed lying in bed with bilateral 1/2-siderails on the bed.

An observation in R464's room on 03/03/23 at 11:13 AM revealed she was lying in bed with bilateral 1/2-siderails on the bed. R464 was again unable to answer questions related to her use and need of the siderails. When questioned, she verbalized nonsensical responses.

In a concurrent interview on 03/03/23 at 4:02 PM with Certified Nurse Aide (CNA) C and CNA D, both CNAs reported R464 was totally dependent on staff with bed mobility and she was not able to use the side rails to assist with mobility or positioning. The CNAs reported R464 was extremely confused, unable to follow directions, and unable to use the siderails due to confusion.

In an interview on 03/03/23 at 4:05 PM, Licensed Practical Nurse (LPN) D, who served as the Unit Manager, stated R464's "Bed Rail Evaluation" done at admission indicated she did not require siderails. LPN D did not know why R464 had siderails on her bed when they were assessed as unnecessary or whether they had been assessed for safety on R464's bed. She stated, "I will need to research who put siderails on her bed." No further information was provided prior to survey exit.

Review of the facility's 10/19/22 "Proper Use of Side Rails" policy revealed, "As part of the

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patient's comprehensive assessment, the following components will be considered when determining the patient's needs, and whether or not the use of side/bed rails meets those needs:
a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms,
b. Size and weight,
c. Sleep habits,
d. Medication(s),
e. Acute medical or surgical interventions,
f. Underlying medical conditions,
g. Existence of delirium,
h. Ability to toilet self safely,
i. Cognition,
j. Communication,
k. Mobility (in and out of bed), and/or
l. Risk of falling.
The Center will attempt to use alternatives prior to using side/bed rails . . .
Obtain informed consent from the patient, or the patient's legal representative for the use of bed rails, prior to installation/use . . . Determine whether or not the side/bed rail/grab bar is a restraint. Side/bed rails/grab bar will be considered a physical restraint when it limits the patient's freedom of movement, keeps the patient from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability . . . Document the medical diagnosis, condition, symptom, or functional reason for the use of the side/bed rail. Obtain physician/physician extender orders for the use of side/bed rails . . . The use of side rails will be specified in the patient's plan of care . . . The Center will provide ongoing monitoring and supervision of side rail/bed rail use for effectiveness. . . . A nurse assigned to the patient will complete reassessments in accordance with the Center's assessment schedule, but not less

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F 700	Continued From page 101 than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. The interdisciplinary team will make decisions regarding when the side/bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the rail. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and rails."	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to complete a performance review of one Certified Nursing Assistant (CNA # 2) of 5 Certified Nursing Assistant's in the survey staff sample. Findings included: On 3/2/2023, a review of five staff inservice education was conducted. Review revealed one employee, CNA (Certified Nursing Assistant) # 2 was hired on 7/28/2020 and terminated on 11/5/2021. An annual performance review was due prior to the termination date of 11/5/2021. An interview was conducted with the Human	F 730	1) C.N.A #2 is no longer employed with center. 2) All residents have the potential to be affected by this deficient practice. Current C.N.A. employee files will be reviewed to ensure a performance appraisal in the last 12 months is in place. Corrections will be made as applicable. 3) The Clinical Services Specialist or designee will re-educate DON and Human Resources manager on completion of required C.N.A. performance reviews once every 12 months. 4) The Human Resource manager or designee will audit 5 C.N.A. education records to ensure completion of	4/23/23

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F 730	Continued From page 102 Resources director who was asked to provide a copy of the annual performance review. During the end of day debriefing on 3/3/2023, the Administrator stated there was no performance review in the employee file for CNA # 2. The Administrator stated performance reviews should be completed annually. No further information was provided.	F 730	performance reviews as required weekly x 12 weeks and report findings to QAPI committee. 5) Date of compliance April 23, 2023	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		4/23/23

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F 732	Continued From page 103 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to post the daily nurse staffing. Findings included: During the initial tour of the facility on 2/28/2023 at 7:30 a.m., there was an observation of the daily posting on the ledge in the lobby had the date of "2-1" listed. On 3/2/2023, during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings of no posting since February 1, 2023. The Administrator stated the Nurse Staffing should be posted daily. No further information was provided.	F 732	1) Daily nurse staffing posted and corrected on 2/28/23. 2) Current residents have the potential to be affected by this deficient practice. 3) The Administrator or designee will re-educate clinical leadership on posting of daily nurse staffing. 4) The Administrator or designee will audit daily 5 days a week to ensure nursing staffing is posted x 12 weeks and findings will be report to QAPI committee. 5) Date of compliance April 23, 2023	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		4/23/23

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F 755	Continued From page 104 §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, the facility staff failed to ensure medications were available as ordered for one resident (Resident # 91) in a survey sample of 71 residents. This happened on multiple occasions. Findings included: For Resident # 91, the facility staff failed to ensure medications were available as ordered by	F 755	1) Resident #91 no longer resides in the center. 2) All residents are at risk. Contracted pharmacy will complete and audit of current residents medication inventory to ensure availability of current active medications. 3) The DON or designee will re-educate licensed nurses on medication administration policy to include	

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F 755	Continued From page 105 the physician, Resident # 91's diagnoses included, but were not limited to: Epilepsy, Cerebrovascular Accident, Diabetes and Hypertension Review of the open electronic clinical record was conducted on 3/2/2023-3/9/2023. Review of the clinical record revealed documentation of medications being unavailable on scheduled times of administration. Examples of times medications were unavailable included but were not limited to: 2/3/2023 11:34 eMar - Medication Administration Note (electronic medication administration record) Note Text: Phenobarbital Solution 20 MG/5 ML (20 milligrams/ 5 milliliters) Give 15 ml via PEG (percutaneous Endoscopic Gastrostomy)-Tube every 12 hours for Epilepsy awaiting pharmacy to deliver 2/2/2023 20:28 eMar - Medication Administration Note Note Text: Phenobarbital Solution 20 MG/5 ML Give 15 ml via PEG-Tube every 12 hours for Epilepsy on order from pharmacy 1/26/2023 23:27 eMar -Medication Administration Note Note Text: Phenobarbital Solution 20 MG/5 ML Give 15 ml via PEG-Tube every 12 hours for Epilepsy awaiting med from pharm (pharmacy)	F 755	procedures for medication availability. Contracted pharmacy will complete and audit of current medication inventory to ensure availability of current active medications. 4) The DON or designee will audit 10% resident eMARs to ensure medications are available and administered as ordered 3x week x 2 weeks, then weekly x 2 and then monthly x 2 and report findings to the QAPI committee. 5) Date of compliance April 23, 2023	

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1/18/2023 18:09
eMar -Medication Administration Note
Note Text: Labetalol HCL Tablet 200 MG
Give 1 tablet via PEG-Tube two times a day for HTN (Hypertension)
not available

12/17/2022 10:47
eMar -Medication Administration Note
Note Text: Phenobarbital Solution 20 MG/5 ML
Give 15 ml by mouth every 12 hours for epilepsy
Pharmacy was called and said they would send the med stat (immediately)

12/16/2022 21:15
eMar -Medication Administration Note
Note Text: Phenobarbital Solution 20 MG/5 ML
Give 15 ml by mouth every 12 hours for epilepsy
Awaiting delivery from pharmacy

The medications that were unavailable included the medication, Phenobarbital prescribed for Epilepsy and Labetalol prescribed for Hypertension.

During an interview on 3/2/2023 at approximately 1:51 p.m., LPN (Licensed Practical Nurse) D stated medications should be provided by the pharmacy. LPN D 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. LPN D also stated the family representative should be notified.

On 3/3/2023 during the end of day debriefing, the Corporate Nurse Consultant stated the expectation was for the pharmacy to make sure

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F 755	Continued From page 107 medications were available for administration by the facility staff as ordered by the physician. The Corporate Nurse Consultant stated the facility staff was expected to contact the Pharmacy whenever medications were not available at the time of administration, check the stat box, notify the physician and follow any new orders. She stated the Pharmacy used by the facility was "local and should be able to provide medications quickly." Review of the stat box inventory revealed no documentation of the two medications Phenobarbital and Labetalol being available in the list of contents. During the end of day debriefings on 3/3/2023 and 3/6/2023, the Administrator and Corporate Nurse Consultant (in the role of interim Director of Nursing) were informed of the findings of medications being unavailable. No further information was provided.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		4/23/23

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F 758	Continued From page 108 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation the facility staff failed to ensure Residents were free of unnecessary	F 758	1) Resident #15 no longer resides in center. 2) All residents receiving PRN	

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F 758	Continued From page 109 psychotropic medications for 2 Residents (#'s 15 &31) in a survey sample of 71 Residents. The findings included: 1. For Resident #15 the facility staff failed to ensure that as needed (PRN) orders for psychotropic drugs are limited to 14 days. On 3/1/23 during clinical record review it was discovered that Resident #15 had an order for PRN Lorazepam (an anti-anxiety medication). The clinical record revealed the following order. 2/9/23 "Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml by mouth every 4 hours as needed for Anxiety or Restlessness -Start Date 02/09/2023" [Note: there is no time frame of 14 days, or a stop date specified for this order] On 3/8/23 an interview was conducted with the acting DON who was asked about PRN anti-anxiety medications needing a stop date. The acting DON replied, there should be a stop date or documentation of the Resident requiring longer therapy and a duration of therapy. On 3/8/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #31 the facility staff failed to provide a stop date for the order for Clonazepam 0.5 mg (a controlled drug: antiseizure medication used for anxiety)	F 758	psychotropic medications will be reviewed to ensure appropriate diagnosis and timeframe for duration of administration. 3) The DON or designee will re-educate current licensed nurses on expectation that PRN psychotropic medications are limited to 14-day use. 4) The DON or designee will audit active PRN psychotropic medications to ensure proper end date weekly x 12 weeks report findings to the QAPI committee. 5) Date of compliance 4/23/23	

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F 758	Continued From page 110 On 3/2/23, a review of the clinical record revealed that Resident #31 had an order for Clonazepam 0.5 mg for anxiety and the psychiatrist discontinued it on 11/15/22. However, the Nurse Practitioner (Employee O) restarted the medication on 2/12/23 without including a stop date. A review of the orders read as follows: "12/13/23 at 2:30 PM Clonazepam 0.5 mg every 12 hours as needed for anxiety. Start date 2/13/23 End Date Indefinite." On 3/6/23 an interview was conducted with the NP who stated she restarted the medication because the resident stated she wanted to see a psychiatrist and was "going through a lot." When asked if she documented restarting the medication or reasons for having and indefinite PRN order, she stated she may have missed that. On 3/6/23 an interview was conducted with the acting DON who was asked about stop dates for PRN psychotropics, she stated that all PRN psychotropics should have a stop date no greater than 14 days from ordering, unless proper documentation is in the chart as to the reason why. On 3/3/23 during the end of day meeting the Administrator was made aware of the concerns no further information was provided	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		4/23/23

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F 761	Continued From page 111 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to 1) label eye drops with an open date for one resident (Resident #515) in a survey sample of 71 residents and 2) failed to secure medications delivered from the pharmacy. The findings include: 1. For Resident #515, the facility failed to label the resident's Dorzolamide eye drops with an open date. On 03/02/2023 at approximately 11:15 AM, a medication cart on north unit was inspected. The	F 761	1) Resident #515 no longer resides in center. LPN D and LPN H re-educated on policy of proper storage and labeling of medication. 2) All residents have the potential to be affected by this deficient practice. Contracted pharmacy will complete and audit of current residents medication inventory to ensure appropriate labeling and storage of current active medications. 3) The DON or designee will re-educate current licensed nurses on the general policy guidelines of medication storage to include upon delivery from pharmacy and	

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F 761	Continued From page 112 inspection found Dorzolamide eye drops (for Resident #515) were not labeled with an open date. On 03/02/2023 at approximately 11:28 AM, an interview was conducted with LPN G. LPN G stated that the eye drops should be labeled and needed to be discarded 30 days after opening. 2. The facility staff failed to secure medications delivered from the pharmacy as evidenced by leaving medications at the nursing station without staff oversight. On 3/3/23 at 8:30 AM, upon the survey team's arrival to the facility it was noted that the pharmacy was delivering medications to the facility. The survey team held the door open for the pharmacy employee and noted that he had two large gray bags with paperwork attached that identified the contracted pharmacy name. On 3/3/23 at 9:36 AM, Surveyor C noted on one nursing unit that the bag of medications was sitting on the nursing station. There was a staff member down the hallway, several doors down who was passing medications. Another employee was seen towards the end of the hallway walking away from the nursing station. Upon further inspection it was noted that there was a white bag stapled to the larger gray bag. The packing slip indicated that "Gabapentin Capsules" with a quantity of 7 were contained within the bag. Review of the packing slip revealed there was an abundance of medications that were contained within the bag. The packing	F 761	labeling. 4) The DON or designee will conduct random audits of medication carts, medication rooms, and nursing units to ensure proper labeling and storage of medications upon delivery from pharmacy weekly x 12 weeks and findings reported to the QAPI committee. 5) Date of compliance April 23, 2023	

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slip listed IV medications and cycle fills.

Surveyor C then went to the unit manager's office/LPN D and made her aware of the unsecured medications. LPN D stated, "they should have taken the items that need to be refrigerated and put in the fridge and then secured the rest in the medication room, I will have to call the pharmacy to see who signed for them". LPN D then retrieved the medications and put them in the medication room where they were secure.

On 3/3/23 at 11:16 AM, an interview was conducted with LPN H, another unit manager. LPN H was asked to explain the process when the pharmacy delivers medications. LPN H said that the pharmacy delivers daily in the morning. "When they bring medications, it is for the next day, they give them to the nurse because they have to be signed for. The nurse then puts then in the medication room until they have time to put them away". When asked why it is important to secure the medications, LPN H said, "so patients won't get in them, and you don't know who is going to get a hold of them, we have a lot of patients that are incoherent, or someone could steal them". LPN H went on to say that "You definitely know where there is a narcotic because that is in a separate white bag".

Review of the facility policy titled; "General Guidelines for Medication Storage" was conducted. This policy read, "... 2. Only licensed nurses, the Consultant Pharmacist and those authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by

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F 761	Continued From page 114 persons with authorized access... 7. Schedule II medications and other drugs subject to abuse are stored in a separate, permanently affixed area and are under double lock. Schedule III-V medications may be stored along with non-controlled drugs but may be under more strict storage controls at the Facility's discretion or as required by state regulations...". On 3/3/23, 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.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		4/23/23

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F 812	Continued From page 115 Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety which have the potential to affect multiple Residents on 2 of 2 nursing units. The findings included: 1. The facility staff failed to label food with the date the item was opened/prepared and/or a use by date. On 2/28/23 at 7:30 AM, a brief initial tour/inspection of the kitchen was conducted with Employee S, a dietary aide. During this tour, the following was noted: In the walk-in refrigerator there was turkey sandwich meat that had been wrapped in cellophane, there was no labeling to indicate when it was opened or to be used by. In the stand-alone refrigerator, there was a bowl of lettuce and another container of tomatoes that were covered but not labeled with a date of when they were prepared or to be used by. In the dry food storage there were two bags of dry pasta that had been opened and were not dated. On 2/28/23 at approximately 7:42 AM, an interview was conducted with Employee S, a dietary aide. When asked about dating of items, stated, "items are dated when we open them". When asked why dating is important, Employee S said, so that you know how long it is good for. On 2/28/23 at approximately 7:50 AM, following	F 812	Items identified to be deficient were corrected on 3/9/23. Food is currently labeled and appropriately dated; food temperatures are currently being monitored; service e ware is being nested after completely dry; dented cans are being removed from shelves to a clearly designated area; and hand soap is available in dispensers at sinks for hand hygiene. 2) Current residents have the potential to be affected if food is not stored and prepared in a safe and sanitary manner. 3) Current cooks and servers will be re-educated on the importance of checking all food, milk and coffee temperatures prior to meal service and recording these temperatures on the food temperature log form. The Dining Services Manager, or designee, will check the food temperature log daily 5 x week x 2 weeks, then weekly x 4 weeks to ensure food temperatures for all meals are taken and properly recorded. Current dietary employees will be re-educated on service ware washing procedures and the importance of allowing all service ware including trays, dome covers/bases, plates, glassware to properly air dry before stacking to prevent microbial growth. The Registered Dietitian provided education to current dietary employees on 3/3/23 on access points where additional soap supplies may be obtained when necessary to refill dispensers. Current dietary staff will be re-educated on the importance of checking canned food items for dents upon delivery and	

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F 812	Continued From page 116 the walk-through, Employee S confirmed all the above observations. On 03/01/23 at 11:30 AM, another more detailed walk-through was conducted of the kitchen with the dietary manager, Employee Q. Employee Q stated all items are to be labeled when opened or prepared so that staff know when to use them by. She was made aware of the findings from 2/28/23. On 3/5/23 at approximately 5:30 PM, the stand-alone refrigerator was checked. Inside there were 3 plates of tossed salads that were wrapped in cellophane that were not labeled or dated as to when they were prepared or to be used by. There was also a container of a brown substance that appeared to be chocolate pudding that had no label to indicate the contents, when it was prepared/opened or to be used by. On 3/7/23 at 10:30 AM, the Dietary manager was made aware of the items in the stand-alone walk-in cooler that were not labeled, that were observed on 3/5/23. A review of the facility policy titled, "Safe Food and Supply Storage" was conducted. This policy read, "... 4. All opened packages of lunch meat must be securely wrapped and dated with a "use by" date of 5 days from date opened. Lunch meat, including ham, should be placed on a drip tray, and stored under or away from produce... 6. Cut tomatoes, lettuce, and melon should be used within 3 days... Dry Goods... 4. If no manufacturer "use by" date is listed, dry goods will be labeled with a "use by" date of 1 year from the date received if unopened. Dry goods may be kept for 3 months from date opened...".	F 812	prior to use in production and will include placing damaged/dented cans in the clearly designated area. 4)The Dining Service Manager, or designee will observe service ware washing 3 x daily following each meal daily 5 x week x 2weeks, then 2 x daily for 4 weeks. Current dietary staff will be required to demonstrate proper service ware washing procedures as part of the employee□s annual competency checklist. An additional tray drying rack was purchased on 3/10/23 to help facilitate air drying immediately following service ware washing. An opening and closing checklist will be completed daily by the Cook, or other designee, to verify soap is available at both kitchen handwashing stations and that all opened and/or prepared food items are properly sealed and labeled with a Use-By date. The checklists will be reviewed by the Dining Services Manager and maintained on file x 90 days. The Registered Dietitian will conduct a weekly sanitation audit x 4 weeks, then monthly thereafter which includes checking for proper air drying of all service ware, food temperature monitoring, availability of soap at the handwashing sinks, proper food labeling, and disposal of any dented or damaged cans and findings reported to the QAPI committee. 5)Date of compliance April 23, 2023	

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On 3/2/23 at 4:29 PM and again on 3/7/23, the facility Administrator was made aware of the above findings.

No further information was provided.

2. The facility staff failed to obtain food temperatures for 42 of 66 meals served from 2/6/23-2/27/23.

On 02/28/23 at 07:42 AM, a brief tour of the kitchen was conducted. The dietary staff were preparing to start the tray line/meal service for breakfast. The cook, Employee P was observed taking temperatures of foods. When asked why temperatures are taken, the cook stated, to make sure it is cooked properly. Employee P then provided the surveyor with the book of where meal temperatures are recorded.

Review of the meal temperature logs revealed that from 2/6/23-2/27/23, 42 of the 66 meals had no temperatures recorded. Copies of the food temperature logs were provided to Surveyor C by facility staff.

On 3/1/23 at approximately 11:15 AM, Employee R, a cook was asked about meal temperatures. Employee R said, "it is important to take temps to make sure food is up to temp, if not, we can't serve it and we are not supposed to serve cold food".

On 03/01/23 at 11:30 AM, Employee Q the dietary manager was asked to obtain the meal temperatures for the past few weeks. Employee Q obtained the meal temperature logs and

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Surveyor C showed the copy of the temperature logs provided to the surveyor on 2/28/23. Employee Q was asked to explain how all the dates with missing documentation on 2/28/23, now had temperatures filled in, Employee Q was not able to explain.

The facility policy titled; "Monitoring Food Temperatures" was reviewed. This policy read, "1. The cook is responsible for checking meat temperatures when items are removed from the oven to ensure proper internal temperature. 2. The staff member serving from a steam table is responsible for checking food temperatures within 15 minutes of start of service. If an item is not at least 135 degrees F, it will be removed from the line, reheated to a minimum of 165 degrees F, and returned to the steam table. Cold food items which are time and temperature sensitive and are above 41 degrees will be chilled in an ice bath to 41 degrees or less. Temperatures are recorded on a Food Temperature Log. 3. Measure and record the temperatures for each food product, milk, and coffee at all meals. Record temperature on a Food Temperature Log. 4. When holding hot foods for service, food temperature should be measured when placing it on the steam table line. 5. No food will be served that does not meet the food code standard temperatures...".

On 3/2/23 at 4:29 PM, during an end of day meeting, the facility Administrator was made aware of the above findings.

No further information was provided.

3. The facility staff failed to dry dishes in a manner to avoid wet nesting to prevent the

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development of microorganism growth.

On 3/5/23 at approximately 6:30 PM, an observation was made of the cleaning of the evening meals dishes. Three employees were working in the dish room. Employee T, a dietary aide was observed removing the racks of dishes from the dishwasher and immediately stacked the wet dishes which included the plate warmer pellets, plates, and bowls. Employee T also removed the meal trays from the dishwasher and immediately stacked them on a cart, while they were still wet. When asked about drying of dishes, Employee T said she put the pellets and plates into the warmer. When asked about allowing them to air dry, Employee T stated, what was being observed is how she does it.

On 3/7/23 at 10:30 AM, an interview was conducted with the dietary manager, Employee Q. When asked about how dishes are to be dried, she said they are to remain on the rack to air dry because it is important so that bacteria don't grow. Employee Q and Surveyor C then walked over to dish room and they observed bowls stacked, eating surface facing up, with water being visible inside the bowls. The dietary manager confirmed the observation of dishes wet nesting. The dietary manager was also made aware of the observations that occurred on 3/5/23.

The facility policy regarding the drying of dishes was requested. The facility stated they did not have a policy or procedure regarding this.

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 4, section 4-901.11,

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titled "Equipment and Utensils, Air-Drying Required" pages 151-152 stated: "After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food; and (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry."

On 3/7/23, during an end of day meeting, the facility Administrator was made aware of the above findings.

No further information was provided.

4. The facility staff failed to remove a dented can so that it was not available for use, to ensure the integrity of the product.

On 2/28/23 at approximately 1:20 PM during observation of the dry storage area of the kitchen revealed on the rack of canned goods, a dented can of marinara sauce that was available for use. Employee S was asked about the facility process with regards to dented cans. Employee S said, "we sit it on the side". When asked, why? Employee S said, "we aren't supposed to use them when dented up". Employee S was shown and confirmed that the can of marinara sauce was dented and should have been put in the designated area so that it wouldn't be available for use.

On 03/01/23 at 11:30 AM, Employee Q the dietary

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manager was interviewed. The dietary manager stated that dented cans are placed in a separate area, designated for dented cans so that they are not used. When asked what the risk of using dented cans is, she said that the quality of the product can be compromised, and the food has the potential to be contaminated from the dent. The dietary manager was made aware of the above findings noted on 2/28/23.

Review of the facility policy titled "Safe Food and Supply Storage" stated, "... 7. Dented cans should be stored in a designated area for return to the distributor or discarded."

On 3/2/23 at 4:29 PM, during an end of day meeting the facility administrator was made aware of the above findings.

No further information was provided.

5. The facility staff failed to have hand soap available in the kitchen, for staff to wash hands prior to the preparation of food.

On 2/28/23 at 07:42 AM, Surveyor C entered the kitchen to conduct a brief tour. Upon entry to the kitchen, Surveyor C proceeded to the hand sink to wash her hands and identified there was no soap, the dispenser was empty. Surveyor C inquired if there was another sink available and the dietary staff stated that was the only hand sink available. Employee P, a dietary aide stated she would go get some.

On 2/28/23 at approximately 7:50 AM, Employee P, the dietary aide returned and informed

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Surveyor C that housekeeping didn't have any extra soap on their cart and would have to wait for a supervisor to arrive to unlock the supply area. The dietary staff then proceeded to prepare the tray line by taking food temperatures and plate set-up. When asked about hand hygiene, the dietary employees stated, "There was soap when I went to wash my hands".

On 3/2/23, during an end of day meeting, the facility was asked to provide any facility policies with regards to hand washing. The facility stated they didn't have a hand washing policy with regards to dietary staff. Review of the Infection Prevention and Control policy was conducted. It read, "....4. Hand Hygiene Protocol: a. Employees will wash hands when coming on duty, between patient contacts, after handling contaminated objects, after PPE removal, before/after eating, before/after toileting, and before going off duty. b. Employees will wash their hands before and after patient care procedures. c. Hands will be washed in accordance with standards of practice...".

On 3/2/23, during an end of day meeting, the facility Administrator was made aware of the above findings. During the end of day meeting, the facility Administrator told the survey team that there are additional soap dispensers in the kitchen available for handwashing.

On 3/3/23 at 9:22 AM, Surveyor C went to kitchen and interviewed the dietary manager. It was noted that the only additional soap available to staff other than the dispenser by the hand sink was the dish soap dispenser at the three-compartment sink. The Dietary manager confirmed this.

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F 812	Continued From page 123 On 3/3/23, the facility administrator provided the survey team with a copy of an in-service training that was conducted with regards to staff being provided a tour of the facility to access points where supplies are maintained. No further information was provided.	F 812		
F 839 SS=E	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to obtain licensure verification after a professional license expired to ensure the license was current for 1 Registered Nurse, (Employee #15) in the survey sample of 25 employees. The findings included: During the survey, reviews of 25 employee records were conducted. The reviews revealed that Employee #15 (an RN) did not have a licensure verification check completed through the Virginia Department of Healthcare Professionals (DHP) Licensure	F 839	1) Employee #15 no longer employed by center. 2) Current residents have the potential to be affected by this deficient practice. The center will conduct a complete audit of current employee personnel files to verify that licenses, backgrounds, references, and other required forms are available and up to date. 3) The Administrator will re-educate Human Resource manager on maintaining complete and accurate employee files. 4) The Administrator or designee will review new employee files weekly x 12 weeks to ensure that employee files are	4/23/23

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F 839	Continued From page 124 Exchange upon expiration of her professional nursing license on 12-31-21. The facility failed to obtain a renewal certificate of licensure without encumbrances. An interview was conducted with the Human Resource Manager on 3-2-23 at approximately 4:00 p.m. The Human Resource Manager stated that the documents could not be found, and that the facility had nothing further to provide. The facility administration was informed of the findings during an end of day briefing on 3-3-23 at approximately 6:30 p.m. The facility did not present any further information about the findings.	F 839	current with up-to-date licenses and report findings to QAPI committee. 5) Date of compliance April 23,2023	
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		4/23/23

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F 880	Continued From page 125 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 126 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed 1) to ensure a multi-use glucometer was disinfected per manufacturer's instructions between use on each resident to prevent potential spread of bloodborne pathogens during finger-stick blood glucose checks for three of three residents (R104, R100, and R105) observed for blood sugar monitoring. R105 was diagnosed with bloodborne pathogens potentially transmissible to other residents using the glucometer. This failure had the potential to transmit infection to all 15 residents who received finger-stick blood glucose monitoring. On 03/03/23 at 2:55 PM, Immediate Jeopardy was called. The Immediate Jeopardy began on 03/03/23 at 10:29 AM, and was removed on 03/06/23 4:30 PM. Deficiencies remain at a level 2 isolated including 2) The facility staff failed to wear proper personal protective equipment (PPE) prior to entering the room of Resident # 101 in a survey sample of 71 residents. Findings include: 1. Review of R104's undated "Profile," located in the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on 11/09/22 with multiple diagnoses including type II diabetes mellitus.	F 880	1) a. Resident #104 no longer resides in the center. Resident #100□s physician was notified of incident on 3/3/2023. Resident #105 no untoward effects noted; Glucometer is currently being cleaned and disinfected prior to obtaining resident□s blood sugar. b. Resident #105 no corrective action needed. Employee D no longer employed by the center. Employee E re-educated on following transmission-based precautions and donning and doffing PPE. 2) Current residents have the potential to be affected by this deficient practice. 3) a. The DON or designee will re-educate current licensed nurses on glucometer cleaning and disinfecting procedure. b. The DON or designee will re-educate current facility staff on transmission-based precautions and donning and doffing PPE. 4) a. The DON or designee will randomly audit 3 licensed nurses to ensure proper cleaning and disinfection of glucometers between patients 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. b. The DON or designee will randomly audit 3 staff members to ensure Transmission Based Precautions are	

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F 880	Continued From page 127 Review of R104's 03/03/23 physician's "Orders," located in the "Orders" tab of the EMR, revealed an 11/09/22 order for Humalog insulin per sliding scale (amount given based on the current blood sugar reading) to be given at 6:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM. There was no specific order for finger-stick blood glucose monitoring. 2. Review of R100's undated "Profile," found in the "Profile" tab of the EMR, revealed she was admitted to the facility on 06/11/22 with multiple diagnoses including type II diabetes mellitus. Review of R100's 03/03/23 physician's "Orders," located in the "Orders" tab of the EMR, revealed a 06/16/22 order for Humalog insulin per sliding scale to be given at 6:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM. There was no specific order for finger-stick blood glucose monitoring. 3. Review of R105's undated "Profile" in the "Profile" tab of the EMR revealed she had diagnoses including osteomyelitis (bone infection that can spread via the bloodstream), methicillin-resistant staphylococcus aureus (MRSA) infection (a staph infection that is difficult to treat because of resistance to antibiotics, that can be spread via the blood. https://www.cdc.gov/mrsa), klebsiella pneumoniae (a bacterium associated with pneumonia spread by person-to-person contact and can be spread through the blood. https://www.cdc.gov/hai/organisms/klebsiella/klebsiella.html), and type II diabetes mellitus. Review of R105's 03/03/23 physician's "Orders," located in the "Orders" tab of the EMR, revealed a 02/09/23 order for blood sugar monitoring at	F 880	being followed with proper donning and doffing of PPE 3x a week for 2 weeks, then weekly for 2 weeks, then monthly x 2 and report findings to the QAPI committee. 5) Date of compliance April 23, 2023.	

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6:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM.

On 03/03/23 at 10:29 AM, Licensed Practical Nurse (LPN) B was observed as she prepared to perform finger-stick blood glucose checks for R104, R100, and R105. LPN B placed three pairs of gloves, three lancets, one glucometer, and three alcohol prep pads on a piece of paper and brought them with her into R104's room. LPN B donned gloves, opened the alcohol prep pad, and wiped R104's finger. LPN B then used a lancet to pierce R104's skin, inserted the test strip in the glucometer, touched the test strip to the finger to obtain the blood sample, and obtained a blood sugar reading of 75. LPN B then discarded her gloves and exited the room without first washing or sanitizing her hands.

LPN B then walked to R100's room and entered the room. LPN B donned gloves without first washing or sanitizing her hands. LPN B then inserted the test strip into the glucometer without first cleaning or sanitizing the glucometer. LPN B then used the lancet to perform the finger stick and touched the test strip to R100'S finger to obtain the blood sample with a blood sugar reading of 254. LPN B then doffed her gloves and exited the room.

LPN B proceeded toward R105's room when Surveyor "I" intervened. LPN B stated she only had one glucometer and used the same glucometer for every resident she cared for. LPN B stated she would wipe it off with an alcohol prep pad when she went back to her cart after obtaining all three residents' blood sugar values. LPN B stated she was trained to sanitize the glucometer between each use, but she was "just trying to hurry up and get it done." LPN B stated

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she used an alcohol prep pad [70% isopropyl alcohol] to clean the glucometer after use. Surveyor "I" then requested LPN B sanitize the glucometer before proceeding with R105's blood sugar check. LPN B was observed to use one alcohol prep pad to wipe the front of the glucometer, and another pad to wipe the back of the glucometer, then placed it on a tissue on top of the cart to dry.

In an interview on 03/03/23 at 10:38 AM, LPN D, who served as the Unit Manager, stated glucometers should be cleaned and sanitized between use on each resident, and the staff were to use the "grey-top" wipes to sanitize the machine. She stated, "We try to have two [glucometers] on each so they can rotate and use one while the other dries." LPN D stated failure to sanitize the glucometer between each resident could lead to transmission of infection and contamination to other residents. Observation of the "grey-top" wipes revealed they were "Sani-Cloth Germicidal Disposable Wipes" with Environmental Protection Agency (EPA) registration #9480-9.

In an interview with the Administrator and Employee F on 03/03/23 at 2:55 PM, Employee F stated the staff should be using the appropriate "Super Sani-cloth" for glucometer disinfection between use on each resident.

Review of the April 2021"Assure Prism" glucometer "User Instruction Manual" under the section "Cleaning and Disinfection" revealed, "The cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter and lancing device before performing the disinfection procedure. The

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disinfection procedure is needed to prevent transmission of blood-borne pathogens . . . The meter should be cleaned and disinfected after use on each patient. This Blood Glucose Monitoring System may only be used for testing multiple patients when Standard Precautions and the manufacturer's disinfection procedures are followed. . . . We have validated Clorox Healthcare Bleach Germicidal Wipes [0.55% Sodium Hypochlorite, EPA#67619-12], Dispatch Hospital Cleaner Disinfectant Towels with Bleach [0.65% Sodium Hypochlorite, EPA#56392-8], CaviWipes1 [0.76% Didecyldimethylammonium chloride, 7.5% Ethanol, 15% isopropanol; EPA#46781-13], and PDI Super Sani-Cloth Germicidal Disposable Wipe [n-Alkly (68% C12, 32% C14) dimethyl ethylbenzyl ammonium chlorides, 0.25% n-Alkyl (60% C14, 30% C16, 5% C12, 5% C18) dimethyl benzyl ammonium chlorides, 0.25%, 55% isopropyl alcohol; EPA#9480-4] for disinfecting the Assure Prism multi meter. These disinfectants are available commercially in towelette form . . . Only wipes with EPA registration numbers listed in the previous tables have been validated for use in cleaning and disinfecting the meter. Any disinfectant product containing the EPA registration numbers may be used on this device."

Review of the facility's 05/27/22 "Blood Glucose Monitoring" policy revealed, "It is the policy of this Center to perform blood glucose monitoring per physician/physician extender's orders . . . The nurse will abide by the infection prevention and control practices of cleaning and disinfection of the glucometer per manufacturer's instructions . . . The nurse is responsible for cleaning and disinfection of the glucometer between patients

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following the manufacturer's instructions."

On 03/03/23 at 2:55 PM, the Administrator and the Regional Clinical Registered Nurse (employee F) were notified the failure to ensure a multi-use glucometer was disinfected between use on each resident to prevent the potential spread of bloodborne pathogens constituted Immediate Jeopardy to the health and safety of the residents who used the multi-use glucometers. The Immediate Jeopardy began on 03/03/23 at 10:29 AM, when observations of the failure to disinfect the glucometer between use on each resident were first made.

The facility presented the following removal plan.

1) All residents have the potential for risk if employee fails to disinfect of glucometer. Facility obtained proper [EPA registered] disinfectant wipes to clean the glucometers. Resident #100 was assessed and is being monitored for any adverse signs or symptoms. MD/RP made aware of incident. All Glucometers disinfected on 3/3/23.

2) Before being permitted to work all licensed nurses (LPNs and RNs) will be educated on and preform [sic] a return demonstration on the process of disinfecting a glucometer after each use.

3) Date of completion 3/3/23 at 6:15pm.

The survey team verified the facility's removal plan by doing the following:

Resident #100's clinical chart was reviewed, and

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it was confirmed that a nursing progress note was entered into the record that the nurse practitioner was made aware of the incident and gave no new orders. The Resident's Responsible party was also made aware of the incident.

Surveyor C made observations on both nursing stations to verify that the correct "purple top" Super Sani cloths (EPA registered) were present and available for staff use.

Surveyor C conducted staff interviews with all of the nurses (LPN/RN) currently working (10 LPNs and 1 RN) and all were able to verbalize the correct way to disinfect a glucometer, able to verbalize that they would do this prior to use and after each use (between each Resident). They would wipe all surfaces of the glucometer with a purple-top sani wipe and then take a clean super sani-wipe and wrap the glucometer and let it sit for 2 minutes, then remove the super sani-wipe and let the glucometer sit on a clean towel to air dry before using. 2 Nurses performed return demonstration.

Facility staff were observed correctly sanitizing glucometers in-between residents.

Immediate Jeopardy was removed on 3/6/23 at 4:30 PM

2. The facility staff failed to wear proper personal protective equipment (PPE) prior to entering the room of a Resident with a known condition that was highly transmissible. This deficient practice was not related to the Immediate Jeopardy.

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On 2/28/23 at approximately 9:00 AM, Resident #105 was observed to have a sign on her room door that read, "Contact Precautions, Prior to Entering Room: Clean hands using alcohol-based hand rub, gown, gloves". There was a station set-up in the hallway, outside of the room that contained isolation gowns, gloves, etc.

On 2/28/23 at approximately 9:03 AM, an interview was conducted with CNA B. CNA B confirmed with the nurse on duty and then responded to the Surveyor that Resident #105 was on isolation for MRSA (Methicillin-resistant Staphylococcus aureus is a cause of staph infection that is difficult to treat because of resistance to some antibiotics).

On 2/28/23 at 9:20 AM, Surveyor C observed Employee D enter the room of Resident #105 without putting on an isolation gown or gloves. Upon Employee D's exit from the room she was asked about the signage on the door, which indicated isolation. Employee D said, "it was with the roommate she had, I overlooked the sign".

On 2/28/23 at 10:12 AM, Employee E, who was a housekeeper was observed in Resident #105's room cleaning without wearing an isolation gown or gloves. When asked about the signage and PPE bin outside of the room, she said "it will say hot room if it is COVID, but we haven't had COVID in a while. If it's something that can be transmitted, I wear it, otherwise I don't". When asked how she wound know if it is something that can or cannot be transmitted and she said she didn't know.

On 2/28/23 at 10:20 AM, an interview was conducted with LPN D, the unit manager. LPN D

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F 880	Continued From page 134 said, "Everyone should be wearing PPE, including housekeeping". Review of the facility policy titled; "Contact Precautions" was conducted. This policy read, "...3. Use of personal protective equipment (PPE) and hand hygiene: a. Perform hand hygiene by using an alcohol-based hand rub prior to donning PPE and room entry. Wash hands with soap and water or use alcohol-based hand rub, in accordance with hand hygiene practices. b. Don gown and gloves upon room entry, doff and discard PPE in appropriate container, perform hand hygiene prior to room exit. During providing care for residents, gloves and gown will be changed after having contact with infective material that may contain high concentrations of microorganisms or if becomes visibly soiled (fecal material or wound drainage) ...". On 3/3/23, during an end of day meeting, the facility Administrator and Corporate Clinical Consultant were made aware of the above findings. No additional information was provided, prior to the conclusion of the survey.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		4/23/23

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F 883	Continued From page 135 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		

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F 883	Continued From page 136 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to 1) provide influenza vaccines for 1 resident, Resident #465, out of 5 residents reviewed for influenza immunization and 2) facility staff failed to provide a pneumococcal vaccine for 1 resident, Residents #465, out of 5 residents reviewed for pneumococcal immunization. The findings included: 1. The facility staff failed to provide influenza immunization for Resident #465. On 2/28/23, clinical record review was performed and revealed that Resident #465, who was admitted to the facility on 2/19/23, had no documentation with regard to influenza immunization, to include the resident's current influenza vaccination status, offer to provide immunization against influenza infection, or documentation of resident refusal or medical contraindication. On 2/28/23 at approximately 3:30 PM, an interview was conducted with the Infection Preventionist (IP) who accessed the clinical record for Resident #465 and verified the findings. A facility policy was requested and received.	F 883	1) Resident # 465 no longer resides in the center. 2) Current residents without the recommended influenza vaccine or pneumonia vaccine are at risk. Current residents□ immunizations will be reviewed to ensure influenza and pneumonia vaccines offered and administered per residents□ choice. 3) The DON and designee will educate current licensed nurses on influenza and pneumonia vaccine policy. 4) The DON and designee will review each new admission to ensure flu and pneumonia vaccines offered 3 x weekly for 2 weeks, then monthly x 2 and report findings to the QAPI committee. 5) Date of compliance April 23,2023	

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F 883	Continued From page 137	F 883		

Review of the facility policy entitled, "Influenza Vaccination", date implemented 6/1/21, subheading, "Policy" read, "It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from influenza by offering our residents...annual immunization against influenza", item #2 read, "Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine", and item #9 read, "The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal".

On 2/28/23 at the end of day meeting, the Facility Administrator, Director of Nursing, and Infection Preventionist were made aware of the findings. No further information was provided.

2. The facility staff failed to provide pneumococcal immunizations for Resident #465.

On 2/28/23, clinical record review was performed and revealed Resident #465 had no documentation with regard to pneumococcal immunization, to include the resident's current pneumococcal vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication.

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F 883	Continued From page 138 On 2/28/23 at approximately 3:30 PM, an interview was conducted with the Infection Preventionist (IP) who accessed the clinical records for Resident #465 and verified the findings. A facility policy was requested and received. Review of the facility policy entitled, "Pneumococcal Vaccine", date implemented 6/1/21, subheading, "Policy", item #1 read, "Each resident will be assessed for pneumococcal immunization upon admission" and item #2 read, "Each resident will be offered a pneumococcal immunization unless sit is medically contraindicated or the resident has already been immunized". On 2/28/23 at the end of day meeting, the Facility Administrator, Director of Nursing, and Infection Preventionist were made aware of the findings. No further information was provided.	F 883		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency;	F 886		4/23/23

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F 886	Continued From page 139	F 886		

(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who

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F 886	Continued From page 140 refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for 2 residents, Resident #114 and Resident #116, in a sample of 5 Residents reviewed for COVID-19 testing. The findings included: 1. For Resident #114, facility staff failed to conduct COVID-19 testing on 2/13/23 and 2/15/23, following her admission to the facility on 2/13/23. The first COVID-19 test was administered on 2/17/23, four days post-admission. 2. For Resident #116, facility staff failed to conduct COVID-19 testing on 2/13/23 and 2/15/23, following her admission to the facility on 2/13/23. The first COVID-19 test was administered on 2/17/23, four days post-admission. On 2/28/23, a clinical record review was conducted and revealed no evidence of COVID-19 testing until 2/17/23, Day 4 post-admission, for both Resident #114 and	F 886	1) Resident #114 was tested for COVID-19 on 2/17/23. Patient is currently without signs and symptoms of COVID-19, is being monitored for signs and symptoms, and tested per policy. Resident #116 no longer resides in center. 2) All residents that were admitted to the facility in the last 30 days will be reviewed to ensure COVID-19 testing was performed at the time of admission per policy. Corrections will be made as indicated at the time of identification. 3) The DON or designee will re-educate current licensed nurses on Covid-19 testing policy. 4) The DON or designee will randomly audit 3 new admissions to ensure Covid-19 testing completed per policy weekly x 12 weeks report finding to QAPI committee. 5) Date of compliance April 23, 2023	

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Resident #116. The COVID-19 Community Transmissibility Level for the facility was "HIGH" for the week 2/13/23 through 2/26/23.

On 2/28/23 at approximately 3:30 PM, an interview was conducted with the Infection Preventionist (IP) who confirmed that COVID-19 community transmissibility levels were high on 2/13/23. The IP accessed the clinical records for both Residents and confirmed their admission dates and COVID-19 testing dates. The IP stated, "it is my expectation that these residents [Resident #114 and #116] would have been immediately [COVID] tested upon their admission here and then again 48 hours later, followed by a third test in another 48 hours, but is does not appear that this [COVID testing] was done". A copy of the facility's COVID-19 testing policy was requested and received

Review of the facility policy titled, "Coronavirus Testing Plan", date revised 11/2/22, subtitle, "Policy Explanation" item 4 read, "In general, admissions in counties where Community Transmissibility levels are high should be tested upon admission..." and item 5, read, "Newly admitted patients and patients who have left the center for >24 hours should have a series of three viral tests for SARS-CoV-2 infection: immediately and, if negative, again 48 hours after the first negative test and, if negative again, 48 hours after the second negative test".

The CDC document entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 11, subheading, "Nursing Homes", item 3 "Managing admissions

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F 886	Continued From page 142 and residents who leave the facility", read, "In general, admissions in counties where Community Transmission levels are high should be tested upon admission...Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test". On 2/28/23, during the end of day meeting, the Facility Administrator and Director of Nursing were made aware of the findings. No additional information was provided.	F 886		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those	F 887		4/23/23

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F 887	Continued From page 143 additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). 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 COVID-19 immunization for 1 resident, Resident #465, in a survey sample of 5 residents reviewed for COVID-19 immunization.	F 887	1) Resident #465 no longer resides in center. Covid-19 vaccine clinic scheduled 4/11/23. 2) All residents were reviewed to determine if Covid-19 vaccine has been	

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F 887	Continued From page 144 The findings included: The facility staff failed to provide evidence that Resident #465 was offered, educated, and provided/or declined COVID-19 vaccination. On 2/28/23, clinical record review was performed for Resident #465, admitted to the facility on 2/19/23. Resident #465 had no documentation with regard to COVID-19 immunization, to include the resident's current COVID-19 vaccination status, offer to provide immunization against COVID-19 infection, or documentation of resident refusal or medical contraindication. On 2/28/23 at approximately 3:30 PM, an interview was conducted with the Infection Preventionist (IP). The IP verified the findings for Resident #465 and stated the COVID-19 immunization status should have been assessed at admission. A facility policy regarding COVID-19 immunization for residents was requested and received. Review of the facility policy titled, "COVID-19 Vaccination--Patients", date revised 11/3/22, subtitle, "Policy" read, "it is the policy of this Center to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our patients the COVID-19 vaccine". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 2, item 1, read, "1.	F 887	offered and/or administered if consent was given. 3) DON or designee will re-educate current licensed nurses on completion of Covid-19 vaccinations per policy. 4) The DON or designee will randomly audit 10% of residents to ensure Covid-19 immunization offered 3x a week for 2 weeks, then weekly for 2 weeks then monthly x 2 and report findings to QAPI committee. 5) Date of compliance April 23, 2023	

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F 887	Continued From page 145 Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses...HCP [Healthcare Personnel], patients, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine". The CDC document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States", updated October 19, 2022, page 3, heading "Recommendations for COVID-19 vaccine use", subheading "Groups recommended for vaccination", read, "COVID-19 vaccination is recommended for everyone ages 6 months and older in the United States for the prevention of COVID-19...CDC recommends that people stay up to date with COVID-19 vaccination by completing a primary series and receiving the most recent booster dose recommended for them by the CDC". On 2/28/23, during the end of day meeting, the Facility Administrator and Director of Nursing were made aware of the findings. No additional information was provided.	F 887		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain an	F 925	1)Resident #56□s room cleaned and treated for pests on 3/3/2023	4/23/23

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F 925	Continued From page 146 effective pest control program for one of 37 residents' (Resident (R) 56) rooms observed in Initial Pool. This failure had the potential to lead to further pest infestation in the facility. Findings include: Review of R56's undated "Profile," found in the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on 10/24/22 with diagnoses including dementia, glaucoma, legal blindness, insomnia, and muscle weakness. Review of R56's significant change in status "Minimum Data Set (MDS)" assessment with an assessment reference date (ARD) of 02/18/23, located in the "MDS" tab of the EMR, revealed she scored two out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating severely impaired cognition. R56 had severely impaired vision and was sometimes able to understand others. She did not exhibit any behavioral symptoms. Review of R56's comprehensive "Care Plan," located in the "Care Plan" tab of the EMR and dated 11/06/22, revealed, "Res. [resident] wears eyeglasses, but her vision is severely impaired . . . and is legally blind" and, "Res. requires assist with her ADLs [activities of daily living] d/t [due to] imp. [impaired] mobility, imp. cognition, generalized muscle weakness, anemia, dementia, glaucoma, legally blind, [and] osteoarthritis. During an observation on 02/28/23 at 1:55 PM, R56 was observed lying in bed in her room. On the floor behind the head of the bed was a piece	F 925	2) Current residents have the potential to be affected by this deficient practice. Pest control audit of resident rooms was completed on 3/27/2023. 3)The Administrator or designee will re-educate maintenance department and housekeeping department on pest control program. 4)The Administrator or designee will audit 10% of Resident rooms 2x weekly x 12 weeks and report findings to QAPI committee. 5)Date of compliance April 23,2023	

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F 925	Continued From page 147	F 925		

of candy with many small black ants swarming on it and crawling in a line on the floor along the baseboard behind R56's bed. R56 was unable to answer questions regarding the cleanliness of her room, responding "help me" to any questioning.

During observations in R56's room on 03/01/23 at 9:00 AM, 10:11 AM, and 12:33 PM; on 03/02/23 at 10:32 AM and 3:50 PM; and on 03/03/23 at 9:21 AM, the candy was still present on the floor behind the head of R56's bed, with a swarm of ants on the candy and crawling along the wall in a line to and from the candy.

In an interview and concurrent observation in R56's room on 03/03/23 at 11:03 AM, the housekeeper assigned to R56's room, employee J, stated there was candy on the floor with ants on and around it. He picked up the piece of candy and threw it away. Employee J stated the candy must have been dropped today, as he cleaned behind the beds every day. Employee J stated, "I get upset when things are on the floor like that . . . they need to keep it clean . . . The floors need to be kept very clean otherwise you get bugs."

In an interview on 03/03/23 at 12:23 PM, the Maintenance Director stated the pest control company came in monthly to spray for pests, and the facility staff did spot treatments with non-toxic boric acid in between pest control visits. The Maintenance Director stated he had received some complaints of ants in the last few months, which typically happened every year around this time. The Maintenance Director any pest sightings were documented on a log, and he had not received any reports of ants in R56's room. Review of the "Pest Sighting Log," provided in a binder by the Maintenance Director, revealed ants

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495085	A. BUILDING _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW ON THE APPOMATTOX HEALTH & REHAB CENTER	201 EPPS STREET HOPEWELL, VA 23860

(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 925	Continued From page 148 were reported in resident rooms on 01/19/23, 01/25/23, 02/01/23, 02/14/23, and 02/20/23. Each of these rooms were sprayed and set up with ant traps. R56's room was not on the log. The Maintenance Director stated the most effective way to keep pests out was to keep the floors clean. He stated the facility needed to keep their floors free of food and things that attract bugs to keep any pests out. Review of the facility's "Pest Control Program" policy revealed, "It is the policy of this center to maintain an effective pest control program that eradicates and contains common household pests and rodents . . . Center will maintain a report system of issues that may arise in between scheduled visits . . . Center will utilize a variety of methods in controlling certain seasonal pests, i.e. flies."	F 925		