STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/12/23 through 3/20/23. 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	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion of set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by both Federal and State Laws	4/26/2023
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 3/12/23 through 3/20/23. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Based on observation, staff interview, resident interview, family interview, clinical record review, and facility document review, the facility staff failed to provide wound management as evidenced by an absence of assessments, monitoring, and/or treatment for 5 out of 33 residents reviewed, resulting in wound infections and/or wound deterioration (Resident #4, Resident #10, Resident #42, Resident #36, and Resident #149). Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity level of 4, Pattern. The Administrator and DON (director of nursing) were notified on 03/15/2023 that the extended survey process had begun at 3:12 PM. Four complaints were investigated during the survey. One complaint was compliant with the regulations. Three complaints were non-compliant with the regulations, resulting in deficient practice being cited. The Life Safety Code survey/report will follow. The census in this 65 certified bed facility was 50	F 000		

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

Pamela Chapman Admin 4/5/23

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

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F 000	Continued From page 1 at the time of the survey. The survey sample consisted of 27 current resident reviews and 6 closed record reviews.	F 000		4/26/2023
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions	F 551	Resident # 199 discharged from the facility on 3/5/2022 and did not return to the facility. The facility was unable to correct action. An initial audit was conducted of all short term care residents who have requested to be transferred to another facility. This audit will also identify the status of the transfer request with any corrective action if needed. Completed on or before 4/4/2023. NHA or designee will re-educate the current Admissions Director and the current Social worker on meeting the needs of transfer request on or before 4/26/2023.	

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F 551	Continued From page 2 or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to assist the resident representative to transfer the resident to a facility of their choice for 1 of 33 residents in the survey sample, Resident #199. The findings were: The facility staff failed to assist the resident's representative with transferring Resident #199 to a nursing home in West Virginia per their	F 551	Every admission will be audited for admissions who have requested to be transferred to another facility weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 551	Continued From page 3 preference. Resident #199's admission record listed his diagnoses included but were not limited to, Covid-19, Type 2 Diabetes Mellitus, and Encephalitis (inflammation of the brain) and Encephalomyelitis (inflammation of the brain and spinal cord). The minimum data set (MDS) with an assessment reference date of 12/16/21 coded the resident's brief interview for mental status (BIMS) a 01 out of 15 in Section C (cognitive patterns). Section G (functional status) coded him needing extensive assistance with bed mobility, eating, and toilet use. The clinical record contained a document titled, Physician Determination of Capacity which the resident's attending physician signed indicating the resident lacked sufficient mental or physical capacity to appreciate the nature and implications of health care decisions. The document was dated 01/20/22. A grandchild was listed as Emergency Contact #1 and POA - medical (power of attorney - medical) on the admission record. The resident's daughter was listed as Contact #2. Under the assessments within the clinical record, a document titled "Post Admission Patient-Family Conference - V 3" with an effective date of 12/17/21 was reviewed. The document was completed by one of the facility's social services employees. Within the "Expectation" portion of the document, it read the resident/resident representative would like to see if a contracted Veteran's Administration (VA) Long Term Care placement would be available and if not, they would like placement in a West Virginia skilled nursing home. The next social services assessment and documentation found in the clinical record was dated 01/13/2022 and read	F 551		

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F 551	Continued From page 4 within the discharge planning/social service plan that social services would assist the family with their preference of transferring the resident to a facility in West Virginia, preferably a VA contract facility. Resident #199 remained in the facility until being transferred to an acute care hospital approximately three (3) months after admission. The administrator was notified of clinical record findings during an in-person interview in her office on 3/14/23 at 1:15 p.m. The surveyor requested to speak with the social services employee involved with Resident #199. The administrator reported that social worker was no longer employed at the facility but would have her call the surveyor if possible. The facility's current social worker was not employed at the facility during Resident #199's stay. On 3/20/23, the administrator provided an email from the facility's social worker to a West Virginia nursing home which read the social worker was following up on a referral request. The email was dated 2/21/22 and indicated the West Virginia nursing home had not received any earlier referral and had been having difficulties with their faxes. The social worker (SW - not a current facility employee) who completed the Post Admission Patient-Family Conference was interviewed via phone on 3/16/23 at 2:56 p.m. At the time of Resident #199's admission, her sole responsibility was to complete the Post Admission document. She recalled finding out the resident was not service - connected enough to be in a Veteran's Administration facility. She reported that after the	F 551		

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F 551	Continued From page 5 resident became Covid positive on 1/25/22, he could not be transferred for 20 days. When asked why a transfer was not facilitated between his admission and becoming Covid positive (over 6 weeks), she reported that a different social worker had the primary responsibility for the facility residents' social service needs during that time. That social worker was not currently employed at the facility and could not be interviewed. These findings were discussed with the administrator in the conference/family room on 03/19/23 in the afternoon.	F 551		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582	Resident #2 was issued an ABN notification on or before 3/20/2023. An initial Medicare audit was completed of all residents to ensure ABN notifications were provided per Medicaid/Medicare coverage/ Liability requirements for the last 30 days. Completed on or before April 5, 2023	4/26/2023

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F 582	Continued From page 6 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility staff failed to provide a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (ABN) notification for one (1) of three (3) residents selected for SNF Beneficiary Notification Review (BNR) (Resident #2). The findings include:	F 582	NHA or designee will re-educate the Clinical Re-imbursement Coordinator, Business Office Manager and the Assistant Business Office Manager on the required submission of the Advanced Beneficiary notification to be completed. This education to be completed on or before 4/26/2023. An audit will be completed of all residents who are required to receive an ABN notice to ensure they have received the notice with any corrective action needed. This audit will be completed weekly X 4 then monthly X 2 weeks or until 100% compliance, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 582	Continued From page 7 Three (3) residents were selected for SNF Beneficiary Notification Review. These three (3) residents were selected from the list of Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months prior to the survey; this list was provided by facility staff members. Resident #2 was marked as not being provided a SNF ABN due to "resident no longer required skilled services (and) switched to Medicaid services". On 3/13/23 at 1:13 p.m., the facility's Business Office Manager (BOM) stated Resident #2 was discharged from Part A with three (3) skilled benefit days remaining; the BOM stayed Resident #2 stayed in the facility. The BOM acknowledged Resident #2 should have received a SNF ABN. On 3/13/13 at 3:35 p.m., the BOM provided an email from the facility's Director of Clinical Reimbursement which indicated that the facility did not have a "formal" policy to address issuing of Beneficiary Protection Notification. This email reported the facility follows CMS (Centers for Medicare & Medicaid Services) guidance, including the Medicare Claims Processing Manual. On 3/13/23 at 3:46 p.m., the facility's Clinical Reimbursement Coordinator (CRC) acknowledged Resident #2 should have received a SNF ABN. The survey team met with the facility's Administrator and Director of Nursing (DON) on 3/17/23 at 4:01 p.m. During this meeting, the surveyor discussed the failure of the facility staff	F 582		

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F 582	Continued From page 8 to issue Resident #2 a SNF ABN when the resident was discharged from Part A services with benefit days remaining.	F 582		4/26/2023
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility staff failed to ensure one (1) of 33 residents had orders, at the time of admission, to guide care (Resident #46). The findings include: Resident #46 was documented as being readmitted to the facility on 2/14/23 at 4:35 p.m. Resident #46 was transported via ambulance to a local emergency department on 2/16/23 at 11:56 a.m. The facility staff failed to promptly obtain wound care and medication orders, for Resident #46, at the time of the readmission. Resident #46's minimum data assessment (MDS), with an assessment reference date (ARD) of 12/15/22, was dated as being completed on 12/29/22. Resident #46 was documented as never or rarely able to understand others and as never or rarely able to make self understood. Resident #46 was documented as being totally dependent on others for eating, bed mobility, dressing, toilet use, and personal hygiene. Resident #46's diagnoses included, but were not limited to: hemiplegia/hemiparesis, seizure	F 635	Resident #46 was discharged 2/16/2023 and did not return to the facility. The facility was unable to correct action. An initial audit was completed by DON/designee on 3/27/2023 of all new admissions from the last 7 days to ensure each admission arrived to the facility with transfer paper work from the admitting hospital and to validate all orders were initiated upon admission. All newly admitted residents have the potential to be affected by the alleged deficient practice.	

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F 635	Continued From page 9 disorder, irregular heartbeat, respiratory failure, and dysphagia. On 3/15/23 at 11:07 a.m., the facility's Director of Nursing (DON) and the Market Clinical Leader (MCL) confirmed new orders were required for residents at the time of readmission to the facility. On 3/15/23 at 11:10 a.m., the DON reported that no paperwork arrived with the resident on readmission at 2/14/23. The DON reported that facility staff should have contacted the discharging hospital to obtain orders for Resident #46's care. The DON reported that if facility staff were unable to obtain orders from the hospital, then either the DON or the Assistant DON should have been notified. On 3/16/23 at 12:22 p.m., the surveyor interviewed the facility's Medical Director via telephone. The Medical Director reported tht the facility staff should have called the sending facility to obtain Resident #46's orders. Resident #46's discharge summary from the local hospital was stamped as having been received at the facility on 2/15/23 (there was no time stamped). This discharge summary included the following information: - " ... pressure ulcers of skin on multiple topographic sites ..." - New discharged medications: (a) amiodarone 200 mg tablet daily by mouth for five (5) days and (b) chlorhexidine gluconate 0.12% mouthwash 10 ml mucous membrane twice a day for thirty days. - Continued medications: (a) liquid multivitamin 5 ml daily; (b) Eliquis 2.5 mg tablet twice a day; (c) ascorbic acid (vitamin C) 500 mg daily; (d) acetaminophen 325 mg tablet every six (6) hours	F 635	NPE/designee will provide re-education to all current licensed nursing staff and additional and newly hired licensed nursing staff prior to the start of their first shift on the process to initiate when admission transfer paper work is not received from the transferring facility upon admission to the Westwood Center. The re-educations will be completed on or before 4/26/2023 or upon hire. The Director of Nursing/designee will complete an audit on all newly admitted residents to ensure each admission arrived to the facility with transfer paper work from the admitting hospital and to validate all orders were	4/26/2023

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F 635	Continued From page 10 as needed; (e) lorazepam 0.5 mg tablet every eight (8) hours as needed; (f) midodrine 10 mg tablet three time a day; (g) pantoprazole 40 mg daily; (h) oxycodone-acetaminophen 10-325 mg tablet twice a day as needed; and (i) lacosamide 150 mg twice a day. Resident #46 had no medications documented as being administered on 2/15/23. All the medication orders were dated 2/15/23 at 10:05 p.m., with scheduled medications to begin on the morning of 2/16/23. Resident #46's clinical documentation had no orders for wound care for the resident's 2/14/23 - 2/16/23 stay at the facility. The survey team met with the facility's Administrator and Director of Nursing (DON) on 3/17/23 at 4:01 p.m. During this meeting, the surveyor discussed the failure of the facility staff to obtain readmission orders for Resident #46. The DON confirmed that Resident #46 had received not medications on 2/15/23. The DON confirmed that Resident #46 had no wound care orders for the stay referenced in this report. The Administrator and the DON reported that readmission orders should have been obtained the same day Resident #46 arrived at the facility.	F 635	initiated upon admission weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 641	Resident #4 Modification of MDS Section M M0100. Determination of Pressure Ulcer/Injury Risk Subsection Z. None of the above was corrected.	

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F 641	Continued From page 11 review, the facility staff failed to ensure an accurate minimum data set (MDS) assessment for 1 of 33 residents, Resident #4. The findings included: For Resident #4 the facility staff failed to properly code a wound on the MDS. Resident #4's face sheet listed diagnoses which included but not limited to multiple sclerosis, depression, anxiety, and contractures of muscles. The most recent MDS with an assessment reference date of 02/06/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section M, skin conditions, subsection M1040, other ulcers, wounds and skin problems coded the resident as "none of the above present". This subsection includes surgical wounds. Resident #4's comprehensive care plan was reviewed and contained care plans for "Resident at nutrition risk r/t (related to) ... Wounds: Surgical PI Open wound to R (right) hip skin fold, healing ..."and" ... is at risk for continuing impaired skin integrity related to diagnosis of MS (multiple sclerosis), impaired mobility ... Type: Pressure ulcers." Surveyor spoke with director of nursing (DON) on 0315/23 at 10:00 am regarding Resident #4's wound. DON stated that wound to resident's right hip is a surgical wound versus a pressure ulcer. Surveyor spoke with MDS coordinator on 03/20/23 at 10:55 am regarding Resident #4's	F 641	An audit will be completed of all current residents with wounds to ensure their individual MDS ARD Assessments Section M Skin Conditions is correct with corrective action if needed. DON/ designee will re-educate current MDS Coordinator on the Section M based on the Centers for Medicare & Medicaid Services Long - Term Care Facility Resident Assessment Instrument 3.0 User's Manual Chapter 3, Skin Conditions. This education will be provided on or before 4/26/2023.	4/26/2023

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F 641	Continued From page 12 wound. Surveyor asked MDS coordinator what "surgical PI" stands for, and MDS stated "I don't know what that is". MDS coordinator also stated resident "had a hip done some time ago". This Surveyor asked MDS to clarify this statement, and MDS coordinator stated that resident had some type of surgery to hip in the past. This Surveyor asked MDS if this should have been coded on the resident's MDS assessment, and MDS coordinator stated that it should have been. The concern of not correctly coding an MDS assessment was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit.	F 641	All current residents with wounds, MDS ARD Assessments Section M Skin Conditions coding will be audited weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655	Resident # 149 was discharged from the facility on 1/23/2023 and did not return to the facility. The facility was unable to correct the action. Resident #36 skin integrity plan of care was updated to reflect current skin integrity interventions. An initial audit was completed by DON/designee of all current residents with impaired skin integrity to ensure a baseline	

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F 655	Continued From page 13 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to initiate a care plan within 48 hours that addressed the resident's clinical needs for 2 of 33 residents, Resident #36 and #149 1. For Resident #36, facility staff failed to implement a baseline care plan to address the resident's needs as evidenced by failure to address surgical wounds on the care plan within 48 hours of admission. Resident #36 was admitted to the facility with	F 655	comprehensive skin integrity care plans were initiated upon admission and revised based on the residents current status. NPE/designee will provide re- education on the process for developing and updating baseline comprehensive skin care plans to reflect the resident's current status on admission and with any significant change in condition, to all current licensed nurses and additional and newly hired licensed nursing staff prior to the start of to the start of their first shift. The re-educations will be completed on or before 4/26/2023 or upon hire.	4/26/2023

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F 655	Continued From page 14 diagnoses including (by listed date of diagnosis) type 2 diabetes mellitus with diabetic polyneuropathy, peripheral vascular disease, morbid obesity, obstructive sleep apnea,muscle weakness, hypertensive heart and chronic kidney disease with heart failure, local infection of the skin and subcutaneous tissue, methicillin resistant staphylococcus aureus infection, chronic obstructive pulmonary disease with acute exacerbation, atrial fibrillation, sepsis due to escherichia coli, and bacteremia. On the minimum data set assessment with assessment reference date 2/1/23, the resident scored 14/15 on the brief interview for mental status, and was assessed as being without signs of delirium, psychosis, or behaviors affecting care. The surveyor interviewed the resident on 3/12/23 concerning life in the facility. The resident had no complaints. When questioned about wound care (the right lower leg ended in a stump covered with a sock) the resident said staff usually changed the dressing on the leg wound daily. Clinical record review revealed two recent hospitalizations with wound infections: 12/2722 through 1/3/23 and 1/14 through 1/20/23. Prior to the hospitalization on 12/27/22, clinical record review revealed A physician order dated 11/7/22 through 1/3/23 for Cleanse area to right stump with WC/VASHE. Apply xeroform, then cover with border foam every day shift Tue, Thu for wound care. The treatment was not documented as completed 12/1, 6, 8,13,15, and 22. The resident was hospitalized for sepsis and right below the knee amputation infection on 12/27.	F 655	DON/designee will complete audits on all newly admitted residents to ensure baseline comprehensive skin care plans are developed upon admission and revised to reflect current status of the resident weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 655	Continued From page 15 The resident was hospitalized 12/27/22 through 1/3/23. Per the hospital discharge, the resident was admitted with sepsis, right BKA (below knee amputation) infection, fever, and more. The surgeon assessed the right BKA wound and determined there was no need for surgical intervention. Dressings continued per surgeon orders. On 1/3/23, the resident returned to the facility. No orders for wound care were entered in the system. Nursing documentation included no skin assessments from 12/28/22 through 1/20/23. The resident was hospitalized from 1/14/23 through 1/20/23. A facility nursing note dated 1/20/23 documented]Note: Resident returned via non-emergent BLS ambulance service. Resident is awake, alert, oriented, and able to make his needs known per his usual. A double lumen PICC line is in place in right upper arm. Resident will be receiving IV Invanz and Zyvox by mouth for VRE and Proteus bacteremia. Resident's buttocks are reddened, but blanchable, and dressing over RLE/foot amputation site is CDI. Enhanced barrier precautions are in place, and staff is aware of the need to glove and gown before providing care, and resident is aware that he needs to sanitize his hands before leaving his room, and notify the nurse if his dressing becomes soiled or loose while he is out of his room. No orders for wound care/dressing changes were entered in the system at the time of return from the hospital. An order was entered dated 1/24/23 for Cleanse wound to RLE with IHWC (in house wound	F 655		

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F 655	Continued From page 16 cleanser), pat dry, apply non-adherent dressing and wrap with gauze and ACE bandage every day shift for wound healing. Wound care was not documented as completed on 1/25, 26, 28, and 29. The resident's comprehensive care plan did not address not address actual skin integrity intervention to monitor wound for worsening signs of infection and notify PCP until a revision on 1/26/23. There was no evidence of care plan revision as the resident was hospitalized with infections and experienced surgical interventions to treat wounds and wound-related infections. The most recent intervention revision was "provide treatment as ordered" dated 7/1/22. On 3/14/23, the surveyor interviewed the assistant director of nursing (ADON) about the admission process. Per the ADON, the admission nurse gets the discharge summary from the hospital. The admission orders are in the discharge summary. The admission orders are entered into the system by the floor nurse when the resident arrives (this step may be performed by the ADON or DON). The nurse calls the physician or nurse practitioner to review the admission orders. A second nurse looks at the admission orders to verify the discharge summary orders match the admission orders in the electronic record. Someone in the nursing department asks the family to sign the admission paperwork. A skin check is done within 2 hours of arrival. Dressings are usually noted during the skin check. The other assessments are usually done within the first 48 hours. There was no mention of initiating or revising the resident's comprehensive care plan.	F 655		

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F 655	Continued From page 17 The surveyor notified the administrator and director of nursing during a summary meeting on 3/20/23 that the baseline care plan did not provide enough information for staff to provide wound care and monitoring for the first 6 days in the facility. 2. For Resident #149, facility staff failed to initiate a baseline care plan to include the minimum healthcare information necessary to care for a resident as evidenced by absence of surgical wound treatment on the baseline care plan. Resident #149 was admitted to the facility with primary diagnosis encounter for orthopedic aftercare following surgical amputation. Secondary diagnoses included diabetes mellitus due to underlying condition with diabetic nephropathy, atrial fibrillation, hypertensive heart disease with heart failure, asthma, infection following a procedure-superficial incisional surgical site-subsequent encounter, muscle weakness, and difficulty walking. On the admission minimum data set assessment (MDS) with assessment reference date 1/19/2023, the resident scored 13/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The MDS also documented the resident had surgery during the prior 100 days, recent surgery requiring SNF care, infection of the foot, surgical wounds, and surgical wound care. The resident's comprehensive care plan documented under Focus: Actual skin impairment R/T (related to) surgical amputation of toes to	F 655		

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F 655	Continued From page 18 right foot...is at risk for complications R/T said amputations (revised 1/24/23 by DON the surveyor requested history of changes, but did not receive it prior to the end of the survey) Interventions initiated 1/14/23: Weekly skin check, Dressing changes will be provided per PCP orders, obtain skilled PT/OT evaluation, and dietician consult as needed. Dressing changes were not initiated until 1/19/2023. A family nurse practitioner (FNP) note dated 1/16/23 indicated an acute visit for follow-up foot pain after amputation of toes on right foot. FNP plan was to continue current pain regimen and for wound of right foot -Follow-up with surgeon on wound orders. A FNP note dated 1/18/23 indicated an acute care visit at the request of the family and nursing to address right foot pain and reported vivid dreams and hallucinations. The FNP noted personally calling the surgeon's office to obtain wound care orders. New orders written for Neurontin for pain; laboratory testing for infection or chemical imbalances, wound dressing changes and intramuscular antibiotic rocephin for 3 days. The resident's Treatment Administration Record (TAR) documented an order to Cleanse Right Foot, surgical site, with warm soap & H2O. Pat Dry. Cover with "sterile" dry dressing every day shift (12 hour 6 A) for wound care. The treatment was documented as administered 1/19, 1/20, 1/21, 1/22, 1/24, and 1/25. The nurse, LPN #5 was unavailable for interview to determine whether the 1/23 treatment was performed. Per the facility record, the resident was sent to	F 655		

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F 655	Continued From page 19 the hospital on 1/25/23 and was admitted for complications after amputation. On 3/14/23, the surveyor interviewed the assistant director of nursing (ADON) about the admission process. Per the ADON, the admission nurse gets the discharge summary from the hospital. The admission orders are in the discharge summary. The admission orders are entered into the system by the floor nurse when the resident arrives (this step may be performed by the ADON or DON). The nurse calls the physician or nurse practitioner to review the admission orders. A second nurse looks at the admission orders to verify the discharge summary orders match the admission orders in the electronic record. Someone in the nursing department asks the family to sign the admission paperwork. A skin check is done within 2 hours of arrival. Dressings are usually noted during the skin check. The other assessments are usually done within the first 48 hours. The surveyor spoke with the FNP on 3/20/23 concerning the resident's wound care and infection. The FNP stated that the wound care nurse was instructed to call the physician for wound orders on 1/16/23. The FNP called the surgeon on 1/18/23 because the resident still had no wound or dressing orders. The FNP stated that failure to perform dressing changes could contribute to infections. The surveyor notified the administrator and director of nursing during a summary meeting on 3/14/23 that the baseline care plan did not provide enough information for staff to provide wound care for the first 6 days in the facility.	F 655		

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F 656 F 656 SS=D	Continued From page 20 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 community was assessed and any referrals to local contact agencies and/or other appropriate	F 656 F 656	Resident # 149 was discharged from the facility on 1/23/2023 and did not return to the facility. The facility was unable to correct the action. An initial audit was completed by DON/designee of all current residents with impaired skin integrity to ensure comprehensive skin integrity care plans are inclusive with wound care interventions to meet the resident's needs. NPE/designee will provide re- education on the process for initiating and updating comprehensive skin care plans to reflect the interventions to meet the residents' wound care needs, to all current licensed nurses and additional and newly hired licensed nursing staff prior to the start of to the start of their first shift. The re-educations will be completed on or before 4/26/2023 or upon hire.	4/26/2023

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F 656	Continued From page 21 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 staff interview, family interview and clinical record review, the facility staff failed to initiate interventions to address the resident's wound care needs for 1 of 33 residents reviewed (Resident #149). Resident #149 was admitted to the facility with diagnoses to include encounter for orthopedic aftercare following surgical amputation, diabetes mellitus due to underlying condition with diabetic nephropathy, atrial fibrillation, hypertensive heart disease with heart failure, asthma, infection following a procedure-superficial incisional surgical site-subsequent encounter, muscle weakness, and difficulty walking. The minimum data set assessment (MDS) with the assessment reference date 1/19/2023 was reviewed. The resident scored 13/15 on the brief interview for mental status, and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The MDS also documented the resident had surgery during the prior 100 days, recent surgery requiring SNF care, infection of the foot, surgical wounds, and surgical wound care. The resident's comprehensive care plan	F 656	DON/designee will complete audits on all current residents with wound care needs to ensure comprehensive skin care plans are revised to reflect interventions for wound care needs of the resident weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 656	Continued From page 22 documented under Focus: Actual skin impairment R/T (related to) surgical amputation of toes to right foot...is at risk for complications R/T said amputations (revised 1/24/23 by DON) Interventions initiated 1/14/23: Weekly skin check, Dressing changes will be provided per PCP orders, obtain skilled PT/OT evaluation, and dietician consult as needed. Interventions initiated by DON on 1/24/23: monitor for pain/discomfort and Tx according to PCP orders and Monitor for worsening of incision site: increased redness, drainage, dehiscence of incision site, increased pain. Notify PCP of any abnormal findings. Actual wound care orders and monitoring were not placed on the care plan until 11 days after the resident's admission. A family nurse practitioner (FNP) note dated 1/16/23 indicated an acute visit for follow-up foot pain after amputation of toes on right foot. The FNP plan was to continue current pain regimen and for wound of right foot - Follow-up with surgeon on wound orders. A FNP note dated 1/18/23 indicated an acute care visit at the request of the family and nursing to address right foot pain and reported vivid dreams and hallucinations. The FNP noted personally calling the surgeon's office to obtain wound care orders. New orders written for Neurontin for pain; laboratory testing for infection or chemical imbalances, wound dressing changes and intramuscular antibiotic rocephin for 3 days. The first wound treatment order was entered in the record on 1/18/2023. Wound monitoring was added to care plan interventions on 1/24/23. The surveyor notified the administrator and director of nursing of the care planning issue	F 656		

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F 656	Continued From page 23 during a summary meeting on 3/20/23.	F 656		4/26/2023
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, the facility staff failed to review and revise the comprehensive person-centered plan of care for 1 of 33 residents in the survey sample, Resident #299.	F 657	Resident # 299 was discharged from the facility on 11/22/2022 and did not return to the facility. The facility was unable to correct the action. An initial audit was completed by DON/designee of all current residents with newly developed wounds to ensure comprehensive skin integrity care plans have been updated to reflect the current status of the residents skin integrity. NPE/designee will provide re- education on the process for initiating and updating comprehensive skin care plans to reflect the current status of the resident's current skin integrity, to all current licensed nurses and	

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F 657	Continued From page 24 The findings included: For Resident #299, the facility staff failed to revise the comprehensive person-centered plan of care following the development of a pressure injury. This was a closed record review. Resident #299's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Aftercare following Joint Replacement Surgery, Dislocation of Internal Right Hip Prosthesis, Chronic Obstructive Pulmonary Disease, Unspecified Dementia, and Type 2 Diabetes Mellitus. The admission minimum data set (MDS) with an assessment reference date (ARD) of 10/25/22 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 indicating the resident was moderately cognitively impaired. The resident was coded as being at risk of developing pressure ulcers/injuries with no current unhealed pressure ulcers/injuries. Resident #299 was coded for the presence of a surgical wound and moisture associated skin damage (MASD). A review of Resident #299's clinical record revealed a nursing progress note dated 10/23/22 at 11:00 am which stated in part " ... Stage 3 noted to coccyx. Pt [patient] states 'yeah, it's sore'. Orders placed ..." A new physician's order to cleanse coccyx with wound cleanser, pat dry, apply zguard, place non-adhesive optifoam on every 3 days or as needed was started on 10/24/22. Surveyor was unable to locate	F 657	additional and newly hired licensed nursing staff prior to the start of to the start of their first shift. The re-educations will be completed on or before 4/26/2023 or upon hire. DON/designee will complete audits on all current residents with wounds to ensure comprehensive skin care plans are revised to reflect the current skin integrity status weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 657	Continued From page 25 documentation describing the area to the coccyx when noted on 10/23/22. Resident #299 was seen by the family nurse practitioner (FNP) on 10/24/22, the progress note stated in part " ...Wound care to buttocks per stage 2 protocol. Dr. [name omitted] consult for stage 2 wound with slough to buttocks ..." This Surveyor was unable to locate any subsequent documentation of the area to the coccyx until 11/01/22 at which time the wound was photographed, measured, and assessed. At that time the area was documented as an unstageable pressure area to the sacrum measuring 9.15 cm in length and 4.91 cm in width with 100% slough. This Surveyor reviewed Resident #299's comprehensive person-centered plan of care and was unable to locate documentation of a pressure injury to the resident's coccyx/buttocks/sacral area. The plan of care included a focus area stating "resident has excoriation to coccyx related to decreased activity and intermittent incontinence of bowel and bladder" created on 10/18/22. According to the clinical record, Resident #299 was admitted to the facility on 10/18/22 and the nursing admission assessment entitled "Nursing Documentation - V 11" dated 10/18/22 at 11:07 pm documented the presence of moisture associated skin damage (MASD) to the coccyx. On 3/20/23 at 9:55 am, surveyor spoke with the Clinical Reimbursement Coordinator (CRC) regarding Resident #299's plan of care. Surveyor informed the CRC they were unable to locate documentation of the pressure injury on Resident	F 657		

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F 657	Continued From page 26 #299's plan of care. CRC reviewed the resident's plan of care and stated, "it's not on here anywhere". This Surveyor asked the CRC if the pressure area should have been on the plan of care, and they stated it probably should have been updated. Surveyor asked the CRC how they were notified when a plan of care needed to be revised and they stated staff talk about changes during morning meetings and care plans are reviewed during the MDS review. Surveyor requested and received the facility policy entitled "Skin Integrity and Wound Management" which read in part " ...The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed ...11. Review care plan and revise as indicated ..." On 3/20/23 at 2:57 pm, the survey team met with the administrator, director of nursing, and the market clinical lead and discussed the concern of staff failing to revise Resident #299's comprehensive person-centered plan of care to reflect the development of an unstageable pressure injury. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/20/23.	F 657		4/26/2023
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658	Resident #10 labs were repeated on 2/13/2023 with no critical findings. Resident #14 labs were repeated on 2/23/2023 with no critical findings.	

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F 658	Continued From page 27 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 document review, the facility staff failed to follow professional standards of practice for the notification and assessment of critical laboratory test results for 2 of 33 Residents, Resident #10, and Resident #14 The findings included: 1. For Resident #10 the facility staff failed to notify the provider, assess and/or treat the resident for a critical potassium (K) level and a critical glucose level. Resident #10's face sheet listed diagnoses which included but not limited to anemia, chronic obstructive pulmonary disease, dementia, basal cell carcinoma of skin, and hypertension. Resident #10's most recent minimum data set with an assessment reference date of 02/07/23 coded the resident as 6 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #10's comprehensive care plan was reviewed and contained a care plan for "Resident is at nutrition risk r/t (related to) need for altered texture diet, diuretic, underweight, hyperkalemia..." Interventions for this care plan included "Labs per orders". Resident #10's clinical record was reviewed and contained a laboratory report dated 02/08/23	F 658	An audit was completed on all labs ordered for the previous 30 days to ensure no critical labs were received and not followed up on by the attending physician, with corrective action if needed. This audit to be completed on or before 4/26/2023. NPE or designee will re-educate all current licensed nursing staff on how to obtain and report critical labs. The NPE/designee will also provide the education to all additional and newly hired licensed nursing staff prior to the start of their first shift. This education to be completed on or before 4/26/2023 or upon hire.	4/26/2023

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F 658	Continued From page 28 which read in part, "Test: K, Result: 6.6, Flag: *H, Reference: 3.6-5.6 mEq/L, Reported: 02/08/23 1944. Result verified by repeat analysis. Critical called to and read back by ... (name omitted) at 02/08/2023 19:39:05 by ... (initials omitted)" and "Test: Glu (glucose), Result: 37, Flag: *L, Reference: 70-110, Reported: 02/08/23 1957. Result verified by repeat analysis. Critical called to and read back by ... (name omitted) at 02/08/2023 19:50:54 by ... (initials omitted). Critical called to and read back by ... (name omitted) at 02/08/2023 19:52:18 by ... (initials omitted)". Handwritten note on the bottom of this report read in part "No nursing notes on this 2/8. I don't see Kayexelate?? Please get 2/10 labs" This note did not have a signature. Resident #10's clinical record also contained a copy of the same laboratory report with a handwritten note at the bottom of the report, which read in part "New orders given 2/13 for repeat labs." This note was signed by the facility family nurse practitioner (FNP). According to Davis Drug Guide.com, Kayexelate is a medication used to treat high levels of potassium. This Surveyor reviewed Resident #10's nursing progress notes on 03/14/23. Surveyor could not locate any documentation that the physician/FNP had been notified or any assessments of the resident had completed. This Surveyor spoke with the assistant director of nursing (ADON) on 03/14/23 at 10:50 am regarding Resident #10's critical labs. ADON stated that MD/FNP should have been notified, and that the facility staff has been instructed to do so. Surveyor asked ADON if this had been done, and ADON stated "Not that I can find". Surveyor asked ADON if an assessment of the resident	F 658	An audit for critical labs will be completed daily during the clinical morning meeting with corrective action if necessary. This audit to be completed weekly X 4 then monthly X 2 or until 100% compliant, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 658	Continued From page 29 should have been done, and ADON stated that it should, but they could not find information on any assessments. This Surveyor spoke with the facility physician (MD) on 03/15/23 at 4:05 pm via telephone. Surveyor asked MD if they had been notified of Resident #10's critical lab values, and MD stated they did not recall being notified. MD stated to surveyor that it was possible the facility family nurse practitioner (FNP) had been notified instead of them and stated they would ask FNP. Surveyor spoke with facility MD again on 03/15/23 at 5:04 pm. MD stated they had spoken with the FNP and confirmed that the FNP had not been notified of the critical results returned on 02/08/23 until 02/13/23. MD stated that this is "very concerning" and "glad the resident had no negative outcome". This Surveyor asked MD what treatment should have been done related to critical lab values, and MD stated that one of the providers should have been notified immediately, resident should have been immediately assessed, administered insulin and D5W (dextrose [sugar] 5% in water) for the high potassium levels, finger stick blood sugar to check blood sugar levels, and given glucose gel if blood sugar was extremely low. MD stated that resident should have gotten "acute care for hyperkalemia (high potassium level), if not transferred out". This Surveyor spoke with the FNP on 03/20/23 at 1:55 pm regarding Resident #10. FNP stated they had not been notified of the critical lab values until "I found it when I rounded next" FNP stated they were in the facility on 02/08/23 and again on 02/13/23. This Surveyor requested and was provided with a	F 658		

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F 658	Continued From page 30 facility policy entitled "NSG 103 Diagnostic Tests" which read in part "Practice Standards: 4. Notify physician/APP (advanced practice practitioner) of diagnostic test results. 4.1 Notify immediately for any critical values. 5. Document date and time of physician/APP notification and response in the medical record." The concern of the facility staff not notifying the MD/FNP, not assessing and/or treating the resident was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. 2. The facility staff failed to assess Resident #14 after receiving telephone notification of a critically low blood glucose level on 2/21/23 at 9:03 p.m. "Low blood sugar (also called hypoglycemia) has many causes, including missing a meal, taking too much insulin, taking other diabetes medicines, exercising more than normal, and drinking alcohol. Blood sugar below 70 mg/dL is considered low ... Low blood sugar can be dangerous and should be treated as soon as possible. (Downloaded from https://www.cdc.gov/diabetes/managing/manage-blood-sugar.html on 3/16/23) Resident #14's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/16/22, was dated as being completed on 12/29/22. Resident #14 was assessed as sometimes able to make self	F 658		

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F 658	Continued From page 31 understood and as sometimes able to understand others. Resident #14 was assessed as having problems with short-term and long-term memory. Resident #14 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #14's was diagnosed with diabetes. Resident #14's clinical record included a laboratory report indicating a critical low blood glucose level was called to the facility on 2/21/23 at 9:03 p.m. Resident #14's blood glucose level was documented as 42 with reference range of 70 - 110 mg/dL. Resident #14's clinical record included a nursing progress note dated 2/21/23 at 9:00 p.m. This nursing progress note included the following information: "Received call from (local hospital initials omitted) Lab with critical Glucose level on resident of 42 from labs drawn this morning, placed in Rounding Book for MD to review." No resident assessment and no finger stick blood sugar check were completed and/or documented related to this low blood glucose report. (An earlier nursing progress note indicated Resident #14 had laboratory blood specimens obtained on 2/21/23 at 5:37 a.m.) Resident #14's next blood glucose/sugar level was documented on 2/23/23 at 6:05 a.m.; this result was 92 mg/dL. On 3/16/23 at 11:49 a.m., the surveyor interviewed, via telephone, the Administrator and the Director of Nursing (DON) related to Resident #14's critically low blood glucose report. The DON reported a finger stick blood sugar should have been immediately obtained for Resident #14 and the resident should have been assessed for symptoms of low blood sugar (hypoglycemia).	F 658		

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F 658	Continued From page 32 On 3/16/23 at 12:22 p.m., the surveyor interviewed the facility's Medical Director via telephone. The Medical Director confirmed the resident should have been assessed for hypoglycemia and should have had a finger stick blood sugar (FSBS) checked. The following information was found in a facility policy titled "NSG115 Physician/Advanced Practice Provider (APP) Notification" (with a revision date of 12/1/21): "Upon identification of a patient who has a change in condition, abnormal laboratory values, or abnormal diagnostics, a licensed nurse will ... Perform appropriate clinical observations ..." The survey team met with the facility's Administrator and Director of Nursing (DON) on 3/17/23 at 4:01 p.m. During this meeting, the surveyor discussed the failure of the facility staff to assess Resident #14 after receiving the aforementioned critically low blood glucose/sugar level.	F 658		
F 684 SS=K	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:	F 684	1. Patient #149 is no longer in the facility. Patients #4, #10, #36 and #42 received a head to toe skin assessment by a licensed nurse to ensure no additional skin breakdown and current	4/26/2023

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F 684	Continued From page 33 Based on observation, staff interview, resident interview, family interview, clinical record review, facility document review, the facility staff failed to provide wound management as evidenced by the absence of assessments, monitoring, and/or treatment for of 5 out 33 residents. This resulted in wound infections and/or wound deterioration for Resident #10, Resident #4, Resident #42, Resident #36, and Resident #149. The facility also failed to implement provider orders at the time they were ordered for 1 of 33 residents reviewed, Resident #199. On 3/15/23 at 3:50 PM, the surveyors notified the facility of the Immediate Jeopardy determination, Level IV Pattern. The facility staff implemented an abatement plan that was verified by the survey team through additional observations, interviews, and document reviews. The facility staff was notified that the Immediate Jeopardy was removed on 3/17/23 at 4:09 PM. The findings included: 1. For Resident #10 the facility staff failed to provide wound management resulting in a wound infection. Resident #10's face sheet listed diagnoses which included but not limited to anemia, chronic obstructive pulmonary disease, dementia, basal cell carcinoma of skin, and hypertension. Resident #10's most recent minimum data set with an assessment reference date of 02/07/23 coded the resident as 6 out of 15 in section C, cognitive patterns. This indicates that the resident	F 684	wounds had ordered treatments in place, and dressings changed, dated and times to reflect treatment per physician's orders. All listed residents at risk for skin breakdown care plans have been updated to reflect the current status of each resident's skin integrity to include actual skin breakdown. All current residents have the potential to be affected by alleged deficient practice. 2. All current residents with wounds were audited by DON/designee on 3/15/2023 to ensure physician's order is in place and treatments completed as ordered as evidenced by completion of noted treatment and documentation thereof. To be completed on or before 3/16/2023.	4/26/2023

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F 684	Continued From page 34 is severely cognitively impaired. Section M, skin conditions, subsection M1040, Other Ulcers, Wounds, and Skin Problems coded the resident as having open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion). Resident #10's comprehensive care plan was reviewed and contained a care plan for "Resident at risk for skin breakdown r/t (related to) decreased mobility, incontinence, fragility of skin, oxygen use..." Interventions for this care plan include "Observe skin condition daily with ADL's (activities of daily living) and report abnormalities, provide wound treatment as ordered, and weekly skin checks by license nurse." Resident #10's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part "Cleanse growth the center of back with Dakin's solution, pat dry, apply Dakin's wet to dry dressing to wound bed and secure with dry dressing, change BID (twice a day) and PRN (as needed) every day shift for wound care" and "Cleanse scalp wound (exposed skull) with soap and water, cleanse periwound with Dakin's solution, pat dry, apply TAO to irritated periwound and cover entire scalp wound with dry dressing BID and PRN every day and night shift for wound care." Resident #10's treatment administration record (TAR) for the month of March 2023 was reviewed and contained entries as above. The entry for "Cleanse growth to center of back..." only had one section for initials on the TAR. These entries were initialed as being completed as ordered. This Surveyor observed Resident #10 on	F 684	100% skin sweep was completed on 3/15/2023 to identify any previously unidentified pressure injuries and or wound. Upon identification of possible pressure injuries and or wound physician notification to be completed, new orders obtained and treatments implemented per order as evidenced by completion of noted treatment and documentation thereof. To be completed on or before 3/16/2023. New admission skin assessments to be completed by wound care lead/DON/Designee within 24 hours of admission beginning 3/16/2023. Physicians to be notified of any identified break in skin integrity, obtain physician's order for treatment and treatments implemented per order as evidenced by completion of noted treatment and documentation thereof. To be completed on or before 3/16/2023.	4/26/2023

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F 684	Continued From page 35 03/12/23 at 3:30 pm. Resident was resting in bed; no dressing was observed in place to scalp wound. Exposed skull was observed by surveyor. Resident #10's clinical record contained a "Physician's Telephone Order" form dated 02/06/23, which read in part "Keflex 500 mg TID (three times a day)-wound infection top of head x 10 days." This Surveyor, along with licensed practical nurse (LPN) #1 and certified nurse's aide (CNA) #1 observed Resident #10 on 03/13/23 at 1:00 pm. Surveyor observed dressing in place to resident's scalp at this time. CNA #1 and LPN #1 rolled resident onto side, and surveyor observed dressing in place to lesion on resident's upper back. Surveyor asked LPN #1 if dressing had a date on it, and LPN #1 first stated that it did not, then stated "Oh, yeah, it does". Surveyor asked LPN #1 what the date on the dressing was, and LPN #1 stated "March 9th". Surveyor requested to see the dressing once it was removed and observed the date on the dressing to read "03/09/23 7a-7p" along with initials. When LPN #1 removed the dressing from Resident #10's wound, surveyor observed moderate amount of drainage both on the dressing and wound bed. Dressing had a dark brown ring, with drainage in the center of the ringed area. Surveyor asked LPN #1 to describe the wound, and LPN #1 stated "greenish-brown, foul-smelling discharge."LPN #1 stated to the surveyor that, according to the date on the dressing, that it appeared that 7 dressing changes have been	F 684	Documentation of wound assessment to be completed by wound care lead/DON/Designee on the skin integrity reports that includes measurements and descriptions of wound. This report is kept in the skin integrity binder located in the DON office. When the report is completed and or the wound is resolved this skin integrity report will be uploaded into the residents electronic medical record. To be completed on or before 3/16/2023. 3. All current licensed nursing staff on site were immediately educated by NPE/designee on Skin Integrity Protocol and Wound Management. All additional current licensed nursing staff will be required to have said education prior to their first scheduled shift.	4/26/2023

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F 684	Continued From page 36 missed to resident's back lesion. Surveyor asked LPN #1 if lesion had worsened since they last observed it, and LPN #1 stated, "It definitely has more drainage." LPN #1 removed the dressing from resident's scalp and stated to surveyor that scalp wound was not supposed to have a dressing on it. This Surveyor observed scant amount of greenish discharge on scalp dressing. LPN #1 later informed surveyor that Resident #10 should have a dressing on scalp lesion. Review of Resident #10's clinical record revealed that resident was placed on oral antibiotic for wound infection starting 03/14/23. This Surveyor spoke with the assistant director of nursing (ADON) on 03/14/23 at 10:50 am regarding Resident #10's wound care. Surveyor asked ADON what their expectations were for wound care, and ADON stated they would expect the nurses to follow the physician's orders for each resident regarding wound care. This Surveyor reviewed Resident #4's clinical record and could not locate any wound assessments, including measurements, description of wounds, or skin assessments. The Survey team spoke with the director of nursing (DON) on 03/15/23 at 10:00 am regarding wound management. DON stated they measure wounds weekly, and that information is located in their office. DON stated that weekly skin assessments were to be performed on all residents and recorded in clinical record.	F 684	4. All residents with wounds including new admissions will be audited to ensure physician is notified, treatment is obtained, treatment is completed per order as evidenced by date, time, initials on dressings, daily x14 days or until 100% compliance is achieved then 3 times a week until 100% compliance achieved. Then weekly x 3 weeks until 100% compliance achieved, then monthly x 3 months until 100% compliance achieved. To be completed on or before 3/16/2023.with ongoing educations as referenced above to be completed prior to shift start. 5. Plan of correction reviewed in Ad Hoc QAPI meeting on 3/15/2023 with the IDT team. Results of audits will continue to be reviewed in monthly QAPI meetings	4/26/2023

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F 684	Continued From page 37 This Surveyor reviewed Resident #10's clinical record and could not locate any skin assessments. This Survey team spoke with family nurse practitioner (FNP) on 03/20/23 at 1:25 pm regarding wound management. Surveyor asked FNP if missed assessments and dressing changes not being done as ordered could contribute to wound infections and FNP stated that it could. The concern of not providing wound management was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. 2. For Resident #4 the facility staff failed to provide wound management which resulted in the resident being treated for a wound infection. Resident #4 was admitted the facility on 02/13/21 and readmitted on 06/08/21. Resident #4's face sheet listed diagnoses which included but not limited to multiple sclerosis, depression, anxiety, and contractures of muscles. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 02/06/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section M, skin conditions, coded the resident as having one stage 1 pressure ulcer that was present upon admission. Section M, subsection M1040, other ulcers,	F 684		

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F 684	Continued From page 38	F 684		

wounds and skin problems coded the resident as "none of the above present". This subsection includes surgical wounds. Section M of Resident #4's admission MDS with an ARD of 02/20/21 coded the resident as having one stage III pressure ulcer present upon admission, one stage IV pressure ulcer present upon admission and one unstageable pressure ulcer present upon admission.

Resident #4's comprehensive care plan was reviewed and contained a care plan for "Resident at nutrition risk r/t (related to) ... Wounds: Surgical PI Open wound to Rt. (right) hip skin fold, healing. PI Rt. Heel ..." and " ... is at risk for continuing impaired skin integrity related to diagnosis of MS (multiple sclerosis), impaired mobility ... Type: Pressure ulcers." Interventions for both care plans included "Provide wound treatment as ordered" and "Labs per orders".

This Surveyor spoke with Resident #4 on 03/12/23 at 3:10 pm. Resident stated they have wounds to right hip and heel and that wound care is supposed to be done twice a day, but there are some nurses that don't do it. Resident #4 stated, "I'm lucky if they do it once a day." Resident #4 was concerned that wound care was not being done as ordered. Surveyor spoke with Resident #4 on 03/13/23 at 11:30 am, and asked resident if their wound care had been completed, and resident stated, "the dressing was changed yesterday (03/12/23) around lunch time and hasn't been changed since".

This Surveyor, along with licensed practical nurse (LPN) #1 and certified nurse's aide (CNA) #1 observed Resident #4's dressing on R hip wound on 03/13/23 at 11:45 am. When CNA #1 rolled

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F 684	Continued From page 39	F 684		

resident over, and dressing became visible, CNA #1 stated to LPN #1, "it (dressing) don't have a date on it". Surveyor asked LPN #1 if dressing should be dated, and LPN #1 stated that it should be. Surveyor observed that dressing was not dated. LPN #1 removed the dressing, and stated, "well, that tells me it's not been changed." Surveyor asked LPN #1 how they could tell dressing had not been changed, and LPN #1 stated by the color of the gauze and the amount of drainage on the dressing.

Resident #4's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part "Cleanse post-surgical wound to right hip with Dakin's solution, pat dry, apply collagen powder to wound bed, cover with calcium alginate and secure with dry dressing BID (twice a day) every day and night shift for Wound Right Hip Order Date 02/28/2023 Start Date 02/28/2023" and "Wound(s): Monitor site(s) daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), If applicable, Additional Documentation in NN (nurse's notes) as needed every day shift. Order Date 03/12/2023. Start Date 03/13/2023."

Resident #4's TAR for the month of March 2023 was reviewed and contained entries which read in part, "Cleanse post-surgical wound to right hip with Dakin's solution, pat dry, apply collagen powder to wound bed, cover with calcium alginate and secure with dry dressing BID (twice a day) every day and night shift for Wound Right Hip. Order Date 02/28/2023. Start Date 02/28/2023", "Cleanse are to right heel with IHWC. Apply betadine, let dry and apply skin prep every night shift for wound care" and "Wound(s): Monitor

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F 684	Continued From page 40 site(s) daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), If applicable, Additional Documentation in NN (nurse's notes) as needed every day shift. Order Date 03/12/2023. Start Date 03/13/2023." These entries were initialed as having been completed for all ordered times. This Surveyor reviewed Resident #4's clinical record from January to present for documentation of wound treatment provided to the right hip, right heel, and healing progress of the wounds. Resident #4's clinical record contained an "Acute Care" summary form dated 01/25/23, which read in part "Chief complaint/Nature of Presenting Problem: Follow-up wounds. Location: Right hip fold. Duration: Chronic. Modifying Factors: Culture done and results pending. Quality: Stable. Review of Systems Skin: Open wound to right hip skin fold. Physical Exam Skin: Wound to right hip skin fold is tender to touch. There is yellow/white drainage to wound, and a foul odor is noted. Optifoam patch in place. Labs/Radiology/Tests. Labs: Wound culture has been collected and results pending per nursing. No results received today. Diagnosis, Assessment and Plan: ...Open wound of right hip. Continue current wound treatment." This was signed by the family nurse practitioner (FNP). Resident #4's clinical record contained a physician's telephone order form dated 01/30/23, which read in part "(1) Culture R (right) hip wound-redness, drainage, foul odor (2) After culture, start Bactrim DS-1 tab PO (by mouth BID (twice daily) x 10 days wound infection." This order was signed by the FNP. Resident #4's clinical record contained a laboratory report dated	F 684		

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F 684	Continued From page 41 02/10/23 for wound culture which indicated the presence of Proteus mirabilis, a gram-negative bacterium. Resident #4's treatment administration record (TAR) for the month of January 2023 was reviewed and contained and entry which read in part, "Cleanse right hip with IHWC (wound cleanser), pat dry, apply Maxsorb, and place Optifoam on wound every night shift for wound healing." This entry had a start date of 01/30/23 listed and was initialed as being completed. There were no previous wound care orders related to right hip noted on this TAR. The TAR for January also contained entries which read in part "Cleanse area to right heels with IHWC. Apply 4 x 4 boarder (sic) gauze or optifoam) gauze or optifoam for cushion. every day shift Mon, Wed, Fri, Sun for wound care-start date-01/04/2023, -D/C (discontinue) date-02/02/2023", "Cleanse area to right heel with IHWC. Apply 4 x 4 boarder (sic) gauze or optifoam for cushion. every night shift for wound care-start date-01/30/2023, -D/C date-02/09/2023" and "Wound(s): Monitor site(s) daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), if applicable, every day shift. The treatment to the heel wound was not initialed as completed on 01/02, 01/03, 01/06, 01/15, 01/18, and 01/23. Resident #4's TAR for the month of February was reviewed and contained entries which read in part, "Cleanse right hip surgical wound with Dakin's solution, pat dry. Apply skin prep to peri-wound. Wet-to-dry dressing using Dakin's to wound bed. Secure with dry dressing. two times a day for wound healing-Start Date-02/09/2023	F 684		

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F 684	Continued From page 42 2000 -D/C Date-02/27/2023 2000", not initialed as completed on 02/18/23 at 8 pm. The TAR for February did not contain any entry for wound monitoring. The TAR for February also contained entries which read in part, "Cleanse area to right heel with IHWC. Apply 4 x 4 boarder (sic) gauze or optifoam for cushion. every night shift for wound care-start date-01/30/2023, -D/C date-02/09/2023" and "Cleanse area to right heel with IHWC. Apply betadine, let dry and apply skin prep every night shift for wound care." This treatment was not initialed as completed on 02/18/23. Resident #4's clinical record contained a physician's telephone order form dated 02/16/23, which read in part "(1) Rocephin 1 gm I.V. q (every) day (2) Repeat wound culture x 7 (3) Barker consult wound vac R hip." This order was signed by the physician. Resident #4's clinical record also contained a physician's order summary for the month of February 2023, which read in part "Culture wound to Right hip one time only for Wound Infection for 1 day" This order had a start date of 02/25/23. Surveyor could not locate results of this wound culture. This Surveyor spoke with the assistant director of nursing (ADON) on 03/17/23 at 12:50 pm regarding Resident #4's wound cultures. ADON stated the culture order on 01/30/23 was collected 3 times, and when the lab was contacted for results, they were told the lab did not have a specimen. ADON stated they could not locate results for culture ordered to be done on 02/25/23.	F 684		

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F 684	Continued From page 43 This Surveyor spoke with medical technician (MT) at the contracted lab on 03/20/23 at 10:15 am regarding Resident #4's wound cultures. MT stated that the only wound culture orders and specimens they had received were on 01/17/23 and 02/10/23. MT stated they had received no other orders or specimens for wound cultures for Resident #4. This Surveyor spoke with FNP on 03/20/23 at 1:25 pm. Surveyor asked FNP when they expected the wound culture ordered on 01/30/23 to be done, and FNP stated they expected it to be done on the order date. FNP said when they asked about the results, "couple of nurses stated they had done it and lab lost it". Surveyor asked FNP if they expected the repeat wound culture to have been done, and FNP stated they did. Surveyor asked FNP if missed assessments and dressing changes not being done as ordered could contribute to wound infections and FNP stated that it could. This Surveyor spoke with the ADON on 03/14/23 at 10:50 am regarding Resident #4's wound care. Surveyor asked ADON what their expectations were for wound care, and ADON stated they would expect the nurses to follow the physician's orders for each resident regarding wound care. Surveyor asked ADON if wound dressings should be dated, and ADON stated that they should be dated and initialed by the nurse completing the wound care. ADON later stated per director of nursing (DON), facility policy did not state that dressings needed to be dated. This Surveyor requested and was provided with a facility policy entitled "Wound Dressings: Aseptic" which read in part, "2. Gather supplies: 2.7	F 684		

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F 684	Continued From page 44 Prepared label or secondary dressing with date and initials. 27. Apply prepared label." This Survey team spoke with the director of nursing (DON) on 03/15/23 at 10:00 am regarding wound management. DON stated they measure wounds weekly, and that information is located in their office. Surveyor asked DON if dressings should be dated and initialed when changed, and DON stated that is not a part of the facility policy, but they were hoping to have that changed, as that is the expectation. Surveyor referred DON to aforementioned policy, and asked DON what "apply prepared label" meant, and DON stated they did not know. Surveyor asked DON if Resident #4's hip wound was pressure related and DON stated that Resident #4's hip wound was surgical rather than pressure. Surveyor asked DON what type of surgery the resident had had to the hip and DON stated, "Looks to me like he/she has had a hip replacement at some point. He/She has about an 18" scar on that hip." This Surveyor reviewed Resident #4's clinical record and could not locate any wound assessments, including measurements or description of wounds. This Surveyor requested and was provided with "Skin Integrity Report" forms, which were contained in a notebook housed in the DON's office. The Skin Integrity Report forms for Resident #4 indicated that wound to right hip was both pressure and surgical. The form did not indicate an initial wound date and contained measurements beginning on 01/30/23 and continuing weekly until 03/08/23 that indicate the wound is decreasing in size. A second form with an initial wound date of 02/09/23, indicated a	F 684		

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F 684	Continued From page 45 pressure area to right heel, staged as a deep tissue injury. Wound was marked as in-house acquired, with measurements beginning on 02/09/23 and continuing weekly through 03/09/23. These measurements indicate no change to wound. This Surveyor requested evidence that Resident #4's hip wound was surgical rather than pressure and was provided with a surgical consult form which read in part "Appt. Date/Time 02/26/2021. Chief Complaint: Skin lesion. HPI (history of present illness): Patient has bilateral hip decubitus ulcers that are necrotic. He/She needs debridement of both. He/She also has been noted to be anemic with hemoglobin in the eight. We will admit him/her to outpatient surgery for transfer transfusion before morning debridement. Plan transfer back to nursing home after surgery. Probable wound VAC application. Patient has severe lower extremity contracture secondary to advanced MS." The concern of not providing wound management for Resident #4 was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. 3. For Resident #42 the facility staff failed provide wound management, resulting in a wound infection. Resident #42's face sheet listed diagnoses which included but not limited to hypertensive heart disease, heart failure, chronic kidney disease,	F 684		

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F 684	Continued From page 46 type 2 diabetes mellitus, peripheral vascular disease, and anxiety. Resident #42's most recent minimum data set with an assessment reference date of 02/04/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. Section M, skin conditions coded the resident as having five stage II pressure ulcers that were present upon admission, and no other skin conditions. Resident #42's comprehensive care plan was reviewed and contained a care plan for "Resident has actual skin breakdown related to top of right foot, right heel, left upper buttocks, left lower buttock, right buttock, coccyx, and sacrum related to decreased activity, incontinence." Interventions for this care plan included "Observe skin for signs/symptoms of skin breakdown, provide wound treatment as ordered, weekly skin checks by licensed nurse, and weekly wound assessment to include measurements and description of wound." Resident's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part "... consult for necrotic wound to R ankle. Needs to be done as soon as possible", "Cleanse area to top of right foot with Dakin's solution, 25%, pat dry. Apply Santyl on nonstick pad to wound bed. Cover with dry dressing daily and prn (as needed) every day shift for wound care", "Cleanse stage 3 PU (pressure ulcer) to L (left) lower buttock with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID (twice a day) and PRN every day and night shift for wound	F 684		

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F 684	Continued From page 47 care", "Cleanse stage 3 PU to L upper buttock with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks", "Cleanse stage 3 PU to R buttocks with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks", "Cleanse unstageable PU on coccyx with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks", "Cleanse unstageable PU to center sacrum with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry dressing to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 10 days", "Cleanse unstageable PU to R heel with Dakin's solution, pat dry, apply skin prep to periwound, apply Santyl on nonstick pad and secure with dry dressing BID and PRN every day and night shift for wound care for 14 days", and "Bactrim DS oral tablet 800-160 mg (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth one time a day for wound infection for 14 days." Resident #42's clinical record contained a "Physician's Telephone Orders" form dated 02/27/23, which read in part "(1) DC (discontinue) Macrobid. (2) Bactrim DS 1 tab PO (by mouth) BID (twice a day) x 10 days-wound infections R ankle, foot." This order was signed by the family nurse practitioner (FNP). Resident #42's treatment administration record	F 684		

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F 684	Continued From page 48 (TAR) for the month of March 2023 was reviewed and contained entries as above. Each of these entries had not been initialed as completed on two separate occasions. Resident #42's February 2023 TAR contained entries, which read in part "Cleanse area to right heel with IHWC (wound cleanser), pat dry and apply bordered foam dressing every day shift for open area", "Cleanse area to right posterior thigh with IHWC, pat dry, and apply 4 x 4 bordered foam dressing every day shift for open area", "Cleanse top of right foot with IHWC, pat dry, and apply bordered foam dressing every day shift for abrasion", and "Cleanse area to coccyx with IHWC, pat dry, and apply bordered foam dressing every day shift for open area." Each of these entries had not been initialed as completed on three separate occasions. This Surveyor, along with licensed practical nurse (LPN) #1 observed Resident #42's dressings to sacrum, coccyx, and buttocks on 03/13/23 at 2:30 pm. Dressing to sacrum did not have a date on it. Dressings to resident's foot, heels, and ankles all had dates and initials. LPN #1 stated they had completed wound care to these area's earlier in the day. Surveyor asked LPN #1 how they knew when the dressings to the sacral area had last been changed, and LPN #1 stated that without a date, there was no way to know when wound care was last completed. This Surveyor spoke with the assistant director of nursing (ADON) on 03/14/23 at 10:50 am regarding Resident #42's wound care. Surveyor asked ADON what their expectations were for wound care, and ADON stated they would expect the nurses to follow the physician's orders for each resident regarding wound care. Surveyor	F 684		

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F 684	Continued From page 49 asked ADON if wound dressings should be dated, and ADON stated that they should be dated and initialed by the nurse completing the wound care. ADON later stated per DON, facility policy did not state that dressings needed to be dated. This Surveyor requested and was provided with a facility policy entitled "Wound Dressings: Aseptic" which read in part, "2. Gather supplies: 2.7 Prepared label or secondary dressing with date and initials. 27. Apply prepared label." The Survey team spoke with the director of nursing (DON) on 03/15/23 at 10:00 am regarding wound management. DON stated they measure wounds weekly, and that information is located in their office. Surveyor asked DON if dressings should be dated and initialed when changed, and DON stated that is not a part of the facility policy, but they were hoping to have that changed, as that is the expectation. Surveyor referred DON to aforementioned policy, and asked DON what "prepared label" meant, and DON stated they did not know. This Surveyor requested and was provided with "Skin Integrity Report" forms, which were contained in a notebook housed in the DON's office. This notebook contained six forms for Resident #42, which addressed unstageable pressure areas to right heel, right achilles, sacrum/coccyx, right buttock, left outer thigh/lower buttock and a stage II pressure areas to upper left buttock. Each of these areas were marked as present upon admission, with weekly measurements beginning on 02/01/23 and continuing through 03/14/23. These measurements indicated the right heel wound was unchanged, right achilles wound had	F 684		

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F 684	Continued From page 50 decreased from 2.5 cm x 1.7 cm to 2.1 cm x 1.3 cm, sacram/coccyx wound had decreased in length from 2 cm to 1 cm, but increased in width from 1 cm to 2.6 cm and went from a depth of 0 to .25 cm. Right buttocks wound decreased in length from 1 cm to 0.8 cm, and increased in width from 0.5 cm to 0.6 cm, and went from a depth of 0 to 0.25 cm. Right outer thigh wound decreased in length from 2 cm to 1.4 cm, and increased in width from 1 cm to 1.5 cm, anad went from a depth of 0 to .25 cm. Left buttock wound decreased in length from 2 cm to 1.8 cm, increased in width from 1.5 cm to 1.7 cm, and went from a depth of 0 to 0.25 cm. Two surveyors, along with LPN #1 observed Resident #42's wounds on 03/14/23 at 4:45 pm. LPN #1 stated that areas to the top of resident's right foot and right ankle/lower leg were arterial rather than pressure. Resident's right heel had dark brown eschar and LPN #1 stated that area was unstageable pressure ulcer. Areas to resident's sacral area (sacrum, coccyx, buttocks) were red with slough present in wound bed. This Survey team spoke with family nurse practitioner (FNP) on 03/20/23 at 1:25 pm regarding wound management. Surveyor asked FNP if missed assessments and dressing changes not being done as ordered could contribute to wound infections and FNP stated that it could. The concern of not providing wound management was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit.	F 684		

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4. For Resident #36, facility staff failed to provide ordered wound care to promote healing.

Resident #36 was admitted to the facility with diagnoses including (by listed date of diagnosis) type 2 diabetes mellitus with diabetic polyneuropathy, peripheral vascular disease, morbid obesity, obstructive sleep apnea, muscle weakness, hypertensive heart and chronic kidney disease with heart failure, local infection of the skin and subcutaneous tissue, methicillin resistant staphylococcus aureus infection, chronic obstructive pulmonary disease with acute exacerbation, atrial fibrillation, sepsis due to escherichia coli, bacteremia. On the minimum data set assessment with assessment reference date 2/1/23, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.

This surveyor interviewed the resident on 3/12/23 concerning life in the facility.

Clinical record review revealed two recent hospitalizations with wound infections: 12/27/22 through 1/3/23 and 1/14 through 1/20/23.

Prior to the hospitalization on 12/27/22, clinical record review revealed
A physician order dated 11/7/22 through 1/3/23 for Cleanse area to right stump with WC/VASHE (wound cleanser). Apply xeroform, then cover with border foam each day shift Tue, Thu for wound care. The treatment was not documented as completed 12/1, 12/6, 12/8, 12/13, 12/15, and 12/22. The resident was hospitalized for sepsis

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F 684	Continued From page 52 and right below the knee amputation infection on 12/27. A nursing progress note dated 12/26/22 stated Note: Resident noted to have scab on LLE front lower area. Redness, swelling and pain surrounding scabbing with bleeding present. This nurse contacted Dr. with new orders: 1) Culture wound in AM 2) CBC (complete blood count) and BMP (basic metabolic panel) 3) Keflex PO BID x 7 days. The most recent prior mention of the wound was a nursing progress note dated 12/21/22: The following skin injury/wound(s) were previously identified and were evaluated as follows: Other(s): Description: diabetic ulcer to right posterior calf. Another note dated 12/21/22 - Late Entry: Note: An improving diabetic wound in-house acquired Location: Right Calf was assessed today. Prognosis: Monitor/Manage: Wound healing not achievable due to untreatable underlying condition. Resident/Responsible Party Notified: 1 The practitioner has been notified: 1. A third note dated 12/21/22 Note: A skin check was performed. The following skin injury/wound(s) were previously identified and were evaluated as follows: Pressure Area(s): Location(s): Diabetic wound to right stump. TX in place. The resident was hospitalized 12/27/22 through 1/3/23. Per the hospital discharge, the resident was admitted with sepsis, right BKA (below knee amputation) infection, fever, and more. The surgeon assessed the right BKA wound and determined there was no need for surgical intervention. Dressings continued per surgeon orders.	F 684		

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F 684	Continued From page 53 On 1/3/23, the resident returned to the facility. No orders for wound care were entered in the system. Nursing documentation included no skin assessments from 1/3/23 through 1/20/23. A facility nursing progress note dated 1/14/23 documented resident flushed, vomiting, low BP and went to hospital. The resident was hospitalized again from 1/14/23 through 1/20/23. Per the hospitalist discharge summary, discharge diagnoses included ESBL proteus and Vancomycin resistant enterococcus bacteremia. The summary indicated the facility staff had been notified the resident would need Intravenous antibiotics for 13 additional days. A facility nursing note dated 1/20/23 read: Resident returned via non-emergent BLS ambulance service. Resident is awake, alert, oriented, and able to make his needs known per his usual. A double lumen PICC line is in place in right upper arm. Resident will be receiving IV Invanz and Zyvox by mouth for VRE and Proteus bacteremia. Resident's buttocks are reddened, but blanchable, and dressing over RLE (right lower extremity)/foot amputation site is CDI (clean/dry/intact). Enhanced barrier precautions are in place, and staff is aware of the need to glove and gown before providing care, and resident is aware that he needs to sanitize his hands before leaving his room, and to notify the nurse if his dressing becomes soiled or loose while he is out of his room. No orders for wound care/dressing changes were entered in the system at the time of return from the hospital. An order was entered dated 1/24/23 for Cleanse wound to RLE with IHWC (in house wound	F 684		

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F 684	Continued From page 54 cleanser), pat dry, apply non-adherent dressing and wrap with gauze and ACE bandage each day shift for wound healing. Wound care was not documented as completed on 1/25/23, 1/26/23, 1/28/23, and 1/29/23. The resident's comprehensive care plan did not address actual skin integrity intervention to monitor wound for worsening signs of infection and notify PCP until a revision on 1/26/23. There was no evidence of care plan revision as the resident was hospitalized with infections and experienced surgical interventions to treat wounds and wound-related infections. On 3/14/23, the surveyor interviewed the assistant director of nursing (ADON) about the admission process. Per the ADON, the admission nurse gets the discharge summary from the hospital. The admission orders are in the discharge summary. The admission orders are entered into the system by the floor nurse when the resident arrives (this step may be performed by the ADON or DON (director of nursing)). The nurse calls the physician or nurse practitioner to review the admission orders. A second nurse looks at the admission orders to verify the discharge summary orders match the admission orders in the electronic record. Someone in the nursing department asks the family to sign the admission paperwork. A skin check is done within 2 hours of arrival. Dressings are usually noted during the skin check. The other assessments are usually done within the first 48 hours. During a meeting on 3/20/23 for the surveyors to discuss wound care issues, the FNP (family nurse practitioner) stated that failure to perform dressing changes could contribute to infections.	F 684		

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F 684	Continued From page 55 This surveyor notified the administrator and director of nursing during a summary meeting on 3/20/23 that the failure to provide wound care consistently in the facility resulted in harm to the resident resulting in re-hospitalizations and wound infections. 5. For Resident #149, facility staff failed to provide post-operative surgical site care, resulting in re-hospitalization and additional surgery. Resident #149 was admitted to the facility with primary diagnosis encounter for orthopedic aftercare following surgical amputation, secondary diagnosis diabetes mellitus due to underlying condition with diabetic nephropathy, and additional diagnoses including atrial fibrillation, hypertensive heart disease with heart failure, asthma, infection following a procedure-superficial incision surgical site-subsequent encounter, muscle weakness, and difficulty walking. On the minimum data set assessment (MDS) with assessment reference date 1/19/2023, the resident scored 13/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The MDS also documented the resident had surgery during the prior 100 days, recent surgery requiring SNAFU (skilled nursing and follow up) care, infection of the foot, surgical wounds, and surgical wound care. The Patient Summary dated 1/13/23 under the section Patient Discharge Instructions/Transfer, Wound Care Instructions, Type: Surgical Incision,	F 684		

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F 684	Continued From page 56 Wound Care: clean with saline and place dry dressing daily. This section of the document immediately followed the Medications You Are to Continue and Medications to Stop Taking sections of the document. The Medications You Are to Continue list was entered as orders in the facility's electronic clinical record. The wound care order was not entered into the facility's electronic clinical record. The admission note dated 1/13/23 documented a dressing to right foot post right second toe amputation. Skilled nursing notes dated 1/13, 1/14, and 1/15 document the wrap to right foot amputation site continues. The resident's comprehensive care plan documented under Focus: Actual skin impairment R/T (related to) surgical amputation of toes to right foot...is at risk for complications R/T said amputations (revised 1/24/23 by DON) Interventions initiated 1/14/23: Weekly skin check, Dressing changes will be provided per PCP orders, obtain skilled PT/OT (physical and occupational therapy) evaluation, and dietician consult as needed. Interventions initiated by DON on 1/24/23: monitor for pain/discomfort and TX according to PCP (primary care physician) orders and Monitor for worsening of incision site: increased redness, drainage, dehiscence of incision site, increased pain. Notify PCP of any abnormal findings. A family nurse practitioner (FNP) note dated 1/16/23 indicated an acute visit for follow-up foot pain after amputation of toes on right foot. FNP plan was to continue current pain regimen and for wound of right foot -Follow-up with surgeon on wound orders. A FNP note dated 1/18/23 indicated an acute care visit at the request of the family and nursing to address right foot pain and	F 684		

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F 684	Continued From page 57	F 684		

reported vivid dreams and hallucinations. The FNP noted personally calling the surgeon's office to obtain wound care orders. New orders written for Neurontin for pain; laboratory testing for infection or chemical imbalances, wound dressing changes and intramuscular antibiotic Rocephin for 3 days.

The resident's Treatment Administration Record (TAR) documented an order to Cleanse Right Foot, surgical site, with warm soap & H2O. Pat Dry. Cover with "sterile" dry dressing each day shift (12 hour 6 A) for wound care. The treatment was documented as administered 1/19, 1/20, 1/21, 1/22, 1/24, and 1/25. The nurse, LPN #5 was unavailable for interview to determine whether the 1/23 treatment was performed.

Per the facility record, the resident was sent to the hospital on 1/25/23 and was admitted for complications after amputation.

On 3/14/23, the surveyor interviewed the assistant director of nursing (ADON) about the admission process. Per the ADON, the admission nurse gets the discharge summary from the hospital. The admission orders are in the discharge summary. The admission orders are entered into the system by the floor nurse when the resident arrives (this step may be performed by the ADON or DON). The nurse calls the physician or nurse practitioner to review the admission orders. A second nurse looks at the admission orders to verify the discharge summary orders match the admission orders in the electronic record. Someone in the nursing department asks the family to sign the admission paperwork. A skin check is done within 2 hours of arrival. Dressings are usually noted during the

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F 684	Continued From page 58 skin check. The other assessments are usually done within the first 48 hours. During a discussion on 3/15/23 at 10 AM of several residents with whom surveyors had wound care concerns, the DON described an electronic wound measuring system that the facility owns, but which no staff member has been trained to use. The DON had 'let the wound nurse go' after the incident. The DON also stated the FNP was the one who finally looked at the wound on 1/18/23 and called the surgeon for orders. This surveyor spoke with the FNP on 3/20/23 concerning the resident's wound care and infection. The FNP stated that the wound care nurse was instructed to call the physician for wound orders on 1/16/23. The FNP called the surgeon on 1/18/23 because the resident still had no wound or dressing orders. The FNP stated that failure to perform dressing changes could contribute to infections. The resident was admitted to a hospital from 1/25 through 2/14/2023. The admission diagnosis was cellulitis of right foot. Discharge diagnoses included non-healing surgical wound to the right lower extremity, post operative amputation wound infection with proteus, wet gangrene of the post operation transmetatarsal amputation; status post right foot amputation on 1/31/2023. This surveyor notified the administrator and director of nursing during a summary meeting on 3/14/23 that the failure to provide wound care for the first 6 days in the facility resulted in harm to the resident resulting in rehospitalization, wound infection, and amputation of the foot. Further	F 684		

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F 684	Continued From page 59 discussions prior to exit on 3/20/23 did not change that conclusion. On 3/16/23 at 2:20 pm, the administrator presented the following Immediate Jeopardy Abatement Plan: "1. Patient #149 is no longer in the facility. Patients #4, #10, #36, and #42 received a head-to-toe skin assessment by a licensed nurse to ensure no additional skin breakdown and current wounds had ordered treatments in place, and dressings changed, dated and times to reflect treatment per physician's orders. All listed residents at risk for skin breakdown care plans have been updated to reflect the current status of each resident's skin integrity to include actual skin breakdown. All current residents have the potential to be affected by alleged deficient practice. 2. All current residents with wounds were audited by DON/designee on 3/15/2023 to ensure physician's order is in place and treatments completed as ordered as evidenced by completion of noted treatment and documentation thereof. To be completed on or before 3/16/2023. 100% skin sweep was completed on 3/15/2023 to identify any previously unidentified pressure injuries and or wound. Upon identification of possible pressure injuries and or wound physician notification to be completed, new orders obtained, and treatments implemented per order as evidenced by completion of noted treatment and documentation thereof. To be completed on or before 3/16/2023. New admission skin assessments to be	F 684		

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F 684	Continued From page 60 completed by wound care lead/DON/Designee within 24 hours of admission beginning 3/16/2023. Physicians to be notified of any identified break in skin integrity, obtain physician's order for treatment and treatments implemented per order as evidenced by completion of noted treatment and documentation thereof. To be completed on or before 3/16/2023 Documentation of wound assessment to be completed by wound care lead/DON/Designee on the skin integrity reports that includes measurements and descriptions of wound. This report is kept in the skin integrity binder located in the DON office. When the report is completed and or the wound is resolved this skin integrity report will be uploaded into the resident's electronic medical record. To be completed on or before 3/16/2023. 3. All current licensed nursing staff on site were immediately educated by the NPE [nurse practice educator]/designee on Skin Integrity Protocol and Wound Management. All additional current licensed nursing staff will be required to have said education prior to their first scheduled shift. All residents with wounds including new admissions will be audited to ensure physician is notified, treatment is obtained, treatment is completed per order as evidenced by date, time initials on dressings, daily x 14 days or until 100% compliance is achieved then 3 times a week until 100% compliance achieved. Then weekly x 3 weeks until 100% compliance achieved, then monthly x 3 months until 100% compliance achieved. To be completed on or before 3/16/2023 with ongoing educations as referenced above to be completed prior to the shift start. 4. Plan of correction reviewed in Ad Hoc QAPI	F 684		

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F 684	Continued From page 61 [Quality Assurance and Performance Improvement] meeting on 3/15/2023 with the IDT [Interdisciplinary Team] team. Results of audits will continue to be reviewed in monthly QAPI meetings." On 3/16/23 at 2:27 pm, the survey team notified the administrator that the facility's abatement plan was accepted and requested the facility's credible evidence for review. The facility began providing credible evidence on 3/16/23 and continued to provide evidence through 3/17/23 at 4:08 pm. The facility presented credible evidence that the abatement plan had been implemented, including evidence of review of all current residents with previously identified wounds to ensure physician's orders and treatments were in place, completion of a full skin assessments of all current residents, provider notification and treatment initiation for newly identified wounds, documentation of current wound assessments, nurse education as outlined in the abatement plan, a daily audit of residents with wounds, and signature confirmation of staff attending an Ad Hoc QAPI meeting on 3/15/23. On the afternoon of 3/17/23, the survey team reviewed each resident's current skin assessment and current physician's orders to ensure all identified skin wounds had a treatment order in place and a current documented description of the wound. The survey team also reviewed the residents' clinical records to verify provider notification of all newly identified wounds. The survey team verified in-service training for licensed nurses through comparison of the list of active nurses with the in-service signature sheet. The survey team observed and/or interviewed each current resident with an	F 684		

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F 684	Continued From page 62 identified wound to ensure each wound dressing was appropriately dated according to the physician's order. On 3/17/23 at 4:00 pm, the survey team met with the administrator, DON, and ADON and discussed the facility's abatement plan. The DON stated they or their designee were responsible for the implementation of the abatement plan and wound treatments would be completed by the floor nurses. On 3/17/23 at 4:09 pm, the survey team notified the administrator, DON, and ADON that the Immediate Jeopardy was abated. No further information regarding this issue was presented to the survey team prior to the exit conference on 3/20/23. 6. The facility staff failed to ensure provider orders for Clindamycin (antibiotic) by mouth, Lasix (diuretic) injectable and Promod (protein supplement) were implemented when ordered for Resident #199. Resident #199's admission record listed his diagnoses included but were not limited to, Covid-19, Type 2 Diabetes Mellitus, and Encephalitis (inflammation of the brain) and Encephalomyelitis (inflammation of the brain and spinal cord). The minimum data set (MDS) with an assessment reference date of 12/16/21 coded the resident's brief interview for mental status (BIMS) a 01 out of 15 in Section C (cognitive patterns). Section G (functional status) coded him needing extensive assistance with bed mobility, eating, and toilet use.	F 684		

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F 684	Continued From page 63 The clinical record contained a nurse practitioner (NP) Acute Visit Document with a date of service on 3/02/22. The diagnosis, assessment and plan portion of the document listed provider orders which included, but were not limited to: 1. Lasix 20mg intramuscular injection in AM. 2. Clindamycin 150mg by mouth twice a day for 5 days for cellulitis of bilateral lower extremities. 3. Promod (or other protein supplement) 30ml by mouth daily. A review of Resident #199's March 2022 Medication Administration Record (MAR) noted: 1. Lasix 20mg IM injection was administered on 3/05/22. 2. Clindamycin 150mg orally was administered on 3/04/22. 3. Promod 30ml by mouth was administered on 3/05/22. The nurse practitioner (NP) who wrote the orders on 3/02/22 was interviewed via phone on 3/17/23 at 2:20 p.m. The NP stated her expectation was for those orders to be implemented the next day, 3/03/22. The administrator was informed of these findings on 3/17/23 (via phone) and again on 03/19/23 in person. No further information was provided prior to the exit conference.	F 684		
F 686 SS=G	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-	F 686		

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F 686	Continued From page 64 (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 observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide the necessary treatment and services to promote wound healing and prevent infection for four of 33 residents in the survey sample, Resident #37, 42, 299, 199. The findings include: 1. For resident #37, the facility failed to provide treatment as ordered to the resident's left heel pressure ulcer leading to osteomyelitis (inflammation of bone caused by infection). In the course of treating the infection, resident #37 received a surgical wound debridement, insertion of a peripherally inserted central catheter (PICC line) for intravenous (IV) antibiotics and two wound cultures. Each of these procedures were invasive and placed the resident at risk for further discomfort and stress. Resident #37's diagnoses included but were not limited to the following: Diabetes type 2, congestive heart failure, chronic kidney disease and difficulty walking.	F 686	Resident #37 and Resident #42 physician's orders are in place and treatments are being completed as ordered evidenced by completion of noted treatment and documentation thereof. Resident # 199 discharged from the facility on 3/5/2022 and Resident #299 discharged from the facility on 11/20/22 and did not return to the facility. The facility was unable to correct action. 100% skin sweep was completed on 3/15/2023 to identify any previously unidentified pressure injuries and or wound. Upon identification of possible pressure injuries and or wound physician notification to be completed, new orders obtained and treatments implemented per order as evidenced by completion of noted treatment and documentation thereof.	4/26/2023

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F 686	Continued From page 65 The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/6/22 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15, indicating minor cognitive impairment. Under the functional ability section of the MDS, resident was coded as being independent with ambulation, with ambulation only occurring once or twice in the lookback period. Under the pain assessment interview section of the MDS, resident reported a pain level of 7 out of 10 on a numeric scale and reported that pain interfered with sleeping and limited their day-to-day activities. On 3/13/23 at 11:30 am surveyor observed resident #37 lying in bed with left foot exposed. Surveyor noted that resident had a wound on their heel that was open with slight drainage. Resident stated that the wound had been there, "a good while" and that the nurse was coming to see about it. Surveyor asked if the area was painful and resident stated, "oh yeah, it hurts most of the time". During the clinical record review, surveyor noted that resident #37 was admitted to the facility on 8/31/22. The Nursing Documentation Assessment for 8/31/22 was reviewed. The nurse documented that the skin was assessed and there were no wounds identified. There is another section that speaks specifically to the feet and the nurse marked "no" to the presence of redness, maceration or breakdown on the heels. The first mention of the left heel wound was by the nurse practitioner (NP) on 9/2/22 in a progress note that stated resident had a "wound to the left heel". A provider order was received on the same date,	F 686	NPE or designee will re-educate all current licensed nursing staff and all additional and newly hired prior to the start of their first shift on Skin Integrity Protocol and Wound Management. All additional current licensed nursing staff will be required to have said education prior to their first scheduled shift. Re-educations will be completed on or before 4/26/2023 or upon hire. All residents with wounds including new admissions will be audited to ensure physician is notified, treatment is obtained, treatment is completed per order. The audit will be completed weekly X 4 then monthly X 2 months or until 100% compliant, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 686	Continued From page 66 9/02/22, to treat the left heel wound by cleansing with wound cleanser and applying a wet to dry dressing daily. According to the September 2022 treatment administration record (TAR) this treatment was not done on 9/3/22 and 9/10/22 as there were blanks for those days. The NP saw resident #37 again on 9/13/22, the progress note documented in part, "wound has healed except one area of peeling skin, which should require minimal treatment". A provider order was received on 9/13/22 to change the frequency of the treatment to every Tuesday, Thursday and Saturday. The October 2022 TAR indicated that the treatment to the left heel wound was not provided 10/6/22, 10/11/22, 10/22/22, and 10/29/22. The November 2022 TAR indicated treatment was also not provided on 11/10/22, 11/15/22, 11/17/22, 11/22/22, and 11/29/22. On November 11, 2022, the NP documented in a progress note that the left heel wound was "draining brown drainage" and gave an order for the antibiotic Bactrim DS 800-160 mg to be given orally twice daily for 10 days. The December 2022 TAR indicated that treatments to the left heel wound were not provided on 12/1/22, 12/6/22, 12/8/22, 12/13/22, 12/15/22, 12/22/22, 12/27/22, and 12/29/22. The January 2022 TAR indicated that treatment to the wound was not provided on 1/3/23, 1/12/23, 1/17/23, and 1/19/23. On 1/6/23 a provider order was received to x-ray the left foot. The conclusion in the radiology report stated, "Subtle osteolysis/erosive changes at the posterior inferior calcaneus concerning for infection/osteomyelitis". An MRI was recommended.	F 686		

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A wound culture of the left heel wound was ordered 1/11/23 which revealed the wound was infected with methicillin resistant staphylococcus aureus (MRSA). Bactrim DS 800-160 mg twice daily for ten days was again ordered for the infection. The wound culture was repeated per provider order on 1/23/23 which was positive for the presence of infection. Surveyor was unable to locate the sensitivity report in the clinical record.

On 1/30/23 the NP documented in a progress note, "ulcer has worsened with foul odor and black areas on edges as well as redness". On 2/1/23 another round of the antibiotic Bactrim DS was ordered twice daily for ten days.

The MRI was done 2/3/23 and the report impression was "large heel wound with osteomyelitis of the posterior calcaneus". Resident #37 underwent a surgical procedure to debride the wound on 2/6/23. On 2/9/23 resident #37 had a PICC line placed, and a wound vac was applied to the left heel.

On 2/13/23 the NP documented in a progress note "left foot wound was originally a diabetic ulcer that healed and then developed into a pressure ulcer due to the patient's habit of laying in the bed and friction on the foot". On 2-23-23 a new provider order was received to administer the antibiotic Vancomycin HCL intravenous solution, 1.5 grams every two days for six weeks for a diagnosis of osteomyelitis of the left heel.

On 3/16/23 at 12:53 PM surveyor interviewed Licensed Practical Nurse (LPN) #3 regarding resident #37 and asked what the blanks on the TAR ' s indicated. They stated, "if there's a blank for those days, it means the treatment wasn't

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F 686	Continued From page 68	F 686		

done". Surveyor reviewed with LPN #3 the missing treatments and the progression of the wound and asked them what their professional opinion was. LPN #3 stated, "I think the lack of treatment caused the wound to get worse".

On 3/16/23 at 2:16 PM, surveyor asked the Director of Nursing (DON) for any wound measurements for resident #37's left heel from their admission 8/31/23 to current.

On 3/20/23 at 11:44 am surveyor interviewed DON regarding the lack of documentation on admission of the left foot wound. DON stated they were not employed at the facility at that time. DON stated the wound should have been captured on the admission assessment/nursing documentation per policy, and if it was not there, she cannot speak as to why. DON agreed that a wound on the heel should be considered as pressure rather than diabetic. DON also stated that resident #37 was "constantly up walking on it and digging their heels in the bed and foot board", before the foot board was removed. Surveyor was provided with a policy entitled, "Skin Integrity and Wound Management", with a revision date of 2/1/23, that reads in part, "A comprehensive initial and ongoing nursing assessment of intrinsic an extrinsic factor that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed". The DON also provided surveyor with copies of wound assessments for resident #37's left heel from September 2022 to November of 2022, but these were labeled as being a wound to the Right heel, not the left. DON reported that they began measuring the wound in January 2023 and provided surveyor with a worksheet entitled, "Skin Integrity Report". This report had measurements

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F 686	Continued From page 69 documented each week beginning 1/25/23. On 3/20/23 at 1:40 PM surveyor interviewed the NP, other staff member #11. Surveyor asked if they were aware of the missed treatments in the months leading up to the osteomyelitis diagnosis, NP stated, "no I was not". Surveyor asked if the missed treatments might have caused the wound to deteriorate, NP stated, "yes it definitely could have". The above concerns were discussed with the Administrator, Director of Nursing and Assistant Director of Nursing on 3/17/23 at 4:00 PM and again with the Administrator and administrative staff #4 on 3/20/23. No further information was provided to the survey team prior to the exit conference. 2. For Resident #42 the facility staff failed to provide treatment to promote healing and prevent infection of pressure ulcers. Resident #42's face sheet listed diagnoses which included but not limited to hypertensive heart disease, heart failure, chronic kidney disease, type 2 diabetes mellitus, peripheral vascular disease, and anxiety. Resident #42's most recent minimum data set with an assessment reference date of 02/04/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. Section M, skin conditions coded the resident as having five stage II pressure ulcers that were present upon admission, and no other skin conditions.	F 686		

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F 686	Continued From page 70 Resident #42's comprehensive care plan was reviewed and contained a care plan for "Resident has actual skin breakdown related to top of right foot, right heel, left upper buttocks, left lower buttock, right buttock, coccyx, and sacrum related to decreased activity, incontinence." Interventions for this care plan included "Observe skin for signs/symptoms of skin breakdown, provide wound treatment as ordered, weekly skin checks by licensed nurse, and weekly wound assessment to include measurements and description of wound." Resident's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part"... consult for necrotic wound to R ankle. Needs to be done as soon as possible", "Cleanse area to top of right foot with Dakin's solution, 25%, pat dry. Apply Santyl on nonstick pad to wound bed. Cover with dry dressing daily and prn (as needed) every day shift for wound care", "Cleanse stage 3 PU (pressure ulcer) to L (left) lower buttock with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID (twice a day) and PRN every day and night shift for wound care", "Cleanse stage 3 PU to L upper buttock with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks", "Cleanse stage 3 PU to R buttocks with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks", "Cleanse unstageable PU on coccyx with Dakin's solution,	F 686		

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F 686	Continued From page 71	F 686		

pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks", "Cleanse unstageable PU to center sacrum with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry dressing to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 10 days", "Cleanse unstageable PU to R heel with Dakin's solution, pat dry, apply skin prep to periwound, apply Santyl on nonstick pad and secure with dry dressing BID and PRN every day and night shift for wound care for 14 days", and "Bactrim DS oral tablet 800-160 mg (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth one time a day for wound infection for 14 days."

Resident #42's clinical record contained a "Physician's Telephone Orders" form dated 02/27/23, which read in part "(1) DC (discontinue) Macrobid. (2) Bactrim DS 1 tab PO (by mouth) BID (twice a day) x 10 days-wound infections R ankle, foot." This order was signed by the family nurse practitioner (FNP).

Resident #42's treatment administration record (TAR) for the month of March 2023 was reviewed and contained entries as above. Each of these entries had not been initialed as completed on two separate occasions. Resident #42's February 2023 TAR contained entries, which read in part "Cleanse area to right heel with IHWC (wound cleanser), pat dry and apply bordered foam dressing every day shift for open area", "Cleanse area to right posterior thigh with IHWC, pat dry, and apply 4 x 4 bordered foam dressing every day shift for open area", "Cleanse top of right foot

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F 686	Continued From page 72 with IHWC, pat dry, and apply bordered foam dressing every day shift for abrasion", and "Cleanse area to coccyx with IHWC, pat dry, and apply bordered foam dressing every day shift for open area." Each of these entries had not been initialed as completed on three separate occasions. Surveyor, along with licensed practical nurse (LPN) #1 observed Resident #42's dressings to sacrum, coccyx, and buttocks on 03/13/23 at 2:30 pm. Dressing to sacrum did not have a date on it. Dressings to resident's foot, heels, and ankles all had dates and initials. LPN #1 stated they had completed wound care to these area's earlier in the day. Surveyor asked LPN #1 how they knew when the dressings to the sacral area had last been changed, and LPN #1 stated that without a date, there was no way to know when wound care was last completed. Surveyor spoke with the assistant director of nursing (ADON) on 03/14/23 at 10:50 am regarding Resident #42's wound care. Surveyor asked ADON what their expectations were for wound care, and ADON stated they would expect the nurses to follow the physician's orders for each resident regarding wound care. Surveyor asked ADON if wound dressings should be dated, and ADON stated that they should be dated and initialed by the nurse completing the wound care. ADON later stated per DON, facility policy did not state that dressings needed to be dated. Surveyor requested and was provided with a facility policy entitled "Wound Dressings: Aseptic" which read in part, "2. Gather supplies: 2.7 Prepared label or secondary dressing with date and initials. 27. Apply prepared label."	F 686		

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F 686	Continued From page 73 Survey team spoke with the director of nursing (DON) on 03/15/23 at 10:00 am regarding wound management. DON stated they measure wounds weekly, and that information is located in their office. Surveyor asked DON if dressings should be dated and initialed when changed, and DON stated that is not a part of the facility policy, but they were hoping to have that changed, as that is the expectation. Surveyor referred DON to aforementioned policy, and asked DON what "prepared label" meant, and DON stated they did not know. Surveyor requested and was provided with "Skin Integrity Report" forms, which were contained in a notebook housed in the DON's office. This notebook contained six forms for Resident #42, which addressed unstageable pressure areas to right heel, right achilles, sacrum/coccyx, right buttock, left outer thigh/lower buttock and a stage II pressure areas to upper left buttock. Each of these areas were marked as present upon admission, with weekly measurements beginning on 02/01/23 and continuing through 03/14/23. Two surveyors, along with LPN #1 observed Resident #42's wounds on 03/14/23 at 4:45 pm. LPN #1 stated that areas to the top of resident's right foot and right ankle/lower leg were arterial rather than pressure. Resident's right heel had dark brown eschar and LPN #1 stated that area was unstageable pressure ulcer. Areas to resident's sacral area (sacrum, coccyx, buttocks) were red with slough present in wound bed. Survey team spoke with family nurse practitioner (FNP) on 03/20/23 at 1:25 pm regarding wound management. Surveyor asked FNP if missed	F 686		

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F 686	Continued From page 74 assessments and dressing changes not being done as ordered could contribute to wound infections and FNP stated that it could. The concern of not providing treatment to promote healing and prevent infection of pressure ulcers management was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. 3. For Resident #299, the facility staff failed to provide treatment as ordered to an area of excoriation that later developed into a pressure injury and failed to document an assessment of the pressure area at the time of discovery. This was a closed record review: Resident #299's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Aftercare following Joint Replacement Surgery, Dislocation of Internal Right Hip Prosthesis, Chronic Obstructive Pulmonary Disease, Unspecified Dementia, and Type 2 Diabetes Mellitus. The admission minimum data set (MDS) with an assessment reference date (ARD) of 10/25/22 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 indicating the resident was moderately cognitively impaired. Resident #299 was coded as requiring extensive assistance with bed mobility, dressing and being totally dependent on staff with toilet use and bathing. The resident was coded as	F 686		

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F 686	Continued From page 75 being at risk of developing pressure ulcers/injuries with no current unhealed pressure ulcers/injuries. Resident #299 was coded for the presence of a surgical wound and moisture associated skin damage (MASD). Resident #299 was admitted to the facility on 10/18/22, the nursing admission assessment entitled "Nursing Documentation - V 11" dated 10/18/22 at 11:07 pm documented the presence of moisture associated skin damage (MASD) to the coccyx. A physician's order to wash coccyx with soap and water, pat dry, and apply Calazime paste every day and night shift for excoriation began 10/19/22. According to the resident's October 2022 Treatment Administration Record (TAR) the treatment to the coccyx was not administered on 10/19/22 nightshift, 10/21/22 dayshift, and 10/22/22 dayshift. A nursing progress note dated 10/23/22 at 11:00 am stated in part " ... Stage 3 noted to coccyx. Pt [patient] states 'yeah, it's sore'. Orders placed ..." A new physician's order to cleanse coccyx with wound cleanser, pat dry, apply zguard, place non-adhesive optifoam on every 3 days or as needed. Surveyor was unable to locate documentation describing the area to the coccyx. Resident #299 was seen by the family nurse practitioner (FNP) on 10/24/22, the progress note stated in part " ...Wound care to buttocks per stage 2 protocol. Dr. [name omitted] consult for stage 2 wound with slough to buttocks ..." Surveyor was unable to locate any subsequent documentation of the area to the coccyx until	F 686		

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F 686	Continued From page 76 11/01/22 at which time the wound was photographed, measured, and assessed. At that time the area was documented as an unstageable pressure area to the sacrum measuring 9.15 cm in length and 4.91 cm in width with 100% of the wound bed with slough. The assessment documented the resident's pain level as a 6 out of 10 stating the resident complains of pain during dressing change and when wet. The assessment also noted to schedule a consult with Dr. [name omitted] immediately. A nursing progress note dated 11/07/22 at 4:59 pm stated in part "Consultation complete with Dr. [name omitted]. Resident is to have wound debridement next Tuesday 11/15/22 at 9 am ..." A nursing progress note dated 11/15/22 at 8:49 am documented in part Resident #299 departed facility for wound debridement. On 3/14/23 at 10:20 am, surveyor spoke with the Clinical Reimbursement Coordinator (CRC) who documented the 11/01/22 wound assessment and they stated they must have been working the floor that day and does not recall the resident's wound. Resident #299's unstageable area to the coccyx was again assessed and photographed on 11/08/22. The area was described as measuring 7.26 cm in length and 4 cm in width reflecting a decrease in size. The wound bed was described as having 100% slough with an intact serum filled blister. Surveyor attempted to interview the wound nurse at the time of Resident #299's admission, however, they were no longer employed by the facility.	F 686		

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F 686	Continued From page 77 Surveyor requested and received the facility policy entitled "Skin Integrity and Wound Management" with an effective date of 7/01/01 and a revision date of 2/01/23 which read in part: 6. The licensed nurse will: 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds. On 3/17/23 at 4:00 pm, the survey team met with the administrator, director of nursing, and assistant director of nursing and discussed the concern of the staff failing to provide treatment to Resident #299's area of excoriation to the coccyx on three separate occasions prior to area deteriorating into a pressure injury and failing to document an assessment of the area when the pressure area was discovered. 4. The facility staff failed to ensure pressure ulcer assessments and treatments were complete for Resident #199. Resident #199's admission record listed his diagnoses included but were not limited to, Covid-19, Type 2 Diabetes Mellitus, and Encephalitis (inflammation of the brain) and Encephalomyelitis (inflammation of the brain and spinal cord). The minimum data set (MDS) with an assessment reference date of 12/16/21 coded the resident's brief interview for mental status (BIMS) a 01 out of 15 in Section C (cognitive patterns). Section G (functional status) coded him needing extensive assistance with bed mobility, eating, and toilet use. The clinical record contained a Transfer	F 686		

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F 686	Continued From page 78 Summary Sheet from an acute care hospital dated 12/01/21 which described Resident #199's skin integrity as multiple skin tears and a stage 2 decubitus on his left buttock. An admission nursing documentation progress note described the resident's skin injury/wounds as multiple skin tears to bilateral arms and pressure: Stage 2 Left Buttocks. Weekly skin check documents, dated 12/17/21 through 03/04/22, were reviewed. The injury/wound regarding the buttocks was described as moisture associated skin damage until 1/21/22 and 1/28/22 when it was described as a pressure injury with treatment in place. The remaining weekly skin check documents described the left buttocks as moisture associated skin damage, and a pressure injury with one week (2/18/22) not noting the left buttock wound. There was no further description noted on the document or within the progress notes; no wound measurements were found. Provider orders for cleansing the stage 2 injury to the left buttock with wound cleanser, pat dry, and apply Optifoam every day shift was not documented for 12/20/21, 01/25/22, and 3/02/22. The administrator was informed of these findings on 3/14/23 during an interview in person on 3/14/23 and again on 3/19/23. On 3/14/23 at approximately 4:45 p.m., the director of nursing (DON) acknowledged she did not find any wound measurements or further wound/injury descriptions for Resident #199. No further information was provided prior to the exit conference.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills	F 693		

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F 693	Continued From page 79 CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility staff failed to ensure that admission orders included nutrition and fluid orders for one (1) of 33 residents, Resident #46. Resident #46 received their nutrition and fluids via enteral means. Resident #46 was not able to intake nutrition and/or fluids orally. (Enteral nutrition is a way of providing nutrition, via tube, directly to an individual's stomach or small intestine.) The findings include: Resident #46 was documented as being	F 693	Resident #46 was discharged 2/16/2023 and did not return to the facility. The facility was unable to correct action. An initial audit was completed by DON/designee on 3/27/2023 of all new admissions from the last 7 days who receive their nutrition and fluids via enteral means to ensure orders were obtained at the time of admission to the facility and initiated prior to the start of the enteral feedings. All newly admitted residents with the need for enteral feedings to provide nutrition and hydration have the potential to be affected by the alleged deficient practice.	4/26/2023

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F 693	Continued From page 81 readmission to the facility. On 3/15/23 at 11:10 a.m., the DON reported no paperwork arrived with the resident on readmission at 2/14/23. The DON reported that facility staff should have contacted the discharging hospital to obtain orders for Resident #46's care. The DON reported if facility staff were unable to obtain orders from the hospital, then either the DON or the Assistant DON should have been notified. On 3/16/23 at 12:22 p.m., the surveyor interviewed the facility's Medical Director via telephone. The Medical Director reported tha the facility staff should have called the sending facility for orders. Resident #46's progress notes included the following information: - For an effective date of 2/14/23 at 11:02 (this was prior to the resident arriving at the facility), it was documented as follows: " ... G-Tube patent with Supplemental nutrition infusing ..." - For an effective date of 2/14/23 at 4:38 p.m., it was documented as follows: "G-tube patent flushed per order." No amount of the flush was documented. No order for the G-tube flush was found. - For an effective date of 2/14/23 at 4:55 p.m., it was documented as follows: "G-tube was patent flushed 60 cc for patient [sic] ... GI complaints/symptoms: diarrhea Diarrhea [sic] noted with Gastrostomy Nutritional supplement ..." The survey team met with the facility's Administrator and Director of Nursing (DON) on 3/17/23 at 4:01 p.m. During this meeting, the	F 693		4/26/2023

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F 693	Continued From page 80 readmitted to the facility on 2/14/23 at 4:35 p.m. Resident #46 was transported via ambulance to a local emergency department on 2/16/23 at 11:56 a.m. The facility staff failed to obtain tube feeding orders for Resident #46 during the aforementioned stay at the facility. Resident #46's minimum data assessment (MDS), with an assessment reference date (ARD) of 12/15/22, was dated as being completed on 12/29/22. Resident #46 was documented as never or rarely able to understand others and as never or rarely able to make self understood. Resident #46 was documented as being totally dependent on others for eating, bed mobility, dressing, toilet use, and personal hygiene. Resident #46's diagnoses included, but were not limited to: hemiplegia/hemiparesis, seizure disorder, respiratory failure, and dysphagia (Dysphagia is defined as a difficulty in swallowing). Resident #46 clinical record was documented as having received nutrition via a feeding tube. On 3/15/23, during an interview beginning at 10:28 a.m., the facility's Market Clinical Leader (MCL) confirmed that no diet orders or tube feeding orders were found for Resident #46's aforementioned readmission. On 3/15/23 at 10:35 a.m., the facility's Dietary Manager reported that Resident #46 was NPO during their 2/14/23 - 2/16/23 stay at the facility (NPO is a medical abbreviation derived from Latin meaning 'nothing by mouth'). On 3/15/23 at 11:07 a.m., the facility's Director of Nursing (DON) and the MCL confirmed new orders were required for residents at the time of	F 693	NPE/designee will provide education on the process to obtain admission orders prior to initiation of enteral feedings and hydration for those residents who require enteral feedings for nutrition and hydration, to all current licensed nurses and additional and newly hired licensed nursing staff prior to the start of to the start of their first shift. The re-educations will be completed on or before 4/26/2023 or upon hire. The Director of Nursing/designee will complete an audit on all newly admitted residents who require enteral feeding for nutrition and hydration weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 693	Continued From page 82 surveyor discussed the failure of the facility staff to obtain tube feeding orders for Resident #46. The DON confirmed Resident #46 did not have tube feeding orders for the readmission referenced in this report. The DON confirmed that they were unable to determine the amount of tube feeding, and/or the amount of fluid provided via tube during the readmission referenced in this report.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide respiratory care consistent with the comprehensive person-centered care plan and physician's orders for 1 of 33 residents in the survey sample, Resident #38. The findings included: For Resident #38, the facility staff failed to administer oxygen as ordered by the physician and according to the resident's comprehensive person-centered care plan. Resident #38's diagnosis list indicated diagnoses,	F 695	Resident #38 O2 setting was corrected upon notification during the survey process per physicians order at 3L/M via nasal cannula continuously. The DON or designee will audit all active orders for oxygen via nasal cannula to ensure the order matches the O2 concentrator setting per physicians order. NPE or designee will re-educate all current licensed nursing staff and all additional and newly hired prior to the start of their first shift that the O2 concentrators are to be set per the physicians orders. Re-educations will be completed on or before 4/26/2023 or upon hire.	4/26/2023

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F 695	Continued From page 83 which included, but not limited to Chronic Obstructive Pulmonary Disease, Nontraumatic Subarachnoid Hemorrhage, Type 2 Diabetes Mellitus, Asthma, and Bipolar Disorder. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/24/22 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 indicating the resident was moderately cognitively impaired. Resident #38 was coded as requiring extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident was also coded as receiving oxygen therapy within the last 14 days. Resident #38's current physician's orders included an active order dated 2/21/23 for oxygen at 3 L/M (liters per minute) via nasal cannula continuously. Resident #38's current comprehensive person-centered care plan included a focus area stating, "Resident exhibits or is at risk for respiratory complications related to COPD [chronic obstructive pulmonary disease]" with an intervention stating "O2 [oxygen] at 3 L/M via N/C [nasal cannula]". On six separate occasions, 3/12/23 at 3:54 pm, 3/13/23 at 8:46 am, 3/13/23 at 11:48 am, 3/13/23 at 3:28 pm, 3/14/23 at 8:20 am, and 3/16/23 at 8:48 am, surveyor observed Resident #38 in bed receiving oxygen via nasal cannula at the delivery rate of 2 L/M per the oxygen concentrator setting. At each observation, the oxygen concentrator was located on the right near the head of the resident's bed.	F 695	An audit will be completed of all residents who are ordered O2 nasal weekly X 4 then monthly X 2 until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 756	Continued From page 85 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756	Resident #14, Resident #17 and Resident #26 Drug Regiment Review (DRR/MRR) were obtained and the attending physicians will review. An audit will be completed for the past 30 days of the DRR/MRRs to ensure they have been reviewed by the attending physician with documentation in the residents' health record of any identified irregularity has been reviewed and what, if any, action has been taken to address it. The DRR/MRRS are to be uploaded in their individual electronic medical records. NPE or designee will re-educate all current licensed nursing staff and all additional and newly hired prior to the start of their first shift that the Drug Regiment Review is to be obtained and the attending physicians is to review with documentation	4/26/2023

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F 756	Continued From page 86 Based on interviews and document review, the facility staff failed to ensure Medication Regimen Reviews (MRRs) were addressed by a medical provider for three (3) of five (5) residents selected for unnecessary medication review (Resident #14, Resident #17, and Resident #26). The findings include: 1. The facility staff failed to ensure three (3) of Resident #14's Medication Regimen Reviews (MRRs) were documented and addressed by a medical provider. Resident #14's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/16/22, was dated as being completed on 12/29/22. Resident #14 was assessed as sometimes able to make self understood and as sometimes able to understand others. Resident #14 was assessed as having problems with short-term and long-term memory. Resident #14 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #14's clinical documentation included the same note on the following three (3) dates: (a) 10/25/22; (b) 11/21/22; and (c) 1/26/23. The note read as "A medication regimen review was performed - see report for comments/reccomendation(s) [sic] noted". Resident #14's clinical documentation failed to included details of the aforementioned MRRs. On 3/14/23 at 1:35 p.m., the facility's Assistant Director of Nursing (ADON) reported they were unable to find details of the three (3) aforementioned MRRs.	F 756	in the residents health record of any identified irregularity has been reviewed and what, if any, action has been taken to address it. The MMRs are to be uploaded in their individual electronic medical records Re-educations will be completed on or before 4/26/2023 or upon hire. An audit of the DRR/MRRs will be completed to ensure they have been reviewed by the attending physician with documentation in the residents' health record of any identified irregularity has been reviewed and what, if any, action has been taken to address it. The DRR/MRRs are to be uploaded in their individual electronic medical records. The audit will be completed weekly X 4 then monthly X 2 months or until 100% compliant, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 756	Continued From page 87 The following information was found in a policy titled "9.1 Medication Regimen Review" (with a revision date of 3/3/20): - "The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it." - "Facility should maintain readily available copies of MRRs on file in the Facility as part of the resident's permanent health record." This policy was provided to the surveyor, on 3/14/23 at 3:05 p.m., by the facility's Market Clinical Leader. The survey team met with the facility's Administrator and Director of Nursing (DON) on 3/17/23 at 4:01 p.m. During this meeting, the surveyor discussed the failure of the facility staff to ensure documentation of the details of Resident #14's MRRs were maintained as part of the resident's clinical documentation. 2. The facility staff failed to ensure three (3) of Resident #17's Medication Regimen Reviews (MRRs) were documented and addressed by a medical provider. Resident #17's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/15/22, was dated as being completed on 12/29/22. Resident #17 was documented as usually able to make self understood and usually able to understand others. Resident #17 was assessed as having problems with short-term and long-term memory. Resident #17 was documented as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene.	F 756		

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F 756	Continued From page 88 Resident #17's clinical documentation included the same note on the following three (3) dates: (a) 10/25/22; (b) 11/21/22; and (c) 1/26/23. The note read as "A medication regimen review was performed - see report for comments/reccomendation(s) [sic] noted". Resident #17's clinical documentation failed to included details of the aforementioned MRRs. On 3/14/23 at 1:30 p.m., the facility's Assistant Director of Nursing (ADON) reported they were unable to find details of the three (3) aforementioned MRRs. The following information was found in a policy titled "9.1 Medication Regimen Review" (with a revision date of 3/3/20): - "The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it." - "Facility should maintain readily available copies of MRRs on file in the Facility as part of the resident's permanent health record." This policy was provided to the surveyor, on 3/14/23 at 3:05 p.m., by the facility's Market Clinical Leader. The survey team met with the facility's Administrator and Director of Nursing (DON) on 3/17/23 at 4:01 p.m. During this meeting, the surveyor discussed the failure of the facility staff to ensure documentation of the details of Resident #17's MRRs were maintained as part of the resident's clinical documentation. 3. The facility staff failed to ensure five (5) of Resident #26's Medication Regimen Reviews	F 756		

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F 756	Continued From page 89 (MRRs) were documented and addressed by a medical provider. Resident #26's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 2/15/23, was dated as being completed on 3/6/23. Resident #26 was documented as usually able to make self understood and usually able to understand others. Resident #26's Brief Interview for Mental Status (BIMS) summary score of four (4) out of 15; this indicated severe cognitive impairment. Resident #26 was documented as requiring assistance with bathing, dressing, toilet use, and personal hygiene. Resident #26's clinical documentation included the same note on the following five (5) dates: (a) 9/1/22, (b) 10/25/22; (c) 11/21/22; (D) 12/13/22, and (e) 1/26/23. The note read as "A medication regimen review was performed - see report for comments/reccomendation(s) [sic] noted". Resident #26's clinical documentation failed to included details of the aforementioned MRRs. On 3/14/23 at 1:32 p.m., the facility's Assistant Director of Nursing (ADON) reported they were unable to find details of the five (5) aforementioned MRRs. The following information was found in a policy titled "9.1 Medication Regimen Review" (with a revision date of 3/3/20): - "The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it." - "Facility should maintain readily available copies of MRRs on file in the Facility as part of the resident's permanent health record."	F 756		

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F 756	Continued From page 90 This policy was provided to the surveyor, on 3/14/23 at 3:05 p.m., by the facility's Market Clinical Leader. The survey team met with the facility's Administrator and Director of Nursing (DON) on 3/17/23 at 4:01 p.m. During this meeting, the surveyor discussed the failure of the facility staff to ensure documentation of the details of Resident #26's MRRs were maintained as part of the resident's clinical documentation.	F 756		
F 770 SS=E	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, the facility staff failed to obtain physician ordered labs for 4 of 33 residents, Resident #4, Resident #42, Resident #11, and Resident#199. The findings included: 1. For Resident #4 the facility staff failed to obtain physician ordered wound cultures. Resident #4's face sheet listed diagnoses which included but not limited to multiple sclerosis,	F 770	Labs were completed as ordered for Resident #4 and Resident #11. Resident #42 discharged from the facility on 4/3/23 Resident 199 was discharged on 3/5/22 and did not return to the facility. The facility was unable to correct action. An audit will be completed to ensure all ordered labs are obtained for the last two weeks.	4/26/2023

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F 770	Continued From page 91 depression, anxiety, and contractures of muscles. The most recent MDS with an assessment reference date of 02/06/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section M, skin conditions, coded the resident as having one stage one pressure ulcer that was present upon admission. Section M, subsection M1040, other ulcers, wounds and skin problems coded the resident as "none of the above present". This subsection includes surgical wounds. Resident #4's comprehensive care plan was reviewed and contained a care plan for ""Resident at nutrition risk r/t (related to) ... Wounds: Surgical PI Open wound to R (right) hip skin fold, healing ..." and " ... is at risk for continuing impaired skin integrity related to diagnosis of MS (multiple sclerosis), impaired mobility ... Type: Pressure ulcers." Interventions for these care plans included "Labs per orders". Resident #4's clinical record was reviewed and contained a physician's telephone order form dated 01/30/23, which read in part "(1) Culture R (right) hip wound-redness, drainage, foul odor (2) After culture, start Bactrim DS-1 tab PO (by mouth) BID (twice daily) x 10 days wound infection." This order was signed by the FNP. Surveyor could not locate a lab report for the ordered wound culture in Resident #4's clinical record until one dated 02/10/23. Resident #4's clinical record contained a physician's telephone order form dated 02/16/23, which read in part "(1) Rocephin 1 gm I.V. q	F 770	Nurse Practice Educator/designee will re-educate of licensed nurses regarding how to properly utilize the new process for ordering labs and obtaining specimens. The re-educations will be completed on or prior to 4/26/2023 or upon hire. An audit for ordered and completed labs will be completed daily during the clinical morning meeting with corrective action if necessary, weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 770	Continued From page 92 (every) day (2) Repeat wound culture x 7 (3) Barker consult wound vac R hip." This order was signed by the physician. Resident #4's clinical record also contained a physician's order summary for the month of February 2023, which read in part "Culture wound to Right hip one time only for Wound Infection for 1 day" This order had a start date of 02/25/23. Surveyor could not locate results of this wound culture. Surveyor spoke with the assistant director of nursing (ADON) on 03/17/23 at 12:50 pm. ADON stated the culture order on 01/30/23 was collected 3 times, and when the lab was contacted for results, they were told the lab did not have a specimen. ADON stated they could not locate results for culture ordered to be done on 02/25/23. Surveyor spoke with medical technician (MT) at the contracted lab on 03/20/23 at 10:15 am regarding Resident #4's wound cultures. MT stated that the only wound culture orders and specimens they had received were on 01/17/23 and 02/10/23. MT stated they had received no other orders or specimens for wound cultures for Resident #4. Surveyor spoke with FNP on 03/20/23 at 1:25 pm. Surveyor asked FNP when they expected the wound culture ordered on 01/30/23 to be done, and FNP stated they expected it to be done on the order date. FNP said when they asked about the results, "couple of nurses stated they had done it and lab lost it". Surveyor requested and was provided with a facility policy entitled "Diagnostic Tests" which read in part, "Policy: Diagnostic tests-including	F 770		

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F 770	Continued From page 93 laboratory, radiologic, pulmonary and waived testing (e.g., fingerstick glucose monitoring, hemoccult testing)-will be performed as ordered. Laboratory services will be available on-site, seven days a week, 24 hours a day with a licensed outside diagnostic service that meets all applicable certification standards and local or state regulations." The concern of not obtaining physician ordered wound cultures was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. 2. For Resident #42 the facility staff failed to obtain a physician ordered CBC (complete blood count) on two separate occasions. Resident #42's face sheet listed diagnoses which included but not limited to hypertensive heart disease, heart failure, chronic kidney disease, type 2 diabetes mellitus, peripheral vascular disease, and anxiety. Resident #42's most recent minimum data set with an assessment reference date of 02/04/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. Resident #42's comprehensive care plan was reviewed and contained a care plan for "Resident exhibits or is at risk for cardiovascular symptoms or complications related to arrhythmia, hypertension, anemia". Interventions for this care	F 770		

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F 770	Continued From page 94 plan included "Monitor labs and report abnormals to physician." Resident #42's clinical record was reviewed and contained an "Acute Visit" form dated 02/01/23 which read in part, "Chief Complaint/Nature of Present Problem: Follow-up anemia. Diagnosis, Assessment and Plan: Anemia -CBC, Iron Panel, B12, Folate in AM (02/02/23)-anemia." Resident #42's clinical record contained a "Physician's Telephone Orders" form dated 02/01/23, which read in part "2-1-23 CBC, iron panel, B12, Folate in AM-anemia." This form was signed by the family nurse practitioner (FNP). Resident #42's clinical record contained a lab report dated 02/02/23 with results of a folate, B12 and iron panel. The lab report did not contain results for a CBC. Surveyor spoke with the assistant director of nursing (ADON) on 03/17/23 at 12:50 pm regarding Resident #42's lab report. ADON stated that lab thought CBC ordered to be done on 02/02/23 was a mistake, and didn't do it, because resident had just had it done on 01/31/23. ADON stated that FNP ordered the CBC to be done on 02/10/23. Surveyor spoke with medical laboratory technician (MLT) on 03/20/23 at 9:30 am regarding Resident #42's lab tests on 02/02/23. MLT stated that the order the lab received did not include a CBC. Surveyor requested and received a copy of the lab requisition form, dated 02/02/23. A CBC was not marked on this form to be collected.	F 770		

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F 770	Continued From page 95 Resident #42's clinical record contained a lab report dated 02/10/23 with a handwritten note signed by the FNP, which read in part "2/15/23 Repeat CBC in AM-2/16 due to leukocytosis (high white blood cell count)." Surveyor could not locate a lab report for 02/16/23. Resident #42's clinical record contained a nurse's progress note dated 02/15/23 which read in part, "Lab CBC-wbc 12.3 HGB (hemoglobin) 9.4. ... (FNP name omitted) notified. NO repeat needed. Resident notified." Surveyor spoke with FNP on 03/20/23 at 1:25 pm. Surveyor asked FNP if they had ordered a repeat CBC to be done on 02/16/23, and FNP stated they had ordered the CBC and wanted it to be done. Surveyor requested and was provided with a facility policy entitled "Diagnostic Tests" which read in part, "Policy: Diagnostic tests-including laboratory, radiologic, pulmonary and waived testing (e.g., fingerstick glucose monitoring, hemoccult testing)-will be performed as ordered. Laboratory services will be available on-site, seven days a week, 24 hours a day with a licensed outside diagnostic service that meets all applicable certification standards and local or state regulations." The concern of not obtaining physician ordered labs was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit.	F 770		

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F 770	Continued From page 96	F 770		

3. For resident #11, the facility staff failed to obtain the following ordered laboratory tests: glycated hemoglobin (HgbA1C), a complete blood count (CBC) and a comprehensive metabolic panel (CMP) as ordered by medical provider on 1/26/23.
Resident #11's diagnosis list includes but is not limited to the following: Type 2 diabetes, dysphasia, morbid obesity, and major depressive disorder.

The most recent Minimum Data Set (MDS) with an assessment reference date (ARD) of 2/1/23 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 indicating the resident is cognitively intact.

During a review of resident #11's record, the surveyor saw an order put in on 1/26/23 for a HgbA1C, CBC, CMP to be done every 6 months starting on 2/16/23. Surveyor was unable to locate the results of these labs in the resident's medical record.
A progress note dated 2/17/23 @ 5:36 a.m. read "Attempted to obtain labs x 1 stick to the right AC without success. Resident stated, "try later". Will pass on to oncoming nurse". Surveyor was unable to find any mention of another nurse attempting to draw the lab tests.

Resident #11 was interviewed on 3/14/23 at 9:35 am and did not recall any attempts by facility staff to draw blood on her recently.
On 3/14/23 at 9:47 am, surveyor asked the Director of Nursing (DON) if she could locate the results of the lab tests ordered to be done on 2/16/23. The DON produced a copy of the

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F 770	Continued From page 97 above-mentioned progress note with a handwritten note on the bottom of the page that read, "I called the lab they have none". Surveyor asked the DON to clarify, and they stated that the labs had not been drawn. DON further stated that the staff was contacting the provider to inform them the labs had not been drawn and would follow any orders given. Surveyor requested and received the policy entitled, "Diagnostic Tests" with a revision date of 6/1/21, that read in part, "Diagnostic tests- including laboratory, radiologic, pulmonary, and waived testing (e.g., fingerstick glucose monitoring, hemoccult testing)- will be performed as ordered. Laboratory services will be available on-site, seven days a week, 24 hours a day with a licensed outside diagnostic service that meets all applicable certification standards and local or state regulations". Surveyor discussed the above issue with administrative staff #4 on 3/14/23 who provided a copy of resident #11's behavior care plan that mentioned care refusals and stated that there was a possibility that the resident refused to let the staff draw the lab. No evidence to verify the resident refused was ever produced. This concern was discussed with the Administrator and administrative staff #4 on 3/14/23 at 5:25 PM. No further information was provided to the survey team prior to the exit conference on 3/20/23. 4. The facility staff failed to ensure provider orders for laboratory studies were implemented	F 770		

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F 770	Continued From page 98 when ordered for Resident #199. Resident #199's admission record listed his diagnoses included but were not limited to, Covid-19, Type 2 Diabetes Mellitus, and Encephalitis (inflammation of the brain) and Encephalomyelitis (inflammation of the brain and spinal cord). The minimum data set (MDS) with an assessment reference date of 12/16/21 coded the resident's brief interview for mental status (BIMS) a 01 out of 15 in Section C (cognitive patterns). Section G (functional status) coded him needing extensive assistance with bed mobility, eating, and toilet use. The clinical record contained a nurse practitioner (NP) Acute Visit Document with a date of service on 3/02/22. The diagnosis, assessment and plan portion of the document listed provider orders for "AM labs: CBC (complete blood count), CMP (complete metabolic panel), PROBNP (used to diagnose heart failure) in AM." Resident #199's lab value results were reviewed and indicated the labs were collected on 03/05/22. The nurse practitioner (NP) who wrote the orders on 3/02/22 was interviewed via phone on 3/17/23 at 2:20 p.m. The NP stated her expectation was the labs would have been collected the next day, 3/03/22. The administrator was informed of these findings on 3/17/23 (via phone) and again on 03/19/23 in person. No further information was provided prior to the exit conference.	F 770		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results	F 773		

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F 773	Continued From page 99 CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to promptly notify a medical provider of Resident #14's critically low blood glucose level. A blood glucose test is a blood test that measures the level of sugar (glucose) in the blood. "Low blood sugar (also called hypoglycemia) has many causes, including missing a meal, taking too much insulin, taking other diabetes medicines, exercising more than normal, and drinking alcohol. Blood sugar below 70 mg/dL is considered low ... Low blood sugar can be dangerous and should be treated as soon as possible. (Downloaded from https://www.cdc.gov/diabetes/managing/manage-blood-sugar.html on 3/16/23) Resident #14's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/16/22, was dated as being completed on 12/29/22. Resident #14 was assessed as sometimes able to make self	F 773	Resident #10 labs were repeated on Feb 13, 2023 with no critical findings. Resident #14 labs were repeated on February 23, 2023 with no critical findings. An audit was completed on all labs ordered for the previous 30 days to ensure no critical labs were received and not followed up on by the attending physician, with corrective action if needed. This audit to be completed on or before April 5, 2023. NPE or designee will re-educate all current licensed nursing staff and all additional and newly hired prior to the start of their first shift on how to obtain and report critical labs. The re-educations will be completed on or prior to 4/26/2023 or upon hire.	4/26/2023

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F 773	Continued From page 100 understood and as sometimes able to understand others. Resident #14 was assessed as having problems with short-term and long-term memory. Resident #14 was assessed as requiring assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #14's was diagnosed with diabetes. Resident #14's clinical record included a laboratory report indicating a critical low blood glucose level was called to the facility on 2/21/23 at 9:03 p.m. Resident #14 blood glucose level was documented as 42 with a reference range of 70 - 110 mg/dL. Resident #14's clinical record included a nursing progress note dated 2/21/23 at 9:00 p.m. This nursing progress note included the following information: "Received call from (local hospital initials omitted) Lab with critical Glucose level on resident of 42 from labs drawn this morning, placed in Rounding Book for MD to review." No resident assessment and no finger stick blood sugar check were completed and/or documented related to the aforementioned critical low blood glucose report. (An earlier documented nursing progress note indicated Resident #14 had laboratory blood specimens obtained on 2/21/23 at 5:37 a.m.) Resident #14's next blood glucose/sugar level was documented on 2/23/23 at 6:05 a.m.; this result was 92 mg/dL. A medical provider signed they reviewed this laboratory result on 2/22/23 (no time was documented). The medical provider gave an order dated 2/22/23 at 8:38 p.m. for Resident #14's blood sugar to be checked twice a day due to "recent hypoglycemia on lab results"; this was dated to be started on 2/23/23 at 6:00 a.m.	F 773	An audit for critical labs will be completed daily during the clinical morning meeting with corrective action if necessary, weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review	4/26/2023

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F 773	Continued From page 101 On 3/16/23 at 11:49 a.m., the surveyor interviewed, via telephone, the Administrator and the Director of Nursing (DON) related to Resident #14's critically low blood glucose report. The DON reported a finger stick blood sugar should have been immediately obtained for Resident #14 and the resident should have been assessed for symptoms of low blood sugar (hypoglycemia). The DON reported a medical provider should have been promptly notified of the critical laboratory results. On 3/16/23 at 12:22 p.m., the surveyor interviewed the facility's Medical Director via telephone. The Medical Director reported neither they nor the facility's nurse practitioner had been notified of Resident #14's critical blood glucose/sugar level. The Medical Director confirmed a medical provider should have been promptly notified of the critical laboratory result. The Medical Director confirmed the resident should have been assessed for hypoglycemia and should have had a finger stick blood sugar (FSBS) checked. The following information was found in a facility policy titled "NSG103 Diagnostic Tests" (with a revision date of 6/1/21): - "Diagnostic test - including laboratory ... will be performed as ordered." - "All diagnostic results are reported to [sic] attending physician/advanced practice provider (APP) promptly." - "Notify physician/APP of diagnostic test results ... Notify immediately for any critical values." The survey team met with the facility's Administrator and Director of Nursing (DON) on	F 773		

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F 773	Continued From page 102 3/17/23 at 4:01 p.m. During this meeting, the surveyor discussed the failure of the facility staff to promptly notify a medical provider of Resident #14's aforementioned critically low blood glucose/sugar level. Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the physician/FNP of critical lab results for 2 of 33 residents, Resident #10 and #14. The findings included: 1. For Resident #10 the facility staff failed to notify the provider, assess and/or treat the resident for a critical potassium (K) level and a critical glucose level. Resident #10's face sheet listed diagnoses which included but not limited to anemia, chronic obstructive pulmonary disease, dementia, basal cell carcinoma of skin, and hypertension. Resident #10's most recent minimum data set with an assessment reference date of 02/07/23 coded the resident as 6 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #10's comprehensive care plan was reviewed and contained a care plan for "Resident is at nutrition risk r/t (related to) need for altered texture diet, diuretic, underweight, hyperkalemia..." Interventions for this care plan included "Labs per orders".	F 773		

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F 773	Continued From page 103 Resident #10's clinical record was reviewed and contained a laboratory report dated which read in part, "Test: K, Result: 6.6, Flag: *H, Reference: 3.6-5.6 mEq/L, Reported: 02/08/23 1944. Result verified by repeat analysis. Critical called to and read back by ... (name omitted) at 02/08/2023 19:39:05 by ... (initials omitted)" and "Test: Glu (glucose), Result: 37, Flag: *L, Reference: 70-110, Reported: 02/08/23 1957. Result verified by repeat analysis. Critical called to and read back by ... (name omitted) at 02/08/2023 19:50:54 by ... (initials omitted). Critical called to and read back by ... (name omitted) at 02/08/2023 19:52:18 by ... (initials omitted)". Handwritten note on the bottom of this report read in part "No nursing notes on this 2/8. I don't see Kayexelate?? Please get 2/10 labs" This note did not have a signature. Resident #10's clinical record also contained a copy of the same laboratory report with a handwritten note at the bottom of the report, which read in part "New orders given 2/13 for repeat labs." This note was signed by the facility family nurse practitioner (FNP). According to Davis Drug Guide.com, Kayexelate is a medication used to treat high levels of potassium. Surveyor reviewed Resident #10's nursing progress notes on 03/14/23. Surveyor could not locate any documentation that the physician/FNP had been notified of the critical potassium or glucose levels. Surveyor spoke with the assistant director of nursing (ADON) on 03/14/23 at 10:50 am regarding Resident #10's critical labs. ADON stated that MD/FNP should have been notified, and that the facility staff has been instructed to do so. Surveyor asked ADON if this had been done,	F 773		

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F 773	Continued From page 104 and ADON stated "Not that I can find". Surveyor spoke with the facility physician (MD) on 03/15/23 at 4:05 pm via telephone. Surveyor asked MD if they had been notified of Resident #10's critical lab values, and MD stated they did not recall being notified. MD stated to surveyor that it was possible the facility family nurse practitioner (FNP) had been notified instead of them and stated they would ask FNP. Surveyor spoke with facility MD again on 03/15/23 at 5:04 pm. MD stated they had spoken with the FNP and confirmed that the FNP had not been notified of the critical results returned on 02/08/23 until 02/13/23. MD stated that this is "very concerning" and "glad the resident had no negative outcome". Surveyor spoke with the FNP on 03/20/23 at 1:55 pm regarding Resident #10. FNP stated they had not been notified of the critical lab values until "I found it when I rounded next" FNP stated they were in the facility on 02/08/23 and again on 02/13/23. Surveyor requested and was provided with a facility policy entitled "NSG 103 Diagnostic Tests" which read in part "Practice Standards: 4. Notify physician/APP (advanced practice practitioner) of diagnostic test results. 4.1 Notify immediately for any critical values. 5. Document date and time of physician/APP notification and response in the medical record." The concern of the facility staff not notifying the MD/FNP of critical lab values was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm.	F 773		

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F 773	Continued From page 105 No further information was provided prior to exit.	F 773		
F 812 SS=D	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: Based on observation, staff interview, and facility document review, the facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility staff failed to discard an out-of-date food item and failed to label opened food items in the refrigerator. The findings include: The facility staff failed to label a bag of shredded cheese that had been opened and failed to	F 812	The unlabeled, open bag of shredded cheese was immediately discarded. The opened, expired bottle of Worcestershire sauce was immediately discarded. An audit was completed to ensure no expired food items and/or open, undated food items in the kitchen with no negative findings. Dietary Manager or Designee will provide re-education to all current dietary staff and any new hired dietary staff prior to the start of their first shift of the open dating food products and First in First out (FIFO) process. Re-educations to be completed on or before 4/26/23	4/26/2023

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F 812	Continued From page 106 discard an opened bottle of Worcestershire Sauce with a use by date of 9/13/22. On 3/12/23 at 2:30 P.M. during the initial tour of the kitchen, surveyor observed an opened, clear bag of shredded cheese with no label or date on it in the walk-in cooler. Other staff member # 3 stated, "they just opened that the other day, we go through cheese fast". Surveyor asked if the bag should have a label on it and they stated that "it should have a date on it when it was opened". Surveyor then observed a large, opened bottle of Worcestershire Sauce with a use by date of 9/13/22. Other staff #3 stated, "I didn't even know that was in here, I'll throw it away". On 3/13/23 at 9:50 am, surveyor met with the Certified Dietary Manager (C.D.M.) and reviewed the above concerns and requested a policy for food storage. C.D.M. confirmed that the food items in question had been discarded. Surveyor reviewed the policy provided, which was entitled, "Food Storage: Cold Foods". The policy had a revised date of 4/2018 and read in part: "All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination". Surveyor met with the Administrator, and administrative staff #4 on 3/13/23 at 5:25 PM and discussed the above concerns. No further information regarding this concern was provided to the survey team prior to the exit conference on 3/20/23.	F 812	Dietary Manager or Designee will audit for FIFO and open dating of food products weekly X 4 then monthly X 2 until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review	4/26/2023
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance	F 865		

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F 865	Continued From page 107 improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full	F 865	IDT team has reviewed and revised the PIP plan for the area of Quality of Care related to wound care with the Abatement Plan focus outlined. QA members will meet monthly to review with corrective action if needed. An audit was conducted on 04/03/23 by QAPI Committee members to ensure all current, open Performance Improvement Plans are appropriately identified via area of concern, have a measurable goal, interventions are detailed and being monitored for progress per QAPI mandates, with corrective action upon discovery.	4/26/2023

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F 865	Continued From page 108 range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect	F 865	Administrator and/or Designee will re-educate the QAPI Committee members on the QAPI process of maintaining an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life for our residents. This re-education will be completed on or before 4/26/2023. Current, open Performance Improvement Plans will be reviewed by QAPI Committee members for appropriate identified area of concern, measurable goals, interventions are detailed and being monitored for progress per QAPI mandates, weekly X 4 then monthly X 2 until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 865	Continued From page 109 organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure a Quality Assurance and Performance (QAPI) Program to meet the needs of the facility as evidenced by repeated deficiencies in the area of Quality of Care related to wound management. The findings included: Quality of Care was previously cited with the 2/21/20 and 5/20/21 Medicare/Medicaid standard surveys for failing to follow physician's orders in regard to treatment administration and/or wound care.	F 865		

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	495200	A. BUILDING _____ B. WING _____	C 03/20/2023

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F 865	Continued From page 110 On 3/20/23 at 12:29 pm, surveyor met with the administrator and discussed the facility QAPI Program. The administrator stated the QAA (Quality Assessment and Assurance) Committee met monthly and consisted of the administrator, director of nursing, interdisciplinary team members, the infection preventionist, and the medical director. The administrator stated the medical director attended at least quarterly and often additional staff members attended. The administrator stated QAA Committee information was entered into a computer system and accessible by the facility governing body. Surveyor requested and received the facility policy entitled "Center Quality Assurance Performance Improvement Process" which read in part: 2. The QAA Committee: 2.8 Assesses, evaluates, and identifies potential improvement opportunities based on: 2.8.2 All current regulatory on-site assessments, including plans of correction, both state/federal surveys and peer review surveys including a review of the plan of correction No further information regarding this concern was presented to the survey team prior to the exit conference on 3/20/23.	F 865		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880	LPN #2 was re-educated on Hand Washing per CDC guidelines and Aseptic Technique Dressing Changes by Nurse Practice Educator (NPE) on 03/27/23. This included return demonstration of both areas by LPN #2.	4/26/2023

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F 880	Continued From page 111 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	An audit was completed on wound care dressing to ensure the Hand Washing per CDC guidelines and Aseptic Technique Dressing Changes by Nurse Practice Educator. Nurse Practice Educator or designee will provide re-education to the process Hand Washing per CDC guidelines and Aseptic Technique Dressing Changes with all licensed nurses and additional and newly hired licensed nursing staff prior to the start of to the start of their first shift. The re-educations will be completed on or before 4/26/2023 or upon hire.	4/26/2023

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F 880	Continued From page 112 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to perform hand hygiene after cleaning the wound and placing a clean dressing for 1 of 33 residents in the survey sample, Resident #36. Resident #36 was admitted to the facility with diagnoses including (by listed date of diagnosis) type 2 diabetes mellitus with diabetic polyneuropathy,peripheral vascular disease, morbid obesity, obstructive sleep apnea,muscle weakness, hypertensive heart and chronic kidney disease with heart failure, local infection of the skin and subcutaneous tissue, methicillin resistant staphylococcus aureus infection, chronic obstructive pulmonary disease with acute exacerbation, atrial fibrillation, sepsis due to escherichia coli, bacteremia. On the minimum	F 880	An audit will be completed by DON and/or designee to observe for proper hand washing per CDC guidelines and Aseptic Technique Dressing Changes completed by licensed nurses, weekly X 4 then monthly X 2 until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4/26/2023

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F 880	Continued From page 113 data set assessment with assessment reference date 2/1/23, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The surveyor interviewed the resident on 3/12/23 concerning life in the facility. The resident had no complaints. When questioned about wound care (the right lower leg ended in a stump covered with a sock) the resident said staff usually changed the dressing on the leg wound daily. Clinical record review revealed two recent hospitalizations with wound infections: 12/2722 through 1/3/23 and 1/14 through 1/20/23. An order was entered dated 1/24/23 for Cleanse wound to RLE with IHWC (in house wound cleanser), pat dry, apply non-adherent dressing and wrap with gauze and ACE bandage every day shift for wound healing. The surveyor observed wound care on 3/13/23 at approximately 2:20 PM. LPN #2 stated that there was no dressing because the physician had removed it to assess the wound. LPN #2 stated that the resident's bedside table had been sanitized by the nurse and the nurse was waiting for the table to dry. The surveyor observed LPN #2 as the nurse donned gloves, then opened a non-adherent pad, non-woven gauze sponges, and a roll of stretch gauze. The nurse sprayed wound wash on non-woven gauze sponges, then sprayed wound wash on the wound, caught the excess on the gauze sponges, and patted the center of the wound and patted around the peri-wound area. The nurse discarded the	F 880		

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F 880	Continued From page 114 sponges, then placed the non-adherent pad and wrapped with stretch gauze. The nurse taped the stretch gauze in place, then dated and initialed another piece of tape and placed it on the dressing. After placing the tape, the nurse pushed up from the floor with gloved hands, then discarded gloves, washed hands for approximately 8 seconds, dried hands with paper towels, and used those paper towels to turn off water. The nurse donned fresh gloves and placed a sock over the resident's new dressing. During wound care observation, the nurse did not change gloves and perform hand hygiene after cleaning the wound and prior to placing the new dressing. The nurse did not wash hands for the recommended length of time. Hand washing was not performed for the CDC guidelines (https://www.cdc.gov/handwashing/when-how-handwashing.html). Follow these five steps every time: 1-Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. 2-Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. 3-Scrub your hands for at least 20 seconds. 4-Rinse your hands well under clean, running water. 5-Dry your hands using a clean towel or an air dryer. The administrator and director of nursing were notified of the concern with hand hygiene during a summary meeting on 3/14/23.	F 880	Outcomes and audits will be presented to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	4/26/2023