STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495389	A. BUILDING _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER HEALTH & REHABILITATION	110 LAUCK DR WINCHESTER, VA 22603

(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 4/10/23 through 4/12/23/23. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This Plan of Correction is submitted to meet requirements established by state and federal law.	
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility]	E 037	1. CNA (Certified Nursing Assistant) #3 was provided training on the Emergency Preparedness Plan. 2. All residents of the facility can be affected by this deficient practice. The facility will complete an audit of all current staff to ensure all have had training on the EP Plan. 3. The facility staff will be provided with training on the Emergency Preparedness Plan. 4. The HR Coordinator will monitor education on the Emergency Plan upon hire and annually. The Emergency Plan is	05/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eva Miller — TITLE: Administrator — (X6) DATE: 5-5-23

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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E 037	Continued From page 1 must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures.	E 037	reviewed annually during the facility assessment and on an Ad hoc basis with significant changes to the facility.	

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E 037	Continued From page 2 (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training.	E 037		

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E 037	Continued From page 3 (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 4 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide emergency preparedness training for one of one CNA (certified nursing assistant) record review. The findings include: The facility staff failed to evidence emergency preparedness training was provided to CNA #3, hired on 9/12/88. On 4/13/23 at 12:22 p.m., OSM (other staff member) #4, the human resources manager, stated she could not provide evidence that CNA #3 was provided emergency preparedness training. OSM #4 stated the facility uses an	E 037		

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E 037	Continued From page 5 online training program and the program changed when the facility was sold in December 2022. OSM #4 stated she sets up the training program then employees receive automatic notifications of certain trainings that are due. On 4/12/23 at 1:39 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/10/23 through 4/12/23. Seven complaints were investigated during the survey (VA00055864-substantiated with deficiency; VA00055797-substantiated with deficiency; VA00055470-substantiated with deficiency; VA00054837-substantiated with deficiency; VA00054702-substantiated with deficiency; VA00054673-substantiated with deficiency; VA00054612-substantiated with deficiency). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care - Requirements. The Life Safety Code survey/report will follow. The census in this 60 bed certified facility was 50 at the time of the survey. The survey sample consisted of 13 current resident reviews and 19 closed record reviews.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580	1. The physician/NP was notified of all dates that Lyrica was not available for administration and facility verified medication availability for residents #37, 14, 262.	5/26/23

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F 580	Continued From page 6 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580	2. All residents of the facility can be affected by this deficient practice. The facility will audit MARS for April, and the provider will be notified of any medications unavailable, and corrections will be made as appropriate. 3. Licensed staff will be educated on the facility policy for medication availability and notification of missing medications. 4. The DON/Designee will audit 3 residents per week for 8 weeks for notification to physician. The results of the weekly audits will be reported monthly to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance.	

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F 580	Continued From page 7 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined the facility staff failed to notify the responsible party and/or the physician when medications were not available for administration for three of 32 residents in the survey sample, Residents #37, #14 and #262. The findings include: 1. For Resident #37 (R37), the facility staff failed to notify the physician when medications when the medication, Lyrica, was not available for administration. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/16/2023, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. An interview was conducted with R37 on 4/10/2023 at approximately 2:00 p.m. R37 stated the facility runs out of their Lyrica (used to treat neuropathic pain) (1) at times. The physician order dated, 2/10/2023, documented, "Lyrica 75 mg; Give 1 capsule by mouth two times a day for neuropathy." The February 2023 medication administration	F 580		

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F 580	Continued From page 8 record (MAR) documented the above order. On 2/12/2023 and 2/13/2023 for the 9:00 a.m. and 9:00 p.m. doses a "9" was documented. On 2/14/2023 for the 9:00 a.m. dose a "9" was documented. A "9" indicated, "Other/See nurse's notes." The nurse's notes for the dates and times with the "9" documented, read, "On order." An interview was conducted with LPN (licensed practical nurse) #2, on 4/11/2023 at 3:14 p.m. When asked what the process is when a medication is not available at the time it is scheduled to be administered, LPN #2 stated, "The (name of pharmacy machine with medications in the building) is the best thing. It has many of the medications we need. If it's a narcotic, then you need two nurses to get it out of the machine." When asked if the medication is not available in the (name of machine), what should the nurse do, LPN #2 stated, "You have to call the pharmacy to get it and notify the nurse practitioner that it is not here." LPN #2 stated the Lyrica was not in the machine. When LPN #2 was shown when the Lyrica was not given and the nurses documented it was on order, LPN #2 stated she was not made aware of the unavailability of the Lyrica [for R37]. LPN #2 stated that sometimes it takes two days to get medications and even the stat (right away) medications can take up to 24 hours to get. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m.	F 580		

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F 580	Continued From page 9 No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605045.html 2. For Resident #14 (R14), the facility staff failed to notify the physician when medication, Lyrica, as not available for administration. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/28/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The physician order dated, 1/6/2023, documented, "Lyrica Capsule 25 mg (milligram); Give 1 capsule by mouth at bedtime for neuropathic pain." The March 2023 MAR (medication administration record) documented the above order for Lyrica. A "9" was documented for the 9:00 p.m. dose on 3/9/2023 through 3/15/2023. A "9" indicated, "Other/See nurse's notes." The nurse's notes for the above dates and 9:00 p.m. dose administration, read, "On order." An interview was conducted with LPN (licensed practical nurse) #2, on 4/11/2023 at 3:14 p.m. When asked what the process is when a medication is not available at the time it is scheduled to be administered, LPN #2 stated, "The (name of pharmacy machine with	F 580		

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F 580	Continued From page 10	F 580		

medications in the building) is the best thing. It has many of the medications we need. If it's a narcotic, then you need two nurses to get it out of the machine." When asked if the medication is not available in the (name of machine), what should the nurse do, LPN #2 stated, "You have to call the pharmacy to get it and notify the nurse practitioner that it is not here." LPN #2 stated the Lyrica was not in the machine. When LPN #2 was shown when the Lyrica was not given and the nurses documented it was on order, LPN #2 stated she was not made aware of the unavailability of the Lyrica [for R14].

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m.

No further information was obtained prior to exit.
3. For Resident #262 (R262), the facility staff failed to notify the physician of medications not administered as ordered on 12/28/2021.

R262 was admitted to the facility on with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1), hypertension and congestive heart failure (2).

The eMAR (electronic medication administration record) for R262 dated 12/1/2021-12/31/2021 documented in part,
- "Metoclopramide HCL (3) Solution 5mg/ml (milligram per milliliter) Use 5mg intravenously three times a day for before meals. Start Date: 12/28/2021 0900 (9:00 a.m.)." The eMAR documented a "9" in the administration area for 12/28/2021 at 9:00 a.m., 1:00 p.m. and 5:00 p.m.

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F 580	Continued From page 11 The eMAR chart codes documented in part, "...9= Other/See Nurse Notes..." - "Diltiazem HCL (4) tablet 30mg Give 1 tablet by mouth three times a day for high blood pressure. Start Date: 12/28/2021 0900." The eMAR documented a "9" in the administration area for 12/28/2021 at 9:00 a.m., 1:00 p.m. and 5:00 p.m. - "Tiotropium Bromide Monohydrate (5) Aerosol Solution 2.5 mcg/act (micrograms) 2 puff inhale orally in the morning for COPD. Start Date: 12/28/2021 0600 (6:00 a.m.). The eMAR documented a "9" in the administration area for 12/28/2021 at 6:00 a.m. - "Symbicort (6) aerosol 160-4.5 mcg/act (Budesonide-Formoterol Fumarate) 2 puff inhale orally two times a day for COPD. Start Date: 12/28/2021 0900." The eMAR documented a "9" in the administration area for 12/28/2021 at 9:00 a.m. - "acetazolamide (7) tablet 125mg Give 1 tablet by mouth one time a day for fluid retention. Start Date: 12/28/2021 0900." The eMAR documented a "9" in the administration area for 12/28/2021 at 9:00 a.m. - "Lexapro (8) 10mg (Escitalopram Oxalate) Give 1 tablet by mouth in the afternoon for depression. Start Date: 12/28/2021 1300 (1:00 p.m.)." The eMAR documented a "9" in the administration area for 12/28/2021 at 1:00 p.m. The nurses notes for R262 documented in part, - "12/28/2021 05:49 (5:49 a.m.) new resident waiting on meds from pharmacy." - "12/28/2021 15:32 (3:32 p.m.) med not avail (available)- waiting for delivery from pharm (pharmacy)." - "12/28/2021 18:38 (6:38 p.m.) med not here yet. Should be coming in very shortly." - "12/28/2021 18:37 (6:38 p.m.) not given as med	F 580		

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is not here and clarification of order needs to be done."
The nurses notes failed to evidence notification of the physician for the medications not administered as ordered on 12/28/2021 at 6:00 a.m., 9:00 a.m., 1:00 p.m. or 5:00 p.m. as documented above.

The physician orders for R262 documented orders for the medications listed above entered on 12/27/2021.

The discharge summary for R262 dated 12/27/2021 from [Name of hospital] documented in part, "...Severe COPD with acute exacerbation in the setting of chronic COPD. Improved. To have scheduled albuterol MDI (metered dose inhaler), prn (as needed) albuterol nebs (nebulizers), Spiriva, Singulair and Symbicort...Discharge Medications: Medication list: Start taking these medications: ...acetazolamide 125mg tablet commonly known as: Diamox, Take 1 tablet (125 mg total) by mouth daily. Start taking on: December 28, 2021...tiotropium 2.5mcg/act inhalation spray Commonly known as: Spiriva respimat Inhale 2 puffs into the lungs every morning. Start taking on: December 28, 2021...Change how you take these medications: ...budesonide-formoterol 160-4.5 mcg/act inhaler Commonly known as: Symbicort Dose: 2 puff Instructions: Inhale 2 puffs into the lungs 2 (two) times daily...Diltiazem 30mg tablet Commonly known as: Cardizem 30mg Instructions: Take 1 tablet (30mg total) by mouth 3 (three) times daily..."

On 4/11/2023 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator stated that there were no nurses

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F 580	Continued From page 13 currently employed at the facility who worked at the facility in December 2021. On 4/11/2023 at 3:25 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that medications were documented as given by signing them off on the eMAR. LPN #2 stated that any refusals or any time a medication was not given the physician was notified and it was documented in the nurses notes. On 4/12/2023 at 12:44 p.m., an interview was conducted with ASM #3, nurse practitioner. ASM #3 stated that they expected for a resident to start getting their medications as soon as possible after admission to the facility. ASM #3 stated that they would expect any pertinent medications such as blood pressure medications and inhalers to be started by the next day after admission. ASM #3 stated that they would expect the nursing staff to inform them of a resident not receiving their medications due to it not arriving from the pharmacy and at times they were able to use an alternate from the stock medications. On 4/12/2023 at 1:29 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the findings. No further information was obtained prior to exit. Reference: (1) chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breathe that can lead to shortness of breath. This information was obtained from the website:	F 580		

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https://www.nlm.nih.gov/medlineplus/copd.html.

(2) congestive heart failure
A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

(3) Metoclopramide injection is used to relieve symptoms caused by slow stomach emptying in people who have diabetes. These symptoms include nausea, vomiting, heartburn, loss of appetite, and feeling of fullness that lasts long after meals. Metoclopramide injection is also used to prevent nausea and vomiting caused by chemotherapy or that may occur after surgery. Metoclopramide injection is also sometimes used to empty the intestines during certain medical procedures. Metoclopramide injection is in a class of medications called prokinetic agents. It works by speeding the movement of food through the stomach and intestines. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601158.html

(4) Diltiazem is used to treat high blood pressure and to control angina (chest pain). Diltiazem is in a class of medications called calcium-channel blockers. It works by relaxing the blood vessels so the heart does not have to pump as hard. It also increases the supply of blood and oxygen to the heart. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684027.h

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F 580	Continued From page 15 tml (5) Tiotropium is used to prevent wheezing, shortness of breath, coughing, and chest tightness in patients with chronic obstructive pulmonary disease (COPD, a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to air sacs in the lungs). Tiotropium is in a class of medications called bronchodilators. It works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a604018.html (6) Formoterol oral inhalation is used to control wheezing, shortness of breath, and chest tightness caused by chronic obstructive pulmonary disease (COPD; a group of lung diseases that includes chronic bronchitis and emphysema). Formoterol is in a class of medications called long-acting beta agonists (LABAs). It works by relaxing and opening air passages in the lungs, making it easier to breathe. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a602023.html (7) Acetazolamide is used to treat glaucoma, a condition in which increased pressure in the eye can lead to gradual loss of vision. Acetazolamide decreases the pressure in the eye. Acetazolamide is also used to reduce the severity and duration of symptoms (upset stomach, headache, shortness of breath, dizziness, drowsiness, and fatigue) of altitude (mountain)	F 580		

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F 580	Continued From page 16 sickness. Acetazolamide is used with other medicines to reduce edema (excess fluid retention) and to help control seizures in certain types of epilepsy. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682756.html (8) Escitalopram is used to treat depression in adults and children and teenagers 12 years of ago or older. Escitalopram is also used to treat generalized anxiety disorder (GAD; excessive worry and tension that disrupts daily life and lasts for 6 months or longer) in adults. Escitalopram is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603005.html	F 580		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607	1. The facility did an audit of all current employees to ensure they have a current criminal background check. The facility does not have access to the employee files for employees terminated prior to 12/1/22 and cannot make changes to the personnel files. 2. All residents of the facility can be affected by this	05/26/23

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F 607	Continued From page 17 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and employee record review, it was determined the facility staff failed to implement their policies for screening potential employees for 13 of 25 employee record reviews. The findings include: For the following employees the criminal background check was not completed within 30 days of hire: 1. OSM (other staff member) #9, hired 12/2/2022. Criminal background check dated 4/11/2023, after it was requested by the survey team. 2. LPN (licensed practical nurse) #6, hired 12/1/2022, criminal background check was dated 9/26/2022. 3. LPN #7 hired on 2/14/2022. There was no evidence of a criminal background check. There was no employee record. 4. RN (registered nurse) #4, hired 6/1/2022.	F 607	deficient practice. The facility will complete a criminal background check within 30 days of hire. The facility will complete an audit on current employee files to ensure they have a current criminal background check. 3. Facility leadership and HR will receive education on facility policy and procedure for obtaining criminal background checks. 4. The administrator/designee will audit up to 3 new hire personnel files weekly X 8 weeks to ensure compliance with the new hire check list. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.	

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F 607	Continued From page 18 There was no evidence of a criminal background check. There was no employee record. 5. CNA (certified nursing assistant) #7, hired 7/1/2022. The criminal background check was dated 3/15/2023. 6. LPN #8, hired 7/13/2021. There was no evidence of a criminal background check. There was no employee record. 7. LPN #9, hired 2/14/2022. There was no evidence of a criminal background check. There was no employee record. 8. CNA (certified nursing assistant) #9, hired 3/11/2022. There was no evidence of a criminal background check. There was no employee record. 9. RN #5, hired 5/16/2022. There was no evidence of a criminal background check. There was no employee record. 10. OSM #12, Human Resources coordinator, hired 8/2/2021. There was no evidence of a criminal background check. There was no employee record. 11. LPN #11, hired 5/10/2022. There was no evidence of a criminal background check. There was no employee record. 12. OSM #14, activities coordinator, hired 8/2/2021. There was no evidence of a criminal background check. 13. OSM #15, social services assistant, hired 7/7/2022. Criminal background check was dated 3/20/2023. An interview was conducted with OSM #4, the business office/human resources (HR) staff member, on 4/12/2023 at 12:19 p.m. When asked the process for hiring a new staff member, OSM #4 stated they go through a recruiting site and select potential employees. Then the process is to bring them in for an initial interview,	F 607		

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F 607	Continued From page 19 complete an application if not already done on the recruitment site, do the reference checks, they complete the rest of the package, which includes fair credit reporting, background check authorization, and sworn statement. If accepting the employee, then they pull the license, sex offenders registry, OIG (office of the inspector general) report, and criminal background check. Once is all done, they bring the staff member in for orientation. When asked how long employee records are retained, OSM #4 state she did not know that answer, but thinks it might be seven years. When asked why there are missing and/or not completed criminal background checks, OSM #4 stated that she just took on this position as HR in addition to her business office duties. OSM #4 further stated she did complete an audit a few months ago and ran some of the ones missing. She stated the other records were not available since the change of ownership of the building. The facility policy, "Abuse" documented in part, "The organization will screen potential employees for a history of abuse, neglect or mistreating residents." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above on 4/12/2023 at 1:31 p.m. No further information was obtained prior to exit.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-	F 622	1. Resident #23. #25 are discharged from the facility and the facility is unable to make any corrective actions to the	05/26/23

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F 622	Continued From page 20 (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F 622	record. #44 went to the hospital and returned and facility is unable to make corrective action for the previous stay. 2. All residents could be affected by the alleged deficient practice. The facility will audit the last 30 days of discharges to validate what was sent with the resident when they discharged from the facility. Corrective action will be performed as appropriate. 3. Licensed nursing staff of the facility will be provided with education on the facility policy for what to send with the patient when discharged to the hospital and where to document what was sent. 4. The DON (Director of Nursing) or designee will perform an audit of up to three discharges each week for 8 weeks for	

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F 622	Continued From page 21 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a	F 622	compliance for sending documentation and documenting what was sent upon resident transfer to the hospital. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.	

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F 622	Continued From page 22 copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to evidence clinical documentation was sent to the receiving facility at the time of resident discharge for three of 32 residents in the survey sample, Residents #23, #25, and #44. The findings include: 1. For Resident #23 (R23), the facility staff failed to evidence required information regarding the resident's clinical status, including a medication list and care plan goals, to the receiving facility when the resident was discharged to the hospital on 2/25/23. A review of R23's clinical record revealed the resident was discharged to the hospital on 2/25/23 and readmitted to the facility on 2/28/23. Further review of the clinical record failed to reveal evidence that the facility provided the receiving hospital with a medication list or care plan goals at the time of the discharge. The resident's E-Interact form dated 2/25/23 did not evidence that the resident's medication list and care plan goals were sent to the hospital. On 4/11/23 at 3:55 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. She stated when a resident is discharged to the hospital, a document is generated (an E-Interact form) which includes a place to check off which information the nurse is sending to the hospital	F 622		

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F 622	Continued From page 23 with the resident. She stated this includes a medication list and care plan goals. After reviewing R23's E-Interact form dated 2/25/23, LPN #2 stated she did not understand why the documents were not checked off as sent to the hospital with the resident. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Facility Initiated Transfers," revealed in part: "The medical record...Will clearly identify the basis or reason for transfer or discharge...Identify Information provided to the receiving provider which at a minimum will include:...Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to treatments and devices (oxygen, implants, IVs, tubes/catheters)...The resident's comprehensive care plan goals; and...Medications (including when last received)." No further information was provided prior to exit. 2. For Resident #25 (R25), the facility staff failed to evidence required information regarding the resident's clinical status, including a medication list and care plan goals, was sent to the receiving facility when the resident was discharged to the hospital on 1/26/23. A review of R25's clinical record revealed the resident was discharged to the hospital on 1/26/23 and readmitted to the facility on 1/31/23.	F 622		

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F 622	Continued From page 24 Further review of the clinical record failed to reveal evidence that the facility provided the receiving hospital with a medication list or care plan goals at the time of the discharge. The resident's E-Interact form dated 1/26/23 did not evidence that the resident's medication list and care plan goals were sent to the hospital. On 4/11/23 at 3:55 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. She stated when a resident is discharged to the hospital, a document is generated (an E-Interact form) which includes a place to check off which information the nurse is sending to the hospital with the resident. She stated this includes a medication list and care plan goals. After reviewing R25's E-Interact form dated 1/26/23, LPN #2 stated she did not understand why the documents were not checked off as sent to the hospital with the resident. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. No further information was provided prior to exit. 3. For Resident #44 (R44), the facility staff failed to evidence which documents were sent to the receiving facility for a transfer to the hospital on 1/8/2023. The E-INTERACT form, dated 1/8/2023 at 7:39 a.m. documented in part, "Fall...Send to ED (emergency department) for eval (evaluation) and treat (treatment) after being found on the floor with head on metal bar, unwitnessed. Resident	F 622		

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	495389	A. BUILDING _____ B. WING _____	C 04/12/2023

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F 622	Continued From page 25 on Eliquis (used to prevent blood clots from forming) (1) 5 mg (milligrams)." An interview was conducted with LPN (licensed practical nurse) #2, on 4/11/2023 at 3:14 p.m. When asked what documents are sent with the resident when they are transferred to the emergency room, LPN #2 stated, the E-INTERACT transfer form, DNR (do not resuscitate) form, if they have one, physician orders, vital signs, medication list, and bed hold notice. When asked if the care plan goals are sent with the resident, LPN #2 stated the E-INTERACT form has that on it. The above E-INTERACT form was reviewed with LPN #2. LPN #2 stated, "They used the wrong form, that is not the transfer form, and there wasn't any documentation of what went with the resident. That was an agency nurse that did that." ASM #1, the administrator, ASM #2, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623	1. Resident #23. #25 are discharged from the facility and the facility is unable to make any corrective actions to the record. #44 was sent to hospital and returned and facility is unable to correct	05/26/23

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F 623	Continued From page 26 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623	record from previous admission. 2. All residents of the facility can be affected by the alleged deficient practice. An audit will be performed for the last 30-day discharges to validate that the resident, emergency contact and Ombudsman were notified of the discharges. Corrections will be made as appropriate. 3. Social Service staff of the facility and IDT team members will be educated on the company policy and guidance for notification of Resident Representative, resident, and Ombudsman in writing of facility-initiated discharges. 4. The Administrator or designee will audit up to 3 residents weekly X 8 weeks who have discharged from the facility for compliance for notification. Results of the weekly audits will be	

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F 623	Continued From page 27 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623	reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.	

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F 623	Continued From page 28 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to evidence written notification to the resident representative (RR), the resident and/or the Office of the State Long-Term Care Ombudsman of a resident's discharge for three of 32 residents in the survey sample, Residents #23, #25, and #44. The findings include: 1. For Resident #23 (R23), the facility staff failed to evidence written notification to the RR, resident and ombudsman when the resident was discharged to the hospital on 2/25/23. A review of R23's clinical record revealed the resident was discharged to the hospital on 2/25/23 and readmitted to the facility on 2/28/23. Further review of the clinical record failed to reveal evidence that the facility notified the RR, resident and ombudsman in writing of the discharge. On 4/11/23 at 3:55 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. She stated when a resident is discharged to the	F 623		

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F 623	Continued From page 29	F 623		

hospital, the nurses are not responsible for notifying the ombudsman in writing or for providing written notification to the resident or RR.

On 4/11/23 at 4:29 p.m., OSM (other staff member) #1, the social services director, was interviewed. She stated if a resident is admitted to the hospital, she types a letter to be sent to the RR. She stated she notifies the ombudsman quarterly of facility discharges to the hospital. She stated she could not provide evidence these notifications were made for R23.

On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns.

A review of the facility policy, "Facility Initiated Transfers," revealed in part: "Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand....Notice must be made as soon as practicable before transfer or discharge when...An immediate transfer or discharge is required by the resident's urgent medical needs...The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman...Copies of notices for emergency transfers will be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis."

No further information was provided prior to exit.

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F 623	Continued From page 30 2. For Resident #25 (R25), the facility staff failed to evidence written notification to the RR, the resident and ombudsman when the resident was discharged to the hospital on 1/26/23. A review of R25's clinical record revealed the resident was discharged to the hospital on 1/26/23 and readmitted to the facility on 1/31/23. Further review of the clinical record failed to reveal evidence that the facility notified the RR, resident and ombudsman in writing of the discharge. On 4/11/23 at 3:55 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. She stated when a resident is discharged to the hospital, the nurses are not responsible for notifying the ombudsman in writing or for providing written notification to the resident or RR. On 4/11/23 at 4:29 p.m., OSM (other staff member) #1, the social services director, was interviewed. She stated if a resident is admitted to the hospital, she types a letter to be sent to the RR. She stated she notifies the ombudsman quarterly of facility discharges to the hospital. She stated she could not provide evidence these notifications were made for R25. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. No further information was provided prior to exit. 3. For Resident #44 (R44), the facility staff failed	F 623		

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F 623	Continued From page 31 to provide the resident and/or responsible party, a written notice of why the resident was being transferred to the hospital on 1/8/2023, and failed to notify the ombudsman of the transfer of 1/8/2023. The E-INTERACT form, dated 1/8/2023 at 7:39 a.m. documented in part, "Fall...Send to ED (emergency department) for eval (evaluation) and treat (treatment) after being found on the floor with head on metal bar, unwitnessed." An interview was conducted with LPN (licensed practical nurse) #2, on 4/11/2023 at 3:14 p.m. When asked if she gives the resident and/or family anything in writing as to why the resident is being transferred to the hospital, LPN #2 stated she has called the emergency room but has not given them anything in writing regarding the transfer. When asked if she notifies the ombudsman, LPN #2 stated she did not. An interview was conducted with OSM (other staff member) #1, the social services director, on 4/11/2023 at 4:34 p.m. When asked if she send the notices of residents being transferred to the hospital to the ombudsman, OSM #1 stated, "I send them if they go over night or are admitted. I don't send them if they go and come back." When asked if she sent one for R44, OSM #1 stated no, the resident didn't get admitted and was not out at midnight. ASM #1, the administrator, ASM #2, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was provided prior to exit.	F 623		

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F 625	Continued From page 32	F 625		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to evidence that a bed hold notice was provided to the resident and/or resident representative at the time of transfer to the hospital, for two of 32 residents in the survey	F 625	1. Residents #23 and #25 were discharged from the facility and changes cannot be made to the resident record. 2. All residents of the facility can be affected by this deficient practice. Facility will conduct an audit on the last 30 days of discharges and validate bed hold policy was given and documented. Corrections will be made as appropriate. 3. Licensed nurses, Social Services and Admissions staff will be provided education on the facility policy for providing bed hold notice and documentation of providing bed hold notice to resident and resident representative upon resident discharge from the facility. 4. The Administrator or	5/26/23

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F 625	Continued From page 33 sample, Residents #23 and #25. The findings include: 1. For Resident #23 (R23), the facility staff failed to evidence bed hold notification was provided to the resident when the resident was discharged to the hospital on 2/25/23. A review of R23's clinical record revealed the resident was discharged to the hospital on 2/25/23 and readmitted to the facility on 2/28/23. Further review of the clinical record failed to reveal evidence that the facility provided the required bed hold notification to the resident at the time of discharge. The resident's E-Interact form dated 2/25/23 did not evidence that the bed hold notification was issued to the resident. On 4/11/23 at 3:55 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. She stated when a resident is discharged to the hospital, a document is generated (an E-Interact form) which includes a place to check off which information the nurse is sending to the hospital with the resident. She stated this includes a bed hold notification. After reviewing R23's E-Interact form dated 2/25/23, LPN #2 stated she did not understand why the bed hold notification was not checked off as having been given to the resident. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Facility Initiated Transfers," failed to reveal information related to	F 625	designee will audit up to 3 residents weekly x 8 weeks who have discharged from the facility for compliance for notification. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.	

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F 625	Continued From page 34 bed hold notifications at the time of discharge. No further information was provided prior to exit. 2. For Resident #25 (R25), the facility staff failed to evidence bed hold notification was provided to the resident when the resident was discharged to the hospital on 1/26/23. A review of R25's clinical record revealed the resident was discharged to the hospital on 1/26/23 and readmitted to the facility on 1/31/23. Further review of the clinical record failed to reveal evidence that the facility provided the required bed hold notification to the resident at the time of discharge. The resident's E-Interact form dated 1/26/23 did not evidence that the bed hold notification was issued to the resident. On 4/11/23 at 3:55 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. She stated when a resident is discharged to the hospital, a document is generated (an E-Interact form) which includes a place to check off which information the nurse is sending to the hospital with the resident. She stated this includes a bed hold notification. After reviewing R25's E-Interact form dated 1/26/23, LPN #2 stated she did not understand why the bed hold notification was not checked off as having been given to the resident. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. No further information was provided prior to exit.	F 625		

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F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer,	F 640	1. Hill Valley Leadership will reach out to Consulate Leadership to request they complete and transmit the discharge MDS' on residents #17, 16,48,47,6,49, and 46. The facility staff do not have access to complete and transmit. 2. All residents who discharge from the facility can be affected by this deficient practice. An audit will be conducted by the MDS coordinator to ensure all discharged residents discharged in the past 30 days have a discharge MDS completed and transmitted. 3. The facility MDS Coordinator will be educated on the RAI manual for completing and transmitting discharge MDS. 4. The MDS coordinator will audit up to 3 discharged	5/26/23

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F 640	Continued From page 36 reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to encode and transmit MDS (minimum data set) assessments to the CMS (Centers for Medicare and Medicaid Services) system for seven of 32 residents in the survey sample, Residents #17, #16, #48, #47, #6, #49 and #46. The findings include: 1. For Resident #17 (R17), the facility staff failed to encode and transmit a discharge MDS assessment after the resident was discharged home on 11/30/22. R17 discharged to home on 11/30/22. A review of the resident's clinical record failed to reveal a discharge MDS assessment was encoded and transmitted. On 4/11/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator. LPN #1 stated she began employment at the facility in September 2022 and the facility was behind on MDS assessments. LPN #1 stated she did not get to complete R17's discharge MDS assessment before the company	F 640	residents weekly x 8 weeks to ensure the discharge MDS has been completed and transmitted. Results of the weekly audits will be submitted to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 640	Continued From page 37 was sold in December 2022 and the record did not pull over once the facility was sold. On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. The facility policy titled, "MDS Completion and Submission Timeframes" documented, "The facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes." 2. For Resident #16 (R16), the facility staff failed to encode and transmit a discharge MDS assessment after the resident was discharged home on 11/25/22. R16 discharged to home on 11/25/22. A review of the resident's clinical record failed to reveal a discharge MDS assessment was encoded and transmitted. On 4/11/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator. LPN #1 stated she began employment at the facility in September 2022 and the facility was behind on MDS assessments. LPN #1 stated she did not get to complete R16's discharge MDS assessment before the company was sold in December 2022 and the record did not pull over once the facility was sold. On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.	F 640		

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F 640	Continued From page 38 3. For Resident #48 (R48), the facility staff failed to encode and transmit a discharge MDS assessment after the resident was discharged home on 11/22/22. R48 discharged to home on 11/22/22. A review of the resident's clinical record failed to reveal a discharge MDS assessment was encoded and transmitted. On 4/11/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator. LPN #1 stated she began employment at the facility in September 2022 and the facility was behind on MDS assessments. LPN #1 stated she did not get to complete R48's discharge MDS assessment before the company was sold in December 2022 and the record did not pull over once the facility was sold. On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. 4. For Resident #47 (R47), the facility staff failed to encode and transmit a discharge MDS assessment after the resident was discharged to another facility on 11/21/22. R47 discharged to another facility on 11/21/22. A review of the resident's clinical record failed to reveal a discharge MDS assessment was encoded and transmitted. On 4/11/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator. LPN #1 stated she began employment at the facility in September 2022 and	F 640		

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the facility was behind on MDS assessments. LPN #1 stated she did not get to complete R47's discharge MDS assessment before the company was sold in December 2022 and the record did not pull over once the facility was sold.

On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.

5. For Resident #6 (R6), the facility staff failed to encode and transmit a discharge MDS assessment after the resident was discharged home on 11/23/22.

R6 discharged to home on 11/23/22. A review of the resident's clinical record failed to reveal a discharge MDS assessment was encoded and transmitted.

On 4/11/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator. LPN #1 stated she began employment at the facility in September 2022 and the facility was behind on MDS assessments. LPN #1 stated she did not get to complete R6's discharge MDS assessment before the company was sold in December 2022 and the record did not pull over once the facility was sold.

On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.

6. For Resident #49 (R49), the facility staff failed to encode and transmit a discharge MDS assessment after the resident was discharged

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F 640	Continued From page 40 home on 11/25/22. R49 discharged to home on 11/25/22. A review of the resident's clinical record failed to reveal a discharge MDS assessment was encoded and transmitted. On 4/11/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator. LPN #1 stated she began employment at the facility in September 2022 and the facility was behind on MDS assessments. LPN #1 stated she did not get to complete R49's discharge MDS assessment before the company was sold in December 2022 and the record did not pull over once the facility was sold. On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. 7. For Resident #46 (R46), the facility staff failed to encode and transmit a discharge MDS assessment after the resident was discharged home on 11/22/22. R46 discharged to home on 11/22/22. A review of the resident's clinical record failed to reveal a discharge MDS assessment was encoded and transmitted. On 4/11/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator. LPN #1 stated she began employment at the facility in September 2022 and the facility was behind on MDS assessments. LPN #1 stated she did not get to complete R46's discharge MDS assessment before the company	F 640		

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F 640	Continued From page 41 was sold in December 2022 and the record did not pull over once the facility was sold. On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.	F 640		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655	1. Resident #210 was provided with a copy of her base line care plan as well as her comprehensive care plan. 2. All new admissions have the potential to be affected by the alleged deficient practice. An audit will be done for the past 30 days to ensure residents are given a copy of their care plan. The base line care plan will be completed within 48 hours and given to the resident by the IDT team at their discharge planning meeting, held within 72 hours of admission. 3. Licensed nursing staff and Social Service staff of the facility will be provided education on the facility	5/26/23

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F 655	Continued From page 42 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, the facility staff failed to provide a resident or the resident representative with a summary of the baseline care plan for one of 32 residents in the survey sample, Resident #210. The findings include: For Resident #210 (R210), the facility staff failed to provide the resident or the representative a summary of the baseline care plan. R210 was admitted to the facility on 4/1/23. A review of R210's clinical record, including the baseline care plan dated 4/1/23 and progress notes for April 2023, failed to reveal the facility staff provided R210 or the resident's representative, a summary of the baseline care plan. On 4/11/23 at 4:28 p.m., an interview was conducted with OSM (other staff member) #1, the social services director. OSM #1 stated a care	F 655	policy on completing the base line care plan and documenting that the resident has received a copy of the base line care plan. 4. The DON or designee will audit 3 residents weekly x 8 weeks to ensure that the residents have base-line care plan is completed within 48 hours and documented as given to the resident at the discharge planning meeting held within 72 hours of admission. The results of the weekly audits will be submitted to the QAPI Committee monthly x 3. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 655	Continued From page 43 conference is held with residents and/or their representatives within 72 hours of admission. OSM #1 stated at the care conference, she offers residents and their families a summary of the baseline care plan. OSM #1 stated that she doesn't specifically document that she offered a summary of the baseline care plan, but she documents that information was given or education was provided. On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.	F 655		
F 656 SS=E	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	F 656	1. Residents #110 and #61 are discharged from the facility and no changes can be made to the comprehensive care plan. The care plans for #14, #37, and #3 were reviewed and updated to reflect the resident's current plan of care. 2. All residents of the facility can be affected by this deficient practice. Facility will conduct an audit of residents Care Plan who have Ostomies, Pressure Ulcers, O2 Therapy and Midodrine. The care plan will be updated as appropriate.	5/26/23

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F 656	Continued From page 44 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for five of 32 residents in the survey sample, Residents # 110, #14, #37, #3 and #61. The findings include: 1. For Resident #110 (R110) the facility staff failed to implement the care plan for colostomy care. On the most recent MDS (minimum data set) assessment, an admission assessment, the resident scored a 12 out of 15 on the BIMS (brief	F 656	3. Licensed nursing staff of the facility will be given education on the care plan's implementation. And the IDT will be provided education of the facility policy and procedure on following/implementing the resident's care plan. 4. The DON or designee will conduct an audit of up to 3 resident care plans per week x 8 weeks for residents who have Ostomies, pressure ulcers, O2 therapy and/or Midodrine. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 656	Continued From page 45	F 656		

interview for mental status) score, indicating the resident was moderately impaired for making daily decisions. In Section H - Bladder and Bowel, the resident was coded as having an ostomy.

The comprehensive care plan dated, 6/16/2022, documented in part, "Focus: Resident has a colostomy." The "Interventions" documented, "Administer care as ordered."

The physician order dated, 6/3/2022, documented, "Ostomy: Colostomy Care every shift and as needed, every 12 hours for Ostomy."

The TAR (treatment administration record) for June 2022 documented the above order. Of the 48 opportunities for completing the colostomy care, 11 were blank. The TAR for July and August did not have the order for colostomy care.

The nurse's notes were reviewed. The nurses documented in their notes, "Bowel has ostomy noted." There was no documentation from June through August of any care provided for the colostomy.

An interview was conducted with LPN (licensed practical nurse) #2 on 4/11/2023 at 3:14 p.m. When asked the purpose of the care plan, LPN #2 stated it is so everyone can see them (the residents) and see what is going on with the resident's care, their refusals, behaviors. LPN #2 further stated the care plans come up generic and you have to go in and personalize them to each resident. Some nurses don't know how to do them. When asked if the care plan should be followed, LPN #2 stated, yes.

ASM #1, the administrator, ASM #2, and ASM #4,

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F 656	Continued From page 46 the regional nurse consultant, were made aware of the above concerns on 4/12/2023 at 1:31 p.m. No further information was provided prior to exit. 2. For Resident #14 (R14), the facility staff failed to implement the care plan for administering treatments to a pressure injury. The comprehensive care plan dated, 2/23/2022, documented in part, "Focus: The resident has pressure injury to sacral area or potential for pressure injury development. Resident has a pressure area to sacral area." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness. Resident has a wound vac. Change dressing to pressure area M-W-F and as necessary. Wound vac has pre-programmed settings. Check for functioning as needed." The physician order dated, 2/28/2022, documented, "Wound Vac (vacuum) with black sponge to be changed M-W-F (Monday - Wednesday - Friday) every day shift every Mond, Wed, Fri to wound." The May 2022 TAR (treatment administration record) documented the above order. On the following dates the wound vac dressing was not documented as being done, the boxes where the staff would initial that the treatment was performed were blank: 5/11/2022, 5/13/2022, 5/16/2022, 5/18/2022, 5/20/2022, 5/23/2022, 5/25/2022, 5/27/2022, and 5/30/2022. The June 2022 TAR documented the above order. There were blanks (unsigned areas) on the TAR for 6/10/2022.	F 656		

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F 656	Continued From page 47 The July 2022 TAR documented the above order. There were blanks on the TAR for 7/1/2022, 7/9/2022, and 7/13/2022. The physician order dated, 8/19/2022, documented, "Wound Care: Sacrum - Cleanse with normal saline, pat dry, apply skin prep to peri wound, place AquaCel AG on wound, secure with silicone super absorbent sacral dressing once daily and PRN (as needed) when soiled or dislodged every night shift for wound care." The September TAR documented the above order. On the following dates the treatment was not documented as being done, the boxes were blank: 9/5/2022, 9/8/2022, 9/9/2022, 9/16/2022, and 9/23/2022. The physician order dated, 9/23/2022, documented, "Wound Care: Sacrum - Cleanse with normal saline, pat dry, apply skin prep to peri wound, place collagen particles on wound, secure with foam dressing once daily and PRN when soiled or dislodged, every night shift for wound care." The September TAR documented the above order. On the following dates the treatment was not documented as being done, the boxes were blank: 9/23/2022, 9/24/2022, 9/25/2022, 9/29/2022, and 9/30/2022. An interview was conducted with LPN (licensed practical nurse) #2 on 4/11/2023 at 3:14 p.m. When asked the purpose of the care plan, LPN #2 stated it is so everyone can see them (the residents) and see what is going on with the resident's care, their refusals, behaviors. LPN #2	F 656		

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further stated the care plans come up generic and you have to go in and personalize them to each resident. Some nurses don't know how to do them. When asked if the care plan should be followed, LPN #2 stated yes.

ASM #1, the administrator, ASM #2, and ASM #4, the regional nurse consultant, were made aware of the above concerns on 4/12/2023 at 1:31 p.m.

No further information was provided prior to exit.

3. For Resident #37, the facility staff failed to implement the care plan for hypotension (low blood pressure).

The comprehensive care plan dated 9/8/2022, documented in part, "Focus: The resident has hypotension." The "Interventions" documented, "Encourage adequate fluid intake and a healthy diet. Encourage resident to get up slowly, sit on side of bed before standing. Give medications as ordered. Monitor for side effects and effectiveness. Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of hypotension, dizziness, fainting, syncope, blurred vision, lack of concentration, nausea, fatigue, cold clammy pale skin."

The physician order dated, 10/7/2022, documented, "Midodrine 10 mg (milligrams)(used to treat orthostatic hypotension. Midodrine works by causing blood vessels to tighten, which increases blood pressure) (1); 1 tablet by mouth every 8 hours for hypotension. Hold if above SBP (systolic blood pressure) 120."

The March 2023 MAR (medication administration record) documented the above order. The MAR

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F 656	Continued From page 49 revealed the medication was administered on the following days and times with a systolic blood pressure greater or above 120: 3/1/2023 at 6:00 a.m. - 134/76 3/1/2023 at 10:00 p.m. - 130/76 3/2/2023 at 6:00 a.m. - 122/63 3/2/2023 at 10:00 p.m. - 122/60 3/4/2023 at 10:00 p.m. - 131/71 3/10/2023 at 2:00 p.m. - 134/62 3/14/2022 at 6:00 a.m. - 124/76 3/15/2023 at 6:00 a.m. - 130/74 3/15/2023 at 2:00 p.m. - 122/60 3/16/2023 at 2:00 p.m. - 161/69 3/18/2023 at 6:00 a.m. - 128/70 3/20/2023 at 2:00 p.m. - 122/68 3/21/2022 at 10:00 p.m. - 124/68 3/25/2023 at 2:00 p.m. - 124/68 3/25/2023 at 10:00 p.m. - 145/83 3/26/2023 at 2:00 p.m. - 124/76 3/29/2023 at 6:00 a.m. - 130/72 The April 2023 MAR documented the above order. The MAR revealed the medication was administered on the following days and times with a systolic blood pressure greater or above 120: 4/4/2023 at 2:00 p.m. there was documented a "NA" (not applicable) where the blood pressure should have been documented. The medication was documented as being administered. 4/5/2023 at 10:00 p.m. - 124/76 4/7/2023 at 6:00 a.m. - 128/70 4/8/2023 at 6:00 a.m. - 158/78 4/11/2023 at 6:00 a.m. - 132/78 An interview was conducted with LPN (licensed practical nurse) #2 on 4/11/2023 at 3:14 p.m. When asked the purpose of the care plan, LPN #2 stated it is so everyone can see them (the residents) and see what is going on with the	F 656		

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F 656	Continued From page 50 resident's care, their refusals, behaviors. LPN #2 further stated the care plans come up generic and you have to go in and personalize them to each resident. Some nurses don't know how to do them. When asked if the care plan should be followed, LPN #2 stated yes. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a616030.html. 4. For Resident #3 (R3), the facility staff failed to implement the care plan for oxygen administration. The comprehensive care plan dated, 8/14/2022, documented in part, "Focus: The resident has oxygen therapy r/t (related to) Respiratory illness." The "Interventions" documented in part, "OXYGEN SETTINGS: O2 (oxygen) via nasal prongs @ (at) 2L (liters) PRN to maintain SPO2 (oxygen saturation) if <(less than) 90%, humidified." On 4/11/2023 at 9:14 a.m. R3 was observed in bed with oxygen on via a nasal cannula. The oxygen concentrator was set at 1.5 LPM (liters per minute). A second observation was made on 4/12/2023 at 8:19 a.m., accompanied by LPN (licensed practical nurse) #2. The oxygen was in	F 656		

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F 656	Continued From page 51	F 656		

use via a nasal cannula. LPN #2 was asked to observe what rate the oxygen was set to. LPN #2 stated, it was somewhere around 1.5 (LPM). When asked if she knew what rate R3 was supposed to be on, LPN #2 stated, it should be 2 LPM. LPN #2 adjusted the rate to 2 LPM.

The physician order dated, 1/16/2023 documented, "Oxygen as needed PRN (as needed) via nasal cannula at 2 L.PRN to maintain SPO2 (oxygen saturation) if <(less than) 90%, humidified."

An interview was conducted with LPN (licensed practical nurse) #2 on 4/11/2023 at 3:14 p.m. When asked the purpose of the care plan, LPN #2 stated it is so everyone can see them (the residents) and see what is going on with the resident's care, their refusals, behaviors. LPN #2 further stated the care plans come up generic and you have to go in and personalize them to each resident. Some nurses don't know how to do them. When asked if the care plan should be followed, LPN #2 stated yes.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above findings on 4/12/2023 at 1:31 p.m.

No further information was provided prior to exit.

5. For Resident #61, the facility staff failed to implement the comprehensive care plan to administer oxygen as ordered.

A review of the clinical record revealed a physician's order dated 2/23/22 oxygen at 3 liters,

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F 656	Continued From page 52 continuous. A review of the resident's care plan revealed one dated 2/28/22 for "The resident has emphysema/COPD (chronic obstructive pulmonary disease)." This care plan included the intervention dated 2/28/22 for "O2 (oxygen) via nasal prongs at 3L (liters per minute) continuous humidified." A review of the Medication / Treatment Administration Records (MAR / TAR) for February and March 2022 failed to reveal any evidence of the oxygen being administered. A review of the nurse's notes revealed the following: On 3/1/22, 3/8/22, 3/14/22, 3/18/22, and 3/21/22 the oxygen was documented as not being used. On 2/24/22, 3/5/22, 3/6/22, 3/7/22, 3/12/22, 3/14/22 and 3/17/22 the oxygen was documented as being administered at 2 liters per minute instead of the ordered 3 liters per minute. On 2/26/22, 2/27/22, 2/28/22, 3/9/22, 3/10/22, 3/11/22, 3/13/22, 3/15/22, 3/16/22, 3/19/22, 3/22/22, and 3/22/22 there was no documentation that the oxygen was administered as ordered. On 4/12/23 at 10:40 AM an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that when a resident is on oxygen, it should be documented on the MAR or TAR. She stated that if a resident has oxygen on, it should be documented somewhere. On 4/12/23 at 11:16 AM, an interview was	F 656		

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F 656	Continued From page 53 conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that if staff are documenting that physician ordered oxygen is not in use, then it should also be documented why. She stated that if it just says it was not in use and does not say the resident refused, then it is not being administered as ordered. On 4/12/23 at 1:11 PM an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked what was the purpose of the care plan, she stated that it was a guide on how to care for the resident and that it should be followed. When asked if the care plan documented to administer oxygen as ordered, and the oxygen was not being administered as ordered, was the care plan being followed, she stated that it was not. A policy regarding care plans was requested however none was provided. On 4/12/23 at approximately 1:30 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657	1. The care plans for residents #34 and #44 were reviewed and updated to reflect the resident's current plan of care.	5/26/23

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F 657	Continued From page 54 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 32 residents in the survey sample, Residents #34 and #44. The findings include: 1. For Resident #34 (R34), the facility staff failed to review and revise the resident's comprehensive care plan for bed rail use. A review of R34's clinical record revealed a side rail (bed rail) evaluation dated 11/17/22 that documented bilateral quarter side rails was recommended to assist with bed mobility. A	F 657	2. All residents of the facility can be affected by this deficient practice. Facility will conduct an audit of residents Care Plan who have had falls or have bed rails. The care plan will be updated as appropriate. 3. Administrative nurses and the IDT will be provided education of updating care plan to reflect current clinical condition of the residents and with any change of status per facility policy and procedure for care planning. 4. The DON or designee will conduct an audit of up to 3 resident care plans per week x 8 weeks for residents who have had falls or have bed rails. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible	

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F 657	Continued From page 55 review of R34's comprehensive care plan dated 12/7/22 failed to reveal documentation regarding bed rails. On 4/10/23 at 4:43 p.m., R34 was observed lying in bed with bilateral quarter bed rails in the upright position. On 4/11/23 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the purpose of the care plan is, "Where everybody can see them and go off with what's going on with the resident." LPN #2 stated residents' care plans should be reviewed and revised to include bed rails, "So everybody can see what they are there for." On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. 2. For Resident #44 (R44) the facility staff failed to review and/or revise the comprehensive care plan after a fall on 1/8/2023. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/18/2023, the resident scored a five out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. The nurse's note dated 1/8/2023 at 7:39 a.m. documented in part, "Fall...Send to ED (emergency department) for eval (evaluation) and treat (treatment) after being found on the floor with head on metal bar, unwitnessed. Resident	F 657	for the on-going monitoring for compliance.	

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F 657	Continued From page 56 on Eliquis (used to prevent blood clots from forming) (1) 5 mg (milligrams)." The comprehensive care plan dated 9/6/2022 documented in part, "Focus: The resident is at risk for falls r/t (related to) deconditioning, gait/balance problems, unaware of safety needs." The "Interventions" were all dated 9/6/2022. On 4/11/2023 at 2:43 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated she could not find the risk management form (fall investigation) for the fall of 1/8/2023. She stated that was before her time. She further stated the risk management form would have documented the reviewing and revising of the care plan if new interventions would have been put into place. The above care plan was reviewed with ASM #2. ASM #2 stated she did not see any revising of the care plan after the fall on 1/8/2023 that sent the resident to the hospital. ASM #1, the administrator, ASM #2, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html	F 657		
F 658 SS=E	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	1. Resident #310 has been discharged and no changes can be made. NP reviewed the order and parameter for the medications on	5/26/23

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F 658	Continued From page 57 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 and clinical record review, it was determined that the facility staff failed to follow professional standards of nursing for medication and treatment administration for four of 32 residents in the survey sample; Residents #310, #37, #14 and #34. The findings include: 1. The facility staff failed to obtain an order regarding the frequency of colostomy bag changes for Resident #310. Resident #310's colostomy bag was not changed between 2/25/22 and 3/5/22, for a period of 9 days. A review of the clinical record revealed that Resident #310 was admitted to the facility on 2/25/22 status post a new colostomy resident. A review of the clinical record revealed that there were no orders on frequency to change the ostomy bag until 3/4/22. This order documented, "change colostomy every 3 days." This order included a "start date" of 3/5/22. A review of the Treatment Administration Record (TAR) revealed the bag was changed on 3/5/22. The next scheduled change was for 3/8/22. A review of the nurse's notes dated 3/8/22 that documented, "Resident wanted to wait till [they] had [their] shower to change [their] colostomy bag/appliance. Will pass on to the next shift to change colostomy." There was no evidence it	F 658	residents #37 and #14. Resident #14 wound has healed so no changes can be made. Resident #34 is getting her medications as ordered. 2. All residents of the facility can be affected by this deficient practice. The facility will conduct an audit of residents Care Plan who have blood pressure parameters and ostomies. The care plan will be updated as appropriate. All residents with ostomies will have an appropriate order in place. 3. Licensed nursing staff of the facility will be provided education on following physicians orders with special focus on orders with parameters. 4. The DON or designee will audit 3 residents per week x 8 weeks to ensure physician orders are being followed. The audits will be reviewed for trends and	

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F 658	Continued From page 58 was done by the following shift. A nurse's note dated 3/6/22 documented, "Resident C/O (complained of) pain to stoma site. Area is red, irritated, with slight inflammation. No S/S (signs/symptoms) of infection noted but resident has required several bag changes in the past few days from picking at wafer. Education and reminders given to not pick at the wafer..." A nurse's note dated 3/7/22 documented, "...resident has required several bag changes in the past few days from picking at wafer. Education and reminders given to not pick at the wafer." On 4/12/23 at 1:00 PM, an interview was conducted with ASM #3 (Administrative Staff Member) the Nurse Practitioner. She stated that, "Every 3 days is not the protocol for colostomy bag changes. Every 7 days or when it leaks." When asked about an order for when to change a colostomy bag, she stated, "To be clear for the facility there should be an order on the frequency but the frequency is variable depending on doctor and patient. If they have a good seal, every 7 days. As long as they have a good seal and no breakdown. I say that but a lot of times it doesn't last that long. The seal breaks, etc., It is good if it makes it 3 to 4 days. I don't like to make it (the order) for 3 days because it can be worn longer. Depends on the resident activity level as well. The max time would be 7 days." When asked if there is not an order at the time of admission on the frequency, should the facility call the physician to clarify an order for frequency, she stated that she would expect nurses to clarify at the time of admission an order for frequency.	F 658	issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 658	Continued From page 59 On 4/12/23 at 1:11 PM an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked how a nurse know how often to change a colostomy bag, she stated there should be an order. When asked if there is a new admission resident with a colostomy, should the resident be in the facility for a week or more before an order is obtained, she stated no. She stated that an order should be obtained on admission. When asked how often should a colostomy bag be changed, she stated she was not sure, hence the need for an order for when to change it. There was no evidence of bag changes before the above order and nurse's notes. From admission on 2/25/22 to the first bag change on 3/5/22 was a period of 9 days without an ostomy bag change. This exceeds the nurse practitioner's statement that it should be changed at least every 7 days. Policies regarding physician's orders and ostomy care and services were requested however none was provided. On 4/12/23 at approximately 1:30 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.	F 658		

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F 658	Continued From page 60 2. For Resident #37, the facility staff failed to follow the physician orders for the administration of Midodrine (used to treat orthostatic hypotension. Midodrine works by causing blood vessels to tighten, which increases blood pressure) (1). On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/16/2023, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. The physician order dated, 10/7/2022, documented, "Midodrine 10 mg (milligrams); 1 tablet by mouth every 8 hours for hypotension. Hold if above SBP (systolic blood pressure) 120." The March 2023 MAR (medication administration record) documented the above order. The MAR documented the medication was administered on the following days and times with a systolic blood pressure greater or above 120: 3/1/2023 at 6:00 a.m. - 134/76 3/1/2023 at 10:00 p.m. - 130/76 3/2/2023 at 6:00 a.m. - 122/63 3/2/2023 at 10:00 p.m. - 122/60 3/4/2023 at 10:00 p.m. - 131/71 3/10/2023 at 2:00 p.m. - 134/62 3/14/2022 at 6:00 a.m. - 124/76 3/15/2023 at 6:00 a.m. - 130/74 3/15/2023 at 2:00 p.m. - 122/60 3/16/2023 at 2:00 p.m. - 161/69 3/18/2023 at 6:00 a.m. - 128/70 3/20/2023 at 2:00 p.m. - 122/68 3/21/2022 at 10:00 p.m. - 124/68	F 658		

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F 658	Continued From page 61 3/25/2023 at 2:00 p.m. - 124/68 3/25/2023 at 10:00 p.m. - 145/83 3/26/2023 at 2:00 p.m. - 124/76 3/29/2023 at 6:00 a.m. - 130/72 The April 2023 MAR documented the above order. The MAR documented the medication was administered on the following days and times with a systolic blood pressure greater or above 120: 4/4/2023 at 2:00 p.m. there was documented a "NA" (not applicable) where the blood pressure should have been documented. The medication was documented as being administered. 4/5/2023 at 10:00 p.m. - 124/76 4/7/2023 at 6:00 a.m. - 128/70 4/8/2023 at 6:00 a.m. - 158/78 4/11/2023 at 6:00 a.m. - 132/78 The comprehensive care plan dated 9/8/2022, documented in part, "Focus: The resident has hypotension." The "Interventions" documented, "Encourage adequate fluid intake and a healthy diet. Encourage resident to get up slowly, sit on side of bed before standing. Give medications as ordered. Monitor for side effects and effectiveness. Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of hypotension, dizziness, fainting, syncope, blurred vision, lack of concentration, nausea, fatigue, cold clammy pale skin." An interview was conducted on 4/11/2023 at 2:26 p.m. with LPN (licensed practical nurse) #2, one of the nurses that administered the Midodrine when the blood pressure was above 120. The above order for Midodrine and the March MAR were reviewed with LPN #2. The blood pressures for when she gave the Midodrine were reviewed. When asked if the medication should have been	F 658		

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F 658	Continued From page 62 given, LPN #2 stated, no. When asked if that is following the physician order, LPN #2 stated, no. A request was made for the facilty policy on Medication Administration on 4/12/2023. No policy was provided. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a616030.html 3. For Resident #14, the facility staff failed to follow the physician orders for the administration of Midodrine. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/28/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The physician order dated, 1/6/2023, documented, "Midodrine 5 mg; Give 5 mg by mouth two times a day for hypotension. Hold for SBP greater than SBP 100." The March 2023 MAR documented the above order. The MAR documented the medication was	F 658		

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F 658	Continued From page 63 administered on the following days and times with a systolic blood pressure greater or above 100: 3/1/2023 at 5:00 p.m. - 120/63 3/2/2023 at 9:00 a.m. - 116/89 3/3/2023 at 9:00 a.m. - 134/70 3/3/2023 at 5:00 p.m. - 124/63 3/4/2023 at 9:00 a.m. - 108/63 3/4/2023 at 5:00 p.m. - 124/60 3/5/2023 at 9:00 a.m. - 123/81 3/5/2023 at 5:00 p.m. - 118/68 3/13/2023 at 9:00 a.m. - 116/60 3/14/2023 at 5:00 p.m. - 118/68 3/17/2023 at 9:00 a.m. - 106/71 3/17/2023 at 5:00 p.m. - 116/60 3/22/2023 at 9:00 a.m. - 117/60 3/22/2023 at 5:00 p.m. - 132/76 3/23/2023 at 9:00 a.m. - 116/79 3/23/2023 at 5:00 p.m. - 124/76 3/27/2023 at 9:00 a.m. - 124/76 3/27/2023 at 5:00 p.m. - 107/69 The April 2023 MAR documented the above order for Midodrine. The MAR documented the medication was administered on the following days and times with a systolic blood pressure greater or above 100: 4/1/2023 at 9:00 a.m. - 119/60 4/1/2023 at 5:00 p.m. - 105/65 4/2/2023 at 9:00 a.m. - 120/72 4/2/2023 at 5:00 p.m. - 115/72 4/5/2023 at 9:00 a.m. - 128/70 4/5/2023 at 5:00 p.m. - 127/77 4/6/2023 at 9:00 a.m. 130/72 4/6/2023 at 5:00 p.m. - 126/68 4/10/2023 at 9:00 a.m. - 136/70 4/10/2023 at 5:00 p.m. = 136/72 4/11/2023 at 9:00 a.m. - 130/77 4/11/2023 at 5:00 p.m. - 136/72	F 658		

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F 658	Continued From page 64 The comprehensive care plan dated, 11/9/2022, documented in part, "Focus: The resident has hypertension r/t (related to) Heart Failure. Resident has orthostatic hypotension." The "Interventions" documented in part, "Give anti-hypertensive medications as ordered. Monitor for side effects. Monitor/record use/side effects of medication. Report tyo MD/NP (medical doctor/nurse practitioner) as necessary." An interview was conducted on 4/11/2023 at 2:26 p.m. with LPN (licensed practical nurse) #2, one of the nurses that administered the Midodrine when the blood pressure was above 120. The above order for Midodrine and the March MAR were reviewed with LPN #2. The blood pressures for when she gave the Midodrine were reviewed. When asked if the medication should have been given, LPN #2 stated, no. When asked if that is following the physician order, LPN #2 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was obtained prior to exit. 4. For Resident #34 (R34), the facility staff failed to administer the medication gabapentin (1) per the physician's order on 3/28/23 and 3/29/23. A review of R34's clinical record revealed a physician's order dated 3/2/23 for gabapentin 100mg (milligrams)- two capsules every eight hours for neuropathy. A review of R34's March 2023 MAR (medication administration record) failed to reveal evidence that R34 was administered gabapentin on 3/28/23 at 10:00 p.m.	F 658		

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F 658	Continued From page 65 and 3/29/23 at 6:00 a.m. Nurses' notes dated 3/28/23 and 3/29/23 documented, "Awaiting delivery from pharmacy." A review of the facility Omnicell list (a list of medications that are maintained in the facility in case a specific medication for a specific resident is not available) revealed gabapentin 100mg capsules were available in the facility. On 4/11/23 at 4:14 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing (and the nurse who documented the above progress notes). ASM #2 stated that on 3/28/23, the nurses ran out of R34's gabapentin so the nurse practitioner sent a new prescription to the pharmacy and the pharmacy staff stated the medication would be delivered on the next run. ASM #2 stated she could not obtain gabapentin from the Omnicell during the night of 3/28/23 or morning of 3/29/23 because two nurses called in and she was the only nurse working. ASM #2 stated two nurses are required to pull gabapentin from the Omnicell because it is a controlled substance. On 4/11/23 at 5:18 p.m., ASM #1, the administrator, and ASM #2 were made aware of the above concern. Reference: (1) Gabapentin is used to relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677	1. Resident Identifier #262 and #263 have both been	5/26/23

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F 677	Continued From page 66 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for two of 32 residents in the survey sample, Residents #263 and #262. The findings include: 1.a. For Resident #263 (R263), the facility staff failed to assist the resident with bathing/showers on multiple dates May 2022 through July 2022. R263's comprehensive care plan dated 10/28/21 documented, "(R263) has an ADL self-care performance deficit r/t (related to) Activity Intolerance, Fatigue, Impaired balance, Limited Mobility, Musculoskeletal impairment and Chronic pain. Resident requires extensive to total care of 1-2 staff for the completion of ADL care..." R263's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/30/22, coded the resident as being totally dependent on one staff with bathing. A review of R263's activities of daily living records for May 2022 through July 2022 revealed a section for staff to document bathing and showers. Further review of R263's clinical record, including ADL records and nurses' notes for May 2022 through July 2022, failed to reveal documentation that the resident was assisted with	F 677	discharged from the facility and no corrections can be made. 2. All dependent residents of the facility can be affected by this deficient practice. The facility will audit the last 14 days of Point of Care (ADL documentation) for compliance and address any findings with corrective action as appropriate. 3. Nursing staff will be educated in the following areas, aiding residents, and documenting ADLs for dependent residents. 4. DON or designee will audit nurse aid documentation of ADL's weekly X 8 weeks. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going	

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F 677	Continued From page 67 bathing and/or showers from 5/18/22 until 5/24/22 (five days), 5/31/22 until 6/7/22 (six days) and 6/11/22 until 7/11/22 (29 days). On 4/11/23 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated residents are provided showers two days each week and when requested. LPN #2 stated showers are evidenced by documentation in the computer (ADL records) and documentation on shower sheets, but the shower sheets were just implemented a month ago. On 4/11/23 at 4:04 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated residents are provided showers or a complete bed bath, per their preference, twice a week. CNA #1 stated that on the other five days, residents are provided partial bed baths. CNA #1 stated that CNAs should document any time that any type of bathing is provided. On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. The facility policy titled, "Activities of Daily Living (ADLs)" documented, "4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); i. Each resident shall receive tub or shower baths	F 677	monitoring for compliance.	

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F 677	Continued From page 68 as often as needed, but not less than twice weekly or as required by state law. Residents preference and/or whose medical conditions prohibit tub or shower baths shall have a sponge bath daily. ii. Residents will be assisted with dressing and grooming as appropriate and resident choice will be respected. iii. Residents shall be assisted with oral care as needed. b. Mobility (transfer and ambulation, including walking); i. Residents will be assisted with transfer and mobility as ordered by the physician/practitioner and/or as instructed in the resident's care plan. c. Elimination (toileting); i. Residents shall be assisted with toileting as needed. ii. Residents who are incontinent of bladder or bowel, will be provided care in a timely manner. d. Dining (meals and snacks); and i. Residents who require assistance with eating or drinking will be provided assistance as instructed in the resident's care plan." 1.b. For Resident #263 (R263), the facility staff failed to assist the resident with transfers out of bed on multiple dates May 2022 through July 2022. R263's comprehensive care plan dated 10/28/21 documented, "(R263) has an ADL self-care performance deficit r/t (related to) Activity Intolerance, Fatigue, Impaired balance, Limited Mobility, Musculoskeletal impairment and Chronic pain. Resident requires extensive to total care of 1-2 staff for the completion of ADL care..." R263's quarterly MDS (minimum data set)	F 677		

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F 677	Continued From page 69	F 677		

assessment with an ARD (assessment reference date) of 5/30/22, coded the resident as requiring extensive assistance of two or more staff with transfers.

A review of R263's activities of daily living records for May 2022 through July 2022 revealed a section for staff to document transfers. Further review of R263's clinical record (including ADL records and nurses' notes for May 2022 through July 2022) failed to reveal documentation that the resident was assisted with transfers on 5/1/22, 5/4/22, 5/5/22, 5/17/22, 6/13/22, 6/24/22, 6/28/22, 6/30/22, 7/1/22, 7/2/22, 7/3/22, 7/4/22, 7/8/22, 7/9/22 and 7/10/22.

On 4/11/23 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated staff should offer residents assistance with getting out of bed every day.

On 4/11/23 at 4:04 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated, "I offer multiple (transfers) throughout the day, every day, to prevent bed sores and stuff. If we transfer at all, it should be documented."

On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.

1.c. For Resident #263 (R263), the facility staff failed to provide eating assistance on multiple dates May 2022 through July 2022.

R263's comprehensive care plan dated 10/28/21 documented, "(R262) has an ADL self-care

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performance deficit r/t (related to) Activity Intolerance, Fatigue, Impaired balance, Limited Mobility, Musculoskeletal impairment and Chronic pain. Resident requires extensive to total care of 1-2 staff for the completion of ADL care..."

R263's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/30/22, coded the resident as requiring extensive assistance of one staff with eating.

A review of R263's activities of daily living records for May 2022 through July 2022 revealed a section for staff to document eating assistance. Further review of R263's clinical record (including ADL records and nurses' notes for May 2022 through July 2022) failed to reveal documentation that the resident was assisted with eating on 5/4/22, 5/5/22, 5/13/22, 5/14/22, 5/17/22, 5/19/22, 5/20/22, 5/28/22, 5/29/22, 5/30/22, 6/1/22, 6/2/22, 6/3/22, 6/4/22, 6/5/22, 6/8/22, 6/10/22, 6/12/22, 6/13/22, 6/14/22, 6/15/22, 6/16/22, 6/17/22, 6/18/22, 6/21/22, 6/22/22, 6/23/22, 6/24/22, 6/25/22, 6/26/22, 6/30/22, 7/1/22, 7/2/22, 7/3/22, 7/4/22, 7/5/22, 7/7/22, 7/8/22, 7/9/22, 7/10/22, 7/14/22, and 7/16/22.

On 4/11/23 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that most of the time, nurses recognize when a resident needs to be fed and tells the CNAs (certified nursing assistants) to feed the resident. LPN #2 stated feeding assistance has to be documented in the ADL records.

On 4/11/23 at 4:04 p.m., an interview was conducted with CNA #1. CNA #1 stated that normally the speech therapist or a report from the

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F 677	Continued From page 71	F 677		

hospital makes them aware of residents who need assistance with eating. CNA #1 stated that she makes the nurse aware and assists residents if she sees that they are having an issue with eating. CNA #1 stated she at least sits with residents and supervises them to see if they require assistance and she documents the assistance provided.

On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.

2. For Resident #262 (R262), the facility staff failed to provide incontinence care.

The comprehensive MDS (minimum data set) had not been completed for R262 due to the short time the resident was in the facility.

The admission nursing assessment for R262 dated 12/27/2021 documented the resident as being alert and oriented to person, place and time. The assessment further documented R262 being moderately short of breath, requiring continuous oxygen, occasionally incontinent of bowel and frequently incontinent of urine. The assessment documented R262 using pads and/or briefs.

The ADL (activities of daily living) Toilet use, B&B (bowel and bladder) Bowel and B&B Bladder documentation dated 12/1/2021-12/31/2021 for R262 documented incontinence care provided on 12/28/2021 on the 7:00 a.m. to 3:00 p.m. shift requiring extensive assistance of one staff member. The ADL Toilet use documentation failed to evidence incontinence care provided on 12/27/2021 evening (3:00 p.m. to 11:00 p.m.) shift

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F 677	Continued From page 72 and night (11:00 p.m. to 7:00 a.m.) shift. It further failed to evidence incontinence care was provided on 12/28/2021 on the evening and night shift. The documentation areas for 12/27/2021 and 12/28/2021 evening and night shifts were observed to be blank. On 4/11/2023 at 3:25 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that ADL's were documented in the computer. LPN #2 stated that blanks meant that they did not do anything. LPN #2 stated that they could not prove that anything was done. On 4/11/2023 at 4:04 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated that incontinence care was provided every two hours. CNA #1 stated that incontinence care was documented on the computer in the ADL's every shift to evidence that it was completed. On 4/12/2023 at 10:37 a.m., an interview was conducted with CNA #2. CNA #2 stated that incontinence care was provided every two hours. CNA #2 stated that they documented incontinence care in the electronic medical record under the ADL-Toilet use and B&B elimination areas. CNA #2 stated that they documented incontinence care every eight hours for each shift. CNA #2 reviewed the ADL-Toilet use and B&B elimination summary for R262 dated 12/1/2021-12/31/2021 and stated that the aide did not document that any care was provided. CNA #2 stated that there was no evidence that incontinence care was provided to R262 except for 12/28/2021 on the day shift. The facility policy "Incontinence" dated November	F 677		

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F 677	Continued From page 73 2017 documented in part, "Based on the resident ' s comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services..." On 4/12/2023 at approximately 1:29 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to administer treatments to a pressure injury for one of 32 residents in the survey sample, Resident #14. The findings include:	F 686	1. Resident Identifier #14's wound was healed effective 10/6/2022. 2. All residents with wounds can be affected by this alleged deficient practice. An audit of all residents with wounds will be completed by the DON or designee to ensure treatments are in place and being done. 3. An in-service on wound care treatments and documentation will be provided to licensed nurses.	5/26/23

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F 686	Continued From page 74 A. For Resident #14 (R14), the facility staff failed to evidence the administration of a wound vacuum for a sacral pressure injury. A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (1) On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 12/28/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. On the MDS, closest to the time of the pressure injury, with an ARD of 5/31/2022, R14 was coded in Section M - Skin Conditions, as having a stage four pressure injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (1)	F 686	4. The DON/Designee will monitor current residents with wounds weekly for compliance with physicians' treatment orders. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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The physician order dated, 2/28/2022, documented, "Wound Vac (vacuum) with black sponge to be changed M-W-F (Monday - Wednesday - Friday) every day shift every Mond, Wed, Fri to wound."

The May 2022 TAR (treatment administration record) documented the above order. On the following dates the wound vac dressing was not documented as being done, the boxes were blank: 5/11/2022, 5/13/2022, 5/16/2022, 5/18/2022, 5/20/2022, 5/23/2022, 5/25/2022, 5/27/2022, and 5/30/2022.

The June 2022 TAR documented the above order. There were blanks on the TAR for 6/10/2022.

The July 2022 TAR documented the above order. There were blanks on the TAR for 7/1/2022, 7/9/2022, and 7/13/2022.

The comprehensive care plan dated, 2/23/2022, documented in part, "Focus: The resident has pressure injury to sacral area or potential for pressure injury development. Resident has a pressure area to sacral area." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness. Resident has a wound vac. Change dressing to pressure area M-W-F and as necessary. Wound vac has pre-programmed settings. Check for functioning as needed."

An interview was conducted with LPN (licensed practical nurse) #2 on 4/11/2023 at 3:14 p.m. When asked what blanks on the TAR indicated, LPN #2 stated, "It means they didn't do it. You can't prove you did it. The nurse might have

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F 686	Continued From page 76	F 686		

forgotten to sign it off but you can't really prove that it was done."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf

B. For Resident #14, the facility staff failed to administer a physician ordered treatment to a sacral pressure injury.

The physician order dated, 8/19/2022, documented, "Wound Care: Sacrum - Cleanse with normal saline, pat dry, apply skin prep to peri wound, place AquaCel AG on wound, secure with silicone super absorbent sacral dressing once daily and PRN (as needed) when soiled or dislodged every night shift for wound care."

The September TAR documented the above order. On the following dates the treatment was not documented as being done, the boxes were blank: 9/5/2022, 9/8/2022, 9/9/2022, 9/16/2022, and 9/23/2022.

The physician order dated, 9/23/2022, documented, "Wound Care: Sacrum - Cleanse with normal saline, pat dry, apply skin prep to peri wound, place collagen particles on wound, secure with foam dressing once daily and PRN when

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F 686	Continued From page 77 soiled or dislodged, every night shift for wound care." The September TAR documented the above order. On the following dates the treatment was not documented as being done, the boxes were blank: 9/23/2022, 9/24/2022, 9/25/2022, 9/29/2022, and 9/30/2022. An interview was conducted with LPN (licensed practical nurse) #2 on 4/11/2023 at 3:14 p.m. When asked what blanks on the TAR indicated, LPN #2 stated, "It means they didn't do it. You can't prove you did it. The nurse might have forgotten to sign it off, but you can't really prove that it was done." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was obtained prior to exit.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 689	1. Education was provided to the family member on the smoking policy. 2. Residents of the facility who have been assessed as being unsafe smokers have the potential to be affected by this deficient practice. Facility staff will be educated on the	5/26/23

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F 689	Continued From page 78 document review, and clinical record review, the facility staff failed to provide smoking supervision for one of 32 residents in the survey sample, Resident #33. The findings include: For Resident #33 (R33), on 4/10/23, the facility staff failed to provide a smoking apron per the resident's safe smoking assessment. R33 was admitted to the facility with diagnoses including Huntington Disease (1). On 4/10/23 at 2:18 p.m. and 3:53 p.m., R33 was sitting in a wheelchair outside on the smoking area patio. R33 had a lit cigarette in hand. R33 was not wearing a smoking apron at either observation. The resident was supervised per facility policy. A review of R33's safe smoking assessment dated 4/10/23 revealed, in part: "1. Is the resident a safe smoker? b. Safe to smoke with supervision. A review of R33's care plan dated 4/8/23 revealed, in part: "...If resident is going to smoke cigarettes resident will need to utilize smoking apron." On 4/11/23 at 3:55 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. She stated that the resident had not smoked to her knowledge prior to 4/10/23. She stated on 4/8/23, the facility became aware of the resident's desire to smoke. She stated if R33 smokes, the resident needs to wear a smoking apron because of her diagnosis of Huntington disease.	F 689	smoking policy. The facility will educate residents and families of smokers by providing them with the smoking policy. 3. Facility Staff will be provided with an education on the facility smoking policy. The facility will educate residents and families of smokers by providing them with the smoking policy. 4. Social Services and Activities will monitor at least 3 smoking times per week for 8 weeks for appropriate use of smoking aprons. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 689	Continued From page 79 On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Smoking Permitted," revealed, in part: "Protective equipment to promote safe smoking will be offered as appropriate based on resident assessment, and the resident will be encouraged and assisted as necessary in using the protective devices." No further information was provided prior to exit. NOTES (1) "Huntington disease is a progressive brain disorder that causes uncontrolled movements, emotional problems, and loss of thinking ability (cognition)." This information is taken from the website https://medlineplus.gov/genetics/condition/huntington-disease/	F 689		
F 691 SS=E	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 691	1. Resident #110 and #310 have been discharged from the facility and staff can make no changes at this time. 2. All residents with a colostomy can be affected by the alleged deficient practice. An audit of all in-house residents with	5/26/23

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F 691	Continued From page 80 Based on staff interview and clinical record review, it was determined the facility staff failed to provide colostomy care for two of 32 residents in the survey sample, Residents #110 and #310. The findings include: Colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. (1) 1. For Resident #110, the facility staff failed to evidence that colostomy care was completed. On the most recent MDS (minimum data set) assessment, an admission assessment, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired for making daily decisions. In Section H - Bladder and Bowel, the resident was coded as having an ostomy. The physician order dated, 6/3/2022, documented, "Ostomy: Colostomy Care every shift and as needed, every 12 hours for Ostomy." The TAR (treatment administration record) for June 2022 documented the above order. Of the 48 opportunities for completing the colostomy care, 11 were blank. A blank on the TAR indicates the treatment was documented as performed. The TAR for July and August did not have the order for colostomy care. The nurse's notes were reviewed. The nurses documented in their notes, "Bowel has ostomy	F 691	ostomies will be done for compliance and corrections will be made as appropriate. 3. All nursing staff will be educated on the facility policy and procedure for providing and documenting colostomy care as ordered by the physician and care plan. 4. DON or designee will audit residents with a colostomy 3 times a week for 8 weeks. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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noted." There was no documentation from June through August of any care provided for the colostomy.

The comprehensive care plan dated, 6/16/2022, documented in part, "Focus: Resident has a colostomy." The "Interventions" documented, "Administer care as ordered."

An interview was conducted with LPN (licensed practical nurse) #2 on 4/11/2023 at 3:14 p.m. When asked what blanks on the TAR indicated, LPN #2 stated, "It means they didn't do it. You can't prove you did it. The nurse might have forgotten to sign it off but you can't really prove that it was done."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 4/12/2023 at 11:09 a.m. When asked what colostomy care consists of, ASM #2 stated, the wafer has to be removed, the area cleaned with soap and water, the skin should be inspected for breakdown and redness, then dry the area thoroughly, apply ostomy paste to make a seal, apply the wafer and make sure you have a good seal. When asked how often this is to be done, ASM #2 stated the ostomy should be checked every 24 hours. When asked where it is documented, ASM #2 stated on the TAR.

A policy on colostomy care was requested, however none was provided.

ASM #1, the administrator, ASM #2, and ASM #4, the regional nurse consultant, were made aware of the above concerns on 4/12/2023 at 1:31 p.m.

No further information was provided prior to exit.

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F 691	Continued From page 82 2. Resident #310's colostomy bag was not changed between 2/25/22 and 3/5/22, for a period of 9 days. A review of the clinical record revealed that there were no orders on frequency to change the ostomy bag until 3/4/22. The order documented, "change colostomy every 3 days" and included a "start date" of 3/5/22. A review of the Treatment Administration Record (TAR) revealed the bag was changed on 3/5/22. The next scheduled change was for 3/8/22. This was not done. A review of the nurse's notes revealed one dated 3/8/22 that documented, "Resident wanted to wait till [they] had [their] shower to change [their] colostomy bag/appliance. Will pass on to the next shift to change colostomy." There was no evidence it was done. A nurse's note dated 3/6/22 documented, "Resident C/O (complained of) pain to stoma site. Area is red, irritated, with slight inflammation. No S/S (signs/symptoms) of infection noted but resident has required several bag changes in the past few days from picking at wafer. Education and reminders given to not pick at the wafer..." A nurse's note dated 3/7/22 documented, "...resident has required several bag changes in the past few days from picking at wafer. Education and reminders given to not pick at the wafer." On 4/12/23 at 1:00 PM, an interview was conducted with ASM #3 (Administrative Staff	F 691		

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Member) the Nurse Practitioner. She stated that, "Every 3 days is not the protocol for colostomy bag changes. Every 7 days or when it leaks." When asked about an order for when to change a colostomy bag, she stated, "To be clear for the facility there should be an order on the frequency but the frequency is variable depending on doctor and patient. If they have a good seal, every 7 days. As long as they have a good seal and no breakdown. I say that but a lot of times it doesn't last that long. The seal breaks, etc., It is good if it makes it 3 to 4 days. I don't like to make it (the order) for 3 days because it can be worn longer. Depends on the resident activity level as well. The max time would be 7 days." When asked if there is not an order at the time of admission on the frequency, should the facility call the physician to clarify an order for frequency, she stated that she would expect nurses to clarify at the time of admission an order for frequency.

There was no evidence of bag changes before the above order and nurse's notes. From admission on 2/25/22 to the first bag change on 3/5/22 was a period of 9 days without an ostomy bag change. This exceeded the nurse practitioner's statement that it should be changed at least every 7 days.

A policy regarding ostomy care and services was requested, however none was provided.

On 4/12/23 at approximately 1:30 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 were made aware of the findings. No further information was provided by the end of the survey.

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WINCHESTER HEALTH & REHABILITATION	110 LAUCK DR WINCHESTER, VA 22603

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F 691	Continued From page 84 Reference: Colostomy (1) https://medlineplus.gov/ency/article/002942.htm	F 691		
F 695 SS=E	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, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide respiratory care and services per plan of care and/or in a sanitary manner for four of 32 residents in the survey sample; Residents #61, #14, #3, and #7. The findings include: 1. For Resident #61, the facility staff failed to ensure that oxygen was administered as ordered on multiple dates in February and March 2022. Resident #61 was admitted to the facility on 2/23/22 and discharged on 3/24/22. A review of the clinical record revealed a physician order dated 2/23/22 for oxygen at 3 liters per minute, continuous.	F 695	1. Resident #1 has been discharged from the facility and no intervention can be provided by facility staff. Resident #14 and resident #3 O2 setting was corrected on the spot during the survey. Resident #14 and #7 O2 tubing was bagged and labeled per policy. 2. All residents that use O2 can be affected by the alleged deficient practice. A facility wide O2 audit will be made for residents utilizing O2. Audit will focus on the setting is correct according to physician order and that O2 tubing is stored in a sanitary manner when not in use.	5/26/23

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F 695	Continued From page 85 A review of the Medication / Treatment Administration Records (MAR / TAR) for February and March 2022 failed to reveal any documentation of the oxygen being administered. A review of the nurse's notes revealed the following: On 3/1/22, 3/8/22, 3/14/22, 3/18/22, and 3/21/22 the oxygen was documented as not being used. On 2/24/22, 3/5/22, 3/6/22, 3/7/22, 3/12/22, 3/14/22 and 3/17/22 the oxygen was documented as being administered at 2 liters per minute instead of the ordered 3 liters per minute. On 2/26/22, 2/27/22, 2/28/22, 3/9/22, 3/10/22, 3/11/22, 3/13/22, 3/15/22, 3/16/22, 3/19/22, and 3/22/22 there was no documentation at all that the oxygen was administered as ordered. On 4/12/23 at 10:40 AM an interview was conducted with LPN #5 (Licensed Practical Nurse). LPN #5 stated that when a resident is on oxygen, it should be documented on the MAR or TAR and that if a resident has oxygen on, it should be documented somewhere. On 4/12/23 at 11:16 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. ASM #2 stated that if staff are documenting that physician ordered oxygen is not in use, then it should also be documented why, and that if it just says it was not in use and does not say the resident refused, then it is not being administered as ordered. A review of the resident's care plan revealed one	F 695	3. Education will be provided to nursing staff following physicians' orders for O2 therapy and a facility policy for storing O2 tubing in a sanitary manner when not in use by the resident. 4. DON or designee will audit 3 residents with O2 weekly X 8 weeks for following physicians order and the sanitary storage of O2 tubing when not in use by the resident. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 695	Continued From page 86 dated 2/28/22 for "The resident has emphysema/COPD (chronic obstructive pulmonary disease)." This care plan included the intervention dated 2/28/22 for "O2 (oxygen) via nasal prongs at 3L (liters per minute) continuous humidified." The facility policy, Oxygen Administration, was reviewed. This policy documented, "...Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration...Documentation...1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment....6. All evaluation data obtained before, during, and after the procedure....8. If the resident refused the procedure, the reason(s) why and the intervention taken..." On 4/12/23 at approximately 1:30 PM at the end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #14 (R14), the facility staff failed to store oxygen tubing in a sanitary manner. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/28/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions.	F 695		

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F 695	Continued From page 87 On 4/10/2023 at 12:25 p.m. R14 was observed sitting in their wheelchair with an oxygen concentrator behind the resident. The nasal cannula was draped over the concentrator and the nose prongs were touching the floor. The tubing was dated 4/9/2023. A second observation was made at 3:06 p.m. The oxygen tubing was still draped over the concentrator and the nasal prongs were touching the floor. The resident stated they only use the oxygen at night and occasionally during the day if they have an "episode." Observation on 4/11/2023 at 8:30 a.m. revealed the oxygen tubing was draped over the oxygen concentrator again. The comprehensive care plan dated, 6/10/2022, documented in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) pneumonia, Exacerbation COPD (chronic obstructive pulmonary disease), Chronic Respiratory Failure with hypoxia." The "Interventions" documented in part, "OXYGEN SETTING: O2 via nasal prongs @ (at) 2 LPM (liters per minute) PRN (as needed)." An interview was conducted with LPN (licensed practical nurse) #2, on 4/12/2023 at 8:11 a.m. When asked how oxygen tubing is to be stored when not in use, LPN #2 stated there is supposed to be a bag with the resident's name on it attached to the oxygen concentrator. The facility policy, "Oxygen Administration" failed to evidence documentation related to storing the oxygen equipment when not in use." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing,	F 695		

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F 695	Continued From page 88 and ASM #4, the regional nurse consultant, were made aware of the above findings on 4/12/2023 at 1:31 p.m. No further information was provided prior to exit. 3. For Resident #3 (R3), the facility staff failed to administer oxygen at the physician prescribed rate. On 4/11/2023 at 9:14 a.m. R3 was observed in bed with oxygen on via a nasal cannula. The oxygen concentrator was set at 1.5 LPM (liters per minute). A second observation was made on 4/12/2023 at 8:19 a.m., accompanied by LPN (licensed practical nurse) #2. The oxygen was in use via a nasal cannula. LPN #2 was asked to observe what rate the oxygen was set to. LPN #2 stated, it was somewhere around 1.5 (LPM). When asked if she knew what rate R3 was supposed to be on, LPN #2 stated, it should be 2 LPM. LPN #2 adjusted the rate to 2 LPM. The physician order dated, 1/16/2023 documented, "Oxygen as needed PRN (as needed) via nasal cannula at 2 L.PRN to maintain SPO2 (oxygen saturation) if <(less than) 90%, humidified." The comprehensive care plan dated, 8/14/2022, documented in part, "Focus: The resident has oxygen therapy r/t (related to) Respiratory illness." The "Interventions" documented in part, "OXYGEN SETTINGS: O2 (oxygen) via nasal prongs @ (at) 2L (liters) PRN to maintain SPO2 (oxygen saturation) if <(less than) 90%, humidified." The facility policy, "Oxygen Administration"	F 695		

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F 695	Continued From page 89	F 695		

documented in part, "Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration...Turn on the oxygen at the number of liters/minute as ordered by the physician/practitioner."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above findings on 4/12/2023 at 1:31 p.m.

No further information was provided prior to exit.

4. For Resident #7 (R7), the facility failed to store oxygen tubing in a sanitary manner.

On 4/10/2023 at approximately 12:45 p.m. the oxygen tubing was observed wrapped around the handlebars of the resident's rollator (walker), and had an oxygen tank attached to it. The oxygen was not in use. The tubing was dated 4/9/2023.

The physician order dated, 11/11/2022, documented, "2 L (liters) oxygen as needed, PRN."

The comprehensive care plan dated, 10/28/2022, documented in part, "Focus: The resident has oxygen therapy r/t respiratory illness." The "Interventions" documented in part, "OXYGEN SETTINGS: O2 via nasal prongs @ 2L continuous. Humidified."

An interview was conducted with LPN (licensed practical nurse) #2, on 4/12/2023 at 8:11 a.m. When asked how oxygen tubing is to be stored when not in use, LPN #2 stated there is supposed

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F 695	Continued From page 90 to be a bag with the resident's name on it attached to the oxygen concentrator. When asked if it was acceptable to have the tubing wrapped around the resident's rollator, LPN #2 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above findings on 4/12/2023 at 1:31 p.m. No further information was provided prior to exit.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide care and services for pain management in a timely manner for one of 32 residents in the survey sample; Resident #10. The findings include: For Resident #10, the facility staff failed to address the resident's complaint of pain on 4/10/23 at 4:10 PM. On the most recent MDS (Minimum Data Set), an	F 697	1. The nurse addressed the resident's pain. She was medicated with relief. The nurses were educated on the process to ensure patient care continuity while one is on break/lunch. 2. All residents who experience pain can be affected by the alleged deficient practice. The facility will complete a pain assessment on every resident and provide intervention as appropriate. 3. All licensed nurses will be	5/26/23

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F 697	Continued From page 91 Admission / 5-Day MDS assessment, dated 3/15/23, Resident #10 was coded as being cognitively intact in ability to make daily life decisions. On 4/10/23 at 4:10 PM Resident #10 was observed and the resident requested something for pain from this surveyor. The resident's facial expression reflected pain and/or discomfort. At that time, RN #1 (Registered Nurse) was notified of the resident's complaint of pain and request for pain medication.. RN #1 stated that they did not know where the resident's assigned nurse was. On 4/10/23 at 4:25 PM a follow up interview was conducted with Resident #10. When asked if anyone had come to see them regarding their pain, the resident stated that no one had. At that time, LPN (Licensed Practical Nurse) #4 was observed at the nurse's station. Upon asking LPN #4 about Resident #10's pain, she stated that she just returned from break and had a written note on her computer about Resident #10's pain. RN #1 had not done anything to address Resident #10's complaint of pain. When asked if another nurse can administer pain medications to her resident when she is on break, she stated that she was not sure about facility rules on that. On 4/11/23 at 7:30 AM, a follow up interview was conducted with LPN #4. When asked if she notified RN #1 that she was going on break the previous afternoon, she stated that she had. When asked about another nurse providing care, treatment and/or medications to her residents when she is on break, she stated that "The other nurse cannot give meds to my patients, that are under my care. The only one that can is the DON	F 697	educated on the timely intervention for pain management. 4. DON/Designee will conduct random audits of 3 residents per week for 8 weeks by asking residents if their pain is addressed timely and corrective action made, as necessary. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 697	Continued From page 92 (Director of Nursing) in an emergency." On 4/11/23 at approximately 7:45 AM, ASM #2 (Administrative Staff Member) the Director of Nursing, was asked about nurses being able to provide medications to another nurse's residents when a nurse is on break. She stated that the nurses have access to all of the residents medication records and that another nurse absolutely can assess another nurse's resident and check for appropriate orders and administer medications, if appropriate. She stated that the nurse would have to just get the keys for the other nurse's medication cart from the other nurse or from her [the DON] who has a set of keys to all of the medication carts. ASM #2 was made aware of RN #1's failure to address the resident's complaint of pain while LPN #4 was on a break on 4/10/23. The facility policy, Pain Management, was reviewed. This policy documented, "The organization will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents ' goals and preferences..." On 4/11/23 at the end-of-day meeting at 5:00 PM, ASM #1 (the Administrator) and ASM #2, were made aware of the findings. No further information was provided by the end of the survey.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698	1. Facility currently getting dialysis communication for resident #32.	5/26/23

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F 698	Continued From page 93 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide complete dialysis care and services for one of 32 residents in the survey sample, Resident #32. The findings include: For Resident #32 (R32), the facility staff failed to ensure adequate communication and collaboration for care with the resident's hemodialysis center. A review of R32's clinical record revealed a physician's order dated 2/15/22 for hemodialysis every Monday, Wednesday and Friday. R32's comprehensive care plan revised on 2/26/22 failed to document information regarding communication with the dialysis center. A review of R32's dialysis communication book (a book that contained communication forms to be completed by facility staff, sent with the resident to dialysis, and returned with documented communication from the dialysis center) failed to reveal any documented communication for the following dialysis days: 3/10/23, 3/13/23, 3/17/23, 3/22/23, 3/27/23, 3/29/23, 3/31/23 and 4/5/23. On 4/11/23 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated there should be a communication	F 698	2. All residents receiving dialysis could be affected by the alleged deficient practice. The facility will audit residents with dialysis to ensure the communication book is being used. 3. All licensed nurses will be educated on completion and monitoring of the pre and post dialysis communication forms. 4. DON or designee will audit three charts of residents on dialysis every week for 8 weeks. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance	

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F 698	Continued From page 94 form completed for each day R32 goes to dialysis. LPN #2 stated she reviewed R32's dialysis communication book and, "It looks like there is stuff missing." On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. The facility policy titled, "End Stage Renal Disease - Care of Resident" documented, "3. Agreements between this facility and the contracted ESRD (end stage renal disease) facility will include all aspects of how the resident's care will be managed including but not limited to: a. the development of a comprehensive and integrated care plan b. the communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination, and collaboration..."	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of	F 700	1. Residents #29 and #34 had consents signed on 4-10-23 and resident #29 had a bedrail assessment completed on 4-10-23. 2. All residents could be affected by the alleged deficient practice. A facility wide bed rail audit will be conducted, and corrective actions taken as appropriate.	5/26/23

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F 700	Continued From page 95 bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed implement bed rail requirements for two of 32 residents in the survey sample, Residents #29 and #34. The findings include: 1. For Resident #29 (R29), the facility staff failed to review with the resident (and/or resident's representative) the risks and benefits of, and obtain consent for, the use of bed rails. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/13/23, R29 was coded as requiring the extensive assistance of staff for bed mobility and transfers. On 4/10/23 at 12:47 p.m. and 3:11 p.m., and on 4/11/23 at 9:18 a.m., R29 was sitting up in bed. At all three observations, bilateral bed rails (quarter rails) were up. A review of R29's physician orders revealed the following: "2/24/21 Patient is required (sic) bilateral 1/4 side rails to assist with repositioning."	F 700	3. All licensed nurses will be educated on the facility policy and procedure for utilizing bed rails on a resident. 4. DON/Designee will monitor bed rail assessments completed on 3 residents per week for 8 weeks. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 96 Further review of R29's clinical record failed to reveal an assessment for the use of bed rails, education regarding the risks and benefits of using bed rails, or a consent for the use of bed rails. On 4/11/23 at 3:55 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. She stated the nursing staff and therapy staff completes an evaluation for the use of bed rails. She stated, "We have to get the consent. We have to find a diagnosis why they need a bed rail." On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. In response to a request for the bed rail policy, the facility staff provided a copy of a blank education and consent for side rails. The document contained no information related to the facility's procedure for assessing for, education about, or obtaining consent for the use of side rails by a resident. No further information was provided prior to exit. 2. For Resident #34 (R34), the facility staff failed to review the risks and benefits of bed rails with the resident (and/or the resident's representative), and failed to obtain informed consent for the use of bed rails. A review of R34's clinical record revealed a side	F 700		

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F 700	Continued From page 97 rail (bed rail) evaluation dated 11/17/22 that documented bilateral quarter side rails was recommended to assist with bed mobility. Further review of R34's clinical record failed to reveal documentation that the facility staff reviewed the risks and benefits of bed rails with R34 (and/or the resident's representative) and obtain informed consent. On 4/10/23 at 4:43 p.m., R34 was observed lying in bed with bilateral quarter bed rails in the upright position. On 4/11/23 at 3:12 p.m., an interview was conducted with LPN (licensed practical nurse) #2 in regard to residents' use of bed rails. LPN #2 stated, "We are supposed to have an eval [evaluation] from therapy. We do an assessment, then we have to get the consent and find a diagnosis as to why they need the bed rails." On 4/11/23 at 5:18 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.	F 700		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725	1. Resident #34 received her medication as ordered the following morning with no adverse effects. 2. All residents can be affected by the alleged deficient practice.	5/26/23

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F 725	Continued From page 98 accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide sufficient staffing for one of 32 residents in the survey sample, Resident #34. The findings include: For Resident #34 (R34), the facility staff failed to administer the medication gabapentin (1) per the physician's order on 3/28/23 and 3/29/23 because there was only one nurse in the facility and two nurses were required to obtain the medication from the facility Omnicell (a machine of medications that are maintained in the facility in case a specific medication for a specific resident is not available). A review of R34's clinical record revealed a physician's order dated 3/2/23 for gabapentin 100mg (milligrams)- two capsules every eight	F 725	3. The facility will institute a system for a backup nurse to come in when necessary to access the Omnicell (Medication dispensing machine) for controlled medications. 4. DON or Designee will audit schedules and staffing sheets to ensure adequate staffing, address attendance issues, and the need for supplemental staff. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 725	Continued From page 99	F 725		

hours for neuropathy. A review of R34's March 2023 MAR (medication administration record) failed to reveal evidence that R34 was administered gabapentin on 3/28/23 at 10:00 p.m. and 3/29/23 at 6:00 a.m. Nurses' notes dated 3/28/23 and 3/29/23 documented, "Awaiting delivery from pharmacy."

A review of the facility Omnicell list revealed gabapentin 100mg capsules were available in the facility.

On 4/11/23 at 4:14 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing (and the nurse who documented the above progress notes). ASM #2 stated that on 3/28/23, the nurses ran out of R34's gabapentin so the nurse practitioner sent a new prescription to the pharmacy and the pharmacy staff stated the medication would be delivered on the next run. ASM #2 stated she could not obtain gabapentin from the Omnicell during the night of 3/28/23 or morning of 3/29/23 because two nurses called in and she was the only nurse working. ASM #2 stated two nurses are required to pull gabapentin from the Omnicell because it is a controlled substance. A review of the staffing sheet for the night of 3/28/23 into the morning of 3/29/23 revealed two nurses called in and ASM #2 was the only nurse in the building.

On 4/11/23 at 4:43 p.m., an interview was conducted with OSM (other staff member) #2, the nurse staffing scheduler. OSM #2 stated nurses work 12-hour shifts and she schedules two nurses for each shift. OSM #2 stated there are a couple of nurses who are willing to pick up extra shifts if other nurses call in, and ASM #2 and the

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F 725	Continued From page 100 unit manager will work the floor if there is no other nurse able to work. OSM #2 stated the facility also contracts with agency staff. On 4/11/23 at 5:18 p.m., ASM #1, the administrator, and ASM #2 were made aware of the above concern. Reference: (1) Gabapentin is used to relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide RN (registered nurse) coverage on three of 30 days reviewed. The findings include:	F 727	1. The facility is unable to make corrections to past noncompliance. 2. All residents could be affected by the alleged deficient practice. 3. The staffing coordinator will schedule the facilities two staff RNs (Registered Nurse) on opposite rotations to cover 7 days per week. Administrative RN will fill in as needed. Staffing coordinator will be inserviced on the regulation for 7 day a week RN coverage for 8 hours per day. The staffing coordinator will notify the	5/26/23

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F 727	Continued From page 101 A review of facility nursing schedules revealed there was no RN coverage on 3/11/23, 4/8/23 and 4/9/23. On 4/11/23 at 4:14 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated the facility is required to have eight hours of RN coverage each day, seven days a week, 365 days a year. ASM #2 stated there was only one other RN besides her, but she recently hired another RN. On 4/11/23 at 5:18 p.m., ASM #1, the administrator, and ASM #2 were made aware of the above concern. The facility policy titled, "Department Duty Hours - Nursing Services" documented, "7. Registered nurse hours will be eight consecutive hours per day; 7 days a week."	F 727	administration if RN coverage is inadequate. 4. DON or Designee will audit schedules and staffing sheets weekly to ensure adequate RN coverage. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755	1. Resident #262 has discharged from the facility and no corrective action can be taken by the facility. Carts were checked to ensure resident #14 and #37 had all ordered medications available. 2. All residents could be affected by the alleged deficient practice. All medication carts will be audited to ensure current	5/26/23

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F 755	Continued From page 102 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure that medications were available for administration for three of 32 residents in the survey sample, Residents #262, #14, and #37. The findings include: 1. For R262, the facility staff failed to ensure medications were available for administration on 12/28/2021. R262 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1), hypertension and congestive heart failure (2). The eMAR (electronic medication administration	F 755	residents have all medications as ordered. 3. Licensed nurses will be educated on the facility Policy and Procedure for ordering and refilling medications promptly. 4. DON/Designee will audit medication availability on 3 residents per week for 8 weeks. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 755	Continued From page 103 record) for R262 dated 12/1/2021-12/31/2021 documented in part, - "Metoclopramide HCL Solution 5mg/ml (milligram per milliliter) Use 5mg intravenously three times a day for before meals. Start Date: 12/28/2021 0900 (9:00 a.m.)." The eMAR documented a "9" in the administration area for 12/28/2021 at 9:00 a.m., 1:00 p.m. and 5:00 p.m. The eMAR chart codes documented in part, "...9= Other/See Nurse Notes..." - "Diltiazem HCL tablet 30mg Give 1 tablet by mouth three times a day for high blood pressure. Start Date: 12/28/2021 0900." The eMAR documented a "9" in the administration area for 12/28/2021 at 9:00 a.m., 1:00 p.m. and 5:00 p.m. - "Tiotropium Bromide Monohydrate Aerosol Solution 2.5 mcg/act (micrograms) 2 puff inhale orally in the morning for COPD. Start Date: 12/28/2021 0600 (6:00 a.m.). The eMAR documented a "9" in the administration area for 12/28/2021 at 6:00 a.m. - "Symbicort aerosol 160-4.5 mcg/act (Budesonide-Formoterol Fumarate) 2 puff inhale orally two times a day for COPD. Start Date: 12/28/2021 0900." The eMAR documented a "9" in the administration area for 12/28/2021 at 9:00 a.m. - "acetazolamide tablet 125mg Give 1 tablet by mouth one time a day for fluid retention. Start Date: 12/28/2021 0900." The eMAR documented a "9" in the administration area for 12/28/2021 at 9:00 a.m. - "Lexapro 10mg (Escitalopram Oxalate) Give 1 tablet by mouth in the afternoon for depression. Start Date: 12/28/2021 1300 (1:00 p.m.)." The eMAR documented a "9" in the administration area for 12/28/2021 at 1:00 p.m. The nurses notes for R262 documented in part,	F 755		

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F 755	Continued From page 104 - "12/28/2021 05:49 (5:49 a.m.) new resident waiting on meds from pharmacy." - "12/28/2021 15:32 (3:32 p.m.) med not avail (available)- waiting for delivery from pharm (pharmacy)." - "12/28/2021 18:38 (6:38 p.m.) med not here yet. Should be coming in very shortly." - "12/28/2021 18:37 (6:38 p.m.) not given as med is not here and clarification of order needs to be done." The physician orders for R262 documented orders for the medications listed above entered on 12/27/2021 and scheduled to start on 12/28/2021. The discharge summary for R262 dated 12/27/2021 from [Name of hospital] documented in part, "...Severe COPD with acute exacerbation in the setting of chronic COPD. Improved. To have scheduled albuterol MDI (metered dose inhaler), prn (as needed) albuterol nebs (nebulizers), Spiriva, Singulair and Symbicort...Discharge Medications: Medication list: Start taking these medications: ...acetazolamide 125mg tablet commonly known as: Diamox, Take 1 tablet (125 mg total) by mouth daily. Start taking on: December 28, 2021...tiotropium 2.5mcg/act inhalation spray Commonly known as: Spiriva respimat inhale 2 puffs into the lungs every morning. Start taking on: December 28, 2021...Change how you take these medications: ...budesonide-formoterol 160-4.5 mcg/act inhaler Commonly known as: Symbicort Dose: 2 puff Instructions: Inhale 2 puffs into the lungs 2 (two) times daily...Diltiazem 30mg tablet Commonly known as: Cardizem 30mg Instructions: Take 1 tablet (30mg total) by mouth 3 (three) times daily..."	F 755		

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F 755	Continued From page 105 On 4/11/2023 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator stated that there were no nurses who worked at the facility in December 2021 that were currently employed at the facility, and the physician who cared for R262 no longer worked at the facility. On 4/12/2023 at 10:08 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that when a new resident was admitted to the facility they received the after visit summary from the admissions coordinator prior to the resident arriving. LPN #2 stated that the admissions coordinator worked with the hospital prior to the resident arriving to ensure that they had everything in place to care for the resident and they reviewed the discharge medications with the physician or nurse practitioner prior to the resident arriving and entered the orders into the computer for the pharmacy. LPN #2 stated that they had a "flash meeting" prior to the resident arriving with social services, admissions and therapy to prepare the room with any equipment the resident may need. LPN #2 stated that when transport arrived with the resident they provided the discharge summary which was compared to the after visit summary for any changes to the discharge medications. They notified the physician or nurse practitioner of any changes in the medications from the discharge summary and sent new orders to the pharmacy. LPN #2 stated that prior to January of 2023 they used another pharmacy which required the medications to be entered prior to 4:00 p.m. to get the medications the next morning. LPN #2 stated that when the medications were entered after 4:00 p.m. they were not received until the following day at	F 755		

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F 755	Continued From page 106	F 755		

midnight. LPN #2 stated that any medications that were needed urgently were called as "stat" to the pharmacy and they were delivered by a local pharmacy in about four hours. LPN #2 stated that the former pharmacy kept a "stat box" at the facility but it mostly contained antibiotics for them to use, and that the former pharmacy was slow getting inhalers to the facility and they would often have to get them sent from the local pharmacy or have the hospital send them with the resident at discharge.

On 4/12/2023 at 12:44 p.m., an interview was conducted with ASM #3, nurse practitioner. ASM #3 stated that they expected for a resident to start getting their medications as soon as possible after admission to the facility. ASM #3 stated that they would expect any pertinent medications such as blood pressure medications and inhalers to be started by the next day after admission. ASM #3 stated that they would expect the nursing staff to inform them of a resident not receiving their medications due to it not arriving from the pharmacy and at times they were able to use an alternate from the stock medications.

On 4/12/2023 at approximately 10:30 a.m., a request was made to ASM #1 for a listing of the medications available to staff in the stat box kept in the facility in December of 2021. On 4/12/2023 at approximately 1:00 p.m., ASM #1 stated that they were unable to get the list of medications that were available in the stat box in December of 2021 from the former pharmacy.

The facility policy, "Medication and Treatment Orders" documented in part, "...11. Drugs and biologicals that are required to be refilled will be reordered from the issuing pharmacy in a timely

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F 755	Continued From page 107 manner prior to the last dosage being administered to ensure that refills are readily available..." The facility policy, "General Guidelines for Medication Administration" revised 8/2020 documented in part, "...The facility has sufficient staff and a medication distribution system to ensure safe administration of medication without unnecessary interruptions...If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at a scheduled time or a starter dose of an antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses, or in accordance with facility policy, of a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response. If an electronic MAR system is used, specific procedures required for resident identification, identification of medications due at specific times, and documentation of administration, refusal, holding of doses, and dosing parameters such as vital signs and lab values are described in the system's user manual..." On 4/12/2023 at 1:29 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the findings. No further information was obtained prior to exit. Reference:	F 755		

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F 755	Continued From page 108 (1) chronic obstructive pulmonary disease (COPD) Disease that makes it difficult to breathe that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) congestive heart failure A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 2. For Resident #14 (R14), the facility staff failed to obtain and administer Lyrica, per the physician order. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/28/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The physician order dated, 1/6/2023, documented, "Lyrica Capsule (used to treat neuropathic pain) (1) 25 mg (milligram); Give 1 capsule by mouth at bedtime for neuropathic pain." The March 2023 MAR (medication administration record) documented the above order for Lyrica. A "9" was documented for the 9:00 p.m. dose on 3/9/2023 through 3/15/2023. A "9" indicated, "Other/See nurse's notes."	F 755		

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F 755	Continued From page 109 The nurse's notes for the above dates and 9:00 p.m. dose administration, documented, "On order." Review of the (name of drug dispensing machine) contents was conducted however, the Lyrica was not listed as being in the machine. An interview was conducted with LPN (licensed practical nurse) #2, on 4/11/2023 at 3:14 p.m. When asked what the process was when a medication is not available at the time it is scheduled to be administered, LPN #2 stated the (name of pharmacy machine with medications in the building) is the best thing. It has many of the medications we need. If it's a narcotic, then you need two nurses to get it out of the machine. When asked if the medication is not available in the (name of machine), what should the nurse to do, LPN #2 stated you have to call the pharmacy to get it and notify the nurse practitioner that it is not here. When asked if Lyrica is in the machine, LPN #2 stated, no it is not. LPN #2 was shown where the Lyrica was not given on the above dates and the nurses documented, on order. LPN #2 stated she was not made aware of the unavailability of the Lyrica for R14. LPN #2 stated that sometimes it takes two days to get medications and even the stat (right away) medications can take up to 24 hours to get. A policy on Medication Administration and Medication Unavailability was requested. No policy was provided. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were	F 755		

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F 755	Continued From page 110 made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605045.html 3. For Resident #37 (R37), the facility staff failed to obtain and administer Lyrica, per the physician order. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/16/2023, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions. An interview was conducted with R37 on 4/10/2023 at approximately 2:00 p.m. R37 stated the facility runs out of their Lyrica at times. The physician order dated, 2/10/2023, documented, "Lyrica 75 mg; Give 1 capsule by mouth two times a day for neuropathy." The February 2023 MAR documented the above order. On 2/12/2023 and 2/13/2023 for the 9:00 a.m. and 9:00 p.m. doses a "9" was documented. On 2/14/2023 for the 9:00 a.m. dose a "9" was documented. A "9" indicates, "Other/See nurse's notes." The nurse's notes for the dates and times with the "9" documented, documented "On order."	F 755		

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F 755	Continued From page 111 An interview was conducted with LPN (licensed practical nurse) #2, on 4/11/2023 at 3:14 p.m. When asked what the process was when a medication is not available at the time it is scheduled to be administered, LPN #2 stated the (name of pharmacy machine with medications in the building) is the best thing. It has many of the medications we need. If it's a narcotic, then you need two nurses to get it out of the machine. When asked if the medication is not available in the (name of machine), what should the nurse to do, LPN #2 stated you have to call the pharmacy to get it and notify the nurse practitioner that it is not here. When asked if Lyrica is in the machine, LPN #2 stated, no it is not. LPN #2 was shown where the Lyrica was not given on the above dates and the nurses documented, on order. LPN #2 stated she was not made aware of the unavailability of the Lyrica for R37. LPN #2 stated that sometimes it takes two days to get medications and even the stat (right away) medications can take up to 24 hours to get. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/11/2023 at 5:07 p.m. No further information was obtained prior to exit.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756	1. The facility is unable to correct past noncompliance but currently has a designated pharmacist assigned and is making monthly visits to the facility and doing a	5/26/23

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F 756	Continued From page 112 §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: Based on staff interview, facility document review, and clinical record review, the facility staff failed to complete a monthly medication regimen review for three of 32 residents in the survey	F 756	monthly Medication Regimen Review. 2. All residents could be affected by the alleged deficient practice. December 22 and January 2023 MRR will be pulled to ensure any recommendations were followed. 3. DON/Designee will retrieve the MMR from pharmacy consultant website monthly and will give to the provider to review and respond to the recommendations. DON will make the changes in PCC. 4. The results will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 756	Continued From page 113 sample, Residents #25, #29, and #20. The findings include: 1. For Resident #25 (R25), the facility pharmacist did not complete a medication regimen review (MRR) in December 2022 or January 2023. A review of R25's clinical record failed to reveal evidence of an MRR in December 2022 and January 2023. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. ASM #1 stated: "We just got a pharmacist." She stated the facility had undergone a change of ownership on 12/1/22, and lost their pharmacist. She stated the facility was without a pharmacist until February 2023. She stated she would check to make sure there were no MRRs for this resident in December 2022 and January 2023. On 4/12/23 at 9:24 a.m., ASM #1 stated: "I couldn't find anything regarding a pharmacist until February [2023]." A review of the facility policy, "Medication Regimen Review," revealed, in part: "The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly." No further information was received prior to exit. 2. For Resident #29 (R29), the facility pharmacist	F 756		

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F 756	Continued From page 114 did not complete a medication regimen review (MRR) in December 2022 or January 2023. A review of R29's clinical record failed to reveal evidence of an MRR in December 2022 and January 2023. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. ASM #1 stated: "We just got a pharmacist." She stated the facility had undergone a change of ownership on 12/1/22, and lost their pharmacist. She stated the facility was without a pharmacist until February 2023. She stated she would check to make sure there were no MRRs for this resident in December 2022 and January 2023. On 4/12/23 at 9:24 a.m., ASM #1 stated: "I couldn't find anything regarding a pharmacist until February [2023]." No further information was received prior to exit. 3. For Resident #20 (R20), the facility pharmacist did not complete a medication regimen review (MRR) in January 2023. A review of R29's clinical record failed to reveal evidence of an MRR in January 2023. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. ASM #1 stated: "We just got a	F 756		

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F 756	Continued From page 115 pharmacist." She stated the facility had undergone a change of ownership on 12/1/22, and lost their pharmacist. She stated the facility was without a pharmacist until February 2023. She stated she would check to make sure there were no MRRs for this resident In and January 2023. On 4/12/23 at 9:24 a.m., ASM #1 stated: "I couldn't find anything regarding a pharmacist until February [2023]." No further information was received prior to exit.	F 756		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803	1. The facility is unable to correct past non-compliance. 2. All residents could be affected by the alleged deficient practice. 3. The dietary manager and staff will be educated on following the published menu. A facility wide audit will be conducted to ensure menus are being followed or menus substituted per policy.	05/26/23

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F 803	Continued From page 116 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow the published menu for one of 32 residents in the survey sample, Resident #23. The findings include: For Resident #23 (R23), the facility staff failed to provide the resident with the items on the lunch menu on 4/10/23. On 4/10/23 at 12:31 p.m., R23 was sitting in a wheelchair, with a tray of food on the overbed table that was in front of the resident. The tray did not contain any chocolate pudding. A review of the meal ticket for R23 for this meal included that the resident should get chocolate pudding. On 4/10/23 at 12:34 p.m., OSM #7, a cook, evaluated the items on R23's tray. OSM #7 stated: "No, this is not right. [R23] should have chocolate pudding. Somebody substituted applesauce instead, but there should be chocolate pudding on the tray." On 4/10/23 at 2:50 p.m., OSM #8, the dining services manager, was interviewed. OSM #8 stated the dietary aide who stands on the side of the tray line with the trays, condiments, silverware, and cold items, is responsible for calling out what should be on the resident's plate. The dietary aide is responsible for making sure	F 803	4. The Dietary Manager/Designee will audit 3 trays per meal for 8 weeks to ensure the published menu is being followed. The results of the audit will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 803	Continued From page 117 items like pudding are placed on the resident's tray. She stated the menu should be followed unless the facility is out of a particular item. She stated: "I was standing right there. I don't know what happened today with (R23)'s lunch tray." She stated (R23) likes chocolate pudding. She stated the dietary aide is usually the last person to touch the tray, and is responsible for making sure the correct items are being served to the resident. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Menus," revealed, in part: "Menu items and available snacks reflect the religious, cultural, and ethnic preferences of the residents, whenever reasonable. Copies of menus are posted in resident areas, in positions and in print large enough for residents to read them." No further information was provided prior to exit.	F 803		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the	F 805	1. The facility is unable to correct past non-compliance. 2. All residents could be affected by the alleged deficient practice. A facility wide audit of therapeutic diets will be conducted to	5/26/23

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F 805	Continued From page 118 facility staff failed to serve food at the physician-ordered consistency for one of 32 residents in the survey sample, Resident #23. The findings include: For Resident #23 (R23), the facility staff failed to serve pureed spinach at lunch on 4/10/23. On 4/10/23 at 12:31 p.m., R23 was sitting in a wheelchair, with a tray of food on the overbed table in front of the resident. The tray contained pureed meat and pasta. The tray also contained a serving of spinach, which was not pureed. Leaves and stems were visible in the serving cup. On 4/10/23 at 12:34 p.m., OSM #7, a cook, evaluated the items on R23's tray. OSM #7 stated: "No, this is not right. That spinach is not pureed." A review of R23's physician orders revealed the following: "3/7/23 Regular diet. Puree texture." On 4/10/23 at 2:50 p.m., OSM #8, the dining services manager, was interviewed. OSM #8 stated the spinach had not been pureed enough at the lunch meal that day. She stated the spinach had been run through the food processor, but clearly needed more moisture to get it to the correct pureed texture. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Therapeutic Diets,"	F 805	ensure the correct diet is on the meal ticket. 3. The dietary manager and staff will be educated on preparing modified texture diets. 4. The Dietary Manager/Designee will audit 3 trays per meal for 8 weeks to ensure the consistency of the modified diet is correct. The results of the audit will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 805	Continued From page 119 revealed, in part: "Therapeutic diets are prescribed by the physician/practitioner to support the resident's treatment and plan of care and in accordance with his or her goals and preferences...A 'therapeutic diet' is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet." No further information was provided prior to exit.	F 805		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to serve food according to a resident's preference for one of 32 residents in the survey sample, Resident #23. The findings include: For Resident #23 (R23), the facility staff served chicken, a documented dislike, to the resident at lunch on 4/10/23	F 806	1. The facility is unable to correct past non-compliance. 2. All residents could be affected by the alleged deficient practice. A facility-wide audit will be conducted to ensure residents' likes and dislikes are up to date. 3. Dietary staff will be educated on substitutions to honor residents likes/dislikes, allergies, and preferences.	5/26/23

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F 806	Continued From page 120 On 4/10/23 at 12:31 p.m., R23 was sitting in a wheelchair, with a tray of food on the overbed table that was in front of the resident. The tray contained a serving of chicken and pasta. A review of the meal ticket for R23 stated in two places that R23 disliked chicken. R23's family member was sitting beside the resident. The family member stated: "We keep telling them she does not like chicken. She never has. But they keep giving it to her." On 4/10/23 at 12:34 p.m., OSM #7, a cook, evaluated the items on R23's tray. OSM #7 stated: "I am so sorry. This is not right. We should not have put chicken on the tray. I know (R23) doesn't like chicken. On 4/10/23 at 2:50 p.m., OSM #8, the dining services manager, was interviewed. She stated she served R23's tray from the steam table line at lunch. She stated: "I'm sorry. I know (R23) does not like chicken. It's my fault. I shouldn't have served it. I don't know what happened." On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Resident Food Preferences," revealed, in part: "On admission and/or re-admission the dietary representative or nursing staff will identify a resident's food preferences...Resident dietary preferences will be reviewed periodically with the resident by the dietary team... When possible, staff will interview the resident and/or resident representative to determine current food	F 806	4. The Dietary Manager/Designee will audit 3 trays per meal for 8 weeks to ensure the substitutions to honor residents likes/dislikes, allergies and preferences are being followed. The results of the audit will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 806	Continued From page 121 preferences based on history and life patterns related to food and mealtimes." No further information was provided prior to exit.	F 806		
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, it was determined that the facility staff failed to serve food in a sanitary manner in one of one facility kitchen. The findings include: On 4/10/23, a facility dietary staff member was standing at the end of the tray line during lunch service. At the time of the observation, the	F 812	1. The off-duty employee exited the building immediately. 2. All residents could be affected by the alleged deficient practice. A dietary department audit will be conducted by the administrator/designee to ensure dietary staff with beards are wearing a beard guard. 3. Dietary staff will be educated to wear a beard guard if they have a beard in the food preparation and serving area if they are on or off duty. 4. Administrator/designee will monitor the dietary staff during meal service 3X week for 8 weeks to ensure sanitation is followed regarding wearing hair restraints, re.	5/26/23

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F 812	Continued From page 122 employee, who had a full beard, was not wearing a beard guard. On 4/10/23 at 12:25 p.m., OSM (other staff member) #6 was standing in the kitchen at the end of the steam table line as lunch trays were being served. OSM #6 had a full beard and mustache. OSM #6 was not wearing a beard guard. OSM #6 stated: "But it's my day off. I just dropped something off for them." OSM #8, the dining services manager was serving lunch trays. OSM #8 stated: "Yes, he is only here for a few minutes. It's his day off." When asked if anyone in the kitchen is supposed to wear a hair net and/or beard guard when in proximity to the tray line, OSM #8 stated: "Yes. That is true." On 4/10/23 at 2:50 p.m., OSM #8 was interviewed. She stated OSM #6 had come to the facility at her request to drop off a needed item. She stated: "He came past the line where he shouldn't have gone without a beard guard. It was partly my fault. He took one more step than he should have." She stated when OSM #6 works, he usually wears all the garb. On 4/11/23 at 5:07 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Prevention of Infection - Dietary Department," revealed, in part: "Dietary staff will wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food." No further information was provided prior to exit.	F 812	beard guards. The results of the audit will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment 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:	F 880	1. The facility is unable to correct past noncompliance. Infection tracking has been completed by the DON/IPC since 1-1-23 2. All residents could be affected by the alleged deficient practice. A root cause analysis was completed by the facility to identify Infection Control gaps and areas of opportunity. 3. Facility reviewed IC and Surveillance P&P and completed an ADHOC QAPI meeting to review F-tag 880. Facility will provide education on facility P&P for Infection Control and Surveillance to current licensed nurses, upon hire for new licensed nurses and annually. The DON/IPC and back-up IPC will complete Modules 1 and 4 of the CDC Infection Control Training for IPC	5/17/23

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F 880	Continued From page 124 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of 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 staff interview and facility document review it was determined the facility staff failed to evidence infection tracking for 9 of 12 months reviewed. The findings include: The facility staff failed to evidence infection tracking for 4/1/2022 through 12/31/2022. On 4/11/2023 at approximately 11:30 a.m., a	F 880	certifications and CMS Targeted Covid-19 Training for Frontline Staff and Management by 5-17-23. 4. The DON/IPC/designee will monitor, track and trend surveillance weekly and the results will be reported to the QAPI committee monthly X 3 months. The QAPI committee is responsible for the on-going monitoring for compliance.	

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F 880	Continued From page 125	F 880		

request was made to ASM (administrative staff member) #2, the director of nursing/infection preventionist, for the facility infection tracking logs for the past 12 months.

On 4/12/2023 at approximately 8:40 a.m., LPN (licensed practical nurse) #2 provided a binder with infection tracking from 1/1/2023 through the present. LPN #2 stated that they were looking for the rest of the logs in the previous director of nursing's office files.

On 4/12/2023 at 10:10 a.m., ASM #2 stated that they did not have any other tracking logs to provide. ASM #2 stated that the logs they had were the ones they had completed since they started working at the facility a few months back. ASM #2 stated that they were notified of new infections in their morning meetings, in chart reviews, and lab reviews. ASM #2 stated that they used the tracking sheets to locate residents and track any trends in infections. ASM #2 stated that they used the information to compile a monthly report which they reported in the QAPI (quality assurance performance improvement) meetings.

The facility policy "Infection Control Surveillance" approved 6/15/2012 documented in part, "...Surveillance refers to a system for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections and detecting unusual pathogens with infection control implications. The ICP (infection control practitioner) coordinates the facilities infection surveillance using the [Name of facility] Infection Surveillance Log...The surveillance log should be completed monthly and managed through the

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F 880	Continued From page 126 QAPI process..." On 4/12/2023 at 1:29 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the above concern. No further information was presented prior to exit.	F 880		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide abuse training for one of one CNA (certified nursing assistant) records reviewed. The findings include: The facility staff failed to evidence abuse training was provided to CNA #3, who was hired on	F 943	1. CNA #3 received abuse and neglect education on 7/26/22 and 11/24/22. This documented training was not easily available during the survey. CNA was re-educated on Abuse and Neglect. 2. All residents could be affected by the alleged deficient practice. The facility will complete an audit of all current staff to ensure all have had abuse and neglect training in the past year. 3. All staff will be educated on the facility policy and procedures for abuse prevention.	5/26/23

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F 943	Continued From page 127 9/12/88. On 4/12/23 at 1:39 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. On 4/13/23 at 12:22 p.m., OSM (other staff member) #4, the human resources manager, stated she could not provide evidence that CNA #3 was provided abuse training. OSM #4 stated the facility uses an online training program and the program changed when the facility was sold in December 2022. OSM #4 stated she sets up the training program then employees receive automatic notifications of certain trainings that are due. OSM #4 stated abuse training is one of the required trainings.	F 943	4. The HR Coordinator will monitor education on Abuse Prevention upon hire and annually. The results will be reported to the QAPI committee monthly X 3 months. The QAPI committee is responsible for the on-going monitoring for compliance.	
F 945 SS=D	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide infection control training for one of one CNA (certified nursing assistant) records reviewed. The findings include: The facility staff failed to evidence infection control training was provided to CNA #3, who was	F 945	1. CNA #3 received Infection Control Training. 2. All residents have the potential to be affected by the alleged deficient practice. The facility will complete an audit of all current staff to ensure all have had infection control training in the past year. 3. All staff will be educated on the facility policy and procedures for Infection Control.	5/26/23

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F 945	Continued From page 128 hired on 9/12/88. On 4/12/23 at 1:39 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern. On 4/13/23 at 12:22 p.m., OSM (other staff member) #4, the human resources manager, stated she could not provide evidence that CNA #3 was provided infection control training. OSM #4 stated the facility uses an online training program and the program changed when the facility was sold in December 2022. OSM #4 stated she sets up the training program then employees receive automatic notifications of certain trainings that are due. OSM #4 stated infection control training is one of the required trainings.	F 945	4. The HR Coordinator will monitor education on Infection Control upon hire and annually. The results will be reported to the QAPI committee monthly x 3 months. The QAPI committee is responsible for the on-going monitoring for compliance.	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947	1. The facility is unable to correct past non-compliance. CNA #3 received her 12 hours annual training for nurse aids. 2. All residents could be affected by the alleged deficient practice. The facility will complete an audit of all current CNAs to ensure all are up to date	5/26/23

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F 947	Continued From page 129 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to provide 12 hours of annual training for one of one CNA (certified nursing assistant) records reviewed. The findings include: The facility staff failed to evidence 12 hours of annual training was provided to CNA #3, who was hired on 9/12/88. On 4/13/23 at 12:22 p.m., OSM (other staff member) #4, the human resources manager, stated she could not provide evidence that CNA #3 was provided 12 hours of annual training. OSM #4 stated the facility uses an online training program and the program changed when the facility was sold in December 2022. OSM #4 stated she sets up the training program then employees receive automatic notifications of certain trainings that are due. OSM #4 stated she did not know who was responsible for ensuring CNAs receive 12 hours of annual training. On 4/12/23 at 1:39 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern.	F 947	on receiving their 12 hours required training. 3. All CNA's will receive their annual 12 hours of required training. 4. The HR Coordinator will monitor education for the 12 hours required training for CNAs upon hire and annually thereafter. The results will be reported.to the QAPI committee monthly x 3 months. The QAPI committee is responsible for the on-going monitoring for compliance.	