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E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted 4/18/23 through 4/20/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/18/23 through 4/20/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 47 certified facility was 30 at the time of the survey. The survey sample consisted of 13 current record reviews and one closed record review.	F 000		
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	F 656		6/2/23

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

Electronically Signed | 05/05/2023

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F 656	Continued From page 1 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate 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 that the facility staff failed to develop and/or implement a care plan for five of 14 residents in the survey sample, Residents #19, #16, #29, #30, and #10. The findings include:	F 656	1. To ensure compliance care plans were developed and implemented for residents #19, #16, #29, #30, and #10 to address the residents□ individualized needs. Resident #19 has been observed to be receiving care as outlined in care plan for use of AFO□s. Resident #16 has	

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F 656	Continued From page 2 1. For Resident #19 (R19), the facility staff failed to implement the care plan for the use of bilateral (both left and right) AFOs (ankle/foot orthoses-which are devices for positioning of the ankle/foot). On 4/19/23 at 9:53 a.m., R19 was sitting in a wheelchair in the facility school room. R19 did not have any positioning devices on their feet or ankles. RN (registered nurse) #2 stated the resident was not wearing an AFO at that moment, and that the staff would put the AFOs on if the resident was positioned in a stander. A review of R19's physician orders revealed, in part: "9/19/22 Apply brace Bilateral AFO until discontinued. Comments: Pt (patient) should wear B (bilateral) AFOs from 8 am - 4 pm when OOB (out of bed) or when in stander." A review of R19's care plan revealed, in part: "11/22/21 Resident will have mobility within the limits of disease...Keep limbs in functional alignment using pillows, wedges, or splints as ordered." On 4/19/23 at 10:57 a.m., RN (registered nurse) #1, the MDS nurse, was interviewed. She stated a resident's care plan should contain information regarding "head to toe systems" for each resident. She stated the care plan should cover safety, falls, nutrition, special equipment, bowel elimination, dehydration, fluid maintenance, communication, and anything having to do with a residents ADLs (activities of daily living). She stated the EMR (electronic medical record) software has a care plan template. This template includes a list of goals and interventions from	F 656	been observed to be receiving care as outlined in care plan for use of hand splints. Resident #30 has a care plan for use of glucose imbalance related to use of Lispro. Resident #29 has a care plan for use of high- risk medication related to use of Diazepam related to resident□s genetic disease. Resident #10 has a care plan developed for safety related to use of bed rails. Residents #19, #16, #29, #30, and #10 did not experience any adverse outcomes related to this issue. 2. To identify other residents who could potentially be affected by this issue a review of records was completed. Any deviation in this practice is being addressed. 3. To ensure future compliance the MDS coordinator will oversee the development and implementation of care plans for residents□ individualized care plans. 4. To monitor the performance to ensure the solutions are sustained there will be periodic checks of care plans- at least 4 times over the next 12 months- as part of the performance improvement process. Any care planning development and/or implementation that is needed will be addressed immediately. 5. It is anticipated that through these actions compliance will be demonstrated by 6/2/2023.	

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which she can choose as she develops the individualized care plan. She stated she has primary responsibility for developing the resident's care plan following the initial MDS (minimum data set) assessment after a resident is admitted. She stated she is also primarily responsible for updating the care plans with new problems and new interventions. She stated the purpose of a care plan is to give the residents the best possible care. She stated the entire interdisciplinary team has access to the care plans. She stated R19's care plan was not being followed if the resident was not wearing the AFOs when out of bed.

On 4/19/23 at 12:05 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the purpose of a care plan is to make sure everyone knows exactly what a resident needs for safety, and for overall care. She stated the care plan should always be followed.

On 4/19/23 at 1:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of performance management, and ASM #3, the director of nursing, were informed of these concerns.

A policy was requested for developing/implementing the care plan, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy.

No further information was provided prior to exit.

2. For Resident #16 (R16), the facility staff failed to implement the care plan for the resident's use

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of bilateral hand splints.

On 4/18/23 at 1:56 p.m., R16 was lying in bed, and was not wearing hand splints.

On 4/19/23 at 9:52 a.m., R16 was sitting in a wheelchair in the facility school room. The resident was not wearing hand splints.

A review of R16's physician orders revealed, in part: "3/25/23 Apply splint Bilateral: Resting Hand Splint Until discontinued. Pt (patient) to wear bilateral...hand splints from 8 am - noon and 1 pm - 4 pm."

A review of R16's care plan revealed, in part: "11/22/21 Resident will have mobility within the limits of disease...Keep limbs in functional alignment using pillows, wedges, or splints as ordered."

On 4/19/23 at 10:57 a.m., RN (registered nurse) #1, the MDS nurse, was interviewed. She stated a resident's care plan should contain information regarding "head to toe systems" for each resident. She stated the care plan should cover safety, falls, nutrition, special equipment, bowel elimination, dehydration, fluid maintenance, communication, and anything having to do with a residents ADLs (activities of daily living). She stated the EMR (electronic medical record) software has a care plan template. This template includes a list of goals and interventions from which she can choose as she develops the individualized care plan. She stated she has primary responsibility for developing the resident's care plan following the initial MDS (minimum data set) assessment after a resident is admitted. She stated she is also primarily

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responsible for updating the care plans with new problems and new interventions. She stated the purpose of a care plan is to give the residents the best possible care. She stated the entire interdisciplinary team has access to the care plans.

On 4/19/23 at 12:05 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the purpose of a care plan is to make sure everyone knows exactly what a resident needs for safety, and for overall care. She stated the care plan should always be followed. She stated R16's care plan was not being followed for the hand splints.

On 4/19/23 at 1:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of performance management, and ASM #3, the director of nursing, were informed of these concerns.

A policy was requested for developing/implementing the care plan, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy.

No further information was provided prior to exit.

3. For Resident #29, the facility staff failed to develop a care plan for the administration of Diazepam (1).

A review of R29's physician's orders revealed, in part: "1/24/23 Diazepam solution 0.21 mg/kg (milligrams per kg (kilograms) 1.5 mg per G tube (feeding tube) every 6 hours." The medication was ordered to treat the symptoms of the

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resident's genetic abnormalities. A review of R29's April 2023 MAR (medication administration record) revealed the resident received the Diazepam as ordered.

A review of R29's comprehensive care plan failed to reveal information related to the administration or monitoring of the Diazepam.

On 4/19/23 at 10:57 a.m., RN (registered nurse) #1, the MDS nurse, was interviewed. She stated a resident's care plan should contain information regarding "head to toe systems" for each resident. She stated the care plan should cover safety, falls, nutrition, special equipment, bowel elimination, dehydration, fluid maintenance, communication, and anything having to do with a residents ADLs (activities of daily living). She stated the EMR (electronic medical record) software has a care plan template. This template includes a list of goals and interventions from which she can choose as she develops the individualized care plan. She stated she has primary responsibility for developing the resident's care plan following the initial MDS (minimum data set) assessment after a resident is admitted. She stated she is also primarily responsible for updating the care plans with new problems and new interventions. She stated the purpose of a care plan is to give the residents the best possible care. When asked if a high-risk medication like Diazepam should be care planned, she stated: "Yes." RN #1 confirmed R29's care plan did not include information related to the risks of Diazepam.

On 4/19/23 at 12:05 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the purpose of a care plan is to make sure everyone

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knows exactly what a resident needs for safety, and for overall care. She stated high-risk medications should have a care plan.

On 4/19/23 at 1:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of performance management, and ASM #3, the director of nursing, were informed of these concerns.

A policy was requested for developing/implementing the care plan, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy.

No further information was provided prior to exit.

(1) "Diazepam is used to relieve anxiety and to control agitation caused by alcohol withdrawal. It is also used along with other medications to control muscle spasms and spasticity caused by certain neurological disorders such as cerebral palsy (condition that causes difficulty with movement and balance), paraplegia (inability to move parts of the body), athetosis (abnormal muscle contractions), and stiff-man syndrome (a rare disorder with muscle rigidity and stiffness)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682047.html.

4. For Resident #30 (R30), the facility failed to develop a plan for the administration of Lispro (1) (a medication used for the treatment of diabetes).

A review of R30's physician's orders revealed, in part: "10/21/22 Insulin Lispro (Humalog) 100

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units/ml (milliliter) injection. Give 1-7 units per sliding scale." A review of R30's April 2023 MAR (medication administration record) revealed the resident received the medication as ordered.

A review of R30's care plan failed to reveal information related to the administration or monitoring of the Lispro.

On 4/19/23 at 10:57 a.m., RN (registered nurse) #1, the MDS nurse, was interviewed. She stated a resident's care plan should contain information regarding "head to toe systems" for each resident. She stated the care plan should cover safety, falls, nutrition, special equipment, bowel elimination, dehydration, fluid maintenance, communication, and anything having to do with a residents ADLs (activities of daily living). She stated the EMR (electronic medical record) software has a care plan template. This template includes a list of goals and interventions from which she can choose as she develops the individualized care plan. She stated she has primary responsibility for developing the resident's care plan following the initial MDS (minimum data set) assessment after a resident is admitted. She stated she is also primarily responsible for updating the care plans with new problems and new interventions. She stated the purpose of a care plan is to give the residents the best possible care. When asked if a high-risk medication like Lispro should be care planned, she stated: "Yes." RN #1 confirmed R30's care plan did not include information related to the risks of Lispro.

On 4/19/23 at 12:05 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the purpose of a care plan is to make sure everyone

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knows exactly what a resident needs for safety, and for overall care. She stated high-risk medications should have a care plan.

On 4/19/23 at 1:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of performance management, and ASM #3, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

A policy was requested for developing/implementing the care plan, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy.

(1) "HUMALOG (Lispro) is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c8ecbd7a-0e22-4fc7-a503-faa58c1b6f3f .

5. For Resident #10, the facility staff failed to develop a care plan to address safety needs, including the use of side rails.

On 4/18/23 at 6:57 AM, 4/19/23 at approximately 11:00 AM, and 4/20/23 at approximately 8:00 AM, Resident #10 was observed in bed, with side rails up on both sides.

A review of the clinical record revealed an order dated 11/30/21 for "Side rails up x4."

A "Consent for use of side rails" dated 10/26/17

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documented, the resident was to have full side rails on left and right sides, and was recommended at all times when the resident was in bed. The purpose of the side rails was documented as "Fall Risk." Risks and benefits were documented on the consent.

A review of the comprehensive care plan failed to address any safety needs for Resident #10, including the fact that they were a fall risk, and for the use of side rails.

On 4/19/23 at 10:57 AM, an interview was conducted with RN #1 (registered nurse), the MDS nurse. She stated a resident's care plan should contain information regarding "head to toe systems" for each resident. She stated the care plan should cover safety, falls, nutrition, special equipment, bowel elimination, dehydration, fluid maintenance, communication, and anything having to do with a residents ADLs (activities of daily living). She stated the EMR (electronic medical record) software has a care plan template. This template includes a list of goals and interventions from which she can choose as she develops the individualized care plan. She stated she has primary responsibility for developing the resident's care plan following the initial MDS (minimum data set) assessment after a resident is admitted. She stated she is also primarily responsible for updating the care plans with new problems and new interventions. She stated the purpose of a care plan is to give the residents the best possible care. She stated the entire interdisciplinary team has access to the care plans.

On 4/19/23 at 12:05 PM, an interview was conducted with LPN #1 (licensed practical nurse).

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F 656	Continued From page 11 She stated the purpose of a care plan is to make sure everyone knows exactly what a resident needs for safety, and for overall care. On 4/19/23 at 1:50 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the Director of Performance Management, and ASM #3, the Director of Nursing, were made aware of the findings. On 4/20/23 at 8:55 AM an interview was conducted with ASM #2. When asked about not having a care plan to address safety needs and the use of side rails, ASM #2 stated that there wasn't one but that there should have been one. A policy was requested for developing care plans, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy. 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 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.	F 657		6/2/23

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F 657	Continued From page 12 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 14 residents in the survey sample, Residents #7 and 22. The findings include: 1. For Resident #7 (R7), the facility staff failed to revise the care plan when the resident developed a pressure ulcer. A review of R7's clinical record revealed the resident was receiving treatment for a pressure ulcer. The record contained the following physician's order: "Sodium Hypochlorous Acid (Vashe Wound Cleanser) 0.333% Once per day [for pressure ulcer] on Monday, Wednesday, Friday." A review of R7's April 2023 TAR (treatment administration record) revealed the resident was receiving the pressure ulcer treatments as ordered.	F 657	1. To ensure compliance care plans were updated and revised for residents #7 and #22 to address the residents individualized needs. Resident #7s care plan was revised to reflect care for pressure ulcer. Resident #22s care plan was updated to address the pressure wound and associated treatments. Residents #7 and #22 did not experience any adverse outcomes related to this issue. 2. To identify other residents who could potentially be affected by this issue a review of records was completed. Any deviation in this practice is being addressed. 3. To ensure ongoing compliance the MDS coordinator will oversee the updating and revision of individualized care plan based on residents individual needs. 4. To monitor performance to ensure the solutions are sustained there will be	

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F 657	Continued From page 13 A review of R7's care plan updated 3/1/23 revealed, in part: "11/22/21 Resident will not experience redness or skin breakdown over the next 90 days." However, the care plan had not been updated to address R7's actual pressure ulcer. On 4/19/23 at 10:57 a.m., RN (registered nurse) #1, the MDS nurse, was interviewed. She stated a resident's care plan should contain information regarding "head to toe systems" for each resident. She stated the care plan should cover safety, falls, nutrition, special equipment, bowel elimination, dehydration, fluid maintenance, communication, and anything having to do with a residents ADLs (activities of daily living). She stated she is responsible for updating the care plan, and it should include the development of a pressure ulcer. On 4/19/23 at 12:05 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the purpose of a care plan is to make sure everyone knows exactly what a resident needs for safety, and for overall care. She stated the MDS nurse updates the care plans for the facility's residents. On 4/19/23 at 1:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of performance management, and ASM #3, the director of nursing, were informed of these concerns. On 4/20/23 at 8:55 AM an interview was conducted with ASM #2. When asked about the care plan not being revised to address the development of the pressure injury, ASM #2 stated that it should be, and that being under a	F 657	periodic checks of care plans- at least 4 times over the next 12 months- as part of the performance improvement process. Any care planning development and/or implementation that is needed will be addressed immediately. 5. It is anticipated that through these actions compliance will be demonstrated by 6/2/2023.	

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new healthcare system and a new electronic medical record system was a learning process for the facility.

A policy was requested for reviewing and revising the care plan, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy.

No further information was provided prior to exit.
2. For Resident #22 the facility staff failed to review and revise the comprehensive care plan to address the development of an actual pressure wound and the associated treatments.

A review of the clinical record revealed a nurse's note dated 8/29/22 that documented, "Pt (patient) has pressure injury to sacrum that appears to be a stage 2. NP (nurse practitioner) at bedside to visualize..."

A review of the physician's orders revealed the following:

1. Dated 1/25/23 for "Please use wedge to position (Resident #22) off of [their] back. Side lying only to avoid sacral pressure.

2. Dated 3/13/23 for wound care daily to sacrum for "Vashe moistened packing strips for appropriate moisture and antimicrobial activity. Mepilex border/sacral to manage exudate and for cover dressing. Change dressing daily.

A review of the comprehensive care plan revealed the following one dated 11/22/21 for "Potential for loss of skin integrity secondary to: impaired mobility, incontinence, gastrostomy and/or jejunal tube site, tracheostomy tube site,

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prolonged wheelchair seating, splint/AFO's/TLSO braces, less/more than ideal body weight, contracture lower extremities, peri-area r/t (related to) intermittent catheterizations, eye irritation, scratching face."

The interventions, dated 11/22/21 documented, "Assess all skin surfaces with bathing, attends changes. Use appropriate ointments, creams and lotions. Keep peri-area clean and dry. Change attends every 4 hours and prn (as needed). Assess skin for pressure and redness with position changes, after splint removal, and after wheelchair seating. Assess g-tube and trach site with routine care. Document bruising and/or reddened areas and report to therapies and MD (medical doctor) for evaluation and/or treatment. Report wheelchair equipment needs for evaluation and repair to therapy or equipment provider. Advise family of noted skin breakdown or injuries incurred. Document any changes in status of skin surfaces involve and report to MD/therapy. MOM's Magic Paste for reddened areas as ordered. Keep nails trimmed to prevent scratching."

Further review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed and revised to address an actual pressure injury that developed and associated treatments and interventions.

On 4/19/23 at 10:57 AM, an interview was conducted with RN #1 (registered nurse), the MDS nurse. She stated a resident's care plan should contain information regarding "head to toe systems" for each resident. She stated the care plan should cover safety, falls, nutrition, special equipment, bowel elimination, dehydration, fluid

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maintenance, communication, and anything having to do with a residents ADLs (activities of daily living). She stated the EMR (electronic medical record) software has a care plan template. This template includes a list of goals and interventions from which she can choose as she develops the individualized care plan. She stated she has primary responsibility for developing the resident's care plan following the initial MDS (minimum data set) assessment after a resident is admitted. She stated she is also primarily responsible for updating the care plans with new problems and new interventions. She stated the purpose of a care plan is to give the residents the best possible care. She stated the entire interdisciplinary team has access to the care plans.

On 4/19/23 at 12:05 PM, an interview was conducted with LPN #1 (licensed practical nurse). She stated the purpose of a care plan is to make sure everyone knows exactly what a resident needs for safety, and for overall care.

On 4/19/23 at 1:50 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the Director of Performance Management, and ASM #3, the Director of Nursing, were made aware of the findings.

On 4/20/23 at 8:55 AM an interview was conducted with ASM #2. When asked about the care plan not being revised to address the development of the pressure injury, ASM #2 stated that it should be, and that being under a new healthcare system and a new electronic medical record system was a learning process for the facility.

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F 657	Continued From page 17 A policy was requested for updating care plans, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy. No further information was provided by the end of the survey.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to apply orthotic devices as ordered for two of 14 residents in the survey sample, Residents #19 and #16. The findings include:	F 688	1. To ensure compliance the certified nurse aide was counseled regarding the need to follow physician orders and to notify licensed nurse related to applying orthotic devices as ordered. Resident #19 was observed to be wearing AFO□s as ordered. Resident #16 was observed wearing hand splints as ordered.	6/2/23

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F 688	Continued From page 18 1. For Resident #19 (R19), the facility staff failed to apply bilateral (both left and right) AFOs (ankle/foot orthoses) (devices for positioning of the ankle/foot) when the resident was out of bed. On 4/19/23 at 9:53 a.m., R19 was sitting in a wheelchair in the facility school room. R19 did not have any positioning devices on his feet or ankles. RN (registered nurse) #2 stated the resident was not wearing an AFO at that moment, and that the staff would put the AFOs on if the resident was positioned in a stander. A review of R19's physician orders revealed, in part: "9/19/22 Apply brace Bilateral AFO until discontinued. Comments: Pt (patient) should wear B (bilateral) AFOs from 8 am - 4 pm when OOB (out of bed) or when in stander." A review of R19's care plan revealed, in part: "11/22/21 Resident will have mobility within the limits of disease...Keep limbs in functional alignment using pillows, wedges, or splints as ordered." On 4/19/23 at 12:00 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated there is a communication book at the nurses' station with information about AFOs for each resident. She stated each resident also has a binder inside their closet door with the AFO information there, as well. On 4/19/23 at 12:05 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated she was responsible for taking care of R19 that day. She stated she checks the physician orders to make sure what AFOs have been ordered by the physician. She stated she was not certain	F 688	Residents #19 and #16 did not experience any adverse outcomes related to this issue. 2. To identify other residents who could potentially be affected by this practice all residents were assessed by Director of Nursing for compliance and were observed to be wearing orthotic devices as ordered. No further deviation in practice was revealed. 3. To ensure future compliance the importance of following orders for application of orthotics was reinforced to all licensed nurses through communication from Director of Nursing. 4. To monitor performance to ensure the solutions are sustained there will be periodic checks of use of orthotics as ordered- at least 4 times over the next 12 months- as part of the performance improvement process. Any deviation in acceptable practice will be addressed and through the organization□s reporting process and any opportunities for improvement will be identified with corrective action steps. 5. It is anticipated that through these actions compliance will be demonstrated by 6/2/2023.	

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whether or not R19 had been wearing AFOs that morning. She stated sometimes the staff decides to give "give the resident a rest" from the orthotics. She stated there was no order to do so, and no place to document why this was not being done.

On 4/19/23 at 12:57 p.m., RN #2 stated sometimes R19 will not tolerate the AFOs, and they are not applied by the staff. She stated the "system" does not allow the staff to document a resident's refusal or intolerance. She stated CNAs (certified nursing assistants) are primarily responsible for applying the AFOs, and should alert the nurse if the resident is not tolerating the braces well. She stated the nurse should write a progress note. She stated she could not find where this had been done for R19.

On 4/19/23 at 1:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of performance management, and ASM #3, the director of nursing, were informed of these concerns.

A policy was requested for implementing physician-ordered orthotic devices, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy.

No further information was provided prior to exit.

2. For Resident #16 (R16), the facility staff failed to apply bilateral (both left and right) hand splints as ordered by the physician.

On 4/18/23 at 1:56 p.m., R16 was lying in bed,

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and was not wearing hand splints.

On 4/19/23 at 9:52 a.m., R16 was sitting in a wheelchair in the facility school room. The resident was not wearing hand splints.

A review of R16's physician orders revealed, in part: "3/25/23 Apply splint Bilateral: Resting Hand Splint Until discontinued. Pt (patient) to wear bilateral...hand splints from 8 am - noon and 1 pm - 4 pm."

A review of R16's care plan did not reveal any information related to the bilateral hand splints.

On 4/19/23 at 12:00 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated there is a communication book at the nurses' station with information about braces and splints for each resident. She stated each resident also has a binder inside their closet door with the information there, as well.

On 4/19/23 at 12:05 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated she was responsible for taking care of R16 that day. She stated she checks the physician orders to make sure what splints have been ordered by the physician. She stated she was not certain whether or not R16 had been wearing hand splints that morning.

On 4/19/23 at 1:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of performance management, and ASM #3, the director of nursing, were informed of these concerns.

A policy was requested for implementing

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F 688	Continued From page 21 physician-ordered orthotic devices, however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy. No further information was provided prior to exit.	F 688		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		6/2/23

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F 732	Continued From page 22 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to post the required staff posting for 33 of 33 days reviewed. The findings include: On 4/19/23 at approximately 10:30 AM a tour of the facility was conducted; the required staff posting for the shift was not observed posted. The facility document that was provided as the daily staff posting was reviewed for the period of 3/18/23 through 4/20/23. The document was a combined document of daily staff posting, as-worked schedule, and staff assignments. The document contained the date, shift, and census but it also contained resident names and did not contain staff hours. On 4/19/23 at 10:45 AM an interview was conducted with RN #2 (Registered Nurse) the unit manager. She stated that she believed the document provided was the staff posting form, and that due to it having resident names on it, the document is not posted for visitors to see but is maintained face down at the front desk. She stated she was not sure what information the staff posting was supposed to contain.	F 732	1. To ensure compliance with the posting of nurse staffing information a tool was developed that included all elements of the required information. No residents experienced any adverse outcomes related to this issue. 2. To identify other residents who could potentially be affected by this issue the nurse staffing information will be placed in a visible location and include all elements of the required information. Any deviation in this practice is being addressed. 3. To ensure future compliance the DON will oversee the development and implementation of the Nurse Staffing information posting. 4. To monitor performance to ensure the solutions are sustained there will be periodic checks of compliance that will occur at least 4 times over the next 12 months- as part of the performance improvement process. Any deviation in postings will be addressed immediately. 5. It is anticipated that through these actions compliance will be demonstrated by 6/2/2023.	

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F 732	Continued From page 23 On 4/19/23 at 11:36 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Performance Management. She stated that this was the document that was provided to meet the request for the staff posting for the last 30 days, which was requested upon the entrance conference on 4/18/23 at 9:00 AM. A policy was requested for staff posting however none was provided. On 4/20/23 at 12:29 PM, ASM #2 stated the facility did not have the requested policy. No further information was provided by the end of the survey.	F 732		
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. §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	F 756		6/2/23

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F 756	Continued From page 24 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, it was determined that the facility staff failed to develop a Medication Regimen Review policy that included required time frames for pharmacist's review and physician's response to the pharmacist's recommendations, for five of 14 residents in the survey sample; Residents #22, #8, #10, #30, and #29. The findings include: 1. For Resident #22 the facility staff failed to ensure the medication regimen review policy contained required time frames for pharmacist's review and physician's response. A review of the clinical record revealed all required monthly medication regimen reviews and	F 756	1. To ensure compliance with the timeframe for pharmacist review and physician response in the drug regimen review for residents #22, #8, #30, #2, and #10 timeframes were added to the facility□s drug regimen review policy. Residents #22, #8, #30, #2, and #10 did not experience any adverse outcomes related to this issue. 2. To identify other residents who could potentially be affected by the timeframe for drug regimen pharmacists□ reviews and physician response all residents□ records were reviewed and no residents experienced any adverse outcomes related to this issue. 3. To ensure future compliance the Administrator will oversee the revision of the Drug Regimen Review policy to	

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	49A022	A. BUILDING _____ B. WING _____	04/20/2023

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F 756	Continued From page 25 no concerns were identified. However, a review of the facility's monthly medication regimen review policy, dated 2/27/23, failed to reveal time frames for pharmacist's review and physician's response. A review of the facility policy "Policy on Medication Regimen Review," dated 2/27/23 failed to document any time frames, including when the physician is to act upon pharmacy recommendations. On 4/19/23 at 11:36 a.m., ASM (administrative staff member) #2, the director of performance management, stated, "We don't have anything else." On 4/19/23 at 1:50 PM, ASM #1, the Administrator, ASM #2, and ASM #3, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #8 the facility staff failed to ensure the medication regimen review policy contained required time frames for pharmacist's review and physician's response. A review of the clinical record revealed all required monthly medication regimen reviews and no concerns were identified. However, a review of the facility's monthly medication regimen review policy, dated 2/27/23, failed to reveal time frames for pharmacist's review and physician's response. A review of the facility policy "Policy on Medication Regimen Review," dated 2/27/23 failed to document any time frames, including	F 756	include time frames for pharmacist review and physician response. 4. To monitor performance to ensure the solutions are sustained there will be periodic checks of pharmacists' reviews and physician response- at least 4 times over the next 12 months- as part of the performance improvement process. Any areas of discrepancy that are identified will be addressed immediately. 5. It is anticipated that through these actions compliance will be demonstrated by 6/2/2023.	

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F 756	Continued From page 26	F 756		

when the physician is to act upon pharmacy recommendations.

On 4/19/23 at 11:36 a.m., ASM (administrative staff member) #2, the director of performance management, stated, "We don't have anything else."

On 4/19/23 at 1:50 PM, ASM #1, the Administrator, ASM #2, and ASM #3, the Director of Nursing, were made aware of the findings.

No further information was provided by the end of the survey.

3. For Resident #10, the facility staff failed to ensure the medication regimen review policy contained required time frames for pharmacist's review and physician's response.

A review of the clinical record revealed all required monthly medication regimen reviews and no concerns were identified. However, a review of the facility's monthly medication regimen review policy, dated 2/27/23, failed to reveal time frames for pharmacist's review and physician's response.

A review of the facility policy "Policy on Medication Regimen Review," dated 2/27/23 failed to document any time frames, including when the physician is to act upon pharmacy recommendations.

On 4/19/23 at 11:36 a.m., ASM (administrative staff member) #2, the director of performance management, stated, "We don't have anything else."

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On 4/19/23 at 1:50 PM, ASM #1, the Administrator, ASM #2, and ASM #3, the Director of Nursing, were made aware of the findings.

No further information was provided by the end of the survey.

4. For Resident #30 (R30), the facility staff failed to ensure the medication regimen review policy contained required time frames for pharmacist's review and physician's response.

R30 was admitted to the facility on 1/24/23.

A review of R30's clinical record revealed all required monthly medication regimen reviews. However, a review of the facility's monthly medication regimen review policy failed to reveal time frames for pharmacist's review and physician's response.

A review of the facility policy "Policy on Medication Regimen Review," dated 2/27/23 failed to document any time frames, including when the physician is to act upon pharmacy recommendations.

On 4/19/23 at 11:36 a.m., ASM (administrative staff member) #2, the director of performance management, stated, "We don't have anything else."

On 4/19/23 at 1:50 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

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5. For Resident #29 (R29), the facility staff failed to ensure the medication regimen review policy contained required time frames for pharmacist's review and physician's response.

R29 was admitted to the facility on 10/21/22.

A review of R29's clinical record revealed all required monthly medication regimen reviews. However, a review of the facility's monthly medication regimen review policy failed to reveal time frames for the physician's response.

A review of the facility policy "Policy on Medication Regimen Review," dated 2/27/23 failed to document any time frames, including when the physician is to act upon pharmacy recommendations.

On 4/19/23 at 11:36 a.m., ASM (administrative staff member) #2, the director of performance management, stated, "We don't have anything else."

On 4/19/23 at 1:50 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.