STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING ______ B. WING ______	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 6/05/23 through 6/09/23. 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 survey was conducted 6/05/23 through 6/09/23. Significant corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Ten (10) complaints were investigated during the survey: 1. VA00058974 - Compliant with regulations 2. VA00058917 - Compliant with regulations 3. VA00057593 - Complaint with regulations 4. VA00056748 - Non-compliant, deficient practice cited 5. VA00056573 - Non-compliant, deficient practice cited 6. VA00055885 - Non-compliant, deficient practice cited 7. VA00055620 - Non-compliant, deficient practice cited 8. VA00055326 - Compliant with regulations 9. VA00054329 - Non-compliant, deficient practice cited 10. VA00054013 - Non-compliant, deficient practice cited The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/29/2023

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

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F 000	Continued From page 1 consisted of 22 current resident reviews and 12 closed record reviews.	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, the facility staff failed to provide advanced written notice of room or roommate change for one of 34 residents in the survey sample, resident #76. The findings included: Resident #76 was moved to a different room on a different unit in April 2022 without being notified of the room move in advance or in writing. Resident #76's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/17/22 had assigned them a brief	F 559	Statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F559- Choose/Be Notified of Room/Roommate change 1-Resident #76 was made aware that he would be notified	7/21/23

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F 559	Continued From page 2 interview for mental status (BIMS) score of 15, indicating they were cognitively intact. The most recent MDS assessment with an ARD of 5/24/23 had not assessed cognitive status, but did indicate there had not been a change in cognition. Resident was noted by surveyor to be alert, oriented to self, time and place. Surveyor interviewed resident #76 on 6/6/23 at 8:13 AM. They stated that they were moved to their current room "about a year ago". Resident #76 stated, "they just came in there and started grabbing up my stuff and carrying it out the door. I yelled at them and asked what they were doing and they said we're moving you. That was it. I really never got a choice or an explanation from anybody". Resident states they know now that it was because he was no longer considered "skilled or short term" but that they, "Had to figure that out on my own". Review of the clinical record revealed that a room change did occur in April 2022. Surveyor was unable to locate evidence in the record that resident #76 was notified that they would be moving. Surveyor requested documentation of the room change notification from the Director of Nursing (DON) on 6/6/23. Surveyor interviewed the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) on 6/7/23 regarding the room change for resident #76. RDCS stated, "We can't find documentation that a notification of room change was given". Surveyor requested and received the policy entitled, "Room to Room Transfer" with an effective date of 11/1/19. The policy read in part,	F 559	if any further room moves are needed while he is in the facility 2-An Audit of Room moves for last 90 days was conducted, any notifications missed were address as appropriate. 3-Regional Director of Clinical Services or designee will educate Discharge Planning Director on the requirements of room changes including written notice of room change. 4-DON or designee will audit room moves in facility For weekly for 4 weeks, then monthly for 2 additional months to ensure requirements are being met. Results of the Audits will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	

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F 559	Continued From page 3 "It is the policy of the Center to make the transfer of a patient to another room or service smooth and uneventful for the patient and to properly document all aspects involved in the transfer". Item #3 under the heading, "Procedure" read, "Notify the patient and the responsible party in advance of the transfer explaining rationale for room transfer". Item #17 read in part, "Include in the progress notes: a. Date, time (or shift) as appropriate, b. Mode of transportation, c. Location of transfer, d. Departments notified, e. Patient's response and how well transfer was tolerated. Surveyor was unable to locate a note with any of the above information in it. The survey team met with the Administrator, DON, and RDCS on 6/9/23 at approximately 3:59 PM and surveyor reviewed this concern with them. No other information was presented to the survey team prior to the exit conference.	F 559		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		7/21/23

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F 578	Continued From page 4 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review facility staff failed to ensure the correct code status was ordered for 3 of 34 records reviewed (Resident #41, #22, 318). The findings were: 1. For Resident #41, the facility staff failed to ensure their Do Not Resuscitate (DNR) preference was accurately ordered by a provider.	F 578	F578 -Request/Refuse/Dc Treatment 1-Resident #41 Code status order has been updated to reflect current code status as DNR. Resident #22 code status order has been updated to reflect current code status as full code. Resident # 318 code status has been updated to reflect current code status as Full Code. 2- Audit of Current residents was conducted to ensure presence and	

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F 578	Continued From page 5 Resident #41's admission record listed diagnoses to include but not limited to pain in left hip, severe protein-calorie malnutrition, esophagitis, major depressive disorder, diaphragmatic hernia, gastrointestinal hemorrhage, gastrostomy, and dysphagia. Resident #41's minimum data set with an assessment reference date of 4/11/23 coded the resident's brief interview for mental status summary score a 15 out of 15. Resident #41's clinical record contained a "Durable Do Not Resuscitate Order" document dated 10/06/22, signed by Resident #41 and one of the facility's nurse practitioners (NP #1). The document had two areas where a check was required to indicate the choice. The first area was checked by the number 1., "The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)". The second area was checked by the letter A., "While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn." The provider orders were reviewed and an order for "FULL CODE" was noted. On 6/09/23 at 10:44 a.m., the director of nursing (DON) provided Resident #41's current orders which indicated an order for "DNR" had been put in for the resident and showed a revision date of 6/07/23. The DON acknowledged Resident #41's code order was erroneously put in as "Full Code" when the resident was re-admitted in April. The DON acknowledged the resident's code order was Full Code in error between 4/04/23 and 6/07/23.	F 578	accuracy of code status order in the medical record on 6/7/2023. Corrections were made as necessary. 3-DON or designee will educate licensed nurses regarding policy for reviewing advanced directives and securing accurate code status order at the time of the admission. 4- Nursing leadership will review new admissions 5 times a week for 4 weeks during clinical meeting to ensure accuracy of code status and advance directive documentation. Corrections will be made as necessary. Results of the reviews will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	

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F 578	Continued From page 6	F 578		

The administrator, DON and regional director of clinical services was informed of this concern during a summary meeting on 06/08/23 at 3:15 p.m. No further information was provided prior to the exit conference.

2. For Resident #22, facility staff failed to ensure a code status order was present in the resident's clinical record.

Resident #22's admission record listed diagnoses to include, but not limited to, pain due to internal orthopedic prosthetic devices, morbid obesity, protein-calorie malnutrition, anxiety disorder, major depressive disorder, chronic kidney disease stage 3, and type 2 diabetes mellitus. Resident #22's minimum data set with an assessment reference date of 5/11/23 coded the resident's brief interview for mental status summary score a 15 out of 15.

Resident #22's provider orders did not contain a code status order as of 6/06/23. The director of nursing (DON) provided a copy of the resident's provider orders on 6/09/23 which included a Full Code order dated 6/07/23, approximately one month after admission. There was no explanation provided for why there had not been a code status order prior to 6/07/23.

The administrator, DON and regional director of clinical services was informed of this concern during a summary meeting on 06/08/23 at 3:15 p.m.

No further information was provided prior to the exit conference.

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F 578	Continued From page 7	F 578		

3. For Resident #318, the facility staff failed to obtain a physician's order for the resident's code status on admission.

Resident #318's diagnosis list indicated diagnoses, which included, but not limited to Encephalopathy, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease Stage 3 A, Congestive Heart Failure, and Generalized Muscle Weakness.

The Admission/Readmission Nursing Collection Tool dated 6/03/23 documented the resident as being cognitively impaired and oriented to person only.

Resident #318 was admitted to the facility on 6/03/23. Upon review of the resident's current physician's orders on 6/05/23, surveyor was unable to locate an order addressing the resident's preferred code status.

Surveyor requested and received the facility policy entitled "Physician's Orders" with an effective date of 3/24/20 which read in part "...2. b. Admission orders should include: ... 12) Code status ..."

On 6/06/23 at 3:40 pm, the survey team met with the Administrator, Director of Nursing, and Regional Nurse and discussed the concern of Resident #318's physician's orders failing to address code status.

No further information regarding this concern was presented to the survey team prior to the exit conference on 6/09/23.

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F 580 SS=D	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 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).	F 580		7/21/23

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F 580	Continued From page 9 §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 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 clinical record review, facility document review and staff interview, the facility staff failed to notify the resident physician of a change in condition for one of 34 residents in the survey sample. The findings include: For resident #366, the facility staff failed to notify the attending physician of a fall that occurred 10/24/22. Resident #366's diagnoses included, but were not limited to an unspecified fracture of the neck, muscle weakness and hypertension. Resident #366's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/22, assigned them a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating they were cognitively intact. The MDS had the resident coded as requiring extensive assistance of one person for bed mobility, transfers, walking and toileting. Review of resident #366's clinical record revealed a progress note labeled, "late entry for 10/24/22	F 580	F580- Notify of Changes 1- Resident #336 has been discharged from the facility 2- Residents with falls in the last 30 days have been reviewed to ensure Resident physician has been Notified. 3-Licensed nurses will be educated by the Staff Development Coordinator /designee on notification to the residents physician of falls. 4- The DON or designee will audit fall documentation 5 times weekly to ensure the resident physician has been notified of falls. Results of the reviews will be presented to the QAPI Committee for review and recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	

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F 580	Continued From page 10 at 10:10 PM" that read, "Writer called to room by assigned CNA (Certified Nursing Assistant). Upon entering room CNA was attempting to transfer resident to bed when resident's foot started to slide causing resident to be halfway on bed and buttock on wheel chair. When assisting CNA to transfer resident completely in bed resident continued to slide more causing transfer to be unsafe. Writer had CNA help transfer resident to floor so we can get more help to make a safe transfer. Another CNA helped with assisting resident off floor and back into wheel chair. No complaints noted from resident of pain or discomfort." Surveyor interviewed the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) on 6/9/23 at approximately 9:55 AM regarding resident #366's fall on 10/24/23. Surveyor asked the DON if the facility would consider this a fall and they stated "yes, it was a fall." They stated that they had not been informed of the incident and only became aware of it when the (adult child) called them to ask about it. "I told (them) I'd have to look into it." They stated that initially there was no progress note in the clinical record and they had the nurse come back and make a late entry. They stated that they had the nurse to call the (adult child) to explain what happened, "I felt like hearing from the nurse that was here when it happened would be more helpful." Surveyor asked if they would expect the nurse to assess the resident for injury and notify the physician after a fall and they stated that they would, but were not sure whether that happened in this case. DON stated that the nurse on duty at the time of the fall worked for an agency and was not available for an interview.	F 580		

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F 580	Continued From page 11	F 580		

On 6/9/23 at 10:46 AM surveyor interviewed Licensed Practical Nurse (LPN) #1 regarding the policy regarding falls at the facility. They stated when a resident falls, the nurse should assess the patient for injury, ask how the fall happened, document the fall and the assessment, provide any first aide that might be needed, call the doctor and notify the responsible party. When asked if the physician should be notified for every fall, they stated yes. Surveyor asked if the resident was lowered to the floor by staff during a transfer, would that be considered a fall and they stated it would be.

On 6/9/23 surveyor requested and received a copy of the policy entitled, "Falls Management Program" with an effective date of 3/31/23. The policy read in part, "The center considers all patients to be at risk for falls and provides an environment as safe as practical for all patients." And, "1. A fall is defined as an unintentional change in elevation coming to rest on the ground, onto the next lower surface (e.g., onto a bed, chair, or bedside mat). An episode where a patient would have fallen, if not for staff intervention, is considered a fall." Under the Procedure heading, "Fall Occurrence 1. Do not move or reposition patient until a licensed nurse has completed a physical and cognitive assessment. A licensed nurse will: Assess, intervene and promptly provide all the necessary interventions for any patient experiencing a fall. Notify the physician, responsible party, and/or EMS if indicated, as well as the supervisor/administrative personnel as appropriate.

There was no indication in resident #366's clinical record that the family was notified, however,

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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 580	Continued From page 12 resident was listed as their own responsible party and was cognitively intact. There was no indication in the clinical record that the physician was notified of the incident. There was no indication in the clinical record that the resident was assessed for injury other than they were asked if they had any pain. The survey team met with the Administrator, Director of Nursing and the Regional Director of Clinical Services on 6/9/23 at approximately 3:59 PM. Surveyor discussed this concern with them at that time. No further information was provided to the survey team prior to the exit conference.	F 580		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, clinical record review and facility document review the facility staff failed to complete a comprehensive minimum data set (MDS) assessment after a	F 637	F637-Comprehensive assessment after significant change 1. Resident #29 had a significant change MDS completed on 6/9/2023 to	7/21/23

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F 637 Continued From page 13

significant change in status for one of 34 residents, Resident #29.

The findings included:

For Resident #29 the facility staff failed to complete a significant change MDS after resident was admitted to hospice services.

Resident #29's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, atrial fibrillation, anemia, and dementia.

Resident #29's most recent MDS with an assessment reference date of 05/25/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section O, Special Treatments, Procedures, and Programs had no areas marked. This is quarterly MDS assessment.

Resident #29's comprehensive care plan was reviewed and contained no care plan related to hospice/end of life care.

Resident #29's clinical record was reviewed and contained a physician's order summary, which read in part "4/28/2023 Hospice consult. One time only for hospice consult for 5 days" and "6/6/2023 Admit to hospice."

Resident #29's clinical record contained nurse's progress notes which read in part "Date of Service: 05/03/2023 Chief Complaint/Nature of Presenting Problem: Medication changes, Hospice review ...", "Date of Service: 05/05/2023 Chief Complaint/Nature of Presenting Illness:

F 637

reflect the change to hospice, care plan has also been updated to reflect hospice/end of life care.
2. Audit conducted of current hospice residents to verify a significant change was completed according to the RAI manual.
3. The Regional Director of MDS will in-service the MDS Coordinators on the process to open and complete a significant change assessment for new hospice residents and on residents that have a significant change according to the RAI Manual.
4. Audit for Significant Changes for residents with newly enrolled hospice/end of life care services will be conducted by MDS Director or designee to verify a Significant Changes was completed per the RAI manual weekly x 4 weeks. Results of the reviews will be presented to the QAPI Committee for review and recommendation.
5- Date of Compliance: July 21, 2023
6- Director of Nursing will be responsible for this POC.

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F 637	Continued From page 14	F 637		

Advanced directives. History of Present Illness: ... with past medical history of COPD (chronic obstructive pulmonary disease), osteoarthritis, osteoporosis, GERD (gastroesophageal reflux disorder), shingles. Patient is seen today for request by nursing for advanced directives ...Patient is now being followed by hospice" and "5/12/2023 ... (name omitted) aware of new hospice orders."

Surveyor spoke with Resident #26's adult child on 06/08/23 at 9:30 am. Surveyor asked adult child when the resident was admitted to hospice services and they replied, "about 3-4 weeks ago."

Surveyor spoke with MDS coordinator #1 on 06/08/23 at 10:55 am regarding Resident #26. Surveyor asked MDS coordinator #1 if a significant change in status MDS should have been completed when resident was admitted to hospice services, and MDS coordinator #1 stated that is should have been. Surveyor asked MDS coordinator #1 in what timeframe should the MDS completed, and MDS coordinator stated, "14 days".

Surveyor requested a facility policy regarding significant change MDS timing, and regional director of clinical services stated they follow the Resident Assessment Instrument (RAI) guidelines.

The RAI manual read in part, "The SCSA (significant change in status assessment) is a comprehensive assessment for a resident that must be completed when the IDT (interdisciplinary team) has determined that a resident meets the significant change guidelines for either major improvement or decline ....A

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F 637	Continued From page 15 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self-limiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD (assessment reference date) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place." The concern of not completing a significant change MDS assessment for Resident #26 was discussed with the administrator, director of nursing and regional director of clinical services on 06/09/23 at 1:45 pm. No further information was provided prior to exit.	F 637		
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	F 655		7/21/23

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F 655	Continued From page 16 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 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.	F 655		

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F 655	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical records review facility staff failed to implement a baseline care plan within 48 hours of admission to address the resident's care needs for one of 34 records in the survey sample. (Resident #171) Resident #171 was admitted with post-surgical malabsorption, protein-calorie malnutrition, and generalized weakness. On the Minimum Data Set assessment with assessment reference date 6/5/23, the resident scored 14/15 on the Brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. On 6/5/23, the surveyor observed the resident with total parenteral nutrition administered through a central line at 63 cc/hour. Orders to change the central line weekly had been entered in the clinical record. There was no admission (6/1/23) weight. The resident weighed 98 lbs on 6/5/23. A dietary note dated 6/5/23 documented BMI 15.2 with ideal body weight 135. The resident's baseline care plan initiated 6/3/2023 for a 6/1/2023 admission contained only one focus area: support independent, self-directed leisure pursuits and activities. No additional focus areas of care were added until 6/5/2023. The surveyor notified the administrator and director of nursing of the concern during a summary meeting on 6/7/2023.	F 655	F655 Baseline Careplan 1-Resident #171 has been discharged from Facility 2-Current resident baseline careplans have been audited to presence of a complete baseline care plan. 3-DON/designee will educate nursing staff and MDS staff to ensure baseline careplans have been initiated within 48 hours of admission to the facility to address resident care needs. 4-DON or designee will review new admissions medical record 5 times a week to verify baseline careplan has been initiated withing 48 hours of admission to address resident care needs. Results of the reviews will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		7/21/23

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F 656	Continued From page 18 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to develop a comprehensive care plan for 2 of 34 residents, Resident #26 and Resident #76.

The findings included:

1. For Resident #26 the facility staff failed to develop a care plan for hospice services.

Resident #29's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, atrial fibrillation, anemia, and dementia.

Resident #29's most recent MDS with an assessment reference date of 05/25/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section O, Special Treatments, Procedures, and Programs had no areas marked. This is quarterly MDS assessment.

Resident #29's comprehensive care plan was reviewed and contained no care plan related to hospice/end of life care.

Resident #29's clinical record was reviewed and contained a physician's order summary, which

F656-Develop/Implement
Comprehensive Careplan
1-Resident #29 careplan has been updated to reflect hospice/end
Of life care, resident #76 currently has no skin impairment, his careplan has been reviewed to verify interventions are in place to prevent
skin impairment
2- Current residents enrolled in hospice services and current residents with skin impairment have had careplan reviews and corrections
have been made as necessary.
3-Regional MDS director/designee will educate MDS staff on the requirement to careplan individual resident needs to include hospice/
end of life care and skin impairment
4-MDS coordinators/designee will audit residents with new skin impairments and newly enrolled hospice services have had care plans updated x 4 weeks
5-Results of the reviews will be presented to the
QAPI Committee for review and Recommendation, once
The committee determines the problem no longer
Exist the review will be conducted on a

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F 656	Continued From page 20 read in part "4/28/2023 Hospice consult. One time only for hospice consult for 5 days" and "6/6/2023 Admit to hospice." Resident #29's clinical record contained nurse's progress notes which read in part "Date of Service: 05/03/2023 Chief Complaint/Nature of Presenting Problem: Medication changes, Hospice review ...", "Date of Service: 05/05/2023 Chief Complaint/Nature of Presenting Illness: Advanced directives. History of Present Illness: ... with past medical history of COPD (chronic obstructive pulmonary disease), osteoarthritis, osteoporosis, GERD (gastroesophageal reflux disorder), shingles. Patient is seen today for request by nursing for advanced directives ...Patient is now being followed by hospice" and "5/12/2023 ... (name omitted) aware of new hospice orders." Surveyor spoke with Resident #26's adult child on 06/08/23 at 9:30 am. Surveyor asked adult child when the resident was admitted to hospice services and they replied, "about 3-4 weeks ago." Surveyor spoke with MDS coordinator #1 on 06/08/23 at 10:55 am regarding Resident #26. Surveyor asked MDS coordinator #1 if a care plan should have been developed when resident was admitted to hospice services, and MDS coordinator #1 stated that is should have been. Surveyor asked MDS coordinator #1 in what timeframe should a care plan have been developed, and MDS coordinator #1 stated, "21 days." The concern of not developing a care plan for hospice services for Resident #26 was discussed with the administrator, director of nursing and regional director of clinical services on 06/09/23	F 656	random basis 6-Date of Compliance: July 21, 2023 Administrator and Director of Nursing are responsible for Implementation of POC	

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at 1:45 pm.

No further information was provided prior to exit.

2. For resident #76 the facility staff failed to develop and implement a comprehensive person centered care plan to prevent and treat pressure ulcers.

The findings included:

Resident #76's diagnoses included spinal stenosis of the lumbar region, diabetes type II, severe morbid obesity and chronic pain.

Resident #76's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 3/21/22 had the resident coded as being at risk for pressure ulcers. They were coded as having pressure reducing devices for the bed and the chair. They were coded as requiring extensive assistance with bed mobility and transfers, incontinent of urine and mostly incontinent of bowel. The Care Area Assessment (CAA) worksheet indicated that the resident would be care planned for pressure ulcer risk. The most recent MDS with an ARD of 5/24/23 had the same risk factors coded.

A wound note in the clinical record dated 4/1/22 read in part, "Patient has a stage II pressure ulcer located on (omitted) sacrum. Calmoseptine and Miracle Cream applied. Another intervention, patient is now placed on two hour turn schedule with pillows and wedges".

The care plan was reviewed and a focus for

F 656 Continued From page 22 F 656

pressure ulcer risk was located with a creation date of 5/29/23. The interventions listed were, "encourage adequate nutrition and hydration", and (keep skin clean and dry as possible". There was no mention of a history of pressure ulcers and there were no interventions for assistance with turning and repositioning or for pressure relieving devices.

Surveyor interviewed resident on 6/6/23 at 8:13 AM. Resident stated that they had no current wounds or skin issues. Surveyor noted a pressure relieving mattress on bed and a cushion in the wheel chair. They stated that a year ago they had trouble getting timely assistance for turning, repositioning and toileting. "I don't need as much help now. I'm strong enough to relieve pressure when I need to. I can't turn all the way, but I can shift enough."

On 6/7/23 surveyor interviewed the Director of Nursing (DON) and the Regional Director of Clinical Services. Surveyor asked the DON and (RDCS) if they would expect there to be a care plan for pressure ulcers implemented in April 2022 when resident #76 developed a pressure ulcer. RDCS stated they would expect to see a care plan implemented at that time. Surveyor asked DON and RCDS for any evidence of a care plan update for that time frame. On 6/8/23, RDCS stated to surveyor, "There was no care plan at that time".

The survey team met with the Administrator, DON and RDCS on 6/9/23 at 3:59 PM, this concern was reviewed with them.

No further information was presented to the survey team prior to the exit conference.

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review and staff interview, the facility staff failed to provide services that meet professional standards of quality following a fall for one of 34 residents in the survey sample, resident #366. The findings include: For resident #366, the facility staff failed to perform a physical assessment, notify the physician and update the care plan after a fall on 10/24/22. Resident #366's diagnoses included, but were not limited to an unspecified fracture of the neck, muscle weakness and hypertension. Resident #366's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/22, assigned them a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating they were cognitively intact. The MDS had the resident coded as requiring extensive assistance of one person for bed mobility, transfers, walking and tilting. Review of resident #366's clinical record revealed a progress note labeled late entry for 10/24/22 at 10:10 PM that read, "Writer called to room by assigned CNA (Certified Nursing Assistant). Upon	F 658	F658- Services Provided to Meet Professional Standards 1- Resident #366 has been discharged from the facility 2- Residents with falls in the last 30 days have been reviewed to ensure Resident physician and RP have been Notified, care plan updated, required assessments have been performed. 3-Licensed nurses will be educated by the Staff Development Coordinator /designee on Fall procedures to include notification to the resident□s physician of falls, RP notifications, Caring planning, and required assessments. 4- The DON or designee will audit fall documentation 5 times per week to ensure Resident physician and RP have been Notified, care plan updated, required assessments have been performed. Results of the reviews will be presented to the QAPI committee for review and recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	7/21/23

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entering room CNA was attempting to transfer resident to bed when resident's foot started to slide causing resident to be halfway on bed and buttock on wheel chair. When assisting CNA to transfer resident completely in bed resident continued to slide more causing transfer to be unsafe. Writer had CNA help transfer resident to floor so we can get more help to make a safe transfer. Another CNA helped with assisting resident off floor and back into wheel chair. No complaints noted from resident of pain or discomfort."

A progress note made by the Director of Nursing (DON) dated Late entry for 10/25/22 at 9:30 PM read, "This writer spoke with (adult child) about concerns (adult child) had with night staff taken (name omitted) to the restroom. (Adult child) stated that x 2 staff had not been taking (patient) to the restroom. (Adult child) also upset because patient stated (they) had fallen from w/c (wheel chair) and was not made aware. Upon investigation with staff patient did not fall he was slipping from the chair and staff had to help (them) back up in chair. Nurse who had patient on night in question did reach out to (adult child)."

Surveyor interviewed the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) on 6/9/23 at approximately 9:55 AM regarding resident #366's fall on 10/24/23. Surveyor asked the DON if the facility would consider this a fall and they stated "yes, it was a fall." They stated that they had not been informed of the incident and only became aware of it when the (adult child) called them to ask about it. "I told (them) I'd have to look into it." They stated that initially there was no progress note in the clinical record and they had the nurse come back and

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make a late entry. They stated that they had the nurse to call the (adult child) to explain what happened, "I felt like hearing from the nurse that was here when it happened would be more helpful." Surveyor asked if they would expect the nurse to assess the resident for injury and notify the physician after a fall and they stated that they would. Surveyor asked if they would expect the care plan to be updated and they stated that they would. They reported that the nurse who made the note and was present at the time of the fall, was employed by an agency and was not available for interview.

On 6/9/23 at 10:46 AM surveyor interviewed Licensed Practical Nurse (LPN) #1 regarding the policy regarding falls at the facility. They stated when a resident falls, the nurse should assess the patient for injury, ask how the fall happened, document the fall and the assessment, provide any first aide that might be needed, call the doctor and notify the responsible party. When asked if the physician should be notified for every fall, they stated yes. Surveyor asked if the resident was lowered to the floor by staff during a transfer, would that be considered a fall and they stated it would be.

On 6/9/23 surveyor requested and received a copy of the policy entitled, "Falls Management Program" with an effective date of 3/31/23. The policy read in part, "The center considers all patients to be at risk for falls and provides an environment as safe as practible for all patients." And, "1. A fall is defined as an unintentional change in elevation coming to rest on the ground, onto the next lower surface (e.g., onto a bed, chair, or bedside mat). An episode where a patient would have fallen, if not for staff

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intervention, is considered a fall." Under the Procedure heading, "Fall Occurrence 1. Do not move or reposition patient until a licensed nurse has completed a physical and cognitive assessment. A licensed nurse will: Assess, intervene and promptly provide all the necessary interventions for any patient experiencing a fall. Notify the physician, responsible party, and/or EMS if indicated, as well as the supervisor/administrative personnel as appropriate. Evaluate, monitor, and document patient response for the first 24 hours (3 consecutive shifts) post fall, include a neurological assessment if the fall was unwitnessed and/or the patient hit his/her head. For the next 48 hours a comprehensive assessment will be documented daily. 4. A licensed nurse will review, revise, and implement interventions to the care plan based on: Post Fall Investigation, Review of Device Assessment, Review of Fall Risk Scoring Tool."

There was no indication in resident #366's clinical record that the family was notified, however, resident was listed as their own responsible party and was cognitively intact. There was no indication in the clinical record that the physician was notified of the incident. There was no indication in the clinical record that the resident was assessed for injury other than they were asked if they had any pain.

Resident #366's care plan was reviewed and surveyor was unable to locate an update regarding the fall on 10/24/22.

The survey team met with the Administrator, Director of Nursing and the Regional Director of Clinical Services on 6/9/23 at approximately 3:59

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F 658	Continued From page 27 PM. Surveyor discussed this concern with them at that time. No further information was provided to the survey team prior to the exit conference.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide treatment and care in accordance with the comprehensive person-centered care plan and physician's orders for 8 of 34 residents in the survey sample, Resident #109, #113, #316, #317, #318, #167, #216, and #41. 1. For Resident #109, the facility staff failed to administer medications as ordered by the medical provider and failed to treat a wound to the chest for five days following admission. Resident #109's diagnosis list indicated diagnoses, which included, but not limited to Neuropathy, Muscle Weakness, Cardiogenic Shock, Laceration to Left Front Wall of Thorax, Pericardial Effusion, Cardiac Tamponade,	F 684	F684-Quality of Care 1-Resident #109,#113, #216, #316, #317,#167, have been discharged from the facility. Treatment orders were initiated for resident #318 for venous ulcers to bilateral lower extremities. A skin assessment was completed to verify no new impairment. Medical provider was notified that resident #318 had missed 3 days of ordered treatment to wounds on bilateral lower extremities, medical provider was notified that resident # 41 had received scheduled pain medications outside of acceptable time frames 6 times	7/21/23

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F 684	Continued From page 28 Hypovolemic Shock, and Low Back Pain. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 5/22/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #109's comprehensive person-centered care plan included an intervention dated 5/19/23 to administered medications as ordered. On 6/05/23 at 4:39 pm, surveyor spoke with Resident #109 who stated their medications were late most days. Surveyor reviewed Resident #109's June 2023 medication administration record (MAR), however, the MAR did not include documentation of the exact time the medications were administered. Surveyor requested and received the "Medication Admin Audit Report" for Resident #109 for 6/01/23 through 6/06/23. This report included the scheduled time of administration for each ordered medication, the actual administration time, and the time administration was documented. Resident #109's current physician's orders included an order dated 5/30/23 for Guaifenesin Oral Liquid 10 ml by mouth four times a day for cough and congestion for 14 days. According to the "Medication Admin Audit Report", Guaifenesin was administered late on 12 separate occasions ranging from 32 minutes to 2 hours and 25 minutes late from 6/01/23 through 6/06/23.	F 684	from 6/1/23-6/6/23 , no new orders were given , resident #41 assessed for pain and medical provider notified with no new orders. 2-Interviews of patients and staff were conducted to reveal if there were any situations where treatments, medications, or care were not able to be carried out accordance with person- centered care plan. Issues were addressed as appropriate. 3-DON/designee will educate licensed nurses on administering meds within acceptable time frames, process of obtaining medications from emergency/backup system(Omnicell) and notification to MD if medication or treatments can not be obtained. DON/designee will educate licensed nurses to transcribe and implement wound care orders from discharge summaries to EMR upon admission. 4-DON/designee will audit new admission orders daily during clinical meeting to verify wound care orders have been entered times 4 weeks. DON/designee will audit late/missed medication report daily and corrections will be made as necessary times 4 weeks. 10% of patients will be interviewed for 2 months and asked if there are situations were treatments, medications or care was late or missing. Results of the reviews will be presented to the QAPI committee for review and recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	

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The current physician's orders also included an order dated 5/18/23 for Methocarbamol 500 mg by mouth four times a day for pain. The "Medication Admin Audit Report" indicated the Methocarbamol was administered late on 12 separate occasions ranging from 32 minutes to 2 hours and 25 minutes late from 6/01/23 through 6/06/23.

Resident #109's current physician's orders included an order dated 5/18/23 for Acetaminophen Extra Strength 500 mg two tablets by mouth four times a day for pain. The "Medication Admin Audit Report" indicated the Acetaminophen was administered late on three separate occasions ranging from 48 minutes to 2 hours and 25 minutes late from 6/01/23 through 6/06/23.

On 6/08/23 at 2:34 pm, surveyor spoke with licensed practical nurse (LPN) #2, who administered the resident's medications late on 6/05/23. LPN #2 stated there were two nurses on the unit that shift, and each had 30 residents to give medication to and Resident #109 was at the end of the hall, and they got to them late. Surveyor asked LPN #2 if medications were administered at the time indicated on the report and they stated yes. Surveyor also asked the LPN if they sign the MARs at the time of administration or afterwards and LPN #2 stated they did both.

On 6/09/23 at 8:46 am, surveyor spoke with registered nurse (RN) #2, who administered the resident's medications late on 6/03/23. RN #2 stated Resident #109 got up and walked in the facility, went to therapy and nurses were not allowed to give medications unless it was in their

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room, or a private area and they did not track the resident down. RN #2 stated they try to give medications within the 1 hour before to 1 hour after scheduled timeframe.

Surveyor requested and received the facility policy entitled "Administration Procedures for All Medications" with a revised date of 8/2020 which read in part " ... IV. Administration ...7. After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR ..."

On 6/05/23 at 4:42 pm, surveyor spoke with Resident #109 who stated the wound to their chest was not packed for four days following admission because the nurse stated they did not know how to do the treatment.

According to Resident #109's clinical record, the resident was admitted to the facility on 5/18/23. The hospital discharge summary dated 5/18/23 included instructions stating in part "Discharge Wound Care: Daily dressing changes, pack wound with saline moistened 4 x 4 gauze and cover with dry gauze ..." Surveyor reviewed the resident's physician orders and this order was not transcribed to the resident's admission orders.

Resident #109 was seen by the nurse practitioner (NP) on 5/19/23, the progress note included documentation stating the resident required daily dressing changes to the wound with saline moistened 4x4 and a dry cover dressing.

Resident #109 was seen by the wound NP on 5/22/23, the progress note described the wound to the resident's left upper quadrant as measuring 3.00 cm x 1.00 cm x 2.5 cm with a moderate

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amount of serosanguineous exudate. Treatment recommendations were to cleanse the wound daily with wound cleanser, apply normal saline packed gauze to the base of the wound and secure with bordered gauze.

A physician's order for treatment to the wound was not transcribed until 5/23/23 at 11:06 am and with the first treatment to the area administered on 5/24/23, six days following admission.

On 6/08/23 at 1:14 pm, surveyor spoke with the treatment nurse regarding the reason for Resident #109's treatment not being initiated upon admission. The treatment nurse stated they were not sure why the order was not entered. The treatment nurse further stated they were unaware of the resident when they were admitted and did not know who reviewed the resident.

On 6/09/23 at 4:05 pm, the survey team met with the Administrator, Director of Nursing, and the Regional Nurse and discussed the concern of Resident #109 receiving medications late on multiple occasions and not receiving treatment to a wound as indicated.

No further information regarding this concern was presented to the survey team prior to the exit conference on 6/09/23.

2. For Resident #113, the facility staff failed to administer the antibiotic, Cefepime as ordered by the provider.

This was a closed record review.

Resident #113's diagnosis list indicated diagnoses, which included, but not limited to

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Dementia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Chronic Combined Systolic and Diastolic Heart Failure, and Cardiac Arrhythmia.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 5/11/23 assigned the resident a brief interview for mental status (BIMS) summary score of 4 out 15 indicating the resident was severely cognitively impaired.

Resident #113's physician's orders included an order dated 5/15/23 for Cefepime 1 gram intramuscularly (IM) one time only for infection and an order dated 5/16/23 for Cefepime 1 gram IM one time a day for three days for infection. According to the resident's May 2023 Medication Administration Record (MAR), the Cefepime was never administered.

According to Resident #113's clinical record, the resident was seen by the nurse practitioner (NP) on 5/15/23 with noted lethargy, increased respirations, oxygen saturation level 85-88%, and decrease in oral fluids. An order was given for stat labs including a complete blood count with differential (CBC) and a complete metabolic panel (CMP) due to lethargy and low-grade temperature.

Resident #113 received a one-time order for Cefepime 1 gram IM on 5/15/23 at 4:10 pm. According to the resident's MAR and a nursing note dated 5/15/23 at 7:37 pm, the Cefepime was not administered due to awaiting arrival from the pharmacy.

The 5/15/23 CBC revealed an elevated white

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blood cell count of 14.98 (normal range 4.5 - 10.5) indicating the presence of infection.

Resident #113 was again seen by the NP the following day, 5/16/23. The progress note stated the antibiotic would be continued due to elevated white blood cells (WBCs). An order was provided on 5/16/23 at 10:19 am for Cefepime 1 gram IM one time a day for three days for infection. According to the resident's May 2023 MAR, the Cefepime was never administered. A nursing progress note dated 5/17/23 at 9:47 pm documented the medication was not administered due to awaiting arrival from the pharmacy. Surveyor was unable to locate additional documentation for the reason the Cefepime was not administered on 5/16/23 or 5/18/23.

Another CBC blood test was completed on 5/19/23 and the resident's WBCs remained elevated at 14.7.

Surveyor requested and received a listing of the facility in-house medication supply maintained in the Omnicell. The inventory list indicated Cefepime 1 gram was available in the facility Omnicell supply to be used for Resident #113. The director of nursing (DON) provided a pharmacy packing slip which indicated three vials of Cefepime were received by the facility on 5/17/23 at 1:25 am.

On 6/09/23 at 1:00 pm, surveyor spoke with the NP who stated they believe Resident #113 received the Cefepime, but the nurses did not sign it off on the MAR. NP stated they were constantly checking on the resident asking the staff if the antibiotics and fluid were given, and they were told they were. NP also stated the

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resident was improving as much as possible.

On 6/09/23 at 1:21 pm, surveyor spoke with the DON and asked if they could provide any evidence of the Cefepime being administered and the DON stated no and stated unless you ask the nurse. Surveyor attempted but was unable to reach the nurse who documented they were awaiting arrival of the Cefepime on 5/15/23 and 5/17/23.

Surveyor requested and received the facility policy entitled "Medication Management/Medication Unavailability" with an effective date of 4/21/22 which read in part " ...3. If medications are determined to be unavailable for administration, licensed nurse will notify the provider of the unavailability. Licensed nurse will document notification to the provider of the unavailability in the medical record. Licensed nurse will notify provider of the unavailability of medication and request an alternate treatment if possible. If alternate treatment is not available, then licensed nurse will activate backup pharmacy process and procedures."

Surveyor also requested and received the facility policy entitled "Administration Procedures for All Medications" with a revised date of 8/2020 which read in part " ... IV. Administration ...7. After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR ..."

On 6/09/23 at 4:05 pm, the survey team met with the Administrator, DON, and Regional Nurse and discussed the concern of Resident #113 not receiving the antibiotic Cefepime as ordered by the provider.

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No further information regarding this concern was presented to the survey team prior to the exit conference on 6/09/23.

3. For Resident #316, the facility staff failed to administer Oxycodone, a narcotic used to treat pain, as ordered by the physician on six (6) separate occasions. Facility staff also failed to administer the resident's medications as ordered on the night of 2/06/22.

This was a closed record review.

Resident #316's diagnosis list indicated diagnoses, which included, not limited to Nondisplaced Trimalleolar Fracture of Left Lower Leg, Type 2 Diabetes Mellitus, Major Depressive Disorder, Seizures, Anxiety Disorder, Essential Hypertension, and History of Transient Ischemic Attack, and Cerebral Infarction.

The quarterly minimum data set (MDS) with an assessment reference date (ARD) of 1/31/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.

Resident #316's comprehensive person-centered care plan included a focus area addressing pain with an intervention to medicate as ordered.

Resident #316's physician's orders included an order dated 2/02/22 at 7:36 am for Oxycodone 5 mg by mouth every 6 hours for 5 days, 2/02/22 through 2/07/22.

According to Resident #316's February 2022 Medication Administration Record (MAR), the

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resident did not receive the scheduled Oxycodone 5 mg as ordered on 2/05/22 at 12:00 pm, 6:00 pm, 2/06/22 at 6:00 am, 12:00 pm, 6:00 pm, 2/07/22 midnight, and 6:00 am. A nursing progress note dated 2/05/22 at 11:53 am stated "holding on pharmacy". A nursing progress note dated 2/07/22 at 8:14 am stated "medication not administered due to supply" and a subsequent note at 8:15 am stated "medication not administered, administration aware and preparing to remove from U". Surveyor was unable to determine which medication the nursing notes were referencing. The facility provided a report from the Omnicell in house medication supply indicating Oxycodone 5 mg was removed on 2/07/22 at 7:48 am for Resident #316. This report indicated this was the only Oxycodone 5 mg removed for Resident #316 from 2/01/22 through 2/07/22 at 8:00 am.

On 6/07/23 at 3:38 pm, the Regional Nurse stated there were no narcotic count sheets for Resident #316's Oxycodone 5 mg from 2/05/22 through 2/08/22. The facility was unable to provide evidence that Resident #316 received Oxycodone as ordered on 2/05/22 at 12:00 pm, 2/05/22 at 6:00 pm, 2/06/22 at 6:00 am, 2/06/22 at 12:00 pm, 2/06/22 at 6:00 pm, and 2/07/22 at midnight.

According to the Omnicell inventory supply list provided by the facility, Oxycodone 5 mg was available in the facility for administration for Resident #316 on the above occasions.

On 6/06/23 at 1:44 pm, surveyor spoke with LPN #4 and asked for the acceptable procedure if a resident's pain medication was not available, and LPN #4 stated they would call the pharmacy for a one-time pass code for the Omnicell and if a new

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script was needed they would call the provider for an e-script.

Resident #316's clinical record included a nursing progress note by the director of nursing (DON) dated 2/07/22 at 12:52 pm which stated in part "This writer received message that rsd [resident] had concerns and wanted to speak with someone about them, upon enter [sic] rsd room with discharge planner rsd was asked if she had concerns rsd states she had concerns about time that her medication was giving [sic] the night before. Concerns was addressed ..."

Surveyor requested and received the "Medication Admin Audit Report" for Resident #316 which provided the scheduled time, actual administration time, and documented time for each of the resident's ordered medications. According to Resident #316's "Medication Admin Audit Report", the resident's scheduled 2/06/22 9:00 pm medications including Ambien, Aricept, Lipitor, Oxcarbazepine, Plavix, Metformin, Topamax, Wellbutrin, Baclofen, Docusate, and Prozac were not documented as administered until the following morning, 2/07/22, between 8:17 am and 8:23 am. According to Resident #316's MAR for 2/06/22, the 9:00 pm dose of Humulin 70/30 was not administered due to resident concerns of hypoglycemia and the 9:00 pm dose of Novolog sliding scale insulin was refused by the resident due to hypoglycemia. There was no documentation of a 9:00 pm blood glucose check. Resident #316's blood glucose was checked the following morning and documented as 198 on 2/07/22 at 9:00 am.

Surveyor was unable to interview the nurse providing care for Resident #316 on the night of

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2/06/22 as they were no longer employed by the facility.

Surveyor requested and received the facility policy entitled "Administration Procedures for All Medications" with a revised date of 8/2020 which read in part " ... IV. Administration ...7. After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR ..."

On 6/09/23 at 4:05 pm, the survey team met with the Administrator, Director of Nursing, and the Regional Nurse and discussed the concern of Resident #316 not receiving medications as ordered by the physician.

No further information regarding this concern was presented to the survey team prior to the exit conference on 6/09/23.

4. For Resident #317, the facility staff failed to administer Lipitor 40 mg, a medication used to treat high cholesterol and triglyceride levels, as ordered by the physician.

This was a closed record review.

Resident #317's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Emphysema, Chronic Congestive Heart Failure, Atherosclerotic Heart Disease, Anxiety Disorder, Muscle Weakness, and Difficulty in Walking.

Resident #317's clinical record included a Speech Language Pathology Worksheet which assigned the resident a brief interview for mental status

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F 684	Continued From page 39 (BIMS) summary score of 12 out of 15 indicating Resident #317 was moderately cognitively impaired. Resident #317's admission physician's orders included an order dated 7/12/22 for Lipitor 40 mg by mouth at bedtime for lipid regulation. According to the resident's July 2022 Medication Administration Record (MAR) a "9" indicating "Other/See Progress Notes" was documented for the 7/12/22 9:00 pm administration of Lipitor. A 7/12/22 11:14 pm nursing progress note stated, "on order". Surveyor attempted to interview the writer of the nursing note; however, they were no longer employed by the facility. Resident #317's MAR was blank for the 7/13/22 9:00 pm administration of Lipitor. Surveyor was unable to locate documentation indicating the reason the medication was not administered. On 6/06/23 at 1:44 pm, surveyor spoke with licensed practical nurse (LPN) #4 who stated 4:00 pm was the cut off time to order medications to be delivered from the pharmacy with the 9:00 pm night delivery. LPN #4 stated if the medications had not arrived, they obtain them from the Omnicell and if the medication was not in the Omnicell, they contact the provider and family. Surveyor requested and received the facility Omnicell list of medications available in the facility at the time of Resident #317's admission and the list indicated Lipitor 40 mg was available for administration on 7/12/22 and 7/13/22. On 6/08/23 at 10:17 am, surveyor met with the Administrator, Director of Nursing, and the Regional Nurse and discussed the concern of Resident #317 not receiving Lipitor as ordered.	F 684		

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The Regional Nurse returned at 3:30 pm and stated they could not find where the Lipitor was administered.

Surveyor requested and received the facility policy entitled Medication Management/Medication Unavailability with an effective date of 4/21/22 which read in part " ... 3. If medications are determined to be unavailable for administration, licensed nurse will notify the provider of the unavailability. Licensed nurse will document notification to the provider of the unavailability in the medical record. Licensed nurse will notify provider of the unavailability of medication and request an alternate treatment if possible. If alternate treatment is not available, then licensed nurse will activate backup pharmacy process and procedures."

No further information regarding this concern was presented to the survey team prior to the exit conference on 6/09/23.

5. For Resident #318, the facility staff failed to transcribe and initiate physician's orders for treatment to bilateral lower extremity vascular ulcers present on admission.

Resident #318's diagnosis list indicated diagnoses, which included, but not limited to Encephalopathy, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease Stage 3 A, Congestive Heart Failure, and Generalized Muscle Weakness.

Resident #318 was admitted to the facility on 6/03/23, the Admission/Readmission Nursing Collection Tool dated 6/03/23 included documentation stating in part, " ... Presence of

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bilateral leg ulcers noted, covered with wrapped gauze dressings ..." On 6/05/23, the surveyor reviewed Resident #318's clinical record and was unable to locate a physician's order for treatment to the bilateral leg ulcers.

Resident #318's hospital Discharge Summary dated 6/03/23 documented in part " ...Lower extremity lymphedema. Continue wound care recommendations ...." A 5/30/23 Wound Care Consult provided to the facility from the hospital included treatment recommendations to clean bilateral lower extremities with water and apply Xeroform daily and cover with ADB pad and secure with roll gauze.

On 6/06/23 at 9:58 am, surveyor spoke with the Director of Nursing (DON) and the Regional Nurse and informed them that the resident did not have treatment orders in place for the lower extremity leg ulcers. An order for treatment was entered and treatment was provided to the areas on 6/06/23, three days following admission to the facility.

On 6/09/23 at 8:42 am, surveyor spoke with registered nurse (RN) #1 who stated they help with the resident admission assessments and the primary nurse enters the admission orders. RN #1 stated there should have been treatment orders for Resident #318's bilateral lower extremity ulcers and if there were no orders on the Discharge Summary, the nurse should call the physician for orders.

Surveyor requested and received the facility policy entitled "Physician's Orders" with an effective date of 3/24/20 which read in part " ... 2. b. Admission orders should include: 9) Other

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F 684	Continued From page 42 orders as indicated by patient's condition with specific directions ..." No further information regarding this concern was presented to the survey team prior to the exit conference on 6/09/23. Based on resident interview, staff interview, clinical records review, and facility documentation facility staff failed to provide treatment and care in accordance with the comprehensive person centered care plan and physician's orders. 6. For Resident #167, facility staff failed to ensure medications were administered within acceptable time frames. Resident #167 was admitted to the facility with diagnoses including hypertension, cardiopulmonary disease, acute respiratory failure, chronic kidney disease, muscle weakness, and repeated falls. The Office of Licensure and Certification received a complaint that residents did not receive medications in a timely manner on 9/23/2022. On the Minimum Data Set assessment with assessment reference date 9/13/22, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. On 6/5/2023, the surveyor interviewed the ombudsman by phone and notified of the complaint investigation. The ombudsman reported visiting the facility on that date. The resident and the resident's room mate reported at 11:20 AM that neither had received morning medications scheduled for 8 and 9 AM. The	F 684		

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nurse practitioner was present for the conversation. The ombudsman spoke with the nurse working the medication cart. That nurse stated there were only 2 nurses for 50 residents and they were behind administering medications.

The surveyor interviewed the nurse practitioner (NP#1) on 6/8/23. The NP was unable to confirm the specific date, but stated that residents frequently complain to the NP that medications are late.

The medication administration record (MAR) documented all medications on all days were administered on time. Surveyors interviewed several medication nurses and learned that the charting software allows nurses to tab through the screens where nurses can document reasons for administering medications outside the expected parameters (within 1 hour of the scheduled time). Nurses typically do not document that medications were administered late.

The surveyor obtained the Medication Administration Audit Report for the resident for 9/23/22. Medications scheduled for 9:00 that date were reported as administered between 13:26 and 13:30.

The administrator and director of nursing were notified of the concern with late medication administration during a summary meeting on 6/7/2023.

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7. For Resident #216, facility staff failed to administer pain medication according to orders or within acceptable time frames. The medication was available in Omnicell.

Resident #216's admission record listed diagnoses to include, but not limited to, cerebral infarction, emphysema, fracture of left fibula, fracture of right tibia, type 2 diabetes, atrial fibrillation, morbid obesity, and obstructive sleep apnea. The minimum data set with an assessment reference date of 11/27/21 coded the brief interview for mental status as 13 out of 15. This was a closed record review.

Resident #216's medication administration record (MAR) for December 2021 contained a schedule for Roxicodone Tablet 5 MG (oxyCODONE HCl) Give 2 tablets by mouth every 6 hours for pain for 10 days to start on 12/07/21 at 7:29 p.m. On 12/10/21 at the 12:00 noon dose, the LPN (licensed practical nurse) documented "9" which according to the MAR's chart codes stood for "Other/See Progress Notes." The LPN's progress note, documented on 12/10/21 at 12:49 p.m., read "awaiting pharmacy refill [sic] md aware [sic] called pharmacy".

The Omnicell inventory list dated 10/14/21 listed Oxycodone IR 5mg Tablet as available. The director of nursing (DON) acknowledged the Oxycodone IR 5mg tablet was the same medication ordered for Resident #216 and should have been retrieved and administered. The LPN who documented waiting on the pharmacy refill was an agency nurse who no longer worked at the facility so was not interviewed.

F 684 Continued From page 45 F 684

The regional director of clinical services was interviewed on 06/09/23 at 11:15 a.m. She reported that although two nurses were required to obtain Oxycodone from the Omnicell, there would have been another nurse within the facility. Since the dose for 12/10/21 at noon was on a Friday in the middle of the day, there would have at least been an administrative nurse working that would not have shown up on the schedule. The working schedule for 12/10/21 showed six nurses scheduled for 7 a.m. to 7 p.m. between the two units, 4 agency nurses and two facility employee nurses. One nurse's name said "late" beside it and one agency nurse was coming in at 8 a.m. The regional director stated there should always be two nurses with access to the Omnicell. All nurses should have access, even agency nurses, but even if an agency nurse was on their first day or for some reason did not have access, there should be someone else there be it an on-call nurse, administrative nurse or a nurse from the other unit.

The facility's pharmacy services' policy titled, "Electronic Interim Box," Policy #3.6 with an effective date of 09-2018 and revision date of 08-2020 was reviewed. The policy read, in part, "IV. Nursing Responsibilities for Emergency or Non-Emergency Dosing.... 5. Upon withdrawal of a controlled substance medication from an electronic interim box, an authorized nurse will be prompted by the electronic interim box to obtain a mandatory second nurse witness to verify and electronically document the controlled substance withdrawal amount and remaining inventory balance after medication withdrawal. 6. In the event that only one nurse is available in the facility, additional staff may be given access to the electronic interim box provided the following:

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a. The electronic interim box has the ability to provide "witness only" access and the additional staff member(s) are only granted this access level. b. The staff member(s) is trained and fully understands the responsibilities and implications of performing witness functions. c. The staff member is part of the resident care team within the facility. Housekeeping, maintenance, kitchen etc. staff should never have access to the electronic interim box."

No further information was provided prior to the exit conference.

8. For Resident #41, the facility failed to administered pain medication according to orders or within acceptable time frames. The medication was available in Omnicell.

Resident #41's admission record listed diagnoses to include but not limited to, pain in left hip, severe protein-calorie malnutrition, esophagitis, major depressive disorder, diaphragmatic hernia, gastrointestinal hemorrhage, gastrostomy, and dysphagia. Resident #41's minimum data set with an assessment reference date of 4/11/23 coded the resident's brief interview for mental status summary score a 15 out of 15.

Upon initially meeting Resident #41 in her room on 6/05/23, the resident reported facility staff did not always administer her pain medications on time. The resident specifically mentioning medications at 9:00 a.m. The resident was lying in bed, smiling and had a pleasant demeanor.

Resident #41's clinical record contained a provider order dated 4/06/23 for Oxycodone HCl

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F 684	Continued From page 47 Oral Tablet 5 mg, give 1 tablet via PEG-Tube every 4 hours for pain. Another order dated 4/05/23 read to administer Acetaminophen Oral Solution 650 MG/20.3 ml by mouth four times a day for pain. A review of Resident #41's "Medication Admin Audit Report" for June noted both the Oxycodone and Acetaminophen medications were scheduled to be given daily at 8:00 a.m. For the Oxycodone and Acetaminophen 8:00 a.m. doses due: 1. On 6/06/23 the medications were documented as administered at 10:43 a.m. (1 hr 43 minutes late). 2. On 6/05/23 the medications were documented as administered at 10:37 a.m. (1 hr 37 minutes late). 3. On 6/04/23 the medications were documented as administered at 9:36 a.m. (36 minutes late). 4. On 6/03/23 the medications were documented as administered at 9:26 a.m. (26 minutes late). 5. On 6/02/23 the medications were documented as administered at 10:24 a.m. (1 hr 24 minutes late). 6. On 6/01/23 the medications were documented as administered at 11:02 a.m. (2 hrs 2 minutes late). The DON reported the medication nurses have a window of time in which to administer medications. The window was one (1) hour before the medication was due until one (1) hour after the medication was due. (e.g. For a medication scheduled to be administered at 8:00 a.m., the nurses could administer the medications between 7:00 a.m. and 9:00 a.m. and still be considered administered on time.) The DON acknowledged Resident #41 had received medications late.	F 684		

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One of the licensed practical nurses (LPN #2) working on Unit 1 with Resident #41 was interviewed in person on 6/08/23 at 2:25 p.m. The nurse reported when there were two (2) nurses on Unit 1 instead of three (3) nurses, that meant there were about 30 residents to receive medications in the mornings and there were a lot of interruptions. Resident #41's room was at the end of the hall and "it is late when I get to her sometimes."

Two policies were provided, 1. Pain Management Assessments, Policy Number 2201 effective 11/01/19, and 2. Administration Procedures for All Medications (a pharmacy provider's policy), policy #9.1 effective 09-2018 with revision date 08-2020. Neither policy addressed timing of medications and/or late administration of medications.

The facility's pharmacy services' policy titled, "Electronic Interim Box," Policy #3.6 with an effective date of 09-2018 and revision date of 08-2020 was reviewed. The policy read, in part, "IV. Nursing Responsibilities for Emergency or Non-Emergency Dosing.... 5. Upon withdrawal of a controlled substance medication from an electronic interim box, an authorized nurse will be prompted by the electronic interim box to obtain a mandatory second nurse witness to verify and electronically document the controlled substance withdrawal amount and remaining inventory balance after medication withdrawal. 6. In the event that only one nurse is available in the facility, additional staff may be given access to the electronic interim box provided the following: a. The electronic interim box has the ability to provide "witness only" access and the additional staff member(s) are only granted this access

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F 684	Continued From page 49 level. b. The staff member(s) is trained and fully understands the responsibilities and implications of performing witness functions. c. The staff member is part of the resident careteam within the facility. Housekeeping, maintenance, kitchen etc. staff should never have access to the electronic interim box." During an end of day summary meeting with the administrator, DON, and regional director of clinical services on 6/07/23, the concern regarding late medication administration was discussed.	F 684		
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 resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure each resident receives adequate supervision and assistive devices to prevent accidents for one of 34 sampled residents (Resident # 76). The findings include: For resident #76, the facility staff failed to ensure resident #76 had the assistance of two staff members during a transfer using a mechanical	F 689	F689-Free of Accidents Hazards/supervision /Devices 1-Resident #76 has been assessed for injuries from accident no injuries have been identified. 2-Current Residents who are transferred by lift were reviewed to ensure adequate supervision and assistive devices. 3-DON/designee will educate current direct care staff the proper use of lift to include the use of two staff members during a Hoyer lift transfer.	7/21/23

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lift, causing them to fall.

Resident #76's diagnoses included but were not limited to, spinal stenosis of the lumbar region, severe morbid obesity and chronic pain.

The annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/24/23 did not assess resident #76's cognition, but prior assessments were coded them as being cognitively intact and during multiple interviews with surveyor, resident #76 was oriented to person , place, time and situation. The most recent MDS is coded to indicate that resident #76 requires extensive assistance of two or more with transfers.

On 6/6/23 at 8:19 AM resident #76 reported to the surveyor that they had a fall from the lift on May 28, 2023. They stated that the Certified Nursing Assistant (CNA) assigned to them was transferring them from the wheel chair to the bed using a lift and they "stepped away from me, I don't know where (gender omitted) went, and the next thing I knew, I was in the floor and the lift was on top of me". Resident denied injury other than being sore. Surveyor asked resident #76 if the CNA had left the room and they stated, "I don't think so". Surveyor asked resident if it was common practice for only one staff member to assist with transfers and they stated no, "All the regular ones know it takes two people, I don't want that one in here anymore".

Surveyor reviewed the clinical record and noted a progress note labeled "Fall Note" that was dated 5/28/23 at 4:00 PM. The note read in part, "What are the risks that could have contributed to the fall: proper lift use. What new interventions were

4-DON/designee will observe 4 Hoyer lift transfers weekly x 4weeks, then 4 lift transfers a month for 2 additional months to ensure proper use by staff. Results of the reviews will be presented to the QAPI Committee for review and Recommendation.
5- Date of Compliance: July 21, 2023
6- Director of Nursing will be responsible for this POC.

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F 689	Continued From page 51 implemented in response to the fall: CNA in-serviced on proper lift use for safety". The care plan was reviewed and the activities of daily living care plan included an intervention that read, "two person assist transfer". On 6/6/23 at 2:45 PM surveyor interviewed the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS). The DON stated that the CNA involved worked for an agency. At the time of the incident they were educated on proper use of the lift to include the use of two staff members but they refused to sign the document. The DON went on to say that they contacted the agency to make sure the CNA was marked as "do not return" to the facility. Surveyor asked how many staff should be present during a transfer with a lift and the DON stated that the expectation is that two staff members should be present any time a lift is used for transfers. Surveyor asked what sort of training or orientation is given to agency staff before working with the residents and they stated "whatever the agency provides." On 6/6/23 at 3:00 PM, surveyor interviewed Licensed Practical Nurse (LPN) #4 who was assigned to resident #76 on 5/28/23. They stated that they were at the nurse's station when the incident occurred and the CNA came to the desk and stated that when they were putting resident #76 to bed, they fell. They stated that they asked the CNA, "Were you in here by yourself?" and the CNA replied, "I always get (omitted) up by myself." LPN #4 stated that they prepared an in-service for the CNA but they refused to sign it and stated, "it's not my fault." LPN #4 stated the CNA then left the facility and did not return to finish the shift.	F 689		

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F 689	Continued From page 52 On 6/8/23 The DON provided the surveyor with a 36 page booklet entitled, "Gale Healthcare Education" for the CNA who was involved in the fall. The booklet had the CNA's name typed in on the title page and the last page had a signature with a date of 5/23/23. A section entitled, "Strategies to prevent falls" begins on page 19. On page 20, the first paragraph reads in part, "Facility supervisors have specific policies and procedures in place to address falls within their facility and it is up to you as a clinician to assist with these policies and procedures when you are working with the residents." The last paragraph reads in part, "...please ensure that you are familiarizing yourself with the facilities fall policies and procedures." The DON also provided the surveyor with a record of staff in-service dated 1/12/23 entitled, "Fall precautions". The sign in sheet did have the signature of the CNA involved in resident #76's fall, however the contents of the in-service did not include anything about using a lift. The facility was unable to produce documentation that the CNA had been educated or trained on the mechanical lift prior to using it. Surveyor requested and received the policy entitled, "Mechanical Lift" with an effective date of 11/1/19. The policy read in part, "1. Two nursing staff must assist with mechanical lift and transfer." On 6/9/23 at 3:59 PM, the survey team met with the Administrator, the DON, and the RDCS. This concern was reviewed. No further information was provided to the survey team prior to the exit conference.	F 689		

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F 695	Continued From page 53	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure that a resident who needs respiratory care, is provided such care consistent with professional standards of practice for 1 of 34 residents in the survey sample, Resident #320. The findings included: For Resident #320, the facility staff administered oxygen without a physician's order. Resident #320's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Acute Pulmonary Edema, Sepsis, Emphysema, Acute Respiratory Failure, Acute on Chronic Diastolic Heart Failure, and Generalized Muscle Weakness. The Medicare 5-Day minimum data set (MDS) with an assessment reference date of 6/05/23 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 indicating the resident was moderately cognitively	F 695	F695-Respiratory/Trach care and Suctioning 1-Res #320 has been discharged from the facility 2-Current residents using oxygen have reviewed to verify physician□s orders and corrections have been made as necessary. 3-DON/designee will educate current licensed nurses to ensure residents using oxygen have physician orders have been initiated. 4-DON/designee will audit 10% of residents using oxygen weekly to ensure current Physician orders times 4 weeks, then 10% a month times 2 months. Results of the reviews will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	7/21/23

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impaired. Resident #320 was coded as receiving oxygen while a resident within the last 14 days.

On 6/05/23 at 4:08 pm and again on 6/06/23 at 10:55 am, surveyor observed Resident #320 in bed receiving oxygen via nasal cannula with the oxygen concentrator set at 2 liters per minute (L/M).

Surveyor reviewed Resident #320's clinical record and was unable to locate a physician's order for oxygen administration.

Resident #320's comprehensive person-centered care plan included a focus area dated 6/05/23 stating the resident was at risk for respiratory complications with an intervention to administer oxygen as ordered.

Resident #320 was readmitted to the facility on 6/01/23, the "Admission/Readmission Nursing Collection Tool" dated 6/01/23 indicated the resident was receiving oxygen via nasal cannula at 3 L/M.

On 6/06/23 at 3:40 pm, the survey team met with the Administrator, Director of Nursing, and the Regional Nurse and discussed the concern of Resident #320 receiving oxygen without a physician's order. An order for the resident to receive oxygen via nasal cannula at 2 L/M was then obtained on 6/06/23 at 3:59 pm.

On 6/09/23 at 8:39 am, surveyor spoke with registered nurse (RN) #1 who stated they did the admission assessment, but the primary nurse entered the admission orders from the discharge summary. RN #1 stated the resident should have had an order for oxygen.

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F 695	Continued From page 55 Surveyor requested and received the facility policy entitled "Physician's Orders" with an effective date of 3/24/20 which read in part "... 2. b. Admission orders should include: ... 9) Other orders as indicated by patient's condition with specific directions ..." No further information regarding this concern was presented to the survey team prior to the exit conference on 6/09/23.	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 resident interview, clinical record review, and staff interviews the facility staff failed to ensure that pain management was provided for a resident in accordance with professional standards, and the resident's preferences for one of 34 residents, Resident #41. The findings were: For Resident #41, the facility failed to administer scheduled pain medication according to orders, or within acceptable time frames. The medication was available in the Omnicell. Resident #41's admission record listed diagnoses to include but not limited to pain in left hip, severe	F 697	F697-Pain Management 1-Resident #41 was assessed for pain. Medical Provider has been Notified that resident had missed 2 doses of scheduled pain Medication on 6/9/2023 . Medication error was documented of Omissions in ordered pain meds. 2-Current residents with scheduled pain medications were reviewed to ensure pain medication was available in medication carts, and an individual pain assessment and pain had been documented. 3-DON/designee will educate licensed nurses on medication administration and pain management. 4-DON/designee will conduct pain	7/21/23

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F 697	Continued From page 56 protein-calorie malnutrition, esophagitis, major depressive disorder, diaphragmatic hernia, gastrointestinal hemorrhage, gastrostomy, and dysphagia. Resident #41's minimum data set with an assessment reference date of 4/11/23 coded the resident's brief interview for mental status summary score a 15 out of 15. The residents care plan included a focus area that read the resident was at risk for pain related to left hip pain. Interventions included: administer medications as ordered, observe for physical indicators of pain, and pain assessment as needed. Another focus area read, "OPIOIDS: the resident is at risk for complications related to the use of opioid secondary to left hip pain." Interventions included: administer medications as ordered, observe for signs and symptoms of over sedation, lethargy and or respiratory complications and notify MD as indicated, pain assessment as needed, and record and track bowel movements. On 6/09/23 at 1:25 p.m. the surveyor interviewed Resident #41 and asked whether the resident felt her pain was managed well. Resident #41 was awake, pleasant and smiling reported that although she had received her pain medication today and was feeling good presently, she did not think she received her pain medication at all overnight. "I didn't rest at all last night. I kept expecting the med nurse to come in, but I don't think she ever did." The resident said when she clicked her call bell button, a CAN (certified nursing assistant) came to the room and said she would get the nurse to come but the nurse did not come, nor did the nurse give the resident her pain medication. The resident stated, "Even this morning, I only just got it and I do get uncomfortable. I mean I couldn't rest at all last	F 697	interview with 4 residents weekly x4 weeks to verify adequate pain management, and will also audit EMR of 4 residents with orders for scheduled pain meds to verify doses are given as ordered x4 weeks. Results of the reviews will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	

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night."

On 6/09/23 at 1:31 p.m., the surveyor requested Resident #41's pain medication administration times from that night from the director of nursing (DON). The administrator was present in the DON's office at the time the surveyor requested the document.

Resident #41's clinical record contained a provider order dated 4/06/23 for Oxymoron HI Oral Tablet 5 mg, give 1 tablet via PEG-Tube every 4 hours for pain. Another order dated 4/05/23 read to administer Acetaminophen Oral Solution 650 MG/20.3 ml by mouth four times a day for pain.

The Omnicell Inventory list dated 4/14/23 was reviewed and noted Oxymoron IRC 5 mg Tablet was available in the system. The regional director of clinical services acknowledged that medication was available to be retrieved from the system.

The DON provided Resident #41's current medication administration record (MAR) for June 2023. The Oxycodone order was scheduled to be administered at midnight, 4:00 a.m., 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. every day. A pain level assessment accompanied each dose on the MAR. For the previous evening and night, the nurse documented:
1. 6/08/23 8:00 p.m. dose: Pain level was noted as an "X" with "5" noted above the nurse's initials. The chart code on the MAR indicated "5" meant "Hold / See Progress Notes." The "Medication Admin Audit Report" noted the Oxycodone dose scheduled for 6/08/23 at 8:00 p.m. (20:00) was documented at 9:14 p.m. (21:14). A progress

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note dated 6/08/23 at 9:14 p.m. and written by the same nurse who documented on the MAR read, "on order".
2. The next scheduled dose of Oxycodone was for 6/09/23 at 0000 (midnight - 4 hours following the 8:00 p.m. dose) per the MAR. The pain level was "0" with "5" noted above the nurse's initials. The "Medication Admin Audit Report" noted the Oxycodone dose scheduled for 6/09/23 at 0000 was documented on 6/08/23 at 11:52 p.m. (23:52). A progress note dated 6/08/23 at 11:51 p.m. (23:51) and written by the same nurse who documented on the MAR read, "on order".
3. 6/09/23 4:00 a.m. dose: Pain level was "5" with "5" noted above the nurse's initials. The "Medication Admin Audit Report" noted that Oxycodone dose was documented on 6/09/23 at 5:45 a.m. A progress noted dated 6/09/23 at 5:45 a.m. and written by the same nurse who documented on the MAR read, "med on order from pharmacy".
4. 6/09/23 8:00 a.m. dose: Pain level was "0" with a check documented above the nurse's initials. The "Medication Admin Audit Report" noted the medication was administered at 9:58 a.m. (58 minutes late.)
5. 6/09/23 12:00 noon dose: Pain level was "0" with a check documented above the nurse's initials. The "Medication Admin Audit Report" noted the medication was administered at 1:13 p.m. (13:13). (13 minutes late.)

The scheduled Acetaminophen pain medication was scheduled to be administered at 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. The three (3) doses scheduled to be administered between 6/08/23 at 8:00 p.m. and 6/09/23 at 12:00 noon were administered however, they were documented as administered more than one hour

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later than the scheduled time:
1. The 6/08/23 8:00 p.m. (20:00) dose was administered at 9:12 p.m. (21:12) per the "Medication Admin Audit Report". Pain was documented as "0".
2. The 6/09/23 8:00 a.m. dose was administered at 10:07 a.m. per the "Medication Admin Audit Report". Pain was documented as "0".
3. The 6/09/23 12:00 noon dose was administered at 1:13 p.m. (13:13) per the "Medication Admin Audit Report". Pain was documented as "0".

Resident #41 was re-interviewed by the surveyor on 6/09/23 at 2:35 p.m. The resident described her pain as "sharp pain on left side down into knee, all on left side." She touched her left side approximately around her rib cage with her hand and ran her hand all the way down her left side and thigh. The resident reported the pain kept her from resting and stated, "I usually rest well." She stated she had received her pain medication at 1:30 p.m. today "so feeling better now."

The survey team met with the administrator, DON, and regional director of clinical services on 6/09/23 at 2:53 p.m. to inform them of concerns described above related to Resident #41's pain management and pain medication administration times. The DON stated the staff should have found a way to give the pain medication. The nurse should have spoken to the night supervisor and gotten it out of the Omnicell. The administrator reported the nurse who did not administer Resident #41's pain medication last night was not part of the medication administration training the facility had provided recently. (The administrator had provided in-service sign-in sheets for medication

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administration training on 6/07/23). The administrator said Resident #41's pain level was often documented as a 6 (six) when medications were given. The surveyor requested a copy of the facility's policy for pain management. The DON reported the medication nurses have a window of time in which to administer medications. The window was one (1) hour before the medication was due until one (1) hour after the medication was due. (e.g. For a medication scheduled to be administered at 8:00 a.m., the nurses could administer the medications between 7:00 a.m. and 9:00 a.m. and still be considered administered on time).

Two policies were provided, 1. Pain Management Assessments, Policy Number 2201 effective 11/01/19, and 2. Administration Procedures for All Medications (a pharmacy provider's policy), policy #9.1 effective 09-2018 with revision date 08-2020. The pain management policy read in part, "3. Administration of pain medication and effectiveness will be documented." And, "5. If pain is not relieved, notify physician. Any unusual findings and follow-up interventions are to be documented on the Progress Notes including notification of physician and responsible party." Neither policy addressed timing of medications and/or late administration of medications.

The facility's pharmacy services' policy titled, "Electronic Interim Box," Policy #3.6 with an effective date of 09-2018 and revision date of 08-2020 was reviewed. The policy read, in part, "IV. Nursing Responsibilities for Emergency or Non-Emergency Dosing.... 5. Upon withdrawal of a controlled substance medication from an electronic interim box, an authorized nurse will be prompted by the electronic interim box to obtain a

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mandatory second nurse witness to verify and electronically document the controlled substance withdrawal amount and remaining inventory balance after medication withdrawal. 6. In the event that only one nurse is available in the facility, additional staff may be given access to the electronic interim box provided the following: a. The electronic interim box has the ability to provide "witness only" access and the additional staff member(s) are only granted this access level. b. The staff member(s) is trained and fully understands the responsibilities and implications of performing witness functions. c. The staff member is part of the resident care team within the facility. Housekeeping, maintenance, kitchen etc. staff should never have access to the electronic interim box."

The administrator returned to the conference with multiple cards of different colored paper which were connected by a ring and reported there was no pain policy, but he had gotten these cards from the MDS staff (minimum data set). The MDS staff used these cards to assess pain. The administrator showed one card with a pain scale from one (1) to ten (10). He stated a pain level of 5 would be considered mild. When asked what a pain level of 1 or 2 would be, the administrator did not respond but looked at another card which read the pain scale started at no pain, mild pain, moderate pain, and severe pain. A surveyor asked what pain level was acceptable and the administrator replied that everyone's pain was individual.

The regional director of clinical services reported to the survey team that she had spoken with Resident #41 since this concern was identified. The resident reported to the director that she (the

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F 697	Continued From page 62 resident) had slept until about 2:00 a.m. last night and was then awake the rest of the night. The director had asked Resident #41 what pain level she could have and still be able to function, and the resident responded, six (6). No further information was provided prior to the exit conference.	F 697		
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 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.	F 725		7/21/23

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F 725	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical records reviews facility staff failed to ensure sufficient nursing staff to assure resident safety and maintain the highest practicable well-being for one of two nursing units. (Unit 1) During the survey, surveyors investigated 3 complaints alleging there was not sufficient staff to provide care as needed. Two directly addressed medication administration. Review revealed that on 9/23/22, three of 7 nurses scheduled to work that day shift called out. The resident named in the complaint (Res #167) received medications scheduled for 8 or 9 AM at 13:30. The ombudsman and the nurse practitioner verified the complainant's allegation. The administrator and director of nursing were made aware of the concern during a summary meeting on 6/8/23.	F 725	F725-Sufficient Nursing Staff 1-Residnet #167 has been discharged from the facility 2. Current staffing schedules were reviewed to ensure adequate facility staff. Contract Staff were added where gaps were identified. 3. DON/designee will educate current licensed nurses on timely medication administration and contingency staffing plans. 4. Administrator or designee will audit staffing as worked schedules including call outs 5 times a week for 4 weeks and Monthly for 2 additional months to ensure adequate nursing staff. Results of the reviews will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Administrator will be responsible for this POC.	
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.	F 727		7/21/23

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F 727	Continued From page 64 §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, facility document review and CMS report the facility staff failed to ensure the services of a registered nurse for at least 8 consecutive hours per day on 6 dates in one fiscal quarter. The PBJ (payroll based journal) staffing data report for January 1-March 31 2022 listed 8 dates with no RN hours reported. The surveyor reviewed the daily staffing sheets for those dates with the director of nursing. On 2 of those dates, 2/6/22 and 2/26/22, a registered nurse supplied by an agency worked 7AM-7PM. On the remaining dates (1/29/22, 2/5/22, 2/19/22, 2/20/22, 3/5/22, and 3/19/22) no registered nurse worked in the facility. The administrator and director of nursing were made aware of the concern during a summary meeting on 6/8/23.	F 727	F727-RN 8hours /7days week/Full Time DON 1. Facility currently has required 8 hours Registered Nurse coverage in center. 2. Current staffing schedules were reviewed to ensure required 8 hours of RN coverage. Contract Staff were added where gaps were identified. 3. Administrator or designee will educate the Staff scheduler on requirement to have 8 hours of registered nurse coverage per day and contingency staffing plans. 4. Administrator or designee will review weekly staffing to ensure registered nurse coverage 8 hours per day is maintained weekly for 4 weeks, then monthly thereafter. Results of the reviews will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Administrator will be responsible for this POC.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		7/21/23

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F 760	Continued From page 65	F 760		

Based on staff interview and clinical record review the facility staff failed to ensure 2 of 34 residents were free from significant medication error.

The findings included:

1. For Resident #26 the facility staff administered the antihypertensive medications metoprolol and amlodipine outside of the physician ordered parameters.

Resident #29's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, atrial fibrillation, and hypertension.

Resident #29's most recent MDS with an assessment reference date of 05/25/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #29's comprehensive care plan was reviewed and contained a care plan for "The resident has potential for altered cardiovascular status r/t (related to) HLD (hyperlipidemia, HTN (hypertension)."

Resident #29's clinical record was reviewed and contained a physician's order summary, which read in part "Metoprolol Tartrate Tablet 25 mg. Give 1 tablet by mouth every morning and at bedtime related to essential (primary) hypertension-hold med if SBP (systolic blood pressure) reads < (less than) 100" and "Norvasc Tablet 10 mg (amlodipine Besylate). Give 1 tablet by mouth in the morning related to essential

F760-Residents are free of Significant Med Errors
1-Medical provider made aware of medication errors
For resident # 29 and resident #70. No new orders at this time were received.
2- An audit of medications with administration parameters was conducted to ensure parameters were properly documented and being followed per physician order.
3-DON/designee will education current licensed nurses on administration of medications with Blood pressure parameters, and insulin administration as ordered.
4-DON/designee will audit scheduled insulin orders, and blood pressure medications with parameters weekly for 4 weeks and Monthly for 2 additional months to ensure medications are being administered per physicians orders.
Results of the reviews will be presented to the QAPI Committee for review and Recommendation.
5- Date of Compliance: July 21, 2023
6- Director of Nursing will be responsible for this POC.

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F 760	Continued From page 66 (primary) hypertension-hold med is SBP reads < 100." Resident #29's medication administration record for the month of May 2023 was reviewed and contained entries as above. The entry for metoprolol was initialed as administered on 05/21/23 at 9:00 pm with a blood pressure of 98/67 and on 05/22/23 at 9:00 am with a blood pressure of 98/67. The entry for amlodipine was initialed as administered on 05/22/23 with a blood pressure of 98/67. The concern of administering the resident's antihypertensive medications outside of the physician ordered parameters was discussed with the administrator, director of nursing, and regional director of clinical services on 06/09/23 at 1:45 pm. No further information provided prior to exit. 2. For Resident #70 the facility staff failed to administer the resident's insulin per the physician's orders. Resident #70's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus, protein calorie malnutrition, and morbid obesity. Resident #70's most recent minimum data set with an assessment reference date of 05/26/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.	F 760		

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F 760	Continued From page 67	F 760		

Resident #70's comprehensive care plan was reviewed and contained a care plan for "Diabetes Mellitus: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus with: insulin use." Interventions for this care plan included "administer insulin as ordered."

Resident #70's clinical record contained a physician's order summary, which read in part "Lantus Solostar Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Glargine). Inject 34 units subcutaneously at bedtime related to Type 2 diabetes mellitus without complications (E11.9)-order date 05/25/23-D/C (discontinue date)-05/30/23."

Resident #70's electronic medication administration record (eMAR) for the month of May 2023 was reviewed and contained an entry, which read in part "Lantus Solostar Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Glargine). Inject 34 units subcutaneously at bedtime related to Type 2 diabetes mellitus without complications (E11.9)-order date 05/25/23-D/C (discontinue date)-05/30/23." This entry had not been initialed as given on 05/25/23, 05/26/23 or 05/27/23.

Resident #70's nurse's progress notes were reviewed, and surveyor could not locate any notes related to the administration of insulin.

Surveyor spoke with director of nursing (DON) on 06/08/23 at 2:30 pm regarding Resident #70's insulin. On 06/09/23 at 1:00 pm, DON stated they had no explanation for the blanks on the eMAR.

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F 760	Continued From page 68 The concern of not administering the resident's insulin per the physician's order was discussed with the administrator, director of nursing, and regional director of clinical services on 06/09/23 at 1:45 pm. No further information provided prior to exit.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The findings included:	F 812	F812-Food Procurement 1-Expired was food immediately removed from the center. 2-Food storage areas were reviewed to ensure that no expired foods was present. 3. Dietary staff will be educated by the Dietary Manager on auditing food	7/21/23

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F 812	Continued From page 69 During a tour of the facility kitchen on 6/5/23 at 2:06 PM, the surveyor noted 4 containers of expired food in the walk- in cooler. The first container was a 5 pound container of sour cream with an expiration date of 3/23/23. The clear plastic film covering the opening was intact indicating it had not been used. The second container was a 5 pound container of cottage cheese with an expiration date of 3/21/23. The clear plastic film covering the opening was intact. The third container was a 5 pound container of cottage cheese with an expiration of 4/22/23. The clear plastic film was intact. The fourth was a 5 pound container of cottage cheese with an expiration of 2/12/23, the clear plastic film was intact. Surveyor interviewed the Dietary Manager who had no knowledge of the expired food and stated that it was their first day on the job. They informed the surveyor that there had not been a manager in place for several months. They took the expired food and disposed of it immediately. The survey team met with the Administrator, Director of Nursing and the Regional Director of Clinical Services on 6/9/23 at 3:59 PM and this concern was discussed. No further information was presented to the survey team prior to the exit conference.	F 812	storage areas daily and verifying expiration dates. 4-Regional Director of Dietary services or designee will complete weekly center walk in cooler audits to ensure foods are within current date time 4 weeks then monthly for 2 additional months. Results of the reviews will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Regional Director of dietary services will be responsible for this POC.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		7/21/23

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F 880	Continued From page 70 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: (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	F 880		

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F 880	Continued From page 71 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 observations, resident family interview, staff interviews, and clinical record review facility staff failed to maintain an effective infection control and prevention program for one of 34 residents (Resident #22) The findings were: For Resident #22, the facility staff failed to initiate transmission-based precautions (TBP) when concern for C-diff was identified. Resident #22's admission record listed diagnoses to include, but not limited to, pain due to internal orthopedic prosthetic devices, morbid obesity, protein-calorie malnutrition, anxiety disorder,	F 880	F880-Infection Prevention& Control 1-Resident #22 has been discharged from the facility 2-Current residents in the center with pending labs for or suspicion of a TBP condition were reviewed to ensure that that TBP□s were properly initiated and documented. 3-DON/designee will educate current nursing staff on initiating transmission-based precautions when concern for cdiff has been identified. 4-Infection Preventionist or designee will complete a twice weekly inspections time 4 weeks of units to ensure TBP have been initiated on residents with concern of	

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F 880	Continued From page 72 major depressive disorder, chronic kidney disease stage 3, and type 2 diabetes mellitus. Resident #22's minimum data set with an assessment reference date of 5/11/23 coded the resident's brief interview for mental status summary score a 15 out of 15. Prior to meeting any residents on Unit 1's 100 hallway on 6/05/23, the surveyor asked the Unit 1 staff whether any resident was on TBP. The staff denied anyone being on transmission-based precautions. No TBP notifications on residents' doors or carts with personal protective equipment (PPE) was observed on Unit 1. Resident #22's husband was interviewed in person while the resident was sleeping on 6/05/23. When the surveyor entered the room on Unit 1, there was a certified nursing assistant (CNA) straightening the sheets on one side of the bed and emptied the garbage can before leaving the room. During the interview, the husband reported the facility staff were running tests to determine whether the resident had C-diff (Clostridioides difficile - bacteria that causes diarrhea and colitis). The resident was in a private room which had no notifications on the door or personal protective equipment (PPE) outside the door to indicate the resident was on transmission-based precautions. Resident #22's clinical record did not contain an order for TBP. On the morning of 6/06/23, there was no notifications on Resident #22's door and no personal protective equipment outside the door noted. The administrator, director of nursing, and regional director of clinical services were informed of the concern about Resident #22's	F 880	c-diff has been identified. Results of the reviews will be presented to the QAPI Committee for review and Recommendation. 5- Date of Compliance: July 21, 2023 6- Director of Nursing will be responsible for this POC.	

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Continued From page 73

TBP status on 6/07/23. The regional director of clinical services reported the expectation would be for the resident to have TBP starting when the possibility of C-diff was identified.

On 6/08/23 at 10:45 a.m., the Unit 1 manager (LPN #3) and LPN #2 were interviewed at the Unit 1 nurses' station about Resident #22's C-diff status. The nurses stated the resident's antibiotic had been changed as of that day. LPN#2 reported the stool sample had been obtained and sent but was rejected due to inconsistent identifying information. The plan was to resend the specimen with Resident #22's next bowel movement.

On 6/09/23, the director of nursing provided a list of Resident #22's orders that included an order for "Contact Precautions: Special Enteric" dated 06/07/23. The order for a "Stool for Cdiff - one time only for 2 days" was dated 6/05/23 at 10:30 a.m.

The facility's infection preventionist (IP), a licensed practical nurse (LPN #10) was interviewed on 6/09/23 at 11:09 a.m. The IP reported the TBPs for Resident #22 began on Wednesday, 6/07/23 and the expectation was Resident #22 would remain on contact precautions at least until the results from the stool study were known and C-diff was either ruled out or not.

No further information was provided to the survey team prior to exit.