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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/25/23 through 07/28/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/25/2023 through 07/28/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 65 certified bed facility was 63 at the time of the survey. The survey sample consisted of 44 resident reviews and 25 employee record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to assess for appropriateness of self-administration of medications for 1 Resident (Resident #23) in a survey sample of 44 Residents.	F 554	Resident #23 was assessed by nurse on 8/14/23 for ability to self-administer medications. Physician order was obtained for self-administration of medication on 8/14/23. Care plan was updated to reflect this change 8/14/23.	9/11/23

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

Electronically Signed | 08/18/2023

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F 554	Continued From page 1 The findings included: For Resident #23, the facility allowed the Resident to have physician ordered ointment, at the bedside, without first assessing the Resident's ability to self-medicate. On 7/25/23 at 3:31 PM, Resident #23 was noted to have a medication cup of a clear ointment at the bedside, unsecured. On 7/25/23 at approximately 3:35 PM, Surveyor C had LPN B accompany her to the room of Resident #23. When asked what the cup of ointment was, LPN B said, she didn't know. When asked if it should be at the bedside, LPN B said, "No" and discarded it in the trash. LPN B then went to the nursing station and looked at Resident #23's physician orders and noted an order for Neosporin ointment that is to be applied twice daily. LPN B said, it must have been left there from the night shift. On 7/25/23, a clinical record review was conducted of Resident #23's chart. This chart revealed no physician order, no assessment of their ability to safely self-administer medications, nor a care plan to indicate the Resident was able to self-administer medications. Also noted in the clinical record, in the admission documents was a document titled, "Self-Administration of Medication Consent Form" that indicated "No, I do not want to exercise my right to self-administer my medications". A physician order dated 7/4/23, was noted that read, "Neosporin Original External Ointment (Neomycin Bacitracin Polymyxin), Apply to groin rash topically two times a day for groin rash".	F 554	All residents have the potential to be affected by this practice. A sweep of resident rooms was conducted on 07/28/23 to ensure there were no additional medications at bedside not properly managed per the self-administer medication policy /procedure. No other residents were identified as being negatively impacted. All Licensed Nursing Staff were educated by the Clinical Services Director on the requirements of F554 and the Medication Self Administration policy and the importance of completing the self-administration assessment if applicable. This includes leaving medications at bedside for residents to administer at a later time. Education completed by 09/01/23. All staff were provided education regarding the on-going monitoring of items in resident rooms to make sure no medication is stored in the rooms, and if discovered it is returned to the nurse immediately for proper storage. Education completed by 09/01/23. The Director of Nurses/Clinical Services Director will monitor all new admissions for self-administration assessment completion if appropriate. Angel rounds now includes checking the resident□s rooms for any medications that should be secured. Director of Nursing or Clinical Services Director will conduct random environmental rounding weekly x 4 and then monthly x 2.	

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F 554	Continued From page 2 On 7/27/23 at 2:40 PM, an interview was conducted with Employee H, who was a Registered Nurse (RN). Employee H develops the nursing care plans for Residents within the facility and when asked about Residents who self-administer medications, Employee H identified that the facility currently has no Residents who self-administer medications. When asked about the storing of medication and leaving medications at the bedside, Employee H indicated that medications are not to be left at the bedside of a Resident. When asked what the associated risks of doing so are, Employee H said, "The resident may not take it, another patient could take it and it is a safety hazard". Review of the facility policy titled; "Self-Administration of Medications" was conducted. This policy read, "1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident... 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents...". On 7/27/23, during the end of day meeting, the Administrator and Director of Nursing were made aware of the concern and no further information was provided. On 7/28/23 at approximately 9 AM, Surveyor C met with Resident #23. Resident #23 reported that staff gives him the ointment that "I put it on myself". Resident #23 went on to say, "I signed a paper last night".	F 554	The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Self-Administration of Medication Policy added to the Nursing new employee orientation packet.	

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F 554	Continued From page 3 On 7/28/23 at 10:16 AM, the facility Administrator provided the survey team with a document titled, "Self-Administration of Medication Consent Form" that Resident #23 signed 7/27/23. The facility Administrator also provided a copy of a BIMS (brief interview for mental status) Evaluation that had been conducted on Resident #23 on 7/23/23, that indicated Resident #23 was cognitively intact. However, there was still no assessment of the Resident's physical ability to determine if self-administering medications was clinically appropriate for the Resident. No further information was provided.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to have call bells accessible for two of two residents (Resident (R)5, and R19) reviewed for accommodation of needs out of 44 sampled residents. These failures had the potential to cause a delay in the provision of care for these two residents. Findings include: Review of the facility policy titled, "Answering the Call light," revised on 11/22, revealed, "Ensure	F 558	Residents #5 and #19 have their call bells within reach when in their room. All Residents in the facility have the potential to be affected by this alleged deficient practice. The Clinical Services Director has educated all Certified Nursing Assistants on maintaining resident call bells within reach when residents are in their room. This education was completed by 09/01/23. This information will be	9/11/23

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F 558	Continued From page 4 that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor." 1. Review of R5's "Medical Diagnosis," sheet located in the "Med Diag [diagnosis]" tab of the electronic medical record (EMR) revealed R5 had diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, and lack of coordination. Review of R5's quarterly "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 06/09/23, located in the "MDS" tab of the EMR, revealed R5 required extensive assistance with bed mobility, transfers, personal hygiene and total dependence with toilet use, was sometimes understood, and had impaired functional range of motion on one side of her upper extremities. R5 scored three out of 15 on the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. Review of R5's comprehensive "Care Plan," dated 06/20/23, and located in the "Care Plan" tab of the EMR, revealed a "Focus" which specified R5 was at high risk for falls related to cerebral vascular accident with hemiplegia, limited physical mobility, poor safety awareness, use of antidepressant for appetite stimulant. A care plan intervention included, "Be sure the call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Observation on 07/25/23 at 2:24 PM, 3:50 PM, and 4:45 PM revealed R5 was in bed and her call	F 558	presented in all Certified Nursing Assistant new hire orientation. The Nurse Managers will monitor call light placement in their assigned rooms 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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bell was out of her reach. The resident's call bell was positioned near the top of her bed on the left side.

Observation on 07/25/23 at 5:10 PM revealed R5 was eating her evening meal in bed with no staff in the room and her call bell out of her reach. The resident's call bell was positioned near the top of her bed on the left side.

Observation on 07/26/23 at 10:08 AM, 12:35 PM, 1:40 PM, and 2:10 PM revealed R5 was seated in a geri-chair in her room and her call bell was out of her reach. R5's call bell was positioned on her bed. During the observation on 07/26/23 at 12:35 PM, R5 was asked if she could reach her call bell that was positioned on her bed. The resident attempted to reach the call bell with her left hand but was unable to reach her call bell.

During an interview on 07/26/23 at 2:10 PM, Certified Nursing Assistant (CNA) E confirmed R5's call bell was out of the resident's reach. CNA E stated R5's call bell should be positioned as close to her as possible because the resident used her call bell to request staff assistance. Observation on 07/26/23 at 2:12 PM revealed CNA E handed R5 her call bell and R5 easily activated the call bell upon request.

During an interview on 07/27/23 at 4:35 PM the Clinical Service Director (CSD) stated R5 should have her call bell within reach to request staff assistance.

2. Review of R19's "Medical Diagnosis," sheet located in the "Med Diag" tab of the EMR, revealed R19 had diagnoses which included

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hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side, and lack of coordination.

Review of R19's quarterly MDS assessment, with an ARD of 06/24/23, located in the "MDS" tab of the EMR, revealed R19 required one-person physical assistance with bed mobility, transfers and walking in room, had unclear speech, and impaired functional range of motion on one side of his upper extremities. R19 scored seven out of 15 on the BIMS which indicated severe cognitive impairment.

Review of R19's comprehensive "Care Plan," dated 07/04/23 and located in the "Care Plan" tab of the EMR, revealed a "Focus" which specified R19 was at a high risk for falls related to gait and balance problems secondary to cerebral vascular accident related to hemiplegia. A care plan intervention included, "Be sure call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance."

Observation on 07/25/23 at 4:39 PM, and from 5:09 PM to 6:12 PM, revealed R19 was seated in his wheelchair in his room and his call light was not accessible to him. The resident's call light was observed to be on his bed next to the wall which was out of his reach.

Observation on 07/25/23 from 5:23 PM to 6:03 PM revealed R19 was seated in a wheelchair in his room with his evening meal in front of him. The resident's call light was observed to be on his bed next to the wall which was out of R19's reach.

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F 558	Continued From page 7 During an interview on 07/25/23 at 6:03 PM CNA E confirmed R19's call bell was out of his reach. CNA E stated R19's call bell should be within his reach because he used it to call staff for assistance. Observation on 07/26/23 at 9:00 AM, and 9:15 AM revealed R19 was seated in his wheelchair in his room and his call bell was not within his reach. The resident's call light was observed to be on his bed next to the wall. During an interview on 07/27/23 at 4:35 PM the CSD confirmed R19's call bell should be within his reach.	F 558		
F 571 SS=E	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of	F 571		9/11/23

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items and services:
(A) Nursing services as required at §483.35.
(B) Food and Nutrition services as required at §483.60.
(C) An activities program as required at §483.24(c).
(D) Room/bed maintenance services.
(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.
(F) Medically-related social services as required at §483.40(d).
(G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.
(ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:
(A) Telephone, including a cellular phone.
(B) Television/radio, personal computer or other

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electronic device for personal use.
(C) Personal comfort items, including smoking materials, notions and novelties, and confections.
(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.
(E) Personal clothing.
(F) Personal reading matter.
(F) Gifts purchased on behalf of a resident.
(H) Flowers and plants.
(I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c).
(J) Non-covered special care services such as privately hired nurses or aides.
(K) Private room, except when therapeutically required (for example, isolation for infection control).
(L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.
(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.
(2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.
(iii) Requests for items and services.
(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.

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F 571	Continued From page 10 (B) The facility must not require a resident to request any item or service as a condition of admission or continued stay. (C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff charged the Resident and deducted from their patient trust account, funds in excess what was due to the facility for three Residents (Resident #17, #37 and #23), in a survey sample of 6 Residents reviewed with trust accounts. This happened on five occasions. The findings included: 1. For Resident #17, the facility staff withdrew $153 in excess of what was due towards the cost of care on two occasions, March 2023, and May 2023. On 7/27/23, Surveyor C received and reviewed the Resident trust account statement for Resident #17 for the year of 2023. During this review it was noted that on March 3, 2023, $1,129 was deducted/withdrawn from the Resident's trust account for "Care Cost Auto WDL [automatic withdrawal]". Review of the "patient pay information" from the Virginia Medicaid Web portal indicated Resident #17 owed the facility $976 each month. Then on 4/7/23, instead of withdrawing the $976	F 571	Residents #17, #37 and #23 are having the correct patient liability amount per the Virginia Medicaid Web portal withdrawn monthly from their resident trust account to cover care cost. Residents in the facility covered under Virginia Medicaid and a resident trust account have the potential to be affected by this alleged deficient practice. The Administrator has reviewed other facility residents with Virginia Medicaid and a resident trust account to validate withdrawn amounts of the past 3 months are accurate. No other concerns were identified. The Administrator has educated the Business Office Manager on confirming accurate amounts per the Virginia Medicaid Web portal are withdrawn from resident trust accounts monthly to cover care cost and immediately refunding residents should an over payment occur The auto draft has been blcoked enabling manual monthly entry. This education was completed 08/21/23. The Administrator or Designee will	

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F 571	Continued From page 11 due for the cost of care, the facility withdrew $823, to offset the overpayment in March. On 5/3/23, another withdrawal for $1129 was made and noted as "Care Cost Auto WDL". Again, Resident #17 was indicated by Medicaid to only owe $976. Then on 6/12/23, when the care cost withdrawal was made, only $823 was deducted to offset the prior months over payment. 2. For Resident #37, the facility staff made deductions from the Resident trust fund more than what was due to the facility. On 7/27/23, Surveyor C received and reviewed the Resident trust account statement for Resident #37 for the year of 2023. During this review it was noted that on March 3, 2023, $1,561 was deducted/withdrawn from the Resident's trust account for "Care Cost Auto WDL [automatic withdrawal]". Review of the "patient pay information" from the Virginia Medicaid Web portal indicated Resident #37 owed the facility $1351 each month. Then on 5/3/23, instead of withdrawing the $1,351 due for the cost of care, the facility withdrew $1,141, to offset the overpayment in March. 3. For Resident #23, the facility staff withdrew excess funds from the Resident's trust account/bank account funds in excess of what was due/owed to the facility on 2 occasions.	F 571	monitor Medicaid recipient resident trust account deductions for accuracy monthly for 3 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Clinical Service Director for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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On 7/27/23, Surveyor C received and reviewed the Resident trust account statement for Resident #23 for the year of 2023. During this review it was noted that on March 1, 2023, a deduction in the amount of $90 was deducted/withdrawn from the Resident's trust account for "Care Cost Auto WDL [automatic withdrawal]". Then on March 3, 2023, an additional amount of $1,158 was withdrawn and noted as a "Care Cost Auto WDL". This totaled $1,248 being withdrawn for the month of March. Review of the "patient pay information" from the Virginia Medicaid Web portal indicated Resident #23 owed the facility $1,065 each month.

Then on 4/7/23, instead of withdrawing the $1,065 due for the cost of care, the facility withdrew $882, to offset the overpayment in March.

On 5/1/23, a withdrawal for care cost was made in the amount of $90. On 5/3/23, an additional withdrawal for $1,158 was made, both were noted as "Care Cost Auto WDL". Again, Resident #23 was indicated by Medicaid to only owe $1,065. Then on 6/12/23, when the care cost withdrawal was made, only $882 was deducted to offset the prior months over payment.

On 7/27/23 at 03:15 PM, an interview was conducted with Employee M, the business office manager (BOM). Employee M confirmed that she determines the amount a Resident owes as a patient pay/liability via the "the Medicaid web portal". Employee M confirmed all the above findings.

When asked about the above findings, Employee

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M then stated, "It pulled automatically", referring to the wrong amounts being set-up to auto-deduct each month. It was expressed that despite it happening in March 2023, corrections were not made until April. Residents were not credited the over payment within the month that the error occurred. Then in April 2023, the same over payments were made and restitution not made until the following month. The BOM said, "I have put a block on it now so it will quit pulling the wrong amount. I must put it in manually". With regards to the corrections not being made until the following month, the business office manager said, "For March there would have had a credit, so I applied it [the credit] to the next month".

Surveyor C asked if any of the above discrepancies/errors had been discussed with the Resident's identified as being affected. The business office manager said, "No". When asked if not refunding overpayments and just waiting until the next month and collect less due to the facility is generally accepted accounting practice, the business office manager said, "Well no, it shouldn't be done that way, it was a mistake, and it was fixed".

On 7/27/23, during the end of day meeting the facility Administrator was made aware of the above findings.

On 7/28/23, the Administrator provided a written statement from Employee M that indicated the Resident trust accounts had been changed on 6/30/23, so that funds will not be automatically withdrawn each month, she will manually enter the amount to be deducted for care costs/patient pay.

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F 571	Continued From page 14 No further information was provided.	F 571		
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, 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	F 578		9/11/23

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F 578	Continued From page 15 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 resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to offer and/or provide Advance Directive planning for 2 residents, Resident #15 and Resident #44, in a survey sample of 44 residents. The findings included: 1. The facility staff failed to offer and/or provide Resident #15 or their Responsible Party (RP) with Advance Directive planning. On 7/25/23 at approximately 11:30 AM, an attempt to interview Resident #15 was made, however she declined. An interview was conducted with her Responsible Party (RP). The RP stated, "I take an active part in planning my mother's care here at the facility, I do not recall anyone ever asking her whether or not she would want CPR [cardiopulmonary resuscitation], but I can tell you that she does not, she has wanted DNR [do not resuscitate] for many years now". On 7/25/23 at approximately 12:15 PM, a clinical record review for Resident #15 was performed and revealed active physician's orders dated 5/25/23 that read, "Active, Full Code" and the patient's profile banner read, "FULL CODE" status which indicated that CPR would be initiated in the event of cardiac and/or respiratory arrest.	F 578	Residents #15 and #44 have advanced directives and corresponding physician orders are evidenced in the medical record. All Residents in the facility have the potential to be affected by this alleged deficient practice. The Admission Director has confirmed current facility residents have the desired advance directive information reflected in their medical record. The Administrator has educated the Social Services Director on offering residents or their responsible party the ability to formulate advanced directives upon admission to the facility and any time desired during stay and the Clinical Service Director on obtaining a physician□s order for the desired advanced directive. Education was completed by 09/01/23. The Resident Assessment Coordinator or Designee will monitor newly admitted and re-admitted residents to validate the offer to formulate advanced directives and that physician□s order corresponds weekly for 4 weeks then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance	

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A "Social Service History & Initial Assessment" note, dated 5/8/23, indicated that Resident #15 was "oriented to person, place, time, and situation, and had a Brief Interview for Mental Status (BIMS) rating of "15", cognitively intact.

There was no documentation in the clinical record that the facility staff offered or provided education about Advance Directive planning, to include the assessment of Code Status, Full Code versus Do Not Resuscitate, with Resident #15 or her Responsible Party (RP).

On 7/25/23 at approximately 3:00 PM, an interview was conducted with the Director of Social Services (DSS) who confirmed the findings and stated that she was responsible for Advance Directive planning with residents and their families. She stated that the lack of documentation for Resident #15 "must have been an oversight". The DSS was informed that the RP had reported that her mother should be a "DNR". A facility policy was requested and received.

Review of the facility policy titled, "Advance Directives", read, "A resident's choice about advance directives will be respected".

On 7/25/23 at approximately 5:00 PM, the DSS reported that she met with Resident #15 and her RP and confirmed Resident #15's wishes to be "DNR". A DNR order was initiated with the physician and documented in the clinical record.

On 7/25/23, at the end of day debriefing, the Facility Administrator and Director of Nursing were updated. No further information was provided.

Improvement Committee by the Clinical Service Director for a period of 3 months. Any concerns identified will be addressed at time of discovery.

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2. Review of the facility policy titled, "Advanced Directives," revised on 09/22, revealed, "The resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy . . . The director of nursing services (DNS) or designee notifies the attending physician of advanced directive (or changes in advanced directives) so that appropriate orders can be documented in the resident's medical record and plan of care . . . The resident's wishes are communicated to the resident's direct care staff and physician by placing the advanced directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care plan meetings."

Review of Resident (R)44's "Medical Diagnosis," sheet located in the "Med Diag[nosis]" tab of the electronic medical record (EMR), revealed R44 was originally admitted with a diagnosis of end stage kidney disease.

Review of R44's "Durable Do Not Resuscitate (DNR) Order," dated 01/26/21, provided by the facility, specified R44 "was capable of making an informed decision about providing, withholding, or withdrawing a specific treatment of course of medical treatment." The DNR order was signed by R44 and R44's physician.

Review of R44's "Base Line Care Plan," dated 03/14/23, located in the "MISC[ellaneous]" tab of the EMR, revealed R44's advanced directive was

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noted as a DNR. The care plan's goal specified; "Resident's Advanced Directives wishes and directions will be carried out in accordance with their advanced directives on an ongoing basis through next review period."

Review of R44's "Hospital Discharge Summary," dated 04/10/23, provided by the facility, specified the resident was a Full Code.

Review of R44's "Physician Orders," located in the "Orders" tab of the EMR, revealed an order for a Full Code dated 04/10/23.

Review of R44's comprehensive "Care Plan," dated 06/12/23, located in the "Care Plan" tab of the EMR, revealed a "Focus" which specified "Advanced Directive [R44's name] has following Advanced Directives on record Do Not Resuscitate." The care plan's goal specified, "Advance Directives are in effect, and [R44's name] wishes and directions will be carried out in accordance with her advance directives." A care plan intervention indicated, "An Advance Directive can be revoked or changed if the resident and/or appointed health care representative changes their mind about the medical care they want delivered."

Review of R44's quarterly "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 06/21/13, located in the "MDS" tab of the EMR, revealed R44 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated R44 was cognitively intact.

During an interview on 07/27/23 at 10:42 AM the Social Worker (SW) stated R44's medical record

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contained conflicting information regarding the resident's code status. The SW stated the R44's EMR had a DNR order dated 01/26/21 and the resident's care plan specified she was a DNR, but R44 had a current physician's order for a Full Code that was initiated on 04/10/23. The SW stated that she would check with R44 regarding this code status discrepancy.

During an interview on 07/27/23 at 10:50 AM the SW stated she spoke with R44, and she wanted to remain a DNR as she had previously specified and as noted in her current care plan. The SW stated on 04/10/23, the facility's Clinical Service Director (CSD) put an order in for R44 to be a Full Code, but she did not know why an order was written to change the resident's code status because that was not what the resident wanted.

During an interview on 07/27/23 at 11:10 AM, the CSD stated she put in an order on 04/10/23 to change R44's code status from DNR to Full Code because the resident's 04/10/23 hospital discharge summary specified the resident was a Full Code. The CSD stated she thought the SW was responsible for checking with the resident when there was a change in a resident's code status to ensure this change was what the resident wanted.

During an interview on 07/27/23 at 11:15 AM the SW stated she did not recall talking with R44 about her code status change from a DNR to a Full Code when she was readmitted to the facility from the hospital on 04/10/23. The SW stated if she was aware R44's code status changed from DNR to Full Code she would have discussed this change with R44 and updated the resident's care plan to reflect this change.

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F 578	Continued From page 20 During an interview on 07/27/23 at 1:20 PM, R44 stated she had not changed her code status from a DNR to Full Code and she wanted to remain a DNR. During an interview on 07/27/23 at 2:40 PM, the Administrator stated she was aware of the error on R44's code status not specifying the resident was a DNR. The Administrator stated R44 could clearly make her code status known and her desire to remain a DNR would be honored by the facility.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		9/11/23

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F 582	Continued From page 21 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to continue skilled services and bill the Resident as requested on the SNF ABN notice (Skilled Nursing Facility Advance Beneficiary Notice) issued to 2 Residents (Resident #14 and #44) in a survey sample of 3 Residents, reviewed for such notices.	F 582	Residents #14 and #44 remain in the facility but have indicated they no longer wish to pursue skilled rehabilitation services at this time. They have chosen option 3. Residents remaining in the facility after their Medicare benefits have ceased have the potential to be affected by this alleged	

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F 582	Continued From page 22 The findings included: 1. For Resident #14, the Resident selected on a SNF ABN form that she wanted to continue to receive the services, and the facility staff ended the services, despite the Resident's request. On 7/26/23, during a review of Resident #14's SNF ABN notice, it was noted that the Resident #14's skilled care services were ending on 4/7/23. The facility staff presented the Resident with a SNF ABN notice on 4/4/23, which Resident #14 selected option 2, which read, "I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed". Review of the therapy notes revealed that Resident #14's last day of therapy services was 4/6/23. Billing documents were reviewed and confirmed the same. On 07/26/23 at 02:46 PM, Surveyor C met with Employee M, the business office manager. Employee M confirmed that Resident #14's last skilled day was 4/6/23, and no further therapy services were provided after that date. 2. For Resident #44, who selected on a SNF ABN notice that she wanted skilled care to continue and she would pay for it, the facility staff stopped the service anyway. On 7/26/23, during a review of Resident #44's SNF ABN notice, it was noted that the Resident #44's skilled care services were ending on	F 582	deficient practice. A 100% audit of all residents who have been issued a SNFABN has been completed to ensure compliance. No issues revealed. The Administrator has educated the Business Office Manager on the process for issuing Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) and instructing the rehabilitation department to continue services should a resident choose option 2 to indicate they will pay out of pocket for continues service in the absence of billing Medicare and forfeiting appeal rights. Education was completed on 09/01/23. The Social Service Director or Designee will monitor completed SNFABN□s to validate residents choosing option 2 continue to receive skilled rehabilitation services weekly for 4 weeks then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months.	

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5/29/23. The facility staff presented the Resident with a SNF ABN notice on 5/25/23, which Resident #44 selected option 2, which read, "I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed".

Review of the therapy notes revealed that Resident #44's last day of therapy services was 5/29/23. Billing documents were reviewed and confirmed the same.

On 07/26/23 at 02:46 PM, Surveyor C met with Employee M, the business office manager. Employee M confirmed that Resident #44's last skilled day was 5/29/23, and no further therapy services were provided after that date.

On 07/26/23 at 02:50 PM, Surveyor C met with Employee M, the business office manager. Employee M confirmed she is responsible for issuing ABN notices to Residents. She was asked to explain her understanding of the options on the ABN form. The business office manager gave the following explanation with regards to option 2, "if someone is staying here, then option 2 should be the one they should pick, because they are agreeing they are going to pay for the bill and that Medicare will not be billed".

Employee M was asked if a Resident selects options 1 or 2 on the SNF ABN form, if this is communicated to anyone and if it changes what services the Resident receives, she said, "I don't think so".

The facility policy regarding skilled nursing facility

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advanced beneficiary notice (SNFABN) was requested. The facility staff indicated they did not have a policy for this.

On 7/26/23 at 4 PM, the business office manager, Employee M, provided the survey team with documents she had with regards to SNF ABN notices, in lieu of a policy. The documents were reviewed and were blank SNF ABN and NOMNC (notice of Medicare non-coverage) forms, in English and Spanish.

In the CMS document, "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)". This instruction sheet read, "...There are 3 options listed on the SNFABN with corresponding check boxes. The beneficiary must check only one option box. If the beneficiary is physically unable to make a selection, the SNF may enter the beneficiary's selection at his/her request and indicate on the notice that this was done for the beneficiary. Otherwise, SNFs are not permitted to select or pre-select an option for the beneficiary as this invalidates the notice...".

The CMS instructions regarding when a resident selects option 2, read: "...When the beneficiary selects Option 2, the care is provided, and the beneficiary pays for it out-of-pocket. The SNF does not submit a claim to Medicare. Since there is no Medicare claim, the beneficiary has no appeal rights. Note: Although Option 2 indicates that Medicare will not be billed, SNFs must still adhere to the Medicare requirements for submitting no pay bills. See Chapter 6 of the Medicare Claims Processing manual for SNF claim submission guidance. ...". Accessed online at:

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F 582	Continued From page 25 https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNF-ABN- On 7/27/23 at 9:29 AM, the facility Administrator was made aware of the above findings. No further information was provided.	F 582		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		9/11/23

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F 657	Continued From page 26 by: Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the care plan following a significant weight loss affecting one Resident (Resident #4) in a survey sample of 44 Residents. The findings included: For Resident #4, who had a significant weight loss while at the facility, the facility staff failed to review and revise the care plan with interventions to address the weight loss and interventions implemented by the facility. From 7/25/23-7/28/23, various observations were made of Resident #4 during the lunch and supper meals. Resident #4 was interviewed and said she had no appetite. Resident #4 was observed to be unable to feed herself and was totally dependent upon facility staff for assistance. A clinical record review was conducted and revealed that Resident #4 was admitted to the facility on 5/21/23, and was noted to weigh 108 lbs. Resident #4's weight was taken almost weekly and noted a continuous decline. On 6/19/23, Resident #4 weighed 97.7 lbs. This was a 10% weight loss in a month. On 7/24/23, Resident #4 weighed 91.7 lbs., which is a total of 16-pound weight loss in just two months. Review of the care plan revealed the Resident's care plan for weight loss risk was not developed until 7/11/23. On 7/27/23, the facility Administrator and Clinical Director were presented with concerns regarding Resident #4's weight by the survey team.	F 657	Resident #4□s care plan was updated on 8/14/23 to reflect interventions in place to prevent further weight loss. All Residents have the potential to be affected by this alleged deficient practice. A 100% audit of all care plans have been done and revealed no issues. The Clinical Consultant educated the Director of Nursing, Clinical Service Director and Certified Dietary Manager on Care plans, Comprehensive Person-Centered Policy and Care Planning Interdisciplinary Team Policy. This education was completed 08/30/23. Care plans will be reviewed weekly in accordance with the care plan review scheduled by the MDS Coordinator and IDT members. All care plans will be updated as indicated. The DON or designee, will complete reviews weekly x4 then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Clinical Service Director for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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F 657	Continued From page 27 On 7/28/23, the facility's Clinical Director presented information that explained they had implemented nutritional supplements, to include but not limited to multivitamin, pro-stat [a protein supplement], high calorie cereal, med pass and even a medication to stimulate the appetite. The clinical director also indicated that a family conference was being scheduled to discuss the option of a gastroenterology consult for the consideration of a feeding tube. None of these interventions nor the weight loss were identified in the Resident's care plan. No further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care and services in accordance with professional standards for 3 residents, Resident #55, Resident #34, and Resident #52, in a sample size of 44 residents. The findings included: 1. For Resident #55, facility staff failed to administer medications as ordered by the physician.	F 658	Resident #55's order for Diprolene cream was discontinued on 8/13/23, all other medications are being administered per the physician's order. Resident #52□s order for zinc paste was discontinued on 8/14/23, all other medications are being administered per the physician□s order. Resident #34 is receiving medications as ordered by the physician with corresponding, accurate documentation to reflect administration. All current residents have had a medication audit completed to ensure	9/11/23

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F 658	Continued From page 28 On 7/25/23 at approximately 11:30 AM, an interview was conducted with Resident #55. Resident #55 stated, "The doctor prescribed my some cream the other day for a rash on my left thigh and I still haven't received it, the rash is still there". On 7/25/23 at approximately 12:15 PM, a clinical record review was performed and revealed a nursing note dated 7/23/23 at 18:54 which documented a telephone order received from the physician for "Diprolene .5% cream, apply to rash once daily..." and an orders administration note dated 7/24/23 at 08:37 which documented "Diprolene External Ointment 0.05%...On order awaiting arrival". There was no documentation of the ointment being administered on Resident #55's medication administration record (MAR) for 7/24/23 and 7/25/23. On 7/25/23 at approximately 12:45 PM, an interview was conducted with the Facility Administrator who was updated on the findings and stated, "I will look into this right away". At approximately 3:00 PM, the Facility Administrator stated that the Pharmacy had just delivered Resident #55's ointment and she had instructed LPN C to administer it to Resident #55 right away. On 7/25/23 at approximately 5:30 PM, a follow-up interview was conducted with Resident #55 who stated, "No one has given me any cream yet, I don't know what is going on, I really want to have it". The Facility Administrator was updated and brought the tube of ointment to the Conference Room stating, "I was reassured that this had been given to Resident #55 a couple of hours	F 658	accurate medication administration per physician orders. Residents in the facility have the potential to be affected by this alleged deficient practice. The Clinical Service Director has educated the Licensed Nurses on Documentation of Medication Administration and following MD orders. Education completed by 09/01/23. Any Licensed Nurse not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in Licensed Nurse new hire orientation. The Clinical Service Director/Director of Nursing will randomly observe resident medication administration to validate ordered medications are administered then accurately documented 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Clinical Service Director for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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ago, I gave it to the nurse as soon as I received it". The tube of ointment was inspected, the cap was removed, and the protective foil under the cap remained intact which indicated that it had not been punctured, which is necessary in order to access the ointment. The Facility Administrator confirmed it did not appear that the ointment had been administered as she was led to believe.

A review of Resident #55's MAR revealed that LPN C actually had documented she had administered a dose to Resident #55 at 3:32 PM, 2 hours previously. The Facility Administrator verified that the administration of medication must be documented immediately following the actual administration and stated, "The nurse did not follow my expectation, the facility policy, or professional nursing standards, I will be re-educating her immediately, this is unacceptable". A facility policy was requested and received.

Review of the facility policy titled, "Documentation of Medication Administration", revised April 2007, item 2, read, "Administration of medication must be documented immediately after (never before) it is given".

According to Lippincott Manual of Nursing Practice, 11th edition, 2019, page 15, "Standards of Practice-General Principles", item 1, read, "The practice of professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are accountable" and Box 2-1, "Common Legal Claims for Departure from the Standards of Care", item 8, read, "Failure to implement a physician's, advanced practice nurse's, or physician assistant's order properly or in a timely

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fashion", item 9, "Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately", item 19, "Failure to make prompt, accurate entries in a patient's medical record" and item 21, "Failure to adhere to facility policy or procedural guidelines".

On 7/25/23 at the end of day de-briefing, the Facility Administrator and Director of Nursing (DON) were updated on the findings. No further information was provided.

2. For Resident #52, the nurse failed to follow the standard of nursing practice as evidenced by the nurse documented the administration of a physician ordered cream, when it had not been administered.

On 07/26/23 at 09:35 AM, LPN E was observed during the medication administration. LPN E pulled and prepared the medication for Resident #52. During the preparation of the medications, LPN E noted that there was an order for "Zinc Paste", LPN E said, "That is the in the room". LPN E was observed to administer the medications to Resident #52, zinc paste was not applied. Upon completion of the Resident taking her pills, LPN E returned to the medication cart.

On 7/26/23, during a clinical record review, Surveyor C was reconciling the medication orders to the medications administered. It was noted that LPN E had signed off that zinc paste had been applied when other medications were administered.

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On 7/26/23, at 12:17 AM, Surveyor C questioned LPN E about signing off the zinc paste. LPN E said, "The CNA administered the zinc paste when they bathed [Resident #52's name redacted] and washed her up".

On 07/26/23 at 12:24 PM, an interview was conducted with CNA E. CNA E confirmed she was assigned to provide care for Resident #52. When asked about her care provided thus far, CNA E said, "I had help this morning and we washed her up. The Resident refused to take her gown off, so I am going back after lunch and try again". When asked if she put any kind of cream on her bottom, CNA E said "yes, we put the protective cream on her". CNA E accompanied surveyor C to the Resident's room and showed the surveyor the tube of cream used. It was protective ointment, CNA E said, "We used to use a white cream that was thicker we used but the rash cleared up so now we use this [protective cream]". CNA E confirmed the white cream previously used was a barrier cream and at no point has she applied a zinc paste to Resident #52.

Review of the facility policy titled, "Documentation of Medication Administration", was conducted. This policy read, "1. A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the Resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given...".

On 7/26/23, during an end of day meeting, the facility administrator and Clinical Director were

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made aware of the above observations during medication administration observations conducted with LPN E.

3. For Resident #34, the nurse failed to follow the nursing standard of practice as evidenced by signing off the wrong medication that was administered.

On 7/27/23 at 9:40 AM, LPN D was observed during the administration of medications. LPN D prepared the medications for Resident #34, which included but was not limited to artificial tears, two drops were to be applied to each eye. LPN D administered the medications including the artificial tears to Resident #34 and notified the Resident she would return later to administer additional eye drops but needed to wait a few minutes between the different drops. LPN D then returned to the medication cart and signed off the medications administered. LPN D signed off that Combigan Solution 0.2-0.5% drop was administered to the left eye, which was not yet administered.

On 7/27/23 at approximately 11 AM, LPN D returned to Resident #34 to administer Combigan Solution 0.2-0.5% eye drops. LPN D then returned to the medication cart and realized she had signed off the administration of this drop when she had administered the artificial tears at 9:40 AM. LPN D said, "I marked the wrong one earlier, it was a mistake".

Review of the facility policy titled, "Documentation of Medication Administration", was conducted. This policy read, "1. A nurse or certified

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F 658	Continued From page 33 medication aide (where applicable) shall document all medications administered to each resident on the Resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given...". The facility Administrator identified Lippincott as their nursing standard of practice. According to the Lippincott Manual of Nursing Practice eighth edition, on page 18, box 2-3 identified "Common legal claims for departure from Standards of Care". An excerpt from this read, "... Failure to administer medications properly and in a timely fashion, or to report and administer omitted doses appropriately... Failure to make prompt, accurate entries in a patient's medical record...". On 7/27/23, during the end of day meeting, the facility Administrator and Clinical Director were made aware of the above observation. No further information was provided/received.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		9/11/23

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F 684	Continued From page 34 by: Based on observation, staff interviews and clinical record review, the facility staff failed to ensure quality of care based on professional standards and the person-centered care plan was provided for one Resident (Resident #38) in a survey sample of 44 Residents. The findings included: For Resident #38 the facility staff failed to ensure that the Resident had appropriate seating to maintain her comfort, relieve pressure, prevent her legs from dangling, which would promote swelling/edema in her legs and feet; and be safe in the facility provided wheelchair. On 7/25/23, Resident #38 was observed sitting in a wheelchair at the nursing station. Resident #38 was observed to be sitting on two cushions, which elevated her to the point that her legs were dangling and not touching the floor. Footrests were not on the chair. Observations of Resident #38's room revealed leg rests and foot pedals for the wheelchair in the floor next to the bed. Also noted was a 1/2 tray that would go on the wheelchair but was not in use. On 7/26/23, a clinical record review was conducted. This review revealed that Resident #38 had an active physician order that was written 10/21/21, that read, "1/2 lap tray while up in wheelchair to aid with positioning". Resident #38's therapy notes revealed a history of a left rotator cuff tear. The therapy notes further revealed that Resident #38 had some limitations on her left upper extremity. On the morning of 7/27/23, Resident #38 was	F 684	Resident #38 is being seated in a wheelchair with a single pressure reducing cushion, elevating leg rests and 1/2 lap tray. Residents utilizing wheelchairs have the potential to be affected by this alleged deficient practice. The Rehab Director/designee has observed other residents utilizing wheelchairs to validate a single cushion and other recommended attachments is present. No other concerns were identified. The Clinical Service Director has educated Certified Nursing Assistants on applying only a single cushion, foot pedals, leg rests and any other specified attachment to resident wheelchairs when in use. Education was completed by 09/01/23. Any Certified Nursing Assistant not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in Certified Nursing Assistant orientation. The Director of Nursing/designee will monitor residents utilizing wheelchairs to validate single cushions and all other recommended attachments are in use weekly for 4 weeks then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Director of Nursing for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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observed to be up in her wheelchair and attending a group activity. Resident #38 was observed again sitting on 2 cushions, which elevated her where only the toes of her right foot would touch the floor. Resident #38 was sitting leaning to the right and her right side/hip was pressing against the side of the wheelchair. The half-tray was not in place, nor were the leg pedals and footrests.

On 07/27/23 at 10:05 AM, an interview was conducted with CNA C. CNA C was asked why Resident #38 was sitting on 2 cushions. CNA C said, "We couldn't find her wheelchair cushion, so I went and got another one, then her family sent her one so now she has two. She sat so low at the table, now this gets her up higher to the table". CNA C was asked about her legs just dangling and feet not touching the floor. CNA C said, "I have to check with therapy about them [leg rests and foot pedals]". During the interview CNA C confirmed that Resident #38 has swelling and edema in her legs and feet "So I only get her up every other day so she can lay down and rest the other days". CNA C was asked about the tray for the wheelchair. CNA C then accompanied Surveyor C to the room of Resident #38 and was shown the 1/2 tray, CNA C said, "Therapy did that to keep her left arm raised to help with the swelling". CNA C then took the 1/2 tray and applied it to the wheelchair. CNA C made no mention of the wheelchair leg rests and foot pedals that were in the room underneath the 1/2 tray.

On 07/27/23 at 10:42 AM, an interview was conducted with Employee N, the Occupational Therapist (OT). The OT was asked to generally explain how Residents should be sitting in a

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wheelchair. The OT said, "90/90/90" [meaning the hips, knees and ankles should all be bent at 90 degrees], the OT then demonstrated this with her feet touching flat on the floor. The OT went on to say, "There should be no sacral sitting and feet shouldn't just be dangling". When asked to elaborate on why feet should not be dangling, Employee N said, "It is bad for blood flow and increased contractures".

Surveyor C asked the therapist, what about wheelchair seat cushions? The occupational therapist stated that, "Everyone should have one, to decrease sacral wounds and for stability". The OT was asked if two cushions was appropriate and the OT said, "No, I have not ever done that". Employee N was then asked specifically about Resident #38's 1/2 tray table for the wheelchair. The OT said, "It is for her sublexed arm, feels uncomfortable with gravity pulling it down, but she doesn't always like to have it". The OT was then asked to accompany Surveyor C to the activity room to observe Resident #38's seating. The OT said, "I saw her recently 2-3 weeks ago and didn't see two cushions under her then. I don't have anything good to say to you right now about how she is sitting, I agree with you. I don't know why she is on 2 cushions." The OT confirmed that Resident #38 was leaning to the right side with her side against the side of the wheelchair. The OT stated she would make adjustments and correct her seating.

On 07/27/23 at 11 AM, Surveyor C observed Resident #38 sitting in the dining room, she was noted to be sitting straight, one foot resting on a footrest and her legs were crossed. The 1/2 tray was removed.

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F 684	Continued From page 37 On 7/27/23 at 11:08 AM, a follow-up interview was conducted with Employee N, the Occupational Therapist and Employee O, the assistant therapy director/physical therapy assistant was present. They both explained that one of the wheelchair cushions was removed, positioned her center of her chair, applied footrests, and removed the tray". Employee O, the assistant therapy director said she found out the Resident "had a different cushion that allowed her feet to rest on the floor which was more appropriate, and we will be working to get her that type of cushion again. We removed the tray because it wasn't appropriate for that chair". When asked what their concerns were with how Resident #38 was seated, the indicated, "It was a concern for pressure, the arm, edema and safety. It wasn't safe". On 7/27/23, during the end of day meeting, the facility Administrator and Clinical Director were made aware of the above findings. No further information was provided.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or	F 685		9/11/23

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F 685	Continued From page 38 the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide/arrange for one Resident (Resident #13) in a survey sample of 44 Residents to obtain new prescription lenses in her glasses, as ordered. The findings included: On 7/25/23 at 2:40 PM, during initial tour, Resident #13 was visited in her room. Resident #13 was asked about her vision and the Resident said, "I need to get my vision checked" and reported she is having difficulty seeing. The Resident did not recall last time she saw eye doctor. On 7/26/23, a clinical record review was conducted of Resident #13's chart. This review revealed the following: Resident #13 had a physician order dated 9/15/22, that read, "May have consultation for ophthalmology, podiatry, dental and optometry as needed". Resident #13's care plan was reviewed, and her vision or use of glasses was not identified on the care plan. Documentation regarding the offering of an eye exam with regards to the Resident's report of difficulty seeing was not found in the clinical chart. On 7/26/23, the facility Administrator was asked to provide any evidence she had with regards to	F 685	Based on Social Services Director interview on 07/27/23 Resident #13 nor her responsible party desire an eye appointment, and resident does not wish to be fitted for glasses. Residents with prescriptions for new glasses have the potential to be affected by this alleged deficient practice. No other residents identified. The Administrator has educated the Social Service Director on assisting residents with prescriptions for glasses to obtain said glasses, including services that assist with cost or offer reduced cost glasses. This education was completed by 08/31/23. The Administrator or Designee will monitor residents receiving prescriptions for glasses to validate every effort is made to obtain glasses monthly for 3 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be promptly addressed.	

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F 685	Continued From page 39	F 685		

Resident #13 seeing an eye doctor. The facility Administrator indicated that Employee E, the social worker handles this and was out of the office for the day.

On 7/27/23, Surveyor C met with Employee E and was provided documentation which included a progress note dated 9/21/22, which read, "SW [social worker] asked [Resident #13's name redacted] ... She does say she is blind in 1 eye and vision is blurry in the other and she is willing to go to an eye doctor to see if new glasses will help her vision. SW to try to get her an appointment with [name of provider redacted] as she will have to go by stretcher".

Employee E also provided evidence of where Resident #13 was seen by the eye doctor on 1/31/23. The note from the eye doctor read, "Vision 20/400 Right eye...New glasses Rx [prescription] given. Optic neuropathy both eyes". Employee E said she had spoken with Resident #13 on this day, 7/27/23, and the Resident reported to her she didn't need new glasses.

On 07/27/23 at 02:06 PM, Resident #13 was visited in her room again. Resident #13's family member and responsible party was also at the bedside. When asked about the new prescription given for glasses, the Resident's family member stated, "They were going to cost $700" and they didn't proceed because they couldn't afford them. When asked if any alternatives or options to assist with the costs were given, the Resident's family member said no.

On 7/27/23, during the end of day meeting, the facility Administrator was made aware of the above findings.

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F 685	Continued From page 40 No further information was provided.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to implement interventions to prevent the development of pressure ulcers for one Resident (Resident #35) in a survey sample of 44 Residents. The findings included: For Resident #35, who was at risk for the development of a pressure ulcer, the facility staff failed to apply heel protective boots as ordered by the physician. A clinical record review was conducted and revealed that Resident #35 had a physician order dated 5/23/23, that read, "place heel protector on	F 686	Resident #35 has protective boots to heels when in bed for pressure ulcer prevention. All residents at risk for developing pressure ulcers have the potential to be affected by this alleged deficient practice. The Resident Assessment Coordinator has reviewed all residents at risk for developing pressure ulcers and appropriate offloading or pressure-redistribution devices are implemented as ordered. No other concerns were identified. The Clinical Service Director has educated the Licensed Nurses on	9/11/23

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F 686	Continued From page 41 right heel every shift for wound". An excerpt from Resident #35's care plan read, "The resident has potential for pressure ulcer development r/t [related to] immobility, incontinent of B&B [bowel and bladder]". Interventions for this care plan focus area was, "Administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown...". Resident #35's most recent Braden Scale for Predicting Pressure Sore Risk was conducted 5/23/23, and the Resident scored 14, which indicated the Resident was at moderate risk for development of pressure sores. On 7/25/23, 7/26/23, and 7/27/23, numerous observations were made of Resident #35. Each observation revealed, Resident #35 was lying in bed, his heels had no protective boots, and his heels were noted to be resting directly on the mattress. On 07/27/23 at 09:55 AM, Surveyor C requested that LPN D accompany her to the room of Resident #35 to make observations of his feet. LPN D confirmed that Resident #35's heels were resting directly on the bed with nothing in place to relive pressure. LPN D and Surveyor C observed Resident #35's feet and LPN D stated that Resident #35's right heel was "boggy" and there was a discolored area on the Resident's left heel that LPN D stated, appeared as a "scab". Following the above observations, LPN D looked in Resident #35's room and was unable to find any heel protective boots. LPN D then went to the supply closet and again was not able to find any heel protective boots. LPN D then called	F 686	Prevention of pressure injuries policy and pressure ulcer prevention protocol. Education completed by 09/01/23. Any Licensed Nurse not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in Licensed Nurse new hire orientation. The Clinical Service Director/Director of Nursing will monitor residents with orders for protective heel boots to validate they are in place 2 times per week for 4 weeks then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Clinical Service Director for a period of 3 months. Any concerns identified will be promptly addressed.	

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another staff member, who handles supplies and then about 15 minutes later, approached Surveyor C and showed the surveyor that she had obtained a pair of heel protective boots and was going to apply them to Resident #35's feet.

Resident #35's most recent skin observation completed 7/24/23, identified no skin impairments.

The facility policy titled; "Prevention of Pressure Injuries" was reviewed. This policy read, "... Prevention: skin care. 1. Keep the skin clean and hydrated... 6. Do not rub or otherwise cause friction on skin that is at risk of pressure injuries. 7. Use facility-approved protective dressings for at risk individuals...".

In the facility provided "Wound Protocols", it read, "Pressure Ulcer Prevention Protocol: ... 8. Position the resident to minimize pressure over bony prominences and shearing forces over the hells and elbows, base of head, and ears, 9. Use appropriate offloading or pressure-redistribution devices...".

On 7/27/23, during the end of day meeting, the facility Administrator and Clinical Director were made aware of the above findings.

On 7/28/23 at 10:55 AM, the facility Administrator provided Surveyor C with a copy of physician orders that were implemented for Resident #35 in response to the above findings. The orders read, "Place heel protector on bilateral heels every shift for wound, skin prep to bilateral heels every shift".

No further information was provided.

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F 688	Continued From page 43	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide splints to address range of motion loss and/or contractures for two of five residents (Resident (R)19, and R5) reviewed for limited range of motion. These failures had the potential to cause worsening contractures for these two residents. Findings include: Review of the facility policy titled "Braces, Splints, and Prostheses," dated 04/20/11 revealed, "Braces, splints, and prostheses assist a resident with support normal joint alignment and positioning. These devices also prevent or	F 688	Residents #19 and #5 are utilizing their respective hand splints daily as ordered. All Residents with limited range of motion and mobility are at risk for this alleged deficient practice. The Clinical Services Director/designee has reviewed all residents limited range of motion and limited mobility with ordered equipment and treatment for prevention and treatment of ROM/Mobility and are applied as ordered. Any concerns identified were addressed. The Clinical Service Director has educated Certified Nursing Assistant and	9/11/23

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F 688	Continued From page 44 minimize deformities such as contractures. As a result, these devices facilitate mobility and activity of daily living skills. Braces, splints and prostheses may only be removed with orders of M.D. [medical doctor]" 1. Review of R19's "Medical Diagnosis," sheet located in the "Med Diag [diagnosis]" tab of the electronic medical record (EMR), revealed R19 had diagnoses which included hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side, and lack of coordination. Review of R19's quarterly "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 06/24/23, located in the "MDS" tab of the EMR, revealed R19 had unclear speech, was usually able to make himself understood, and had impaired functional range of motion on one side of his upper extremities. R19 scored seven out of fifteen on the Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. Review of R19's comprehensive "Care Plan," dated 07/04/23 and located in the "Care Plan" tab of the EMR, revealed a "Focus" which specified R19 had impaired limited physical mobility related to cerebral vascular accident with right hemiplegia. A care plan intervention included, "right hand splint for contracture management." Review of R19's July 2023 "Physician Orders," located in the "Orders" tab of the EMR, revealed an order, initiated on 04/12/23, for R19 to wear a right-hand resting splint during daily functional activities and for staff to perform range of motion to his right upper extremity joints prior to putting	F 688	Licensed Nurse on Braces, Splints and Prosthesis Protocol/Policy. Also educated Licensed Nurses on following MD orders. Education was completed by 09/01/23. Any Certified Nursing Assistant or Licensed Nurse not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in Certified Nursing Assistant and Licensed Nurse new hire orientation. The Clinical Services Director/Director of Nursing will monitor residents with ordered splints for contracture management to validate they are in place 2 times per week for 4 weeks then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Director of Nurses/designee for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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the splint on in the morning and after taking it off in the evening.

Observation on 07/25/23 at 4:39 PM, and from 5:09 PM to 6:12 PM, revealed R19 was seated in his wheelchair with his right hand contracted into a fist. There was no splint in R19's contracted right hand.

Observation on 07/26/23 at 9:00 AM, and 9:15 AM revealed R19 was seated in his wheelchair with his right hand contracted into a fist. There was no splint in R19's contracted right hand.

During an interview on 07/25/23 at 6:03 PM Certified Nursing Assistant (CNA) E stated R19 did have a splint to wear on his contracted right hand, but she did not know where the splint could be located.

During an interview on 07/27/23 at 4:35 PM the Clinical Service Director (CSD) stated R19 should have a splint on his contracted right hand as ordered during the day and as specified on his care plan.

2. Review of R5's "Medical Diagnosis," sheet located in the "Med Diag" tab of the EMR, revealed R5 had diagnoses which included hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting right dominant side, and lack of coordination.

Review of R5's quarterly "MDS" assessment, with an ARD of 06/09/23, located in the "MDS" tab of the EMR, revealed R5 had impaired functional range of motion on one side of her upper

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F 688	Continued From page 46	F 688		

extremity. R5 scored three out of fifteen on the BIMS which indicated severe cognitive impairment.

Review of R5's comprehensive "Care Plan," dated 06/20/23 and located in the "Care Plan" tab of the EMR, revealed a "Focus" which specified R5 had an Activity of Daily Living (ADL) self-care performance deficit relate to limited mobility, limited range of motion, and stroke. A care plan intervention included, "Left hand splint for contracture management."

Review of R5's July 2023 "Physician Orders," located in the "Orders" tab of the EMR, revealed an order, initiated on 04/12/23, for R5 to wear a left resting hand splint during daily functional activities as tolerated.

Observation on 07/25/23 at 2:24 PM, 3:50 PM, and 4:45 PM revealed R5 was in bed with her left hand contracted into a fist. There was no splint on R5's contracted left hand.

Observation on 07/26/23 at 10:08 AM, 12:35 PM, 1:40 PM, and 2:10 PM revealed R5 was seated in a Geri-chair with her left hand contracted into a fist. There was no splint in R5's contracted left hand.

During an interview on 07/26/23 at 2:10 PM CNA E stated she did not recall R5 had a splint to wear on her contracted left hand. CNA E stated she provided R5 with passive range of motion during the morning.

During an interview on 07/27/23 at 4:35 PM the CSD stated R5 should have a splint on her contracted left hand as ordered and as specified

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F 688	Continued From page 47 on her care plan.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to administer enteral feedings as ordered for one of one sampled Resident (R)213 reviewed for enteral feedings. This failure had the potential to cause weight loss and/or other nutritional complications for this resident. Findings include:	F 693	Resident #213 is no longer a resident. All Residents ordered to receive enteral nutrition have the potential to be affected by this alleged deficient practice. The Director of Nursing has reviewed residents receiving enteral nutrition to validate the correct formula is infusing at the correct rate. No other concerns were identified.	9/11/23

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F 693	Continued From page 48 Review of the facility's policy titled, "Enteral Nutrition," revised on 11/18, revealed, "Adequate nutritional support through enteral nutrition is provided to residents as ordered." Review of R213's "Medical Diagnosis," sheet located in the "Med Diag [diagnosis]" tab of the electronic medical record (EMR), revealed R213 had diagnoses which included dysphagia and severe protein-calorie malnutrition. Review of R213's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/10/23, located in "MDS" tab of the EMR, specified the resident had a feeding tube and received 51 percent or more of her total calories through the feeding tube. The resident had a "Brief Interview for Mental Status (BIMS)" score of 0/15, which indicated severe cognitive impairment. Review of R213's "Physician Orders," located in the "Orders" tab of the EMR, revealed an order dated 07/11/23, for the resident to receive "Jevity 1.5 at 50 ml/hr (milliliters per hour) via pump for a total of 1800 calories a day." Review of R213's care plan located in the "Care Plan" tab of the EMR, revealed a "Focus" area initiated on 07/17/23 that specified, "FEEDING TUBE: The resident requires tube feeding, PEG (percutaneous endoscopic gastrostomy) tube r/t (related to) severe protein-calorie malnutrition." A care plan approach specified, "The resident is dependent with tube feeding and water flushes. See MD [medical doctor] orders for current feeding orders." Observation on 07/25/23 at 2:20 PM revealed	F 693	The Clinical Service Director has educated Licensed Nurses on Enteral Feeding policy and emphasizing on providing the correct formula at the rate ordered by the physician. Education was completed by 09/01/23. Any Licensed Nurse not receiving education by this date will receive prior to next scheduled shift. This information will be presented in Licensed Nurse new hire orientation. The Director of Nurses/designee will monitor residents receiving enteral nutrition to validate the correct formula is provided at the correct rate per the physician□s order 2 times per week for 4 weeks then monthly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Director of Nursing for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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F 693	Continued From page 49	F 693		

R213 was in bed with a PEG tube in place. A tube feeding pump positioned next to the resident was observed administering Jevity 1.2 at a rate of 50 ml/hr via R213's PEG tube.

Observation on 07/26/23 at 2:22 PM revealed R213 was seated in a chair in her room. A tube feeding pump positioned next to the resident was observed administering Jevity 1.2 at a rate of 50 ml/hr via R213's PEG tube.

Observation on 07/26/23 at 3:55 PM revealed R213 was seated in a chair in her room. A tube feeding pump positioned next to the resident was observed administering Jevity 1.2 at a rate of 50 mls/hr. The documentation noted on the bottle of Jevity being administered specified the bottle was hung on 07/26/23 at 10:40 AM.

During an interview on 07/26/23 at 4:10 PM, a Licensed Practical Nurse (LPN) F, confirmed R213 was fed by a PEG tube. LPN F checked R213's physician orders and stated the resident had a current order to receive Jevity 1.5 at a rate of 50 ml/hr.

On 07/26/23 at 4:12 PM LPN F observed the enteral formula being administered to R213 and confirmed the resident was not receiving the correct formula. LPN F confirmed the resident was receiving Jevity 1.2 at a rate of 50 ml/hr via her PEG tube not Jevity 1.5 that was ordered by the resident's physician on 07/11/23.

07/27/23 at 4:35 PM the Clinical Service Director confirmed the nursing staff incorrectly administered Jevity 1.2 instead of Jevity 1.5 to R213 on 07/25/23 and 07/26/23.

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F 755	Continued From page 50	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to implement a system to assure the accurate	F 755	Residents #15 and #14□s controlled substances are signed out and deducted from the corresponding narcotic declining	9/11/23

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F 755	Continued From page 51 accounting of controlled medications on 2 of 3 medication carts inspected and failed to ensure medications were available for use for 1 (Resident #55) of 44 sampled residents. The findings included: 1. The facility staff failed to ensure the correct quantity of controlled medications was accurate on 2 medication carts. On 07/26/23 at 09:11 AM, a medication cart on the East wing nursing station. The observation/inspection was conducted in the presence of LPN E. During a controlled medication count, it was noted that Resident #164's Clonazepam 1 mg tablet's corresponding controlled drug count sheet indicated 9 tablets should be present. Observation of the card revealed only 8 tablets. LPN E confirmed the findings. Observation of Resident #15's Lorazepam 0.5 mg revealed 3 tablets present and the controlled medication count sheet indicated 4 tablets should have been present. Resident #15's Tramadol HCL 50 mg tablet medication card was noted to be empty and contained no medication, but the controlled medication count sheet indicated one pill should have been present. LPN E again confirmed the findings and inaccuracies. LPN E then said, "I gave those this morning, but they called me to the phone for a doctor's call". Surveyor C asked when controlled medications are to be signed out and LPN E said, "I try to sign them out as I give them". On 07/26/23 at 11:34 AM, an inspection was	F 755	count sheet immediately following administration. Resident #164_ no longer resides in the facility. Resident #55's order for Diprolene cream was discontinued on 8/13/23 and Resident #55 is her own responsible party. All current residents have had a medication audit completed to ensure accurate medication administration per physician orders. All Residents in the facility have the potential be affected by this alleged deficient practice. The Clinical Services Director has educated the Licensed Nurses on Medication Administration Documentation, Controlled Substances Policy and Protocol What to do if medications cannot be found or are not available? Education completed by 09/ 01/23. Any Licensed Nurse not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in Licensed Nurse new hire orientation. The Clinical Service Director/Director of Nursing will randomly observe resident medication administration and review the narcotic declining count sheets to validate ordered medications are administered then accurately and immediately documented if given 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Clinical Service Director for a period of 3 months.	

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F 755	Continued From page 52 conducted of the East wing medication cart with LPN F. During an audit of the controlled medications, it was noted that Resident #14 was ordered Oxycodone/APAP Tab 10-325 mg. The controlled medication count sheet indicated 22 tablets should have been present and only 21 tablets was noted. LPN G confirmed the findings and stated, "The resident had come up to me wanting it [the pill]", so she administered it and then "got called away and didn't sign it out". LPN G stated that controlled medications should be signed off at the time it is pulled to ensure a correct accounting of the controlled medications. Review of the facility policy titled; "Controlled Substances" was conducted. Excerpts from this policy read, "...8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift... 10. Upon Administration: a. The nurse administering the medication is responsible for recording: 1. name of the Resident receiving the medication; 2. name, strength, and dose of the medication, 3. time of administration, 4. method of administration, 5. quantity of the medication remaining; and 6. signature of the nurse administering medication...". On 7/26/23, during the end of day meeting, the facility Administrator was made aware of the above concerns. No further information was provided.	F 755	Any concerns identified will be addressed at time of discovery	

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F 755	Continued From page 53	F 755		

2. For Resident #55, Diprolene ointment was ordered by the physician, however was unavailable for administration.

On 7/25/23 at approximately 11:30 AM, an interview was conducted with Resident #55. Resident #55 stated, "The doctor prescribed my some cream the other day for a rash on my left thigh and I still haven't received it, the rash is still there".

On 7/25/23 at approximately 12:15 PM, a clinical record review was performed and revealed a physician's order which read, "Diprolene External Ointment 0.05% (Betamethasone Dipropionate Augmented), apply to left hip and thigh rash topically one time a day for rash until 8/6/23, start date 7/24/23 at 0900". There was no documentation of the ointment being administered on Resident #55's medication administration record (MAR) for 7/24/23 and 7/25/23.

A nursing note dated 7/23/23 at 18:54 documental a telephone order received from the physician for "Diprolene .5% cream, apply to rash once daily..." and an orders administration note dated 7/24/23 at 08:37 which documented "Diprolene External Ointment 0.05%...On order awaiting arrival" and 7/25/23 at 11:56, "Diprolene External Ointment....Med on order". There was no documentation that the physician was notified of the unavailability of the ordered medication from the pharmacy.

On 7/25/23 at approximately 12:45 PM, an interview was conducted with the Facility Administrator who was updated on the findings and stated, "I will look into this right away". At

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F 755	Continued From page 54 approximately 3:00 PM, the Facility Administrator stated that the Pharmacy had just delivered Resident #55's ointment. A facility policy was requested and received. Review of the facility document titled, "What to do if medications cannot be found or are not available?", read, "6. Call the provider for further instructions; Is there an alternate medication available; order to hold medication until medication arrives? 7. Notify the resident/RP of the delay and what action has been ordered by the provider, 8. Document in the medical record...". On 7/25/23 at the end of day de-briefing, the Facility Administrator and Director of Nursing (DON) were updated on the findings. No further information was provided.	F 755		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested,	F 791		9/11/23

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F 791	Continued From page 55 assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility staff failed to offer routine dental care for one Resident (Resident #13) in a survey sample of 44 Residents. The findings included: On 7/25/23, during initial tour, Resident #13 was visited in her room. Resident #13 was observed to have many teeth that were broken at the gum and were discolored, black in color. When asked,	F 791	Resident #13 has again declined to pursue dental services when offered on 07/27/23. Residents with dental concerns have the potential to be affected by this alleged deficient practice. The Resident Assessment Coordinator has reviewed current residents to identify those with dental concerns in need of dental services. No other concerns were identified.	

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F 791	Continued From page 56 Resident #13 denied pain, but also stated she had not seen a dentist. When asked if this was something she would be interested in, Resident #13 indicated yes. On 7/26/23, a clinical record review was conducted of Resident #13's chart. This review revealed the following: Resident #13 had a physician order dated 9/15/22, that read, "May have consultation for ophthalmology, podiatry, dental and optometry as needed". Resident #13 had a care plan that read, "[Resident #13's name redacted] has oral/dental health problems r/t [related to] Poor oral hygiene". The associated interventions for this care plan read, "... Coordinate arrangements for dental care, transportation as needed/as ordered, [Resident #13's name redacted] requires mouth inspections quarterly and PRN [as needed]. Report changes to the nurse...". Further review revealed no evidence of any oral/mouth inspections or dental services being offered. On 7/26/23, the facility Administrator was asked to provide any evidence she had with regards to Resident #13's dental status. The facility Administrator indicated that Employee E, the social worker handles this and was out of the office for the day. On 7/27/23, Surveyor C met with Employee E and was provided documentation which included a progress note written 9/21/22, by Employee E. This note read, "SW [social worker] asked [Resident #13's name redacted] about her teeth and she says they do not bother her, and she is	F 791	The Administrator has educated the Social Service Director on arranging services for residents with dental concerns and re-addressing residents with dental concerns at every quarterly care conference should they initially decline services. Education was completed by 09/01/23. The Administrator/designee will monitor residents with dental concerns to validate receipt of services for 3 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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F 791	Continued From page 57 not interested in going to the dentist...". An "Oral Cavity Observation" form conducted 9/14/22, was provided, which indicated no dental concerns. Surveyor C asked if she had any evidence that dental services had been revisited with the Resident or any oral observations were conducted since Sept. 2022, and Employee E said "no". On 7/27/23, during the end of day meeting, the facility Administrator and Clinical Director were made aware of the above findings. No further information was provided.	F 791		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition	F 803		9/11/23

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F 803	Continued From page 58 professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to serve the planned menu as approved by the facility's Registered Dietitian (RD) to residents with physician's orders for regular, mechanical soft, or pureed diets. This failure had the potential to affect 61 residents who were served meals from the facility's kitchen. Findings include: Review of the facility's policy titled, "Menus," revised on 10/17, revealed, "Menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. . . Menus for regular and therapeutic diets are written at least two (2) weeks in advance, and are dated and posted in the kitchen at least one (1) week in advance." A group interview meeting was conducted on 07/26/23 at 1:00 PM with five residents whom the facility identified as reliable historians. During the meeting, two of the five residents (R53, and R56), voiced concerns about the kitchen not always serving the facility's planned menu. Observation on 07/26/23 at 4:40 PM revealed unidentified dietary staff were preparing resident evening meal trays from the kitchen's tray line and the only menu posted in the kitchen was for	F 803	Residents #53 and #56 confirm they are receiving the planned menu items for meals. Residents receiving oral nutrition have the potential to be affected by this alleged deficient practice. The Dietician has educated the Dietary Manager on providing the planned menus for all diet types and the dietary department employees on preparing the meals adhering to the planned menus for all diet types& unless a substitution is absolutely necessary. Education was completed by 09/01/23. Any dietary department employee not receiving education by this date will receive prior to next scheduled shift. This information will be presented in dietary employee new hire orientation. The Administrator will monitor resident meals for all diet types to validate planned menus are followed 2 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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F 803	Continued From page 59	F 803		

regular diets. Review of the menu revealed staff were not serving the Caesar salad and ice cream sundae that was planned on the menu for regular diets. Staff were serving a tossed salad instead of the Cesar salad and a cup of ice cream instead of the ice cream sundae.

Review of the RD approved regular diet for the evening meal of 07/26/23 revealed the following foods were on the menu to be served: pizza, Caesar salad, bread stick, and ice cream sundae.

Review of the RD approved mechanical soft diet menu for the evening meal of 07/26/23 revealed the following foods were on the menu to be served; four cheese pasta, capri blend vegetables, a bread stick, and an ice cream sundae.

Review of the RD approved pureed diet menu for the evening meal of 07/26/23 revealed the following foods were on the menu to be served; pureed four cheese pasta, pureed carpi blend vegetables, pureed bread stick, and pudding parfait.

Observation on 07/26/23 at 4:42 PM revealed unidentified dietary staff served residents on mechanical soft diets the following on their meal trays: chopped chicken nuggets, broccoli, a bread stick, and a cup of ice cream. The dietary staff were observed to serve residents on pureed diets the following on their meal trays: pureed pizza, pureed broccoli, pureed bread stick, and a cup of ice cream.

During an interview on 07/26/23 at 4:45 PM, Cook (C)1, who prepared and served the evening meal on 7/26/23 confirmed the regular diet menu was

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not being served as planned. C1 also stated menus for mechanical soft and pureed diet were not available for the kitchen staff to follow; so, for the 07/26/23 evening meal she decided to serve residents on mechanical soft diets chopped chicken nuggets, broccoli, bread stick, and ice cream, and she decided to serve residents on pureed diets pureed pizza, pureed broccoli, pureed bread, and ice cream. C1 stated she documented the menu changes for the regular menu on the "Menu Substitution Log," C1 stated changes were made to the facility's regular menu approximately one to two times per week.

Review of the kitchen's July 2023, "Menu Substitution Log" revealed staff documented menu changes were made on 07/05/23, 07/11/23, 07/20/23, 07/25/23, and 07/26/23.

During an interview on 07/26/23 at 4:50 PM the Dietary Manager (DM) stated the facility's current resident population had physician's orders to receive diets which included regular, mechanical soft, or pureed. The DM confirmed the regular diet menu was the only menu posted in the kitchen and this menu was not being followed as planned by staff during the evening meal of 07/26/23. The DM explained the menus for mechanical soft and pureed diets were not available in the kitchen for staff to follow, so staff chopped and pureed the foods that were planned on the regular menu to serve to residents on mechanical soft or pureed diets at meals. The DM stated the facility's RD approved the facility's menu which included the menu extensions for mechanical soft and pureed diets, but the RD approved menus for mechanical soft and pureed diets were not available for staff to utilize and it was this way since April 2023 when she started

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F 803	Continued From page 61 working at the facility as the DM. The DM stated she would locate the consultant RD approved facility menus and left the kitchen area. The DM returned to the kitchen with a copy of the facility's planned menu that was signed and approved by the consultant RD which included menus for mechanical soft and pureed diets. During an interview on 07/26/23 at 4:55 PM the DM also stated staff documented menu changes on the "Menu Substitution Log" when they made changes to the regular diet menu and the RD reviewed this documentation during her next facility visit. During an interview on 07/26/23 at 5:03 PM the Administrator stated the facility's approved menu for all diet types needed to be available to the kitchen staff, so the menu could be prepared as planned. During an interview on 07/28/23 at 9:15 AM the facility's consultant RD stated she expected the facility's approved menu to be accessible to dietary staff, so the menu could be prepared at each meal as planned for all diet types.	F 803		
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.	F 812		9/11/23

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F 812	Continued From page 62 (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, interview, and facility policy review, the facility failed to serve milk from the kitchen's tray line at an internal temperature of 41 degrees Fahrenheit (F.) or below and staff failed to wear hair restraints when they served soup to residents from two crock pots in the facility's main dining room for 25 out of 61 residents who consumed meals prepared at the facility. Findings include: Review of the facility's policy titled, "Food Safety," with a revised date of 12/13, revealed, ". . . All cold items need to be held at 40 [degrees] F. or lower. To keep food cold during service surround product with draining ice or keep refrigerated and only pull a few out as needed during service." Review of the facility's policy titled, "Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices," with a revised date of 11/22, revealed, "All employees who handle food, prepare or serve food are trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to	F 812	No residents cited. Residents receiving oral nutrition have the potential to be affected by this alleged deficient practice. The Dietary Manager has educated dietary department employees on holding cartons of milk on ice to maintain a temperature below 41 degrees and the Certified Nursing Assistants and activity department employees on donning hair nets to serve soup to residents in the facility dining room. Education was completed by 09/01/23. Any dietary or activity department employee or Certified Nursing Assistant not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in dietary employee and Certified Nursing Assistant new hire orientation. The Dietary Manager will monitor holding temperatures of milk to validate it is below 41 degrees and the serving of soup in the facility dining room to validate servers are donning hair nets 2 times per week for 4	

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F 812	Continued From page 63 working with food or serving food to residents . . . Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens." 1. Observation on 07/26/23 at 4:48 PM of food and beverages being served from the kitchen's evening tray line revealed cartons of milk were being served from a plastic container which did not contain any ice to keep the milk cold. Temperature monitoring of one of these cartons of milk revealed it had an elevated internal temperature of 46.8 degrees F. During an interview on 07/26/23 at 4:50 PM, the Dietary Manager (DM) stated when staff serve cartons of milk from the kitchen tray line, they are expected to keep the milk covered in ice to maintain its internal temperature at 41 degrees F. or below. 2. Observation in the facility's main dining room on 07/25/23 at 11:15 AM revealed there were two opened cock pots of soup on a countertop. Observation on 07/25/23 at 11:18 AM revealed there were 24 residents in the dining room and Employee G, Employee H, Employee K, and Certified Nursing Assistant (CNA) D served soup from the two crock pots to residents in the dining room. Closer observations of Employee G, Employee H, Employee K, and CNA D revealed they were not wearing hair restraints when they removed soup from the crock pots, placed the soup into bowls or cups and served the soup to residents seated in the dining room. Observation in the facility's main dining room on 07/27/23 at 11:18 AM revealed there were two	F 812	weeks then weekly for 2 months. Results of monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Dietary Manager for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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F 812	Continued From page 64 opened cock pots of soup on a countertop. Observation on 07/25/23 from 11:18 AM to 11:27 AM revealed Employee G, Employee N, Employee K, and CNA D served soup from the two crock pots to approximately 24 residents who were in the dining room. Closer observations of Employee G, Employee N, Employee K, and CNA D revealed they were not wearing hair restraints when they removed soup from the crock pots, placed the soup into bowls or cups and served it to residents seated in the dining room. During an interview on 07/27/23 at 12:05 PM Employee G and Employee K stated they had not been instructed to wear hairnets when they served residents soup from the crock pots in the dining room. Employee G also stated that she was aware hairnets were available right inside the kitchen door but had not been instructed to wear a hair restraint when serving soup from the crock pots in the dining room. During an interview on 07/27/23 at 12:15 PM the Dietary Manager (DM) confirmed staff had not been previously instructed to wear hair nets when they served soup to residents from the two opened crock pots in the dining room.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		9/11/23

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F 880	Continued From page 65 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 66 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to implement infection control practices to prevent the spread of infection on 2 of 2 nursing units, which had the potential to affect multiple Residents. The findings included: 1. The facility staff failed to adhere to standard precautions and perform hand hygiene/cleanse hands between Residents during medication administration. On 7/26/23 at 8:58 AM until 10:05 AM, continuous observations of medication administration were conducted with LPN E. The following was observed: LPN E retrieved from the medication cart, the	F 880	Resident #33, #40, #7, and #52 are receiving medications in accordance with proper infection control practices that include hand hygiene. Resident #52 is receiving blood glucose checks with a blood glucose machine appropriately sanitized and air dried on a barrier protected surface, and is receiving insulin injections after having injection site cleansed with a single use alcohol wipe. Resident #35 is receiving peri care then soiled brief is being bagged in room to transport from room to soiled trash bin. Resident #7 is recieving eye drops according to protocol. All Residents in the facility have the potential to be affected by this alleged deficient practice. The Clinical Services Director has	

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F 880	Continued From page 67 medications for Resident #33. LPN E then approached Resident #33, who was sitting in the hallway across from the nursing station, administered the medications, then returned to the medication cart to dispose of the medication cup and water cup. LPN E then proceeded to retrieve the medications from the cart for Resident #40. LPN E prepared the medications at the medication cart, then went to the nourishment room on the other nursing unit to retrieve a liquid medication supplement. LPN E then returned to the medication cart and poured the supplement into a cup. LPN E and Surveyor C went to Resident #40's room, and the nurse administered the medications and supplement to the Resident. LPN E then returned to the nursing station, opened the door to the medication room, poured the remaining liquid supplement in the sink and threw the cup away. LPN E then returned to the medication cart and began pulling the medications for Resident #7. LPN E put two bottles of eye drops into her pocket and had a cup of the pills and a cup of water in each hand, entered the room of Resident #7. LPN E then provided the Resident the cup of medications, which the Resident took a few from the cup at a time and then would drink water and repeat this process until all 9 pills had been taken. LPN E then put on a pair of gloves and administered eye drops to both eyes of Resident #7. LPN E told Resident #7 and Surveyor C she would return to administer the other eye drops later because she needed to wait between the two drops. LPN E then returned to the medication cart, parked in the hallway, removed her gloves, and then proceeded to document on	F 880	educated Licensed Nurses on proper hand hygiene during medication administration, including donning of gloves, administering eye drops, and single use alcohol wipes and process for blood glucose machines. The Clinical Services Director has educated the CNAs on appropriately bagging soiled brief in room to transport to soiled receptacle, Education completed by 09/01/23, and this education will be presented in the nurse/cna new hire orientation. The Clinical Services Director/Director of Nursing will randomly observe Licensed Nurse medication administration to validate proper infection control practices, and CNAs on the completion of peri care to validate bagging soiled briefs in room for transport to soiled receptacle 2 times per week for 4 weeks then weekly for 2 months. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Clinical Services Director for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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the computer the administration of the pills and the eye drops.

LPN E then at 9:35 AM, began retrieving the medications for Resident #52 from the cart. Following the preparation of the medications, LPN E entered Resident #52's room, administered the po (my mouth) medications/pills. LPN E then donned (put on) gloves, checked the Resident's blood sugar, removed the insulin vial from her pocket and realized the syringe wasn't large enough. LPN E then returned to the medication cart parked in the hallway, opened the cart, and using her gloved hand started touching items in the cart looking for the correct insulin syringe. LPN E then went to the nursing station, opened another medication cart, went through the drawer, touching many items with her gloved hands and obtained 3 syringes. LPN E then, still with the gloves on, returned to the prior cart parked in the hallway, placed two of the syringes in the top drawer of the medication cart and then opened one syringe. She used an alcohol swab to cleanse the diaphragm/seal on the top of the insulin vial and then laid the used alcohol prep pad directly onto the surface of the medication cart.

LPN E then proceeded to draw up the correct amount of insulin into the syringe. LPN E then picked up the used alcohol prep pad from the top of the medication cart, returned to the Resident's room and uses the same previously used alcohol prep pad to cleanse the back of the left arm of Resident #52, where the insulin was to be administered. LPN E then administered the insulin, exited the room, and returned to the medication cart in the hallway. LPN E was still wearing the same pair of gloves initially put on

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following the checking of Resident #52's blood sugar. LPN E then picked up her ink pen and wrote down Resident #52's blood sugar reading on a sheet of paper. LPN E then collected and discarded the trash from the top of the medication cart. LPN E then doffed (removed) her gloves, put on a clean pair of gloves opened the medication cart to retrieve a Sani cloth wipe. LPN E then proceeded to wipe all sides of glucometer once and placed the glucometer directly onto the medication cart to air dry. LPN E then removed her gloves and proceeded to use the computer to document the administration of the medications to Resident #52.

On 07/26/23 at 09:53 AM, Employee P, the maintenance director approached LPN E at the medication cart and asked if she had the paperwork ready for Resident #44, as he was getting ready to take the Resident to dialysis. LPN E said she did not and then walked to the nursing station, completed a form and then went back to the hallway to retrieve a vital sign machine and obtained Resident #44's vital signs. LPN E then recorded the vital signs on the paper and handed it to Employee P.

On 07/26/23 at 09:59 AM, LPN E returned to the medication cart and used hand sanitizer for the first time since the observation began at 8:58 AM.

On 07/26/23 at 10:00 AM, LPN E returned to the room of Resident #7 and administered drops to the Resident's right eye. No gloves were put on during this task. LPN E then returned to the medication cart and immediately began retrieving medications from the cart for another Resident. Again, no additional hand hygiene was performed.

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On 7/26/23, in the late morning, LPN E was approached by Surveyor C. When asked about hand hygiene and a discussion held about the observations during the administration of medications. LPN E apologized and said she should have washed her hands between each Resident.

Review of the facility's infection prevention and control policy was conducted. An excerpt from this policy read, "... 2. The program is based on accepted national infection prevention and control standards. 3. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program...".

The Centers for Disease Control and Prevention (CDC) gives guidance in their document titled, "Hand Hygiene in Healthcare Settings". The document read, "Clean Hands Count for Healthcare Providers: Protect yourself and your patients from potentially deadly germs by cleaning your hands. Be sure you clean your hands the right way at the right times...When to perform hand hygiene? Multiple opportunities for hand hygiene may occur during a single care episode. Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, after caring for a person with known or suspected infectious diarrhea, before moving from work on a soiled body site to a clean body site on the same patient...".

The above referenced CDC document went on to

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state, "...Glove Use: Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. Never wear the same pair of gloves in the care of more than one patient. Carefully remove gloves to prevent hand contamination...".
Accessed online at:
https://www.cdc.gov/handhygiene/providers/index.html

The Centers for Disease Control and Prevention (CDC) gives guidance in their document titled, "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings". Excerpts from this document read as follows: "...5a. Hand Hygiene: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient, Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, Before moving

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from work on a soiled body site to a clean body site on the same patient, After touching a patient or the patient's immediate environment, After contact with blood, body fluids or contaminated surfaces, Immediately after glove removal. Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled. Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered ...". Accessed online at: https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html

On 7/26/23, during the end of day meeting, the facility Administrator and Clinical Director were made aware of the above observations and concerns.

No additional information was provided.

2. The facility staff failed to practice infection control practices to prevent the spread of infection, as evidenced by the re-use of an alcohol prep pad, during insulin administration involving Resident #52.

On 7/26/23 at 9:37 AM, LPN E was observed during the preparation and administration of medications for Resident #52. LPN E administered the po (my mouth) medications/pills. LPN E then donned (put on) gloves, checked the Resident's blood sugar, removed the insulin vial from her pocket and realized the syringe wasn't large enough. LPN E then returns to the medication cart parked in the hallway, opens the cart, and starts using her hands to observe the

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syringes in the cart, then goes to the nursing station, opens another medication cart, goes through the drawer, touching many items with her gloved hands and obtains 3 syringes. LPN E then, still with the gloves on, returns to the prior cart parked in the hallway, places two of the syringes in the top drawer, then opens one syringe, uses an alcohol swab to cleanse the diaphragms/seal on the top of the insulin vial and then lays the used alcohol prep pad directly onto the surface of the medication cart.

LPN E then proceeded to draw the correct amount of insulin into the syringe. LPN E then picked up the used alcohol prep pad from the top of the medication cart, returned to the Resident's room and uses the same previously used alcohol prep pad to cleanse the back of the left arm of Resident #52, where the insulin was to be administered. LPN E then administered the insulin, exited the room, and returns to the medication cart in the hallway. LPN E was still wearing the same pair of gloves initially put on following the checking of Resident #52's blood sugar. LPN E then proceeded to pick up her ink pen and write down Resident #52's blood sugar reading on a sheet of paper. LPN E then collected and discarded the trash from the top of the medication cart. LPN E then doffed (removed) her gloves, put on a clean pair of gloves, opened the medication cart to retrieve a Sani cloth wipe. LPN E then proceeded to wipe all sides of glucometer once and placed the glucometer directly onto the medication cart to air dry. LPN E then removed her gloves and proceeded to use the computer to document the administration of the medications to Resident #52, all without performing any hand hygiene.

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The Centers for Disease Control and Prevention (CDC) gives guidance in their document titled, "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings". Excerpts from this document read as follows: "...5. Standard Precautions: Use Standard Precautions to care for all patients in all settings. Standard Precautions include: 5a. Hand hygiene, 5b. Environmental cleaning and disinfection, 5c. Injection and medication safety...

Standard Precautions are the basic practices that apply to all patient care, regardless of the patient's suspected or confirmed infectious state, and apply to all settings where care is delivered. These practices protect healthcare personnel and prevent healthcare personnel or the environment from transmitting infections to other patients...".

The above referenced document went on to give the following guidance specific to the administration of injections and medications. It read, "...5c. Injection and Medication Safety: Prepare medications in a designated clean medication preparation area that is separated from potential sources of contamination, including sinks or other water sources. Use aseptic technique when preparing and administering medications. Disinfect the access diaphragms of medication vials before inserting a device into the vial. Use needles and syringes for one patient only (this includes manufactured prefilled syringes and cartridge devices such as insulin pens). Enter medication containers with a new needle and a new syringe, even when obtaining additional doses for the same patient...". Accessed online at: https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html

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On 7/27/23, during the end of day meeting, the facility Administrator and Clinical Director were made aware of the above observations.

No further information was provided.

3. The facility staff failed to handle a soiled incontinence brief in a manner to prevent the spread of infection.

On 07/27/23 at 09:55 AM, Surveyor C requested that LPN D accompany her to the room of Resident #35 to make observations of his feet. During this observation, a soiled incontinence brief was noted to be open to air/not in a bag sitting in a chair at the bedside. LPN D confirmed that the brief was soiled. LPN D put on gloves and picked up the soiled incontinence brief, exited the room carrying the brief, still open to air/unbagged through the hall passing about 4 Resident rooms to place the brief in a trash receptacle in the hallway. When asked how the brief should have been handled, she indicated it should not have been sitting in a chair due to infection control concerns and stated, "I will take care of it" and said she would speak to the CNA.

On 07/27/23 at 11:58 AM, an interview was conducted with CNA B. When asked to explain how soiled incontinence briefs are to be handled, CNA B said, "We are to put it in a bag and put it in the trash". When asked why it is put in a bag, CNA B said, "because it's infection control".

On 7/27/23 at 2:30 PM, an interview was conducted with CNA C. When asked how soiled incontinence briefs are to be handled, CNA C

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said, "I remove the soiled brief and put it in a bag, but I had left one". When asked why it was sitting in the chair open to air, CNA C said, "I had forgot it and got distracted". When asked why the soiled briefs are to be placed in a bag, CNA C said, "To keep the germs from other parts".

Review of the facility's infection prevention and control policy was conducted. An excerpt from this policy read, "... 2. The program is based on accepted national infection prevention and control standards. 3. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program...".

The Centers for Disease Control and Prevention (CDC) gives guidance in their document titled, "Environmental Infection Control Guidelines: Guidelines for Environmental Infection Control in Health-Care Facilities (2003)". The document categorizes practices by categories and identified category IC as: "Required by state or federal regulation or representing an established association standard. (Note: Abbreviations for governing agencies and regulatory citations are listed, where appropriate. Recommendations from regulations adopted at state levels are also noted. Recommendations from AIA guidelines cite the appropriate sections of the standard)".

An excerpt from the above referenced CDC document read, "...G.III. Routine Handling of Contaminated Laundry: ... G.III.B. Bag or otherwise contain contaminated textiles and fabrics at the point of use. (OSHA: 29 CFR 1910.1030 § d.4.iv), G.III.B.1. Do not sort or prerinse contaminated textiles or fabrics in

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F 880	Continued From page 77 patient-care areas. (OSHA: 29 CFR 1910.1030 §d.4.iv), G.III.B.2. Use leak-resistant containment for textiles and fabrics contaminated with blood or body substances. (OSHA: 29 CFR 1910.1030 § d.4.iv)...". This information was accessed online at: https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html#g On 7/27/23, during the end of day meeting, the facility Administrator and Clinical Director were made aware of the above observation. Both confirmed that soiled briefs are to be placed in a bag and not sat on other surfaces to prevent the spread of infection. No further information was provided.	F 880		