STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495328	A. BUILDING _____ B. WING _____	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE OF TAPPAHANNOCK	1150 MARSH STREET TAPPAHANNOCK, VA 22560

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 05/30/2023 through 06/01/2023. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. VA00058962- substantiated with deficiency VA00058935- substantiated with deficiency. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 10 resident reviews.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced	F 552		7/12/23

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

Electronically Signed | 06/23/2023

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F 552	Continued From page 1 by: Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to afford a Resident the ability to make decisions in their care affecting 1 Resident (Resident #4) in a survey sample of 10 Residents. The findings included: For Resident #4, who requested to go to the hospital, the facility staff failed to contact the physician and let them know of the Resident's request, instead the facility staff told the Resident he would have to sign out Against Medical Advice (AMA) and pay for the transport. During an interview on 5/30/23, conducted in the late morning, Resident #4 stated that he had requested to go to the hospital following his admission after learning that the facility did not have his IV antibiotics. Resident #4 stated he was told he would have to sign out AMA and pay for the transport. During this interview, Resident #4 verbalized that he is scared to death because "I have an artificial pig valve in my heart that they have replaced once, and they can't replace it again". The Resident said, so if it gets infected and fails, I am going to die, I am scared about not getting my antibiotics like I am supposed to. On 5/30/23-5/31/23, a clinical record review was conducted. The review revealed a progress note that read, "SS [social services] note for 5/26/2023 SS talked with resident as he wants to be move [sic] back to [hospital name redacted], but does want [sic] to pay for transportation & will not sign AMA as doesn't want to be held responsible for anything to do with his stay in facility, as he stated	F 552	1) Resident #4 was discharged home on 6.17.2023. 2) All residents have the potential to be affected, no further residents requested to go to the hospital. 3) DON/Designee to re-educate all facility licensed nursing staff and department managers on resident rights. 4) Social Services/Designee will complete a weekly audit of 5 residents/responsible parties X 3 months to ensure resident rights are honored. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) Date Certain 7/12/2023	

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he had been told that the facility would have his medication (IV) when he arrived, but hadn't arrived like wanted it too [sic]. SS informed resident that he was able to leave the facility, but that he would have to sign the form (AMA) & pay for the transportation. SS even tried to do an assessment on resident, but he refused to do that as well. He's been on his phone the entire day."

There was no evidence in the clinical record that the physician had been called and notified of the Resident's request to go to the hospital and reason why.

Review of the hospital records in the Resident's chart at the facility, were reviewed. Documents within the hospital records read, "... recent hospitalization for Osteomyelitis of left great toe who presented to the ED [emergency department] on 5/18 after discharge to a SNF [skilled nursing facility], due to the facility not having the appropriate antibiotics at their facility. He was previously admitted from 5/1-5/16 for osteomyelitis of left great toe, and septic arthritis for left first interphalangeal joint, and is s/p [status post] I and D [incision and drainage]. He was discharged with instructions to continue IV unasyn [antibiotic] and daptomycin [antibiotic] via PICC [peripherally inserted central catheter] through 6/13, with ID [infectious disease] and podiatry follow-up outpatient, but accepting facility did not have the antibiotics required upon arrival so immediately sent to [hospital name redacted] ED [emergency department] for IV antibiotic administration. Case management found a facility [this facility] that can accommodate his both IV abx [antibiotic] therapy (Unasyn and daptomycin) for the pt [patient]. Pt will be discharged to SNF to complete the IV abx

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therapy".

On 6/1/23 at approximately 8:45 AM, an interview was conducted with Employee E, the social worker. The social worker was asked about Resident #4's request to go to the hospital the day after his admission and for her to explain her interaction with the Resident about this. The Social worker said, "He had come in, I went to do my assessment with him, and he said he was unhappy because his IV meds was behind time, he said he wanted to transfer and go back to the hospital. I came down and talked with [Employee C's name redacted] [Employee C was the Corporate clinical support consultant and interim Director of Nursing at the time] and asked about how that worked, and she said he could sign AMA and he would have to pay to have a squad come back to get him. I went back to tell him that and he said he wasn't going to pay, he felt like we or the hospital should pay, and I told him by him wanting to leave and this was his idea he would have to pay".

On 6/1/23, an interview was conducted with Employee C, the corporate clinical support consultant and prior interim director of nursing. Employee C was asked about the process when a Resident requests to go to the hospital and Resident #4 being told he would have to sign out AMA and pay for transport. Employee C stated that because the doctor didn't order to send the Resident out the Resident would have to sign out AMA and be responsible for the transport. Employee C was advised there was no evidence that the physician had been made aware of Resident #4's request to go to the hospital.

A review was conducted of the facility policy titled,

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"Resident Rights". An excerpt from this policy read, "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ... p. be informed of, and participate in, his or her care planning and treatment ... s. choose an attending physician and participate in decision-making regarding his or her care...".

The facility staff provided the survey team with a policy titled, "Transportation, Social Services". This policy was reviewed and it read, "Our facility shall help arrange transportation for residents as needed. 1. Except in emergencies, the resident or his or her representative (sponsor) shall be expected to arrange for transportation (e.g., to outside physician or clinic appointments or for a planned transfer or discharge from the facility)...".

On 6/1/23, during a meeting with the Administrator, Director of Nursing, Corporate clinical support consultant and Chief Executive Officer, the facility staff were made aware of the above concerns and that the Resident had requested to be sent to the hospital which was denied and there was no evidence that the physician was notified of this request.

Following the meeting noted above, the facility staff provided a policy titled, "Discharging a Resident without a Physician's Approval". The facility had highlighted section 3 of this policy which read, "3. If a resident or representative (sponsor) insists upon being discharged without the approval of the attending physician, the resident and/or representative (sponsor) must sign a Release of Responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's

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F 552	Continued From page 5 medical record and witnessed by two staff members". No further information was provided.	F 552		
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 meds for 1 Resident (#10) in a survey sample of 10 Residents. The findings included: For Resident #10 the facility allowed Resident #10 to have Chlorhexidine Gluconate, a prescription disinfecting mouthwash used to treat periodontal disease, and Chloraseptic, an over-the-counter oral antiseptic and pain reliever at the bedside without first assessing his ability to self-medicate. On 6/1/23 at approximately 5:00 PM, Surveyors B & C observed a bottle of Chlorhexidine Gluconate and a bottle of Chloraseptic spray on the bedside table. When asked what they were for, Resident # 10 answered that they were for his mouth. At that time, an interview was conducted with LPN B who stated that Resident #10 does not self-administer medications. She stated that the mouthwash and spray must have been from the hospital as he	F 554	1) 6.1.2023 Resident #10 was assessed for self-administration of meds and found not capable of self-administration. 2) All residents have the potential to be affected. Facility wide audit completed by DON/Designee to determine if any other residents wanted to self-administer their medications. Residents choosing to self-administer were assessed for ability. 3) Re-educated all facility licensed staff on resident rights to self-administer medications when clinically appropriate. Reviewed in resident council concerns for self-administration protocols. 4) Social Services/Designee will complete a weekly audit of 5 residents/responsible parties X 3 months to ensure resident rights are honored. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee.	7/12/23

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F 554	Continued From page 6 was recently admitted from the hospital. On 6/1/23 at approximately 5:45 PM the Director of Nursing submitted the assessment for self-administration of medications for Resident #10. The assessment was dated 6/1/23 at 5:42 PM and the results of the assessment revealed that Resident #10 is not capable of self-administration of medications. On 6/1/23 during the end of day meeting, the Administrator was made aware of the concern and no further information was provided.	F 554	5) Date Certain 7/12/2023	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on Resident interview, facility staff interview, clinical record review, and facility documentation review, the facility staff failed to uphold Resident's rights to be treated with dignity and respect for 1 Resident (Resident #6) in a survey sample of 10 Residents. The findings included: For Resident #6, the facility staff failed to uphold a Resident's right to be treated with dignity and	F 557	1) Administrator/Designee reviewed with resident his right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Verbal understanding voiced. 2) All residents have the potential to be affected. No other residents expressed	7/12/23

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F 557	Continued From page 7 respect as evidenced by the facility staff waiting until the Resident was out of the facility to remove items identified as a safety hazard. On 5/30/23 at 2:34 PM, Resident #6 requested to see a Surveyor. Surveyor B visited Resident #6 in his room. During this interview, Resident #6 verbalized the following: "Back in March or April, I left on a visit to go to a doctor appointment, I had items in my room. They do ambassador rounds every day and hadn't said anything. When I came back, I noticed the items missing". When asked what the items were, Resident #6 said, Lysol, bug spray and glade air freshener. Resident #6 went on to say, "no one said anything to me during the daily checks, but when I leave to go on my visit, it was taken out of my room without anything being said to me, then on May 16, I go out for a surgery. On this table, I had a bottle of rubbing alcohol and once I go out for my surgery, they come in and take it. I am in here every day, if they say we can't have this stuff, why am I the only one that can't have these items, why am I the only one that the items are being confiscated from, why wait until I am not here and take it. What if I had something of value and come back and that is gone?". On 5/30/23, a clinical record review was conducted. There was an entry in Resident #6's chart dated 5/18/23, that indicated the previous interim administrator attempted to call Resident #6 in response to a message Resident #6 had left. On 5/30/23, during the end of day meeting, Surveyor B requested that the facility staff provide any documentation they had with regards to items being removed from Resident #6's room and any	F 557	lack of dignity or respect. 3)Re-educated all facility staff and reviewed in resident council resident rights to be treated with dignity and respect. 4) Social Services/Designee will complete a weekly audit of 5 residents/responsible parties X 3 months to ensure resident rights are honored. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) Date Certain 7/12/2023	

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policy or documents they have that list items Residents are permitted or not permitted to have.

On 5/31/23 at 5:30 PM, during the end of day meeting, Surveyor B informed the facility administration that no information had been received regarding Resident #6's items being removed. Employee C, the corporate nurse and previous interim director of nursing, said that "During customer service rounds, [Employee G's name redacted], the activities director, located something inappropriate, [which was listed as air freshener and bug spray], they are on the shelf in the admin office, [previous interim administrator's name redacted] and I, talked to him and let him know. During his hospitalization there was a report of green rubbing alcohol in his room, it is also on the shelf. [Employee L/previous interim administrator] returned a call to him about it".

During the above meeting, Surveyor B asked, what items Residents can or cannot have and why Resident #6 couldn't have such items. Employee C said, " anything that could be a danger to himself, or others and we don't allow chemicals to be out in the open without being locked. Someone could go in and drink the green alcohol thinking it was a drink". Employee C went on to say, items not permitted include "anything considered hazardous, OTC [over the counter medications], any cleaning supply type of thing, anything that could pose a danger to someone else, air freshener are not technically allowed".

Following the above noted, end of day meeting, Surveyor B accompanied the administrator to her office and noted a can of Lysol, isopropyl alcohol-wintergreen, raid ant and roach spray, and glade air fresher that all had Resident #6's name written

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on the cans.

On 6/1/23 at 10:15 AM, Surveyors B and C made observations in the facility in Resident rooms of Lysol in Resident #1's room, medications at the bedside in Resident #10's room, multiple Resident's with mouthwash that contained alcohol, wound cleanser, gold bond medicated powder, etc.

On 6/1/23 at 11:37 AM, an interview was conducted with Employee G, the activities director. Employee G confirmed that she conducts rounds on Resident #6's room daily. When asked to describe the purpose of the rounds, Employee G said, "we make sure everything is labeled and nothing supposed to be in the rooms is pulled like OTC medications, etc.". When asked if she found items in Resident #6's room and removed them, Employee G said, she found bug spray and made the Administrator aware, but didn't remove them. Employee G went on to say that Employee C had found green alcohol in the room and "she addressed it with him". Surveyor B asked, why can Residents not have those items? Employee C said, "We have wanderers, and they can go in there, it is dangerous."

Review of the facility policy titled, Resident Rights, was conducted. This policy read, "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ... b. be treated with respect, kindness, and dignity...".

During an end of day meeting held on 6/1/23, with the facility corporate staff and administration, the survey team discussed that Resident #6's feeling

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F 557	Continued From page 10 that he was being singled out, on having items removed from his room, were validated since the surveyors had observed similar items that could be considered hazardous in multiple other Resident rooms. No additional information was provided.	F 557		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review and facility documentation review, the facility staff neglected to provide care and services for 1 Resident (Resident #4) in a survey sample of 10 Residents. This negligence resulted in mental anguish and emotional distress which constituted harm for Resident #4. The findings included: 1. For Resident #4 the facility staff neglected to	F 600	(1) Resident #4 completed all ordered IV Antibiotic treatment and exhibited no signs and symptoms of further or acute infection. Discharged home on 6.17.2023. (2) All residents receiving IV Antibiotics have the potential to be affected. All active IV orders reviewed and confirmed with provider. (3) DON/Designee re-educating all facility	7/12/23

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F 600	Continued From page 11 obtain and provide his IV antibiotic medications upon admission, as agreed upon, which resulted in Resident #4 being in fear of his life. This resulted in mental anguish and emotional distress which constituted harm for Resident #4. On 5/30/23 at 12:13 PM, Resident #4 was visited in his room. Resident #4 said that he was not doing well because "my meds have not been available for 24 hours, I had a prior problem at another facility, this is very serious to me, I had an infection in the pig valve in my heart and I got here, and they didn't have my IV antibiotics. My understanding is the hospital gave me a dose before I left there and then this place would have it in time for my next dose. That didn't happen. They said if I had brought it with me, they could have given the next dose, I asked what happened to the next two doses. They have replaced that artificial valve in my heart once and can't do it again, if it gets infected, I will die". On 5/31/23 at approximately 1:40 PM, Resident #4 was visited in his room again. Resident #4's wife was at the bedside and said, "I've been worried to death, the danger of infection scares us. He has a pig valve in his heart that got infected and failed and they had to replace it. They have told us they can't go in again and they guaranteed us that he would get his medicines here. If that valve gets infected, he will die. I am so glad you are looking into this. It happened at another facility, and he had to be sent back to the hospital because they didn't have his medicine but here, they told him to go back to the hospital he would have to sign out against medical advice". On 5/30/23-5/31/23, a clinical record review was	F 600	licensed staff to notify provider if IV antibiotics are not available. (4) DON/Designee will complete a weekly audit of IV antibiotics for availability and completion of treatment. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. (5) 7.12.2023	

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conducted. The review included the records from the hospital prior to Resident #4's admission on 5/25/23 to this facility.

The "Discharge SNF/Rehab Instructions" form read, "... [Resident #4's name redacted] ... recent hospitalization for Osteomyelitis of left great toe who presented to the ED [emergency department] on 5/18 after discharge to a SNF [skilled nursing facility], due to the facility not having the appropriate antibiotics at their facility. He was previously admitted from 5/1-5/16 for osteomyelitis of left great toe, and septic arthritis for left first interphalangeal joint, and is s/p [status post] I and D [incision and drainage]. He was discharged with instructions to continue IV unasyn [antibiotic] and daptomycin [antibiotic] via PICC [peripherally inserted central catheter] through 6/13, with ID [infectious disease] and podiatry follow-up outpatient, but accepting facility did not have the antibiotics required upon arrival so immediately sent to [hospital name redacted] ED [emergency department] for IV antibiotic administration. Case management found a facility [this facility] that can accommodate his both IV abx [antibiotic] therapy (Unasyn and daptomycin) for the pt [patient]. Pt will be discharged to SNF to complete the IV abx therapy".

Physician orders dated 5/25/23, read, "Unasyn 3-gram solution for injection: intravenous four times daily and Daptomycin 500 mg intravenous solution: intravenously evening shift daily give 8mg/kg...".

Review of the medication administration record (MAR) for May 2023, Resident #4 did not receive the Unasyn until the 5 PM dose on 5/26/23 and

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didn't receive the Daptomycin until 5/28/23.

Review of the clinical record revealed no communication with the attending physician at the facility nor the infectious disease doctor who ordered the IV antibiotics to notify of the missed doses of treatment so that alternate orders could be obtained.

On 6/1/23 at 8:40 AM, an interview was conducted with Employee D, the admissions director. Employee D was asked about Resident #4 being accepted for admission and the discussion of his needs. Employee D said it was discussed prior to admission that Resident #4 would need the IV antibiotics available to start immediately. Employee D said she called the pharmacy and was told the medications were available. Employee D went on to say, "I asked them [the hospital] to send a dose with him and she said she didn't think they could do it, but when the nurse called [LPN B's name redacted] to give report they told her they were sending the next dose and it didn't come with him".

On 6/1/23 at 11:17 am, an interview was conducted with LPN B. LPN B said, "I started doing his [Resident #4] pre-admit orders, I was in report when he arrived. I did get report from the hospital on him, and they said they were going to send IV antibiotics with him. We needed the rate on one of his medications, I passed on to [LPN F's name redacted] that the rate was to come in his orders". LPN B said that "when [Employee D's name redacted] got paperwork she said they wanted to make sure his IV antibiotics were here".

On 6/1/23, LPN B and LPN C confirmed that the

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pharmacy makes two deliveries to the facility daily.

On 6/1/23 at 5:25 PM, an interview was conducted with Employee F, the nurse practitioner (NP). The NP was asked about the process for obtaining medications for a new admission. The NP said, "typically the nurses enter the orders and contact the pharmacy and the meds come on the next run". When asked if Residents who are on IV antibiotics are supposed to miss doses, the NP said, "Is it acceptable, no, does it occur, yes. For IV's it is going to be hard to get upon arrival unless the hospital would send with the patient".

During the above interview, the NP was asked to explain the risks to a patient who misses doses of IV antibiotics. The NP said, "It delays the treatment of the infection, may have to extend the treatment. Usually those folks are followed by infectious disease". When asked if she would expect there to be communication with the doctor or nurse practitioner when doses are missed, the NP said, "Yes, they should reach out to infectious disease or myself".

Review of the facility's abuse policy titled, "Abuse and Neglect- Clinical Protocol" was conducted. This policy read, "Neglect is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness". The "Recognizing Signs and Symptoms of Abuse/Neglect " policy read the same with regards to the definition of neglect. Additionally this policy went on to read, "... b. signs of actual physical neglect: ... 5. Improper use/administration of medication; 6. Inadequate provision of care...".

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F 600	Continued From page 15 On 6/1/23, prior to lunch, the facility's corporate staff, facility administrator and director of nursing were made aware of the above. On 6/1/23, the Corporate Clinical Support Consultant provided Surveyor B with a progress note that she had written on 6/1/23 at 1:12 PM, that read, "Spoke with [Nurse Practitioner's name redacted] regarding missed doses of IV abt. Inquired about extending the dose and she stated she would evaluate him on her upcoming visit. Resident has had no s/s [signs and symptoms] of infection, foot incision clean dry and without signs of infection. Resident has been afebrile ". No further information was provided.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		7/12/23

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F 656	Continued From page 16 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement the care plan for falls for 1 of 10 sampled residents (Resident #7). The findings include: 1. For Resident # 7 the facility staff failed to have fall mats in place as outlined in her care plan and failed to provide measurable objectives related to	F 656	1) Administrator/DON verified bilateral fall mats in place when resident in bed on 6.1.2023. Care plan reviewed and revised as appropriate by MDS Coordinator. 2) All residents with falls have the potential to be affected. Fall care plan interventions for active residents reviewed by DON/Designee to ensure implementation of interventions and measurable objectives.	

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F 656	Continued From page 17 "frequent observations" as outlined in her care plan. Resident # 7 was unable to be interviewed due to her cognitive status and diagnosis of Alzheimer's Dementia and history of CVA. Resident #7 is unable to walk and uses a wheelchair, she is total care with all aspects of ADLs (activities of daily living) except for eating. Her most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/5/23 coded Resident #7 as having a BIMS (Brief Interview of Mental Status) score of 99 indicating she is unable to effectively communicate to answer the questions due to severe cognitive impairment. On 5/31/23 a review of the clinical record revealed that Resident #7 had an unwitnessed fall with injury on 5/22/23. A review of the progress notes revealed the following note. "5/22/23 7:18 PM - At 6:45 PM Call to res room by CNA; noted res lying on the floor beside bed; alert responds to verbal stimuli; noted blood on floor beside resident; skin tear to bridge of nose; goose egg on right side of forehead; resident able to move all extremities without difficulty; Vital signs 97.2 79 20 139/87 O2 sat 99% on ra [room air]; resident out of floor x 2 staff and into w/c; DON notified; 6:52 PM notified [nurse practitioner name redacted] gave orders for bacitracin bid to bridge of nose and follow facility protocol for neuro checks. If any COC [change in condition] send out to or hosp. for eval. 6:58 PM notified [daughters name redacted]; res now sitting up in w/c; will continue to monitor neuro checks in process."	F 656	3) Re-education provided to all facility nursing staff by DON/Designee to include implementation of fall interventions, measurable objectives, and fall protocol. 4) DON/Designee will audit residents with fall mat(s) for placement twice weekly. DON/Designee to perform weekly audit of fall interventions for measurable objectives. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	

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On 5/31/23 at approximately 2:00 PM an interview was conducted with RN B who stated that there were not fall mats beside the bed on the day of the fall. She stated the Resident was found on the floor next to her bed by the CNA. She states that the Resident had a cut on the bridge of her nose and a hematoma to her right forehead and there was blood on the floor. She also stated that the Resident's eyes became black and blue in the day or two following the fall.

A review of the Resident's care plan revealed that Resident #7 had been care planned for falls and on 5/17/23 an intervention was added that read: "Fall mats each side of the bed." Resident #7's care plan also had an intervention dated 3/1/22 that read: "Frequent observations of Resident."

On 5/31/23 at 4:00 PM, an interview was conducted with CNA B who stated she was unaware of the care plan saying frequent observations. She stated there was no specific times for rounding on her. She stated that she looks in on everybody at least every 2 hours but there is no set schedule or time for observations of Resident #7.

On 6/1/23 at approximately 11:55 AM, an interview was conducted with LPN B who stated that there was no specific time to do rounds on Resident #7. She stated staff are aware of which Residents tend to get up without assistance and they watch them a little closer or bring up to the nurse's station so they can be watched. When asked if there is documentation to track how often a Resident is rounded on if they have been care planned for "Frequent Observations" she stated the only time that was done is when a Resident is

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on 1 to 1 observations.

On 6/1/23 a review of the clinical record showed that the Resident #7 was identified on her care plan as a fall risk however when asked, the facility could not produce any fall assessments since admission on 10/14/15, and there was no fall assessment completed post fall.

Excerpts from the Policy entitled "Falls and Fall Risk Management" are as follows:

Pg 1. Definition.
"Unless there is evidence suggesting otherwise, when a Resident is found on the floor, a fall is considered to have occurred."

"Fall Risk Factors:
Resident conditions that may contribute to the risk of falls include:
c. delirium and other cognitive impairment
g. medication side effects
i. functional impairment
j. visual impairment"

Pg 2
"Medical factors that contribute to the risk of falls include.
a. arthritis
d. neurological disorders
e. balance and gait disorder

Resident - Centered Approaches to Managing Falls and Fall Risk:
1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.

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F 656	Continued From page 20 On 6/1/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to	F 657	1) Resident #7□s care plan reviewed and revised by MDS Coordinator.	7/12/23

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F 657	Continued From page 21 review and revise the care plan for 1 Resident (#7) in a survey sample of 10 Residents. The findings included: For Resident #7 the facility staff failed to revise the care plan with appropriate interventions after a fall. On 5/31/23 during clinical record review, it was found that on 5/22/23 Resident #7 was found on the floor beside her bed. Resident #7 had an injury to her nose and her and the right side of her forehead. A review of the care plan for interventions after the fall revealed the following update: "After consulting with hospice an order for ABHR [ABHR is a transdermal cream made from Ativan, Benadryl, Haldol and Risperdal] compound gel to be applied to the inside of wrist BID as needed for terminal agitation to prevent falls." On 6/1/23 at 5:25 PM, an interview was conducted with the NP who stated that ABHR is not appropriate intervention for falls as it will cause drowsiness. She stated she does not order this medication and that is given through hospice. When asked if the physician is called when new hospice medications are started, and she stated that they were not. On 6/1/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657	2) All residents have the potential to be affected. Fall care plan reviewed by DON/Designee for appropriate fall interventions. 3) Re-education provided to all facility nursing staff by DON/Designee to appropriate fall interventions. 4) DON/Designee will perform weekly audit of fall interventions to ensure they are appropriate. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		7/12/23

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F 658	Continued From page 22 §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 Resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to assess a Resident and report changes to the physician for two Residents (Resident #1 and #4) in a survey sample of 10 Residents. The findings included: 1a) For Resident #1 the facility staff failed to assess the Resident following an injury to her leg, which later was identified to be fractured and 1b) failed to notify the physician when there was a delay in obtaining a STAT (urgent) x-ray. On 5/30/23 at 1:24 PM, an interview was conducted with Resident #1 concerning the events when her leg was broken. Resident #1 stated, "One of the employees was with maintenance, he was trying to be funny and grabbed my wheelchair and told my friend [Resident #8] he was kidnapping me. He turned around in fast speed and this leg [left leg] was hurt, from me having broke it several years ago. Anyway he turned it around at a high speed and it got caught underneath the w/c and it broke my tibia. I've been in the bed ever since". Resident #1 went on to say, "He [Employee K] teased me and my boyfriend". Surveyor B asked, has he pushed you in your wheelchair before?	F 658	1) Resident #1 was assessed 5.13.2023 and provider notified and sent to hospital to obtain x-ray. Resident #4□s insulin order clarified with provider to include blood sugar checks. 2) All residents with injuries and orders for insulin have the potential to be affected. No further residents with injuries identified. DON/Designee to ensure all residents with insulin orders have blood sugar monitoring ordered. 3) All licensed facility staff re-educated on need for assessment post injury and the need for blood sugar monitoring with use of insulin. 4) DON/Designee to review incidents in clinical meeting to ensure post-incident assessments completed. DON/Designee to review new insulin orders in clinical meeting to ensure blood sugar monitoring present. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	

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Resident #1 said, "No he isn't authorized to do that. He [Resident #8] turned to close the door behind us and that is when he [Employee K] pulled the back of my chair and took off and said kidnapping. Both of my shoes came off...Everything happened so fast this leg got bent back and I couldn't get it out of the way". The Resident stated they put her back in bed following the incident and said they were going to get an x-ray.

On 5/30/23-5/31/23, a clinical record review was conducted. This review revealed the following entries:

"5/12/23 2:49 PM, Resident c/o [complained of] of pain 10/10 [pain rating of 10 out of 10] in left knee and ankle, staff member advised this writer that resident twisted foot while being pushed in wheel chair, [Nurse practitioner name redacted] ordered Stat XRAY of left knee/Tib/Fib [tibia and fibula] and ankle, [mobile x-ray company name redacted] claim #[number redacted]". There was no indication of any assessment of the Resident to include but not limited to: vital signs, assessment of her leg/foot, etc.

"5/12/23 at 10:30 PM, [name of x-ray company redacted] called and stated that the state x-ray order will not be able to be performed until tomorrow morning".

"5/13/23 at 3:20 PM, Resident's niece [name redacted] called our facility saying that resident had called her c/o [complaining of] not having her x-ray and she was in pain, [x-ray company name redacted] was called by this nurse they stated they would call there [sic] tech and find out a time...".

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"5/13/23 at 5:37 PM, [x-ray company name redacted] called an ETA [estimated time of arrival] will was [sic] still unable to be provided. The order was placed for stat yesterday. [Company name redacted] refused to provided [sic] policy details on stat procedures. States the x-ray will be performed tonight but unaware of what time".

The review showed it was not until 5/13/23 at 8:45 PM, that there was any documentation of the Resident's leg being assessed and the provider being made aware of the inability to obtain the x-ray ordered. The progress note read, "Since [x-ray company name redacted] will be unable to perform the stat x-ray orders placed on 5/12/23 until sometime on 5/14/23, on-call provider gave order to send resident to the ER [emergency room] to have x-rays performed as the left leg is very swollen, bruising and resident has intense pain with any movement and her mobility has been altered...".

Surveyor B obtained and reviewed the hospital emergency room records regarding Resident #1's visit. The hospital records read, "Comments: ... with obvious external rotation of the left leg and deformity and questionable swelling of the proximal thigh... Inspection of her left lower extremity reveal shortening of the left leg with external rotation and questionable swelling of the proximal thigh...". The notes with regards to x-ray results read, "x-ray of the foot, tib-fib and knee reveal nondisplaced fracture of the proximal tibia...".

On 5/30/23 at 1:44 PM, an in-person interview was conducted with the attending physician/medical director. When asked to define

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what stat means, the physician said, "Stat: to be honest when I think something needs to be stat, I usually send to hospital. I would think to rule out, I would expect within a couple of hours". The physician was asked, if the facility staff are unable to carry out an order you give timely would you expect them to call you and let you know there is a delay? The physician said, "absolutely...". The physician further confirmed by the facility staff keeping him aware of the situation and any delay in their ability to complete an order given it allows him the opportunity to make alternate orders and determine treatment options.

On 5/31/23 at approximately 11:30 AM, an interview was conducted with LPN C, who was the nurse when the incident with Resident #1 occurred and also who took the order for the stat x-ray. LPN C was asked about the incident. LPN C said, "I was at the nursing station, she was pushed in and said she was in pain, said her foot got twisted up. The x-ray company didn't come on my shift, they aren't good, even if we order stat that means nothing to them, they say 2-4 hours for stat, but we can go days before they come".

On 6/1/23 at 5:25 PM, a telephone interview was conducted with the Nurse practitioner (NP) who was the ordering practitioner for the stat x-ray. When asked if she expected to be made aware if the order was not able to be carried out, she said, "Yes". When asked if she was made aware of the delay in being able to obtain the stat x-ray, she indicated that it was close to the end of her shift when she gave the order and since it was a Friday, she would have expected staff to call the on-call provider. The NP went on to say she was later made aware by the on-call provider that "there was a delay, and the patient was sent to

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the hospital." There were no further details in the clinical record regarding the details of the incident.

The "Lippincott Manual of Nursing Practice" Eights Edition was referenced. On page 18, in box 2-3 "Common Legal Claims for Departure from Standards of Care" read, "...Failure to implement a physician/NP/PA order properly or in a timely fashion..."

The American Nurses Association (ANA) Standards of Practice refers to the document, "The Nursing: Scope and Standards of Practice, 4th Edition, this resource is meant to inform and guide registered nurses (RNs) in providing safe, quality, and competent patient care". The document read, "...The ANA Standards of Practice outline and describe a competent level of care for registered nurses to follow. From assessment to diagnosis, planning to implementation, the below standards are fundamental to the nursing care process, and foundational for all registered nurses: 1. Assessment: RNs must be able to effectively collect data and patient information that is relative to their condition or situation. This is part of the assessment process...".

On 6/1/23, during an end of day meeting, the corporate staff and facility administration were made aware of the above findings.

No further information was provided.

2) For Resident #4, the facility failed to clarify orders concerning giving insulin three times daily

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without monitoring blood sugars.

On 5/30/23 at 12:13 PM, an interview was conducted with Resident #4. During this interview, Resident #4 expressed concern over medication issues he had since being admitted to the facility within the past week.

On 5/30/23-5/31/23, a clinical record review was conducted of Resident #4's electronic health record. This review revealed the following:

The hospital discharge orders read, "insulin lispro 100 unit/ml injection vial. Your last dose was 8 units on May 25, 2023, 9:18 AM. Inject 8 units into the skin 3 times daily as needed for high blood sugar".

The facility order dated 5/25/23, read, "Insulin Lispro 100 unit/ml subcutaneous solution: subcutaneous before meals daily- 8 units". The order did not include monitoring blood sugars levels.

The first blood glucose check for Resident #4 was on 5/26/23, but it was not checked again until 5/30/23 at 6:30 AM.

On 6/1/23 at 5:25 PM, an interview was conducted with Employee F, the nurse practitioner (NP). The NP was asked about diabetic management. She said, "If they are on insulin, they should have their blood sugar checked prior to administration of insulin". The NP was asked what is the risk of administering insulin without knowing a Resident's blood sugar? She said, "it's not a safe practice, you need to know. You want to avoid hypo and hyperglycemic episodes". She was asked to explain the risk of

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being hypoglycemic or hyperglycemic episodes. The NP said, "you risk hospitalization, readmission, morbidity and mortality".

The facility policy titled, "Diabetes- Clinical Protocol" was reviewed. This document read, "... 3. For the resident receiving insulin who is well controlled: monitor blood glucose levels twice a day if on insulin (for example, before breakfast and lunch and as necessary); monitor 3 to 4 times a day if on intensive insulin therapy or sliding-scale insulin; monitor as indicated if the individual is fasting before a medical procedure, has returned to the facility after a significant absence, or has an acute infection or illness...".

The American Diabetes Association (ADA) gives the following information/standards in the publication titled, "Diabetes Care Volume 46, Supplement 1, January 2023. 6. Glycemic Targets: Standards of Care in Diabetes- 2023. Diabetes Care 2023;46(Suppl. 1): S97-S110". An excerpt on page 10 of the document read, "... INTERCURRENT ILLNESS: Stressful events (e.g., illness, trauma, surgery) may worsen glycemic control and precipitate diabetic ketoacidosis or nonketotic hyperglycemic hyperosmolar state, life-threatening conditions that require immediate medical care to prevent complications and death. Any condition leading to deterioration in glycemic control necessitates more frequent monitoring of blood glucose...".

On 6/1/23, during the end of day meeting, the facility's corporate staff, Administrator and Director of Nursing were made aware of the above findings.

No further information was provided.

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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 by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure a Resident received timely care/treatment to ensure the quality of care for 1 Resident (Resident #1) in a survey sample of 10 Residents. The findings included: For Resident #1, the facility staff failed to coordinate transportation services to an orthopedic specialist as ordered which resulted in a delay in treatment/evaluation for a confirmed tibia fracture. On 5/30/23, in the afternoon, Resident #1 was visited in her room. Resident #1 reported that she had a "broken tibia" and had been to the hospital. On 6/1/23, at approximately 8:45 AM, during an interview with the therapy director, the therapy director reported there was a delay in Resident #1 seeing the orthopedic surgeon due to a transportation issue.	F 684	1) Resident #1 followed-up ortho on 5.22.2023. 2) All residents that require transportation to appointments have the potential to be affected. No further transportation conflicts identified during audit by DON/Designee. 3) Re-educate all licensed facility nursing staff to document in the electronic health record attempts to coordinate transportation for residents to their appointments. Notify provider if unable to obtain transportation for further instruction. 4) DON/Designee to validate transportation log to resident record weekly to confirm transportation has been coordinated appropriately. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee.	7/12/23

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F 684	Continued From page 30 On 6/1/23, Surveyor B reviewed the hospital records again and it stated that while in the emergency room the on-call orthopedist was consulted and agreed to placing the Resident "in an immobilizer and having her follow-up in the orthopedic clinic". It went on to read, "Patient will be discharged with a knee immobilizer and pain medication instruction to follow-up in the orthopedic clinic hopefully this coming week. Her nurse was called and informed of plan". Review of the clinical record revealed a progress note dated 5/14/23 at 11:16 AM, that read, "... to schedule an appointment with ortho on Monday". There was another note dated 5/15/23 at 8:55 AM, that read, "ortho was called an appointment was made for Thursday, May 18, 2023...". There was no note to indicate Resident #1 did not attend the appointment as scheduled and/or any reasons why. There was a progress note dated 5/22/23 at 10:32 AM, that read, "staff with resident at 950 am for appointment with ortho this morning, resident out via stretcher". On 6/1/23, the Corporate Clinical Support Consultant, who was the prior interim Director of Nursing at this facility, stated that the facility protocol for appointments is that they have a shower aide who helps set-up transport and when everything is confirmed it is put in the appointment book. Surveyor B was given the appointment book. Review of the appointment book only noted the appointment on 5/22/23. Surveyor B asked the Corporate clinical support consultant about prior appointments, and she stated she knew Resident #1 had a prior appointment but they could not get transport and therefore she didn't go. The Corporate nurse did	F 684	5) 7.12.2023	

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F 684	Continued From page 31 not know any further details. On the afternoon of 6/1/23, Surveyor B was provided a statement from the therapy manager that indicated Resident #1 had an appointment for May 18, but was not able to attend the appointment due to a lack of transportation. On the afternoon of 6/1/23, the facility administration was made aware that Surveyor B wanted to talk with the staff member who manages appointments since there was no documentation or evidence of the facility staff's efforts to obtain transportation to the missed appointment. The staff person who arranges transportation was not made available to the surveyor prior to survey exit. The facility staff provided the survey team with a policy titled, "Transportation, Social Services". This policy was reviewed, and it read, "Our facility shall help arrange transportation for residents as needed. 1. Except in emergencies, the resident or his or her representative (sponsor) shall be expected to arrange for transportation (e.g., to outside physician or clinic appointments or for a planned transfer or discharge from the facility) ...". On 6/1/23, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No further information was provided.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		7/12/23

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F 689	Continued From page 32 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on Resident interviews, staff interviews, clinical record documentation and facility documentation review, the facility staff failed to provide adequate supervision, failed to implement fall precautions and failed to ensure a Resident received assistance in a manner to prevent accidents/injury for 1 Residents (Resident #1) in a survey sample of 10 Residents. Resident #1 sustained a fractured tibia this constituted harm for Resident #1. The findings included: 1. For Resident #1 the facility staff failed to ensure the Resident was assisted by facility staff in a manner to prevent injury, which resulted in a fractured tibia/resulting in harm. On 5/30/23 at 1:24 PM, an interview was conducted with Resident #1. Resident #1 stated, "[On 5/12/23] one of the employees was with maintenance, he was trying to be funny and grabbed my wheelchair and told my friend [Resident #8] he was kidnapping me. He turned around in fast speed and this leg [left leg] was hurt, from me having broke it several years ago. Anyway he turned it around at a high speed and it got caught underneath the w/c and it broke my tibia. I've been in the bed ever since". Resident #1 went on to say, "He [Employee K] teased me	F 689	1) Resident #1 was ultimately sent to the hospital 5.13.2023, x-ray obtained, and followed up with ortho 5.22.2023. 2) All residents have the risk to be affected with no further accidents or injuries observed or reported. 3) Re-education provided to all facility staff and department managers to include strategies for providing assistance in a manner to prevent injury when transporting resident by wheelchair. 4) DON/Designee to complete weekly audit of 5 residents requiring assistance with transportation by wheelchair to ensure safety and appropriate strategies utilized. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	

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and my boyfriend".

When Surveyor B asked, has he pushed you in your wheelchair before? Resident #1 said, "No he isn't authorized to do that. He [Resident #8] turned to close the door behind us and that is when he [Employee K] pulled the back of my chair and took off and said 'kidnapping.' Both of my shoes came off...Everything happened so fast this leg got bent back and I couldn't get it out of the way".

On 5/31/23 at 11 AM, an interview was conducted with CNA B. CNA B stated she was working the day of Resident #1's incident but was not assigned to care for Resident #1 that day. CNA B's accounting of the events of that day were as follows, "The housekeeping guy [Employee K's name redacted] came and took her wheelchair and said they were going for a joy ride and that is when it happened." CNA B had no further details of the incident.

On 5/31/23 at approximately 11:15 AM, an interview was conducted with LPN C. LPN C said, "I was at the nurses' station and a Resident [Resident #8] pushed her in, she said she was in pain. They said they were pushing her inside from outside and her foot got twisted up".

On 5/31/23 at 12 noon, an interview was conducted with Resident #8. Resident #8 gave the following accounting of the events on 5/12/23 involving Resident #1. Resident #8 said, "We were coming in the door, I turned around to close the door and [Employee K's name redacted] started pushing her chair real fast and her [Resident #1] leg went under the chair. I pushed her to her room". Resident #8 stated, "He didn't

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mean to do it".

On 6/1/23 at 3:30 PM, an interview was conducted with Employee K, the housekeeping supervisor. When asked to describe what happened, Employee K said, "I remember that very clearly, we were in the dining room I remember she was stuck on the entrance going into the patio and she was trying to get off, I asked if she needed my help, I went over pulled her in and asked if she would like me to take her to her room, I started rolling her to her room, she put her foot down and jammed her foot on the floor, She said "ow my leg" I immediately took her to the nurses station, the nurses tended to her. That was pretty much it." When asked if anyone else was around Employee K said, Resident #8 was present because he was trying to help Resident #1 get "unhooked" [across the door threshold]. Employee K denied that there was any joking/playfulness, or any ill intent.

On 5/30/23-5/31/23, a clinical record review was conducted. This review revealed an entry by LPN C dated 5/12/23 at 2:49 PM, that read, "Resident c/o [complained of] of pain 10/10 [pain rating of 10 out of 10] in left knee and ankle, staff member advised this writer that resident twisted foot while being pushed in wheel chair, [Nurse practitioner name redacted] ordered Stat XRAY of left knee/Tib/Fib [tibia and fibula] and ankle, [mobile x-ray company name redacted] claim #39196429".

There were no further details in the clinical record regarding the details of the incident.

On 5/30/23 and again on 5/31/23, Surveyor B requested for the facility to provide any

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documentation/investigation, etc. that had been conducted regarding the incident involving Resident #1 which resulted in the fractured tibia.

On 5/30/23 the facility staff provided an incident report, which read, "Patient was sitting in her wheelchair and she usually propels herself in her wheelchair. She asked the housekeeping manager to push her to her room. He began to push her, and she said ouch my leg. It appeared that she jammed her left foot on the floor". They also provided an in-service education sheet where Employee K/the housekeeping manager was educated. It read, "F/u [follow-up] to incident re: fx [fracture] on Resident after being moved by housekeeping director. Monitor location of resident's legs/feet during transport if there are no pedals on wheelchair it is meant that they self-propel and should do so. Safety guidelines with moving of residents".

The facility staff also provided a copy of an email from Employee K, the housekeeping supervisor, to the Administrator dated 5/15/23. The email read, "On 5/12/23, I noticed that [Resident #8's name redacted] was trying to pull [Resident #1's name redacted] wheelchair into the dining room by way of the patio door and was having trouble doing so. I assisted with helping by pulling the wheel chair in the dining room and did so successfully. She stated that she was going to her room, as I began pushing her to her room she screamed out 'ouch my leg' it appeared that she jammed her left foot into the floor. She stated that she was in a lot of pain. I immediately too her to the Nurses station [sic]".

Surveyor B obtained and reviewed the hospital emergency room records regarding Resident #1's

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F 689	Continued From page 36 visit. The hospital records read, "Comments: ... with obvious external rotation of the left leg and deformity and questionable swelling of the proximal thigh... Inspection of her left lower extremity reveal shortening of the left leg with external rotation and questionable swelling of the proximal thigh...". The notes with regards to x-ray results read, "x-ray of the foot, tib-fib and knee reveal nondisplaced fracture of the proximal tibia...". On 5/31/23, during an end of day meeting, the corporate staff and facility administration were made aware of the above findings and that it resulted in harm for Resident #1. No further information was provided.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		7/12/23

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F 732	Continued From page 37 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation the facility staff failed to include the required information in the Nurse Staffing Information post, which has the potential to affect all Residents. On 5/31/23 observation was made of the Nurse Staffing Posting at the Nurses Station. The posting had the number of RNs, LPNs, CNAs working but not the actual hours the RNs, LPNs, and CNAs worked. On 6/1/23 at approximately 12:00 PM Surveyor B expressed concerned about the Nurse Staffing Posting not containing the required elements. On 6/1/23 during the end of day meeting the Corporate Clinical Support Nurse stated that she	F 732	1) Posted staff nursing information sheet updated to include actual hours worked on 6.1.2023. 2) All residents have the potential to be affected, but none identified. 3) Re-education provided to staffing coordinator and all licensed nursing staff on requirement by clinical support nurse to include updating off hours and on weekends. 4) Administrator/Designee to verify the nurse staffing information post for accuracy three times weekly. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI	

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F 732	Continued From page 38 had reviewed the regulation and was now clear on what information was required to be on the Nurse Staffing Posting. On 6/1/23 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.	F 732	Committee. 5) 7.12.2023	
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	F 755		7/12/23

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F 755	Continued From page 39 §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 interview clinical record review and facility documentation the facility staff failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for 2 Residents (#9 and #7) in a survey sample of 10 Residents. The findings included: 1. For Resident #9, the facility staff failed to ensure the accurate accounting of Phenobarbital, a controlled medication. A review of the count sheet revealed that the Resident's bottle of Phenobarbital had to be "Count Corrected" on 2 occasions. The count sheet was started on 4/18/23 there was 275 ml. of Phenobarbital Elixir in the bottle. On 5/15/23 at 9:00 PM the count sheet was signed off as having 267.5 ml in the bottle. On 5/16/23 the narcotic count sheet was signed off as having 22.95 ml in the bottle. On 5/17/23 RN D corrected the count at 3:30 PM by writing corrected count 100 ml in the bottle and signing the count sheet without the presence of a co-signer. There is no documentation to show that the nurse notified the supervisor or DON, and no	F 755	1) Resident #9□s phenobarbital has since been discontinued with alternative replacement utilized. Resident #7□s Lorazepam 0.5ml obtained on 6.2.2023. 2) All residents with controlled medications have the potential to be affected, all medication carts audited at time of survey to verify no further corrected counts or inconsistencies with availability of liquid controlled medications identified by clinical support specialist and DON. 3) Re-education to be provided to all facility licensed nursing staff by DON/Designee to immediately notify DON/Administrator of any controlled medication discrepancies and need for two nurses to signatures when editing controlled medication documents. Re-education of medication administration rights. 4) DON/Designee to complete audit of controlled medication counts for discrepancies in count and confirmation of appropriate dosage available. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	

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F 755	Continued From page 40	F 755		

investigation was done.

On 5/31/23 at approximately 3:00 PM an interview was conducted with the Administrator and the Corporate Clinical Support Consultant who were shown the count sheet and asked if this is standard practice to have one nurse sign off on a count sheet to correct a count. The Corporate Clinical Support Consultant stated that it was neither facility policy nor standard of practice. When asked if an investigation had been done into the missing medication, she stated that there had not.

A review of the facility policy entitled "Controlled Substances" read:
"Policy Statement- The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances."

"8. Licensed Nurses are to count controlled medications and the end of each shift. The nurse coming on duty and the nurse going off duty count together. The must document and report any discrepancies to the Director of Nursing Services / designee at the time observed.

"9. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility [sic] parties and shall give the Administrator a written report of such findings."

"10. The Director of Nursing Services shall consult with the provider pharmacy and the Administrator to determine whether any further legal action is indicated."

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F 755	Continued From page 41 On 6/1/23 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. 2. For Resident #7, the facility staff failed to obtain physician ordered Lorazepam 0.5 ml. On 5/31/23 a review of the clinical record revealed that Resident #7 had orders for Lorazepam that read: Lorazepam 2 mg/ml oral concentrate Administer 0.5 ml oral twice a day for behaviors and agitation order date 4/19/23. Lorazepam 2 mg/ml oral concentrate Administer 0.25ml sublingually every 1 hour as needed for agitation Order date 1/26/23. A review of the MAR (Medication Administration Record) revealed that Resident #7 did not get her routine scheduled dose of Lorazepam on 5/24/23 (both morning and evening doses) 5/25/23 (both morning and evening doses) 5/26/23 (the evening dose) 5/27/23 (the morning dose). A review of the count sheets revealed on 5/29/23 facility staff were pulling the scheduled medication from the PRN order and using 2 of the 0.25 ml syringes for each administration. On 5/31/22 at approximately 12:55 PM, an interview was conducted with RN B who stated that she thought the staff pulled from the PRN to give the scheduled dose because they may have been out of the routine scheduled dose.	F 755		

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F 755	Continued From page 42 On 6/1/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure that Residents did not receive unnecessary drugs to include duplicate drug therapy for 2 Residents (#5 & #7) in a survey sample of 10 Residents.	F 757	1) Resident #5□s Xanax order has since been discontinued. Resident # 7□s Morphine diagnosis clarified for use of pain by provider. 2) All residents have the potential to be affected. DON/Designee to complete audit	7/12/23

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F 757	Continued From page 43 The findings included: For Resident # 5 the facility staff received and administered Lorazepam and Xanax (both anti-anxiety medication) at the same time. This constitutes unnecessary medication by way of duplicate drug therapy. On 5/31/23 during clinical record review it was found that Resident #5 had orders that read: "Xanax 1mg [milligrams] tablet twice daily in the morning and in the evening for agitation" "Lorazepam 2 mg/ml [milligrams per milliliter] Administer 0.25ml [equivalent to 0.5 mg] every hour as needed for anxiety and agitation order date 3/27/23." "Xanax 0.5 mg tablet oral as needed 1 tablet in the morning and 1 tablet in the evening PRN [as needed] for anxiety order date 3/27/23." On 6/1/23 a review of the progress notes revealed that on 4/13/23 LPN administered both Lorazepam 0.5 mg PRN and Xanax 0.5mg PRN at 8:19 PM On 6/1/23 at 5:35 PM an interview was conducted with the Nurse Practitioner who was asked about the orders for Xanax and Lorazepam some medications are prescribed through hospice and the physicians are aware that the Resident is on hospice, but hospice does not notify them when new medications are started. She stated that there would be no need for the Xanax order if they already had the Lorazepam order as they both are anti-anxiety medications.	F 757	for duplicative therapy and inappropriate diagnosis. 3) Re-education provided to all facility licensed nursing staff by DON/Designee to include review of proper medication administration (including refraining from duplicative therapy and appropriate use of medications based on ordered diagnosis). 4) DON/Designee will review new orders twice weekly to identify any risk of duplicative therapy and/or incorrect diagnosis for medication use. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	

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On 6/1/23 during the end of day meeting, the Administrator was made aware of the concerns and no further information was available.

2. For Resident # 7 the facility staff gave morphine (a narcotic pain medication) for behaviors, constituting giving an unnecessary medication.

On 5/31/23 during clinical record review it was noted that the Resident had the following orders:

Morphine 20 mg/5 ml (4ml) oral solution sublingual every 1 hour as needed. Order date 1/25/23.

On 6/1/23 during clinical record review it was noted that Resident #7 received a dose of morphine "late morning due to behaviors." The note read, "4/27/23 7:57 AM Resident noted this morning repeatedly yelling out removing clothing and bed linen, she was redirected offered a snack and fluids, total adl [activities of daily living] care rendered and all non-pharm interventions unsuccessful. PRN ABHR [ABHR is a transdermal cream made from Ativan, Benadryl, Haldol and Risperdal] and Morphine administered / applied at 5:53 am and was effective."

"5/27/23 2:30 pm Administered ABHR as well as morphine attempted to get vitals resident yelling and punching."

On 6/1/23 at 5:35 PM, an interview was conducted with the Nurse Practitioner who was asked about giving Morphine for behaviors and she stated that it was not acceptable to give

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F 757	Continued From page 45 morphine for behaviors. She stated that the resident had a PRN medication for behaviors. On 6/1/23 during the end of day meeting, the Administrator was made aware of the concerns and no further information was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		7/12/23

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F 758	Continued From page 46 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure that Residents did not receive unnecessary medications anti-anxiety medications were not prescribed for more than 14 days for 1 Residents (#5) in a survey sample of 10 Residents. The findings included: For Resident # 5 the facility staff failed to make sure the Resident did not have PRN (as needed) Lorazepam and Xanax orders that were more than 14 days without the proper documentation by the physician. On 5/31/23 during clinical record review it was found that Resident #5 had orders that read: "Lorazepam [an anti-anxiety medication] 2 mg/ml	F 758	1) Resident #5 no longer resides at facility. 2) All residents with PRN psychotropic medications have the potential to be affected. Audit completed by DON/Designee to ensure PRN psychotropic medications have a stop date of 14 days or less. 3) Re-education provided to all facility licensed nursing staff to include use and duration of PRN psychotropic medications. 4) DON/Designee will review new orders twice weekly to verify appropriate stop dates on PRN psychotropic medications. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities,	

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F 758	Continued From page 47 Administer 0.25 ml every hour as needed for anxiety and agitation order date 3/27/23." "Xanax 0.5 mg tablet oral as needed 1 tablet in the morning and 1 tablet in the evening PRN for anxiety order date 3/27/23." On 6/1/23 at approximately 1:00 PM an interview was conducted with Corporate Nurse who was asked about the regulation regarding the length of time a PRN anti-anxiety is given. The Corporate Nurse said 2 weeks unless the doctor puts in the appropriate documentation. When asked if the same applies to hospice she stated that hospice is no exception to the rule. When asked if she was aware of the PRN orders that have been on the charts for months, she indicated that she was aware and was working with the doctors and with hospice to get that fixed. On 6/1/23 during the end of day meeting the Administrator was made aware and no further information was provided.	F 758	monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own	F 776		7/12/23

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F 776	Continued From page 48 diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. 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 obtain an x-ray in a timely fashion, resulting in the Resident having to be sent to the hospital to obtain the x-ray, affecting 1 Resident (Resident #1) in a survey sample of 10 Residents. The findings included: For Resident #1, the facility staff failed to obtain an x-ray ordered STAT [urgent/meaning immediately], which resulted in the Resident having to be sent to the hospital over 30 hours later, which had the potential to delay treatment. On 5/30/23 at 1:24 PM, an interview was conducted with Resident #1. Resident #1 stated she had injured her leg and "the nurse said she was going to request an x-ray". The Resident went on to say that she had to wait until she was taken to the hospital for the x-ray to be done. On 5/30/23-5/31/23, a clinical record review was conducted. This review revealed the following entries with regards to an x-ray being obtained: "5/12/23 2:49 PM, Resident c/o [complained of] of pain 10/10 [pain rating of 10 out of 10] in left knee and ankle, staff member advised this writer that resident twisted foot while being pushed in wheel chair, [Nurse practitioner name redacted] ordered Stat XRAY of left knee/Tib/Fib [tibia and fibula] and ankle, [mobile x-ray company name	F 776	1) Resident #1 received x-ray at hospital on 5.13.2023. 2) All residents with orders for STAT x-rays have the potential to be affected with none identified on 30 days look back of orders. 3) Re-education provided to all facility licensed nursing staff to include notified of MD if x-ray unable to be completed timely. 4) DON/Designee to complete audit of new x-ray orders during clinical meeting for timely completion. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	

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redacted] claim #[number redacted]".

"5/12/23 at 10:30 PM, [name of x-ray company redacted] called and stated that the state x-ray order will not be able to be performed until tomorrow morning".

"5/13/23 at 3:20 PM, Resident's niece [name redacted] called our facility saying that resident had called her c/o not having her x-ray and she was in pain, [x-ray company name redacted] was called by this nurse they stated they would call there [sic] tech and find out a time...".

"5/13/23 at 5:37 PM, [x-ray company name redacted] called an ETA [estimated time of arrival] will was [sic] still unable to be provided. The order was placed for stat yesterday. [Company name redacted] refused to provided [sic] policy details on stat procedures. States the x-ray will be performed tonight but unaware of what time".

"5/13/23 at 8:45 PM, Since [x-ray company name redacted] will be unable to perform the stat x-ray orders placed on 5/12/23 until sometime on 5/14/23, on-call provider gave order to send resident to the ER [emergency room] to have x-rays performed as the left leg is very swollen, bruising and resident has intense pain with any movement and her mobility has been altered...".

"5/13/23 at 11:46 PM, resident left facility at 9:15PM via EMS [emergency medical services] transferred to [hospital name redacted].

Surveyor B obtained and reviewed the hospital emergency room records regarding Resident #1's visit. The hospital records read, "Comments: ... with obvious external rotation of the left leg and

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deformity and questionable swelling of the proximal thigh... Inspection of her left lower extremity reveal shortening of the left leg with external rotation and questionable swelling of the proximal thigh...". The notes with regards to x-ray results read, "x-ray of the foot, tib-fib and knee reveal nondisplaced fracture of the proximal tibia...".

On 5/30/23 at 1:44 PM, an in-person interview was conducted with the attending physician/medical director. When asked to define what stat means, the doctor said, "Stat: to be honest when I think something needs to be stat, I usually send to hospital. I would think to rule out, I would expect within a couple of hours". The doctor was asked, if the facility staff are unable to carry out an order you give timely would you expect them to call you and let you know there is a delay? The doctor said, "absolutely, if my suspicion is high for an injury, I would say send to the ER". The doctor further confirmed by the facility staff keeping him aware of the situation and any delay in their ability to complete an order given it allows him the opportunity to make alternate orders and determine treatment options.

On 5/31/23 at approximately 11:30 AM, an interview was conducted with LPN C, who was the nurse when the incident with Resident #1 occurred and also who took the order for the stat x-ray. LPN C was asked about the incident. LPN C said, "I was at the nursing station, she was pushed in and said she was in pain, said her foot got twisted up. The x-ray company didn't come on my shift, they aren't good, even if we order stat that means nothing to them, they say 2-4 hours for stat, but we can go days before they come".

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F 776	Continued From page 51 On 6/1/23 at 5:25 PM, a telephone interview was conducted with the Nurse practitioner (NP) who was the ordering practitioner for the stat x-ray. When asked about a stat order, the NP said, "I would like it completed the same day or as soon as possible". When asked if she expects to be made aware if this is unable to be done, she said, "Yes". When asked if she was made aware of the delay in being able to obtain the stat x-ray, she indicated that it was close to the end of her shift when she gave the order and since it was a Friday, she would have expected staff to call the on-call provider. The NP went on to say she was later made aware by the on-call provider that "there was a delay, and the patient was sent to the hospital". Review of the facility policy titled, "Availability of Services, Diagnostic" as conducted. This policy read, "... 4. The following diagnostic services are available twenty-four (24) hours a day, seven (7) days a week, including holidays: ...g. Radiology...". The facility provided the survey team with a copy of a valid and current contract with an outside provider who would perform x-rays for the facility. On 5/31/23 and again on 6/1/23, the corporate staff and facility administration were made aware of the concern regarding the delay in obtaining an ordered x-ray for Resident #1, which was done 30 hours after the receipt of an order for a stat x-ray to be performed. No further information was provided.	F 776		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2)	F 825		7/12/23

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F 825	Continued From page 52 §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide rehab services as determined to be necessary for 1 Resident (Resident #1) in a survey sample of 10 Residents. The findings included: For Resident #1, the facility failed to implement therapy services for over four weeks after being evaluated and notified no insurance pre-approval was needed. On 5/30/23, Resident #1 was visited in her room and expressed concern and frustration that she had not been out of the bed in over 2 weeks.	F 825	1) Resident #1 re-evaluated by therapy on 6.1.2023. 2) All residents have the potential to be affected. DOR/Designee will complete audit on all current residents to determine therapy needs by 6.30.2023. 3) Re-education provided to DOR by regional operations director of therapy to include timely therapy services received. 4) Administrator/Designee to conduct weekly audit of residents identified with a need for therapy services. Audits to be reviewed monthly at QAPI Committee for	

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F 825	Continued From page 53 On 5/30/23-5/31/23, a clinical record review was performed. There was no evidence of any therapy services being provided to Resident #1 during this time. On 6/1/23 at 8:48 AM, an interview was conducted with Employee H, the therapy manager. Employee H accessed the records for Resident #1 and stated Resident #1 had been on therapy services several times throughout her stay at the facility. Employee H further stated that Resident #1 had been evaluated by physical therapy on 4/29/23, and they have never heard back from the insurance company for authorization to start services. Employee H went on to say that she emails the business office manager and several corporate level staff when insurance authorizations are needed and send the evaluation. With regards to Resident #1, Employee H said, "we have been waiting and never got authorization". Surveyor B requested a copy of the email(s) that were sent. Employee H/the therapy director accessed her email that was sent on 6/1/23 at 1:53 PM. The email read, "Let me know when it is approval [sic] to start treatments on the above patients", and Resident #1 was noted in the subject line of the email. The email had a response on 6/1/23 at 1:55 PM, from the business office manager to the rehab director that read, "[Resident #1's name redacted] doesn't require approval...". Employee H, the therapy director then responded to that email with "Thanks...". The email stating prior approval wasn't needed was pointed out by Surveyor B to Employee H, Employee H stated, "..., I will have to check on that... but she is being evaluated today".	F 825	gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	

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F 825	Continued From page 54 During the above interview, Employee H provided Surveyor B with a copy of the physical therapy evaluation performed on 4/29/23. This document was reviewed and excerpts from it read, "Assessment Summary: Clinical Impressions: Patient referred to PT evaluation due to decline in functional mobility... Patient presents with impaired transfer skills, unsteady gait and impaired balance. She needs Min A [minimum assistance of staff] with sit to stand transfers & ambulation for safety ... Risk Factors: due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: falls, muscle atrophy, immobility, further decline in function, limited out-of-bed activity, pressure sores, decreased skin integrity, decrease in level of mobility and decreased ability to return to prior level of assistance". During an end of day meeting held on 6/1/23, the corporate staff and facility administration were made aware of the above findings. No further information was provided.	F 825		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to maintain an effective pest control program for 2 Residents (#1 & #5) in a survey sample of 10	F 925	1) Residents #1 and #5 resided in room 121 during the time of survey. Room 121 was included in bed bug dog report as being checked by dog. Room 105 was	7/12/23

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F 925	Continued From page 55 Residents. The findings included: For Residents #1 & #5, who are roommates, the facility staff failed check the room for reported bed bugs. On 5/31/23 at approximately 11:00 AM, an interview was conducted with Resident 1 who stated that she was supposed to be moved to another room because they found a bug in her room and needed to treat her room. When asked if the room treated, she stated that it was not. During clinical record review a progress note was found stating on 5/24/23 a bed bug was found on Resident #1's pillow and the family was notified of the incident and that the Resident was being showered and checked for bites and moved to room 133 until pest control could come out to service the room. During clinical record review a note progress note was found in Resident # 5's chart that stated the family was notified of a bed bug being found in the room and that the Resident was being showered and checked for bites a moved to room 133 until the pest control service was completed. Due to cognitive status Resident #5 was unable to be interviewed. An interview was conducted on 5/31/23 at 2:00 PM with the Corporate Nurse Support Consultant who said that they were planning to move the Residents to another room but the "Dog came in and they cleared the room." When asked what she meant by "cleared the room," she stated that the dog did not alert to any active bed bugs in	F 925	checked by Terminex on 5.15.2023 and 6.2.2023 2) All residents have the potential to be affected without any additional pest concerns identified or reported. 3) Re-education provided to facility staff by Administrator/Designee regarding their continued diligence to report any pest control concerns. 4) Administrator/Designee to complete weekly audit of pest control logs and program. Audits to be reviewed monthly at QAPI Committee for gaps and opportunities, monthly x3 or until determined to be resolved by the QAPI Committee. 5) 7.12.2023	

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room. When asked when that was done, she supplied the pest control logs.

A review of the maintenance logs revealed that the maintenance log read as follows:

"May 13 - Contacted pest control - bed bugs"
"May 20 - Contacted pest control - bed bugs"
"May 27 - Dog brought in no sign of bed bugs."

A review of the company that inspects for bed bugs report read:

"K-9 - Roger" [Bed bug detecting dog]
"Rooms -"121 - negative, 123 - negative, 131 - negative, 133 - negative"

NOTE: The K-9 is not shown as checking room 105 which is the room that Resident #'s 1 and 5 share.

On 6/1/23 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.