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	495267	A. BUILDING _____ B. WING _____	C 09/01/2023

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/29/23 through 09/01/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/29/2023 through 9/1/2023. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints (VA00057852- substantiated with deficiency, VA00059561- substantiated with deficiency, VA00059245- substantiated with deficiency, VA00056712- substantiated with deficiency and VA00059398- substantiated with no deficiency) were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 107 at the time of the survey. The survey sample consisted of 36 current resident reviews and nine closed record reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to assess	F 554	1. Resident #72 was assessed for self-administration of Fluticasone nasal spray completed 8/30/2023. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents self-administering medication has been performed to ensure assessment related to self-administration of medication is complete.	

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

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F 554	Continued From page 1 one of 45 residents in the survey sample for self-administration of medication, Resident #72. The findings include: For Resident #72 (R72), the facility staff failed to assess for self-administration of medication. During the medication administration observation task, R72 was observed to have a bottle of Fluticasone nasal spray (1) on the overbed table and self administered the medication when asked by LPN (licensed practical nurse) #7. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/16/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 8/30/2023 at 8:05 a.m., an observation was made of LPN #7 preparing and administering medications to R72. LPN #7 prepared a medication cup of scheduled morning medications and entered R72's room to administer the medications. After R72 was observed taking the medications, LPN #7 picked up the Fluticasone nasal spray that was observed on the overbed table beside the bed and asked R72 to take the medication. R72 was observed to place one spray in each nostril and advised LPN #7 that the bottle was almost empty and they needed a replacement. After exiting R72's room LPN #7 stated that R72 kept the Fluticasone nasal spray at their bedside because they were able to self-administer the medication and always did it themselves. She stated that the nurse practitioner had given the staff permission to leave the medication with R72.	F 554	3. DON/designee will educate licensed nursing staff regarding performing self-administration of medication assessment for residents that self-administer medications. 4. DON/designee will perform an audit for any new self-administration of medications weekly x4 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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The physician orders for R72 documented in part, "Fluticasone Propionate Nasal Suspension 50 MCG (microgram)/ACT (Fluticasone Propionate (Nasal)) 1 spray in each nostril one time a day for for sneezing. The order failed to evidence guidance to leave at the bedside for self-administration.

Review of R72's clinical record failed to evidence an assessment for self-administration of medications.

The comprehensive care plan for R72 failed to evidence self administration of the Fluticasone.

On 8/30/2023 at 5:06 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of a medication self administration assessment and a physician's order for self-administration and leave at bedside order for the Fluticasone nasal spray.

On 8/31/2023 at 9:20 a.m., ASM #2, the director of nursing provided a medication self administration assessment dated 8/30/2023 at 6:28 p.m. and stated that it had been completed the night before. ASM #2 stated that R72 should have had one completed prior to 8/30/2023 if the medication was at the bedside and self-administered.

The facility policy, "Self-Administration of Medication and Treatments" dated 10/1/2021 documented in part, "Policy: Residents have the right to self-administer medications / treatments if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so... 8. Self-administered medications and/or

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treatment supplies will be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them..."

On 8/31/2023 at 4:31 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant were made aware of the above concern.

No further information was presented prior to exit.

(1) fluticasone nasal spray
Fluticasone comes as a (prescription and nonprescription) liquid to spray in the nose. When nonprescription fluticasone nasal spray is used to relieve hay fever and other allergy symptoms, it is usually sprayed in each nostril once daily. When prescription fluticasone nasal spray is used to treat nonallergic rhinitis, it is usually sprayed in each nostril one or two times a day. When prescription fluticasone nasal spray is used to treat nasal polyps, it is usually sprayed in each nostril two times a day. Follow the directions on your prescription or product label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Use fluticasone exactly as directed. Do not use more or less of it or use it more often than directed on the package label or prescribed by your doctor. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695002.html

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F 558 F 558 SS=E	Continued From page 4 Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document, it was determined that the facility staff failed to accommodate needs for one of 45 residents in the survey sample, Resident #28. The findings include: The facility staff failed to accommodate Resident #28 (R28) with their bathing preference. R28 was admitted to the facility on 2/4/2022 with diagnoses that included but were not limited to severe morbid obesity (1) and body mass index [BMI] 70 or greater, adult (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/23/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that they were cognitively intact for making daily decisions. Section G coded R28 as requiring extensive assistance of two or more persons for transfers and totally dependent on one person for bathing. It documented R28 not steady, but able to stabilize without staff assistance when walking and turning around and not steady and only able	F 558 F 558	1.Resident #28 received an initial shower on 9/7/2023. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents was performed to ensure a shower was completed for the current week. 3. DON/designee will educate nursing staff regarding providing shower/bathing in accordance with resident preferences. 4. DON/designee will perform an audit of daily shower completion 5x week x4 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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to stabilize with staff assistance when moving from a seated to standing position, moving on and off the toilet and for surface to surface transfers. The assessment documented R28 not having any impairments in the upper or lower extremities, and using a walker and a wheelchair.

On 8/29/2023 at 12:33 p.m., an interview was conducted with R28. R28 stated that they had resided at the facility for over a year and really wanted to get a shower. R28 stated that the nurses aides and therapy kept telling them that they were trying to get them a bedside commode that they could use as a shower chair but they had never gotten one. R28 stated that they had only received bed baths since they were at the facility and there were only certain CNA's (certified nursing assistants) who would do their bath due to their size so they had to wait until they were working to get their baths. R28 stated that it made them mad and they had never been to the shower or been offered a shower because of their size. R28 stated that no one should have to go without a shower and they were looking to transfer to another facility and that was one of the reasons.

Review of the ADL documentation for R28 from 6/1/2023 to the present failed to evidence documentation of a shower received. The documentation only evidenced bed baths or partial bed baths.

On 8/31/2023 at 10:50 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that showers were twice a week and the CNA's documented them in the computer. LPN #7 stated that there were several CNA's who worked with R28 the most because

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they knew their routine and preferences. LPN #7 stated that R28 only received bed baths as far as they knew.

On 8/31/2023 at 11:01 a.m., an interview was conducted with CNA #5. CNA #5 stated that R28 was totally dependent on staff for bathing and always got bed baths. She stated that R28 would not fit on the shower equipment they had. She stated that they were supposed to be getting R28 a shower chair so they could go to the shower but it had not come in yet. She stated that R28 was one of two obese residents who needed the shower chair and the facility was working to buy the chair for them to use for the residents. She stated that the head of therapy had been working to get the chair. She stated that R28 received bed baths from her and one other aide twice a week when they were working because some of the other CNA's were intimidated by the resident's size but she did not mind. She stated that R28 had been here over a year and had always wanted showers since they had worked with them but they were unable to provide them.

On 8/31/2023 at 2:04 p.m., an interview was conducted with OSM (other staff member) #7, the director of rehab. OSM #7 stated that they had been working with administration to get R28 a bedside commode that could be used as a shower chair. He stated that they had received one chair that was too narrow and they had sent it back and were working on getting another one the correct size. He stated that R28 was currently receiving physical therapy services for ambulation and then occupational therapy planned to pick the resident up for ADL training. He stated that the facility should have equipment that could accommodate R28's needs and requests to have

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a shower. He stated that the facility should have attempted to accommodate R28's request to have a shower prior to this point.

On 8/31/2023 at 2:45 p.m., OSM #7 provided dates that the bariatric bedside commode was shipped on 8/9/2023, arrived on 8/15/2023. He stated this commode was too narrow and was returned and a new order was submitted on 8/15/2023 and approved by administration on 8/21/2023. When asked if R28 had been assessed to receive a shower prior to this, OSM #7 stated that therapy had not starting working on this until June 2023 and they were not sure if shower stretchers were made that allowed the head of bed to be elevated or not.

On 8/31/2023 at 3:16 p.m., an interview was conducted with OSM #10, the admissions director/director of social services. OSM #10 stated that they were in the admissions director role when R28 was admitted in February of 2022. She stated that when bariatric residents were admitted they reviewed the medical records with the director of nursing to determine the status prior to the hospitalization, the current hospital level, and their equipment needs. OSM #10 stated that determined that they had the proper equipment in the facility to care for the resident including the bed, shower chairs and lifts. She stated that the administrator had the final decision to admit the resident. She stated that resident equipment usually went through therapy and was patient specific. She stated that she thought that R28 was the first bariatric resident they admitted and the administrator at that time said that they had just gotten a hoyer lift that accommodated 600 pounds so they could admit them. She stated that the initial plan was for R28 to stay for

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short term rehab but they have since been there long term. She stated that she would expect the facility to have the equipment to care for R28 and provide a shower if that was their preference and they were able to shower.

On 8/31/2023 at 3:49 p.m., an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing. ASM #2 stated that the facility should have the equipment for bariatric residents to provide a shower if the resident wanted one. ASM #2 stated that they were not sure what weight R28 came in at and what weight their current bariatric equipment held.

On 8/31/2023 at 3:52 p.m., an interview was conducted with ASM #1, the administrator and OSM #7, the director of rehab. ASM #1 stated that R28 was almost 600 pounds and their wheelchair was too wide to fit in their shower room so the staff gave them bed baths and physical therapy was working to get a bedside commode so they could get him in the shower. OSM #7 stated that R28 had admitted to the facility "pretty much bed bound" and therapy had started working with them to sit on the side of the bed in February of 2023 and initiated the order for the bedside commode in May of 2023. ASM #1 stated that R28 had to get bed baths until April of 2023. At this time, a request was made to ASM #1 and OSM #7 for evidence that R28 was bed-bound and unable to receive a shower from the admission date 2/4/2022 to April of 2023. A request was made for evidence of evaluations completed prior to February of 2023 documenting that R28 was not able to shower. No evidence was provided.

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The facility provided policy "Accommodation of Needs" dated 9/1/2023 documented in part, "The facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and wellbeing... 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis... 3. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility... g. providing a variety of types (for example, chairs with and without arms), sizes (height and depth), and firmness of furniture in rooms and common areas so that residents with varying degrees of strength and mobility can independently arise to a standing position..."

The facility policy "Assistive Devices and Equipment" dated 10/1/2021 documented in part, "... 1. Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. These may include (but are not limited to):
a. specialized eating utensils and equipment;
b. safety devices for the bathroom (grab bars, toilet risers, bedside commodes, etc.); and
c. mobility devices (wheelchairs, walkers, and canes)..."

On 9/1/2023 at 8:53 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern.

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F 558	Continued From page 10 No further information was provided prior to exit. References: (1) Obesity means weighing more than what is healthy for a given height. Obesity is a serious, chronic disease. It can lead to other health problems, including diabetes, heart disease, and some cancers. This information was obtained from the website: https://medlineplus.gov/ency/article/007297.htm (2) Your BMI estimates how much you should weigh based on your height... There are three classes of obesity: Class 1: BMI of 30 to less than 35. Class 2: BMI of 35 to less than 40. Class 3: BMI of 40 or higher. Class 3 is considered "severe obesity." This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm	F 558		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make	F 561	1. Resident #28 received an initial shower on 9/7/2023. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents was performed to ensure a shower was completed for the current week. 3. DON/designee will educate nursing staff regarding providing shower/bathing in accordance with resident preferences.	

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F 561	Continued From page 11 choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document, it was determined that the facility staff failed to provide care according to resident preference for one of 45 residents in the survey sample, Resident #28. The findings include: The facility staff failed to provide bathing according to resident requests and preferences for Resident #28 (R28). R28 was admitted to the facility on 2/4/2022 with diagnoses that included but were not limited to severe morbid obesity (1) and body mass index [BMI] 70 or greater, adult (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/23/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that they were cognitively intact for making daily decisions. Section G coded R28 as requiring extensive	F 561	4. DON/designee will perform an audit of daily shower completion 5x week x4 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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assistance of two or more persons for transfers and totally dependent on one person for bathing. It documented R28 not steady, but able to stabilize without staff assistance when walking and turning around and not steady and only able to stabilize with staff assistance when moving from a seated to standing position, moving on and off the toilet and for surface to surface transfers. The assessment documented R28 not having any impairments in the upper or lower extremities, and using a walker and a wheelchair.

On 8/29/2023 at 12:33 p.m., an interview was conducted with R28. R28 stated that they had resided at the facility for over a year and really wanted to get a shower. R28 stated that the nurses aides and therapy kept telling them that they were trying to get them a bedside commode that they could use as a shower chair but they had never gotten one. R28 stated that they had only received bed baths since they were at the facility and there were only certain CNA's (certified nursing assistants) who would do their bath due to their size so they had to wait until they were working to get their baths. R28 stated that they had never been to the shower or been offered a shower because of their size. R28 stated that it made them mad and that no one should have to go without a shower and they were looking to transfer to another facility and this was one of the reasons.

Review of the ADL documentation for R28 from 6/1/2023 to the present failed to evidence documentation of a shower received. The documentation only evidenced bed baths or partial bed baths.

On 8/31/2023 at 10:50 a.m., an interview was

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conducted with LPN (licensed practical nurse) #7. LPN #7 stated that showers were twice a week and the CNA's documented them in the computer. LPN #7 stated that there were several CNA's who worked with R28 the most because they knew their routine and preferences. LPN #7 stated that R28 only received bed baths as far as they knew.

On 8/31/2023 at 11:01 a.m., an interview was conducted with CNA #5. CNA #5 stated that R28 was totally dependent on staff for bathing and always got bed baths. She stated that R28 would not fit on the shower equipment they had. She stated that they were supposed to be getting R28 a shower chair so they could go to the shower but it had not come in yet. She stated that R28 was one of two obese residents who needed the shower chair and the facility was working to buy the chair for them to use for the residents. She stated that the head of therapy had been working to get the chair. She stated that R28 received bed baths from her and one other aide twice a week when they were working because some of the other CNA's were intimidated by the resident's size but she did not mind. She stated that R28 had been here over a year and had always wanted showers.

On 9/1/2023 at 8:53 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern.

The facility policy "Assistive Devices and Equipment" dated 10/1/2021 documented in part, "... 1. Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. These may include

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F 561	Continued From page 14 (but are not limited to): a. specialized eating utensils and equipment; b. safety devices for the bathroom (grab bars, toilet risers, bedside commodes, etc.); and c. mobility devices (wheelchairs, walkers, and canes)..." The facility provided policy "Accommodation of Needs" dated 9/1/2023 documented in part, "The facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and wellbeing..." No further information was provided prior to exit. References: (1) Obesity means weighing more than what is healthy for a given height. Obesity is a serious, chronic disease. It can lead to other health problems, including diabetes, heart disease, and some cancers. This information was obtained from the website: https://medlineplus.gov/ency/article/007297.htm (2) Your BMI estimates how much you should weigh based on your height... There are three classes of obesity: Class 1: BMI of 30 to less than 35. Class 2: BMI of 35 to less than 40. Class 3: BMI of 40 or higher. Class 3 is considered "severe obesity." This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize	F 565		

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F 565	Continued From page 15 and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to resolve resident concerns expressed at Resident Council meetings for two of three months of minutes	F 565	1. Dietary grievances voiced during resident council August 2023 have been resolved. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. Resident council minutes for September 2023 were reviewed to ensure appropriate/timely resolution of grievances. 3. NHA/designee will educate the dietary manager, activities staff, and social work staff regarding the grievance process, specifically as it relates to reviewing and resolving concerns/grievances within 5 business days. 4. NHA will review the grievance log five days a week for one (1) month and then weekly for three (3) months. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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reviewed, June and July 2023.

The findings include:

In both June and July 2023, residents raised concerns about breakfast food during the Resident Council meetings; the facility failed to respond to and resolve these concerns.

A review of Resident Council meeting minutes from June 2023 revealed, in part: "Resident Concerns/Issues...[resident] states when she receives her toast for breakfast, it is not toasted, it is a plain white piece of bread...[resident] stated when she receives her toast for breakfast, it is not toasted, it is a plain white piece of bread... [resident] does not receive any condiments with her toast or meals...[resident] states she wants to have scrambled or boiled eggs for breakfast twice a week...[resident] states when she receives her toast for breakfast, it is not toasted, it is a plain white piece of bread...Response and follow up: I emailed my regional director about the toaster isn't working properly...[residents] are receiving condiments, they would like extra for every meal." The response and follow up was written by OSM (other staff member) #1, the dietary manager.

A review of Resident Council meeting minutes from July 2023 revealed, in part: "Resident Concerns/Issues...[resident] states he would like hard boiled eggs for breakfast at times...[resident] states when she receives toast, it is not toasted... [resident] states breakfast is often the same items served...Response and follow up: I have told [name of corporate facility staff] on Wednesday, July 28, 2023 at 11:00 a.m. [about the toaster]...I also told [name of corporate contract dining services staff]. I haven't had any

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updates from them...I put boiled eggs on for certain days...The menus are done by the [name of contract dining services company] dietician." The response and follow up was written by OSM (other staff member) #1, the dietary manager.

On 8/30/23 at 9:45 a.m., OSM (other staff member) #2, the Regional Director of dining services. When asked if bacon was provided for the residents, OSM #2 stated, "No, we have a do not have it in stock." OSM #2 stated the corporate dietician does not believe bacon has any nutritive value, so it is not offered to the residents. When asked if it could be on the alternate menu, OSM #2 stated, "No, we are not purchasing it because it does not have any nutritive value. We would not purchase an item for a few residents. Residents might want steak, but we cannot give them steak."

On 8/30/23 at 4:08 p.m., OSM #15, the activities director, was interviewed. She stated she attends Resident Council meetings, and writes down everything residents say. She fills out a concern form for each concern expressed, and gives it to the appropriate department head. She stated all concerns related to food are given to OSM #1. She stated she expects the forms to be returned to her within 48 hours, and expects the concern to be resolved. She stated: "We are here to listen to [residents'] concerns. As a leadership team, we need to come up with some sort of solution." She stated OSM #1 attends all Resident Council meetings so residents are able to express concerns about food directly to her. When asked if OSM #1's responses about the toaster and the breakfast menus are actually resolutions of the concerns, she stated: "It's not a resolution, and I'm not okay with it." She added: "The issue with

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the toaster is that it is broken."

On 8/30/23 at 2:25 p.m. with OSM #3, the registered dietician. When asked how the menus are reviewed, OSM #3 stated, they are corporate menus, set by the corporate dietician. When asked if bacon was ever on the menu, OSM #3 stated it is not on the menu because there is no nutritive value. She added: "You see that a lot in long term care. You get very little nutrition from bacon and sausage."

On 8/30/23 at 4:17 p.m., OSM #1 was interviewed. She stated she is employed by a contract company. She stated she attends the beginning of each Resident Council meeting to listen to resident concerns about food. She stated the residents also have input into the meal of the month menu. She stated: "We need to know what they want and need. This is their home. We need their input." She stated she answers residents' concerns "right then and there." When asked if her documented responses to the concerns about toast and breakfast menus are satisfactory resolutions for the residents, she stated: "I can see how that may not resolve the issues." She stated residents have been complaining about breakfast/toast since she began work at the facility in mid-April 2023. She stated she has informed the facility's corporate staff and her company's corporate staff that the toaster is not working correctly, and they are still discussing it between them. She informed her contract company's corporate staff on her second day of employment in April 2023. No offers of resolution about the broken toaster have come from either corporate staff. She stated the issue about breakfast menus revolves around the residents wanting bacon. There is no bacon anywhere on

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F 565	Continued From page 19 any of the menus. She stated: "I told them I would take it to the people who make the menus, but I am in the middle. [The corporate contract dietician] said bacon is an empty calorie, so they won't let me add it to the menu." On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. No further information was provided prior to exit.	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	1. Curtain changes were completed for rooms 144, 147, and 160. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was performed to examine all current privacy currents to ensure cleanliness. 3. NHA/designee will educate housekeeping department regarding ensuring privacy curtains are clean. 4. NHA/designee will perform an audit of 10 privacy curtains weekly x4 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a clean and homelike environment for three of 31 rooms on the north unit.

The findings include:

1. The facility staff failed to maintain a clean and homelike environment for room 160. Resident #23 was a resident in room 160. Dried pureed food was found when the cubicle curtain was pulled for privacy during resident care.

An interview was conducted on 8/31/23 at 10:11 AM, with OSM (other staff member) #8, housekeeping.
When asked how rooms are cleaned, OSM #8 stated, they are cleaned every day. They sweep and mop, wipe all surfaces with peroxide multi

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surface cleaner, it takes 3 minutes to dry. OSM #8 stated, "When the resident goes home, we clean the curtains. If the curtain is dirty while the resident is here, we change the curtain. We are to look at the curtain every day. We clean in hallways, common areas every day."

An interview was conducted on 8/31/23 at 2:55 PM with LPN (licensed practical nurse) #9. When shown the stains on the cubicle curtain, LPN #9 stated, "It looks like dried food. I will contact laundry to get a new curtain."

On 9/1/23 at 9:55 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant was made aware of the findings.

According to the facility's "Homelike Environment" policy, which revealed, "Residents will be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible."

No further information was provided prior to exit.

2. The facility staff failed to maintain a clean privacy curtain in 2 of 31 resident rooms on the North unit, Room 144A and Room 147A.

On 8/29/2023 at 12:56 p.m., an observation was made of the privacy curtain in Room 144A. Two large brown stains were visible on the lower third portion of the privacy curtain. Additional observations of the privacy curtain with the visible stains were made on 8/29/2023 at 3:34 p.m. and 8/30/2023 at 8:35 a.m.

On 8/29/2023 at 1:19 p.m., an observation was

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made of the privacy curtain in Room 147A. One black stain was visible on the bottom of the privacy curtain and one brown circular stain was observed in the center of the privacy curtain. Additional observations of the privacy curtain with the visible stains were made on 8/29/2023 at 3:37 p.m. and 8/30/2023 at 1:45 p.m.

On 8/31/2023 at 10:11 a.m., an interview was conducted with OSM (other staff member) #8, housekeeping. OSM #8 stated that each resident room was cleaned daily and the privacy curtains were looked at every day and cleaned when dirty.

On 8/31/2023 at 10:19 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that if privacy curtains needed cleaning they reported it to housekeeping.

On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that they were not sure how often privacy curtains were cleaned or changed and was working to find out the practice in the facility. LPN #9 viewed the privacy curtain in Room 144A with the two large brown stains on the lower third portion of the privacy curtain and stated that the curtain needed to be cleaned and was not homelike. She viewed the privacy curtain in Room 147A with the black stain on the bottom and the brown circular stain in the center of the privacy curtain and stated that the curtain needed to be cleaned and was not homelike.

The facility provided policy, "Homelike Environment" dated 10/21/2023 documented in part, "...2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a

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F 584	Continued From page 23 personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment..." On 9/1/2023 at 8:53 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the above concern. No further information was presented prior to exit.	F 584		
F 600 SS=D	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 staff interview, facility document review and clinical record review, the facility failed to protect the resident's right to be free from physical abuse by another resident, for one of 45 residents in the survey sample, Residents #65. The findings include:	F 600	1. The incident between residents #65 and #36 has already occurred; therefore, the alleged deficient practice may not be retroactively corrected. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was performed of progress notes of current residents since 9/14/2023 to identify residents with documented aggressive behaviors and ensure there is an intervention in place. 3. DON/designee will educate all staff regarding resident's rights to include the right to be free from physical abuse by another resident.	

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F 600	Continued From page 24 The facility failed to protect Resident #65 from physical abuse from another resident, Resident #36 on 2/14/23 and 4/13/23. Resident #65 was admitted to the facility on 5/12/21 with diagnosis that included but were not limited to: Alzheimer's Disease, diabetes mellitus and dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/23/23, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the comprehensive care plan dated 12/17/22, which revealed, "FOCUS: The resident has a behavior problem of pushing other residents in their wheelchairs, inviting another resident into her room, spending time in another resident room, trying to help another resident use the bathroom. INTERVENTIONS: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed." Resident #36 was admitted to the facility on 2/1/22 with diagnoses that included, but were not limited to: Alzheimer's Disease, psychotic symptoms and dementia. Resident #36's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/11/23, coded the resident as scoring a 02 out of 15 on	F 600	4. DON/designee will perform an audit of the progress notes of current residents to identify documented aggressive behaviors and ensure an intervention is in place 3x week x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

A review of Resident #36's comprehensive care plan dated 2/17/23, which revealed, "FOCUS: Resident has behavioral problem of becoming agitated and aggressive towards other residents and had episode of grabbing another resident. Resident has the potential to display the following behaviors: verbal and physical aggression, throwing drinks at other residents, standing on radiator in attempt to jump off.
INTERVENTIONS: Provide redirection away from other residents when agitation is occurring in the dining room. Consider possible room change/ unit change. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes."

A review of the facility synopsis of events dated 2/14/23 revealed, "At approximately 5:30 PM on 2/14/23, staff observed Resident #36 getting up from the table she was sitting at. She approached [Resident #65] from the back, grabbed her by the top of her head and threw her on the floor. The residents were separated and assesses; no injuries noted. When asked, [Resident #36] reported, she [Resident #65] was sitting at a table and I told her to get up from the table, she did not want to, so I pulled her up by her hair because she steals everything. [Resident #65] was unable to report what happened."

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A review of the facility synopsis of events dated 4/13/23 revealed, "[Resident #65] was found on the floor in her room. Table/belongings appeared disheveled. [Resident #36's] walker was in the room. [Resident #36] stated, she pulled [Resident #65] for unknown reasons. [Resident #36] pulled [Resident #65's] hair and slapped her in the face. Residents immediately separated, assessed for injuries with no injuries noted and [Resident #65] moved to another hallway."

A review of the progress note date 2/14/23 at 7:43 PM, revealed, "Shouting was heard in the dining so raised my head up and saw resident siting on the floor and the other resident that hits her was being pulled away by other staff members. No injuries noted. DON, MD, RP (director of nursing, medical doctor, responsible party) notified. Facility...Continue to monitor resident."

A review of the Nurse Practitioner (NP) note dated 4/12/23 at 10:02 AM, revealed, "Asked to see by staff for facility event. Patient was struck in face and had hair pulled by another resident. no complaints of injury from staff. Patient appears at baseline. PSYCH: Calm at this time. Plan: Alzheimer's Dementia: continue with Donepezil, Memantine, Depakote, Seroquel. Geri psych follow-up recommended for further eval and med management."

An interview was conducted on 8/31/23 at 1:35 PM with LPN (licensed practical nurse) #3. When asked to define abuse, LPN #3 stated, any verbal, physical, sexual, mental act that causes the resident stress. Asked if a resident striking another resident and pulling them to the floor was

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abuse, LPN #3 stated, "Yes, it is abuse." When asked about specific interactions between Resident #65 and Resident #36, LPN #3 stated, "For whatever reason, it appeared that [Resident #36] targeted [Resident #65]. We would separate them and then moved [Resident #65] to another hall." There were no further incidents identified once Resident #65 was moved.

An interview was conducted on 8/31/23 at 1:55 PM with LPN #9. When asked to define abuse, LPN #1 stated, it can be verbal, physical, sexual, financial or mental acts which impact a resident. When asked if a resident striking another resident and pulling them to the floor constituted abuse, LPN #1 stated, yes, that would be abuse. When asked what actions would be taken, LPN #1 stated they would separate the residents, assess them and make sure there was no injury. When asked if she had witnessed any interactions between Resident #36 and Resident #65, LPN #1 stated, "Not that I can remember."

On 9/1/23 at 9:55 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant was made aware of the findings.

A review of the facility's "Abuse" policy, revealed, "Prevention: The assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident's rooms, resident with self-injurious behaviors, residents with communication disorders, residents that require heavy nursing care and/or are totally dependent on staff. Protection: In the event of an allegation or

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F 600	Continued From page 28 observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative and protect the resident and other residents from further harm or incident. The resident's plan of care will be revised to reflect interventions to minimize recurrence and to treat any injury of harm identified through assessment of the resident." No further information was provided prior to exit.	F 600		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655	1. Resident #153 and Resident #353 have been discharged from the facility. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was performed of current residents admitted since 9/1/2023 to ensure fall care plan interventions are in place. An audit was performed of current residents with pacemakers to ensure the care plan reflects the pacemaker. 3. DON/designee will educate Licensed Nursing staff regarding developing a baseline careplan to include fall prevention, as well as the presence of a pacemaker.	

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F 655	Continued From page 29 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to develop a baseline care plan for two of 45 residents in the survey sample; Residents #153 and #353. The findings include: The facility policy, "Baseline Care Plans" was reviewed. This policy documented, "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care	F 655	4. DON/designee will perform an audit of new admissions to ensure the baseline careplan includes fall interventions, as well as the presence of a pacemaker as indicated 3x week x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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plan to meet the resident's immediate care needs...."

1. The facility staff failed to develop a baseline care plan for fall prevention with interventions, for Resident #153.

Resident #153 was admitted to the facility on 9/9/22 and discharged on 9/28/22. The resident had diagnoses of but not limited to dementia, difficulty walking, lack of coordination, and visual loss. The admission/5-day MDS (Minimum Data Set) dated 9/13/22 coded the resident as being cognitively impaired in ability to make daily life decisions, scoring a 6 our of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

A nurse's note dated 9/21/22 documented, "Resident called writer to her room this morning for assistance to bathroom. At that time resident was observed with unsteady gait post fall but did not appear to be in pain. Resident was transferred safely back to her wheelchair without any concerns at this time."

Another nurse's note dated 9/21/22 documented, "Call to room by second nurse, observed patient sitting on the floor in her room. "I was trying to walk around and I fell" Intermittent disorientation at pt's (patient's) baseline. Assessed with redness noted to (R) (right) elbow. Old bruise to (R) arm. (L) (left) arm dialysis shunt with positive bruit and thrill. No bleeding noted. Pt with complain of pain to (R) arm and back. Back with no open wound or bruise noted at this time. Pt with an order for scheduled am (morning) pain med. Pain medicine given. Assisted into wc (wheel chair) and neurochecks initiated."

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The admission nursing assessment dated 9/9/22, under "Mobility/Safety" documented, "Prior. Indoor Mobility (Ambulation): Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. Needed Some Help - Resident needed partial assistance from another person to complete activities."

The "Safety - Resident Evaluation" dated 9/9/22 documented that the resident had an impaired gait which was defined on the document as, "- difficulty rising from chair, uses chair arms to get up, bounces to rise; - keeps head down when walking, watches the ground; - grasps furniture, person or aid when ambulating. Cannot walk unassisted." Under the section for "Mental Status" which was defined as "...measures the residents self-assessment of his/her own ability to ambulate. Ask the resident, "Are you able to go to the bathroom alone, or do you need assistance?" The coded response was documented as, "Overestimates or forgets limits." This form documented the scoring for the fall risk section as, "Morse Fall Scoring: High Risk 45 and higher; Moderate Risk 25-44; Low Risk 0-24." Resident #153 was coded a score of 85, which was high risk.

A review of the care plan revealed that a base line care plan was started, dated 9/12/22, for "(Resident #153) is at risk for falls r/t (related to) gait/balance problems, vision impairment..." This care plan included the goal dated 9/12/22 for "(Resident #153) will be free of falls through the review date." This care plan, however, did not contain any interventions to be implemented to prevent falls in this visually impaired, cognitively

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impaired resident with dementia and difficulty walking. All interventions were dated 9/21/22 after the above fall occurred.

Further review of the clinical record failed to reveal any evidence of fall interventions being implemented.

On 8/1/23 at 12:45 PM an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that if interventions are put in place, it should be in the care plan. She stated that all residents would be at risk for falls. She stated that a baseline should be developed on admission with interventions. She stated, "If there aren't any interventions, then what was done to prevent a fall? A care plan should have interventions."

On 8/31/23 at 3:00 PM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that a baseline fall care plan was not developed. She stated that on the admission assessment, there are boxes to check for a care area to be care planned and boxes to check for interventions to be added. She stated that interventions for falls were not checked to be added on the baseline care plan.

On 8/31/23 at 4:30 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Nurse Consultant were made aware of the findings. No further information was provided.

2. The facility failed to develop a baseline care plan to include pacemaker monitoring upon admission for Resident #353.

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F 655	Continued From page 33 Resident #353 was admitted to the facility on 4/3/23 with diagnoses that include but are not limited to: pacemaker and Afib (atrial fibrillation). A review of the baseline care plan failed to evidence pacemaker monitoring. A pacemaker was implanted in Resident #353 on 3/31/23. A review of the baseline care plan dated 12/29/22, revealed, "FOCUS: Resident has potential/actual impairment to skin integrity of the (SPECIFY location) related to: __. The resident has bladder incontinence. Patient has MASD (moisture associated skin damage) to coccyx area. INTERVENTIONS: Follow facility protocols for treatment of injury. Clean peri-area with each incontinence episode. Apply zinc oxide to coccyx area per treatment." An interview was conducted on 8/31/23 at 1:35 PM with LPN (licensed practical nurse) #3. When asked the purpose of the baseline care plan, LPN #3 stated it was to initiate the plan of care for the resident based on admission assessment and orders. When asked if a resident admitted with an implanted pacemaker should have the pacemaker included on their care plan, LPN #3 stated, yes, of course. On 9/1/23 at 9:55 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant was made aware of the findings. No further information was provided prior to exit.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		

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F 656	Continued From page 34 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656	1. Resident #28 non-pharmacological intervention monitoring has been added to MAR (Medication Administration Record). Resident #28's care plan has been updated to include diabetes, diuretic medication, and anticoagulant medication. Resident #72's careplan has been updated to reflect patient's need for supervision and occasional assistance with bathing. Resident #10's fluid restriction has been discontinued and the careplan has been updated accordingly. Resident #25's daily weight has been discontinued; and weights are now Monday, Wednesday, and Friday therefore weights are now obtained as ordered per careplan. Resident #87 and Resident #98 have discharged from the facility.	

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F 656	Continued From page 35 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 observations, resident interviews, staff interviews, clinical record reviews and facility document reviews it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for six of 45 residents in the survey sample, Residents #28, #72, #10, #98, #25, and #87. The findings include: 1. For Resident #28 (R28), the facility staff failed to, implement the care plan for non-pharmacological interventions prior to as needed pain medications; develop the care plan for a diagnosis of diabetes; develop the care plan for the use of a diuretic medication; and develop the care plan for the use of an anticoagulant medication. Resident #28's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/23/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The assessment documented R28 having a diagnosis of Diabetes Mellitus, receiving as needed pain medication and not receiving non-medication interventions for pain. The assessment further documented R28 receiving anticoagulant, diuretic and opioid	F 656	2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was performed of current residents receiving PRN pain medication to ensure an order for nonpharmacological interventions is in place. An audit was performed of current resident with a diagnosis of diabetes; as well as an order for diuretic and anticoagulant medications has been performed to ensure an appropriate care plan is in place. An audit of current residents was performed to ensure a shower was completed for the current week. An audit of current residents with ordered fluid restrictions was performed to ensure the provider is aware of any noncompliance since 9/1/2023. An audit was performed of current residents receiving psychotropic medications to ensure target behavior monitoring is in place. An audit of current residents with weight orders was performed to ensure compliance since 9/1/2023. An audit was performed of current residents with an order for a helmet to ensure placement as per care plan.	

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F 656	Continued From page 36 medications. The comprehensive care plan for R28 documented in part, "The resident has chronic pain r/t (related to) ADL (activities of daily living), mobility. Date Initiated: 11/11/2022. Revision on: 01/10/2023." Under "Interventions" it documented in part, "Provide Non-pharmacological interventions such as redirection, distraction, repositioning, visualization, etc. Date Initiated: 11/11/2022..." The comprehensive care plan failed to evidence a care plan related to diabetes, anticoagulant or diuretic medications. On 8/29/2023 at 12:33 p.m., an interview was conducted with R28. R28 stated that they took medications for pain. R28 stated that they asked the nurses for pain medication when they needed it and sometimes they tried to reposition them before they gave them the medications and sometimes it made it hurt a little less. The physician orders for R28 documented in part, - "Eliquis Tablet 5 MG (milligram) (Apixaban) Give 1 tablet by mouth two times a day for VTE (venous thromboembolism). Order Date: 12/24/2022." - "Furosemide Tablet 80 MG Give 1 tablet by mouth two times a day for Edema. Order Date: 12/5/2022." - "Hydrocodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for Pain. Order Date: 01/03/2023." - "Metformin HCl ER (extended release) Tablet Extended Release 24 Hour 750 MG Give 1 tablet by mouth one time a day related to Type 2 Diabetes Mellitus Without Complications. Order Date: 12/13/2022." - "Trulicity Subcutaneous Solution Pen-injector	F 656	3. DON/designee will educate licensed nursing staff regarding development and implementation of the care plan to include nonpharmacological interventions for residents receiving PRN pain medication; care plan interventions for residents with a diagnosis of diabetes, as well as those receiving diuretic and anticoagulant medications; providing showers in accordance with residents' preference; notification of the provider related to noncompliance with fluid restrictions; monitor and record target behavior symptoms related to psychotropic medication use; obtaining weights per order; and placing a device such as a helmet per order/care plan.	

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F 656	Continued From page 37 1.5 MG/0.5ML (milliliter) (Dulaglutide) Inject 1.5 mg subcutaneously one time a day every Sat (Saturday) related to Type 2 Diabetes Mellitus Without Complications. Order Date: 07/21/2023." Review of the eMAR (electronic medication administration record) for R28 dated 7/1/2023-7/31/2023 failed to evidence non-pharmacological interventions prior to administration of the as needed Hydrocodone-Acetaminophen on 7/2/2023 at 4:26 a.m. for a pain level of 9, on 7/6/2023 at 10:41 a.m. for a pain level of 5, on 7/9/2023 at 2:39 a.m. for a pain level of 9, on 7/14/2023 at 4:55 a.m. for a pain level of 9, on 7/19/2023 at 3:55 a.m. for a pain level of 3, on 7/25/2023 at 11:20 a.m. for a pain level of 5, on 7/28/2023 at 4:59 a.m. for a pain level of 9, on 7/30/2023 at 5:01 a.m. for a pain level of 9 and 7/31/2023 at 6:07 a.m. for a pain level of 9. Review of the eMAR for R28 dated 8/1/2023-8/31/2023 failed to evidence non-pharmacological interventions prior to administration of the as needed Hydrocodone-Acetaminophen on 8/1/2023 at 2:07 a.m. for a pain level of 2, on 8/2/2023 at 4:00 a.m., for a pain level of 3, on 8/6/2023 at 1:16 a.m., for a pain level of 9, on 8/7/2023 at 2:05 a.m. for a pain level of 2, on 8/11/2023 at 11:36 a.m. for a pain level of 8, on 8/13/2023 at 9:39 a.m. for a pain level of 7, on 8/14/2023 at 8:55 a.m. for a pain level of 5, on 8/21/2023 at 3:43 a.m. for a pain level of 9, and on 8/23/2023 at 9:02 a.m. for a pain level of 5. Review of the progress notes failed to evidence non-pharmacological interventions prior to administration of the as needed	F 656	4. DON/designee will perform an audit of current residents receiving PRN pain medication to ensure an order for nonpharmacological interventions is in place. DON/designee will perform an audit of current residents with a diagnosis of diabetes; as well as current residents with an order for diuretic and anticoagulant medications to ensure an appropriate care plan is in place. DON/designee will perform an audit of current residents to ensure a shower was completed for the current week. DON/designee will perform an audit of current residents with ordered fluid restrictions to ensure the provider is aware of any noncompliance. DON/designee will perform an audit of current residents receiving psychotropic medications to ensure target behavior monitoring is in place. DON/designee will perform an audit of current residents with weight orders to ensure compliance. DON/designee will perform an audit of current residents with an order for a helmet to ensure placement as per care plan. These audits to be performed 3x week x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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Hydrocodone-Acetaminophen on the dates and times listed above.

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of non-pharmacological interventions offered prior to administration of the as needed Hydrocodone-Acetaminophen on the dates and times documented above in July and August of 2023.

On 8/31/2023 at 3:14 p.m., ASM #2, the interim director of nursing stated that they did not have evidence of non-pharmacological interventions offered prior to administration of the as needed Hydrocodone-Acetaminophen on the dates and times documented above in July and August of 2023 to provide.

On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that the purpose of the care plan was to create an individualized plan for the resident and showed how the staff treated the residents on a day to day basis. She stated that the nursing staff were responsible for the care plan and they developed, reviewed and revised the care plans. She stated that the care plan should be implemented because it allowed them to see if improvement was needed or additional needs should be added. She stated that she would expect to see anticoagulants and diuretics on the care plan. She stated that the staff should monitor the resident for risk of bleeding and diabetic residents should have a care plan in place whether or not they were insulin dependent. She stated that residents who received diuretics had care plans in place for monitoring for signs of

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fluid overload.

On 8/31/2023 at 10:50 a.m., an interview was conducted with LPN #7. LPN #7 stated that care plans were developed by the unit manager and director of nursing and the care plan team. She stated that the care plan should be implemented because it was the plan for the residents care and part of the care needed to meet their needs. She stated that non-pharmacologic interventions were attempted prior to as needed pain medications. She stated that residents pain level was assessed and then the non-pharmacologic pain intervention was offered prior to the medication. She stated that at times R28 would refuse and just ask for the medication. She stated that the refusal should be documented. She stated that she did not think that the non-pharmacologic interventions were documented.

On 8/31/2023 at 2:27 p.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that MDS staff completed the admission baseline care plan and the MDS assessment and the daily updates were completed by nursing staff. She stated that a care plan would be developed for diabetes, anticoagulants and diuretics. She stated that if it was observed during the MDS assessment then they would develop the care plan and if started after the assessment then nursing would do it. She stated that the purpose of the care plan was to guide the staff how to provide the best care to the residents and address the goals in their care.

The facility policy "Care plan goals and objectives" dated 10/1/2021 documented in part, "Care plans shall incorporate goals and objectives that lead to the resident's highest

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obtainable level of independence...3. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and:
a. Are resident oriented;
b. Are behaviorally stated;
c. Are measurable; and
d. Contain timetables to meet the resident's needs in accordance with the comprehensive assessment..."

On 9/1/2023 at 8:53 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant were made aware of the findings.

No further information was provided prior to exit.

2. For Resident #72 (R72), the facility staff failed to implement the comprehensive care plan to assist with bathing/showering.

On the most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 6/16/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The assessment documented R72 requiring supervision of one person for personal hygiene and being independent in bathing with assistance of one person.

The comprehensive care plan for R72 documented in part, "(Name of R72) has an ADL (activities of daily living) self-care performance deficit r/t (related to) Activity Intolerance. Date Initiated: 11/11/2021. Revision on: 06/10/2022."

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Under "Interventions" it documented in part, "Bathing/Showering: The resident is able to perform with staff assistance. Date Initiated: 11/11/2021. Revision on: 11/12/2021."

On 8/29/2023 at 12:32 p.m., an interview was conducted with R72. R72 stated that there were times when they did not get their showers when they were scheduled. R72 stated that they were supposed to get showers twice a week and there were days when they were scheduled and the staff would tell them that they did not have time or were going on break and could not do it.

Review of the ADL documentation for R72 from 7/1/2023 to the present failed to evidence a bath or shower provided on 7/20/2023, 7/27/2023, 8/7/2023, 8/17/2023 or 8/28/2023.

The clinical record for R72 failed to evidence refusals for baths/showers on the dates above.

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a bath or shower for R72 on the dates listed above.

On 8/31/2023 at 3:49 p.m., ASM #2, the interim director of nursing stated that they did not have evidence of a bath or shower for R72 on the dates listed above to provide.

On 8/31/2023 at 10:19 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that showers were given twice a week and more often if needed or requested. She stated that baths or showers were documented in the computer in the ADL documentation and if the resident refused the

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bath or shower they documented that also and notified the nurse.

On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that the purpose of the care plan was to create an individualized plan for the resident and showed how the staff treated the residents on a day to day basis. She stated that the nursing staff were responsible for the care plan and they developed, reviewed and revised the care plans. She stated that the care plan should be implemented because it allowed them to see if improvement was needed or additional needs should be added.

On 8/31/2023 at 10:50 a.m., an interview was conducted with LPN #7. She stated that the care plan should be implemented because it was the plan for the residents care and part of the care needed to meet their needs.

On 8/31/2023 at 4:31 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

3. For Resident #10 (R10), the facility staff failed to implement the comprehensive care plan to report non-compliance with fluid restrictions to the physician.

On the most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 7/19/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the

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resident was cognitively intact for making daily decisions.

The comprehensive care plan for R10 documented in part, "Noncompliance with fluid restriction. Noncompliance with keeping non skid socks on with eucerine [sic] cream. Date Initiated: 04/27/2023. Revision on: 04/27/2023." Under "Interventions" it documented in part, "...Report non compliance to MD (medical doctor). Date Initiated: 04/27/2023."

The physician orders for R10 documented in part, "Fluid Restriction 2000cc per day: 600cc breakfast, 120cc morning medpass, 480cc lunch, 120cc afternoon medpass, 480cc dinner, 120cc evening meds, 80cc extra every shift related to Acute On Chronic Diastolic (Congestive) heart failure. Order Date: 09/02/2021."

Review of the eTAR (electronic treatment administration record) dated 6/1/2023-6/30/2023 for R10 documented intake amounts totaled for each shift. The eTAR documented a total amount of 2700cc on 6/4/2023, 2340cc on 6/19/2023 and 2360cc on 6/28/2023. The eTAR failed to evidence notification of the physician of non-compliance with the 2000cc per day fluid restrictions.

Review of the eTAR dated 7/1/2023-7/31/2023 for R10 documented intake amounts totaled for each shift. The eTAR documented a total amount of 2700cc on 7/19/2023, 2910cc on 7/26/2023, 3000cc on 7/28/2023, and 3000cc on 7/29/2023. The eTAR failed to evidence notification of the physician of non-compliance with the 2000cc per day fluid restrictions.

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Review of the eTAR dated 8/1/2023-8/31/2023 for R10 documented intake amounts totaled for each shift. The eTAR documented a total amount of 2520cc on 8/2/2023 and 3600cc on 8/29/2023. The eTAR failed to evidence notification of the physician of non-compliance with the 2000cc per day fluid restrictions.

The clinical record for R10 failed to evidence notification of the physician/provider for the non-compliance of the fluid restrictions on the dates listed above.

On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that the purpose of the care plan was to create an individualized plan for the resident and showed how the staff treated the residents on a day to day basis. She stated that the care plan should be implemented because it allowed them to see if improvement was needed or additional needs should be added. She stated that when residents were on fluid restrictions they reviewed them daily and notified the nurse practitioner if they went over the limit and educated the resident. She stated that there should be documentation in the progress notes regarding notification of the nurse practitioner of the non-compliance with fluid restrictions.

On 8/31/2023 at 10:50 a.m., an interview was conducted with LPN #7. She stated that the care plan should be implemented because it was the plan for the residents care and part of the care needed to meet their needs.

On 8/31/2023 at 4:31 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the

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regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

4. For Resident #98 (R98), the facility staff failed to implement the comprehensive care plan to monitor and record target behavior symptoms related to psychotropic medication use.

On the most recent MDS (minimum data set) a significant change assessment with an ARD (assessment reference date) of 7/6/2023, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The assessment documented R98 receiving an antipsychotic medication 6 of the 7 days during the assessment period.

The comprehensive care plan for R98 documented in part, "[Name of R98] uses psychotropic medications r/t (related to) Anxiety. Date Initiated: 06/09/2023. Revision on: 08/09/2023." Under "Interventions" it documented in part, "Administer Psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q-Shift. (every shift). Date Initiated: 06/01/2023... Monitor/record occurrence of for target behavior symptoms and document per facility protocol. Date Initiated: 06/09/2023. Revision on: 08/30/2023."

The physician orders for R98 documented in part,
- "Risperidone Oral Tablet 2 MG (milligram) (Risperidone) Give 1 tablet by mouth one time a day for Anxiety. Order Date: 7/1/2023."

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The clinical record for R98 failed to evidence monitoring for side effects, effectiveness or target behavior symptoms for psychotropic medication use.

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of behavior and adverse effect monitoring for R98 from 6/1/2023 to the present.

On 8/31/2023 at 4:00 p.m., ASM #2, the interim director of nursing stated that they did not have any evidence of behavior or adverse effect monitoring for R98 to provide and they had put something in place at that point.

On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that the purpose of the care plan was to create an individualized plan for the resident and showed how the staff treated the residents on a day to day basis. She stated that the care plan should be implemented because it allowed them to see if improvement was needed or additional needs should be added. She stated that residents who received psychotropic medications were monitored for behaviors and any changes in their baseline. She stated that the monitoring was documented in the clinical record, typically on the medication administration record and done every shift.

On 8/31/2023 at 10:50 a.m., an interview was conducted with LPN #7. She stated that the care plan should be implemented because it was the plan for the residents care and part of the care needed to meet their needs.

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On 8/31/2023 at 4:31 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

5. For Resident #25 (R25), the facility staff failed to implement the care plan to obtain weights as ordered.

A review of R25's orders revealed the following orders:
"7/28/23 Notify primary clinician for Weight gain of 2 or more pounds in 1 day or 5 pounds or more in 5 days."

"7/29/23 Hemodialysis at [name of dialysis center]...MWF (Monday, Wednesday, Friday."

A review of R25's weights revealed weights were recorded on the following dates in August 2023: 8/2, 8/4, 8/10, 8/13, 8/18, 8/21, and 8/23. The clinical record revealed no other weights recorded for R25 in August 2023.

A review of R25's care plan dated 6/26/23 revealed, in part: "The resident has ESRD (end stage renal disease) and receives dialysis...Pre-Post dialysis weights."

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. After reviewing R25's order for notifying the provider for weight gain, she looked at the weights recorded in the medical record. She stated: "If the order is to notify the physician for weight changes over one day, then we should be weighing the resident every day." She stated there was no way to follow the provider's order unless the resident had been

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weighed every day. She stated the purpose of the care plan is to know the resident's baseline and to mark improvements or declines in the resident's function. She stated everyone in the facility is responsible for implementing the care plan.

On 8/31/23 at 3:45 p.m., ASM (administrative staff member) #2, the interim director of nursing, provided weights from the dialysis center. When asked if these weights were a part of R25's clinical record, she stated: "No. We don't get these unless I request them." She stated she had received the weights that day.

On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

No further information was provided prior to exit.

6. For Resident #87 (R87), the facility staff failed to implement the care plan to prevent injury from a fall by placing a helmet on the resident's head.

On the following dates and times, R87 was observed lying in bed, without a helmet: 8/29/23 at 12:25 p.m. and 3:41 p.m.; 8/30/23 at 8:46 a.m. and 1:07 p.m.

A review of R87's orders revealed the following order, dated 6/14/23: "Foam helmet on at all times. Check placement and document refusal."

A review of R87's care plan dated 1/18/23 and updated 6/14/23 revealed, in part: "[R87] has had an actual fall...Foam helmet at all times per family

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F 656	Continued From page 49 request. Document removal/refusals. Patient non-compliant with wearing foam helmet at times." On 8/31/23 at 10:26 a.m., CNA (certified nursing assistant) #8 was interviewed. She stated: "[R87] is supposed to have a helmet on all the time. Even in bed." She stated she "always" puts a helmet on R87 because the resident's family has asked for it. On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated R87 is supposed to wear a helmet at all times "because her family thinks it will help." She stated the resident wears it and still falls and hits her head. She stated: "The helmet is not working, and it is what the family wants." She stated the purpose of the care plan is to know the resident's baseline and to mark improvements or declines in the resident's function. She stated everyone in the facility is responsible for implementing the care plan. On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. No further information was provided prior to exit.	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	F 657		

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F 657	Continued From page 50 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 resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to review and/or revise the care plan for three of 45 residents in the survey sample; Residents #153, #65, and #50. The findings include: The facility policy, "Care Plan Goals and Objectives" was reviewed. This policy documented, "Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. 1. Care plan	F 657	1. Resident #153 has been discharged from the facility. Resident #65's care plan was updated to reflect the intervention of a room change to protect her from physical abuse from another resident. Resident # 50's care plan was updated to reflect the resident no longer an active smoker. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was performed of current residents experiencing a fall within the past two weeks to ensure review/revision of the care plan. An audit was performed of current residents experiencing physical aggression from another resident in the past two weeks to ensure the care plan was updated accordingly. An audit was performed of current residents that smoke to ensure the care plan addresses smoking status.	

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F 657	Continued From page 51 goals and objectives are defined as the desired outcome for a specific resident problem or opportunity....2. When goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly....5. Goals and objectives are reviewed/revised: a. When there has been a significant change in the resident's condition; b. When the desired outcome has not been achieved..." 1. For Resident #153, the facility staff failed to review and/or revise the care plan after falls on 9/23/22 and 9/24/22. Resident #153 was admitted to the facility on 9/9/22 and discharged on 9/28/22. The resident had diagnoses of but not limited to: dementia, difficulty walking, lack of coordination, and visual loss. The admission/5-day MDS (Minimum Data Set) dated 9/13/22 coded the resident as being cognitively impaired in ability to make daily life decisions, scoring a 6 our of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A nurse's note dated 9/23/22 documented, "Pt [patient] was found on the floor of her bedroom in R [right] side lying position next to bed. Pt stated she was attempting to go to the bathroom. Writer along with CNA [Certified Nursing Assistant] on duty assisted resident back to w/c...Skin assessment performed, resident obtained a s/t (skin tear) to R fa (forearm), bleeding controlled, cleaned with NS (normal saline), applied steri-strips and covered with dry dressing. NP (nurse practitioner) and RP (responsible party) are both aware if incident. Neuro checks	F 657	3. DON/designee will educate Licensed Nursing staff regarding reviewing/revising a care plan post fall. DON/designee will educate licensed nursing staff regarding documenting interventions to protect the resident from physical abuse from another resident post incident. DON/designee will educate licensed nursing staff regarding inclusion of smoking into the care plan for residents who are active smokers. 4. DON/designee will audit the care plan of current residents who experience a fall to ensure review/revision of fall interventions 3x week x4weeks. DON/designee will perform an audit of residents experiencing physical aggression from another resident to ensure implementation of an intervention to protect the resident from physical abuse from another resident 3x week x4weeks. DON/Designee will perform an audit of residents that currently smoke or with a history of smoking to ensure incorporation into the care plan 3x week x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of compliance 10/16/2023.	

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initiated."

A nurse's note dated 9/24/22 documented, "Was informed by CNA that resident was on the floor. Upon entering the room. She was able to stand and was assisted back to bed. Replied "No" when asked if she hurt anywhere. Vital signs taken, skin assessment done, no new changes observed. Will continue to observe."

A review of the care plan revealed one dated 9/12/22 and revised on 9/21/22 included: "[Resident #153] has had an actual fall on 9/21/22 and is at risk for additional falls r/t [related to] Gait/balance problems, Vision impairment..." All the interventions were dated 9/21/22.

Further review of the care plan failed to reveal any evidence of being reviewed and/or revised after either of the above two falls.

A review of the facility reports for each of the above falls also failed to reveal any evidence that the care plan was reviewed and/or revised after either of the above falls.

On 8/31/23 at 12:45 PM an interview was conducted with LPN #4 (Licensed Practical Nurse). She stated that usually, after a fall, the interdisciplinary team will review the resident and care plan and add new interventions if needed.

On 8/31/23 at 3:00 PM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. She stated that there was no evidence of the care plan being reviewed or revised after the above two falls.

On 8/31/23 at 4:30 PM, ASM #1 the

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Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Nurse Consultant were made aware of the findings. No further information was provided.

2. For Resident #65, the facility failed to revise the comprehensive care plan after resident to resident abuse occurred.

Resident #65 was admitted to the facility on 5/12/21 with diagnoses that included but were not limited to: Alzheimer's Disease and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/23/23, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

A review of the comprehensive care plan dated 12/17/22, which revealed, "FOCUS: The resident has a behavior problem of pushing other residents in their wheelchairs, inviting another resident into her room, spending time in another resident room, trying to help another resident use the bathroom. INTERVENTIONS: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed."

A review of the facility synopsis of events dated 2/14/23 revealed, "At approximately 5:30 PM on 2/14/23, staff observed [Resident #36] getting up from the table she was sitting at. She approached [Resident #65] from the back,

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grabbed her by the top of her head and threw her on the floor. The residents were separated and assesses; no injuries noted. When asked, [Resident #36] reported, she [Resident #65] was sitting at a table and I told her to get up from the table, she did not want to, so I pulled her up by her hair because she steals everything. [Resident #65] was unable to report what happened."

A review of the facility event synopsis dated 4/13/23 revealed, "[Resident #65] was found on the floor in her room. Table/belongings appeared disheveled. Resident [#36's] walker was in the room. [Resident #36] stated, she pulled [Resident #65] for unknown reasons. [Resident #36] pulled [Resident #65's] hair and slapped her in the face. Residents immediately separated, assessed for injuries with no injuries noted and [Resident #65] moved to another hallway."

An interview was conducted on 8/31/23 at 1:35 PM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3 stated, it is to develop the plan of care and actions the resident needs for their life. When asked who revises the care plan, LPN #3 stated, they all can revise the care plan. When asked if a resident is the recipient of abuse from another resident, should the care plan be revised, LPN #3 stated, yes, of course it should be.

An interview was conducted on 8/31/23 at 2:55 PM with LPN #9. When asked the purpose of the care plan, LPN #9 stated, it is to set the standard of care for the specific needs of the resident. When asked if a resident is the recipient of abuse from another resident, should the care plan be revised, LPN #9 stated, it must be revised to

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account for new actions to protect the resident.

On 9/1/23 at 9:55 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant was made aware of the findings.

A review of the facility's "Care Plan and Goals" policy, revealed, "Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence."

No further information was provided prior to exit.

3. For Resident #50 (R50), the facility staff failed to review and revise the comprehensive care plan regarding smoking.

On the most recent annual MDS (minimum data set) assessment, with an ARD (assessment reference date) of 4/18/2023, the resident was assessed as not currently using tobacco.

The comprehensive care plan for R50 documented in part, "Smoking: [Name of R50] is an active
smoker. Date Initiated: 03/31/2020."

The Safety-Resident Evaluation dated 6/4/2023 documented in part, "...Does the resident use tobacco products? No..."

On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that the purpose of the care plan was to create an individualized plan for the resident and showed how the staff treated the residents on a day to day basis. She stated that the nursing staff were responsible for the care

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F 657	Continued From page 56 plan and they developed, reviewed and revised the care plans. She stated that the care plan should be implemented because it allowed them to see if improvement was needed or additional needs should be added. She stated that R50 did not smoke and they were unsure if they had ever smoked. She stated that R50's care plan was not accurate and needed to be revised. On 9/1/2023 at 8:53 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant were made aware of the findings. No further information was provided prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review, and clinical record review, the facility staff failed to follow professional standards of care for three of 45 residents in the survey sample, Residents #6, #253, and #303. The findings include: 1. For Resident #6 (R6), the facility staff administered a medication to her to which the resident had a documented allergy.	F 658	1. NP (Nurse Practitioner) notified Resident #6 had an allergy to Erythromycin, but Azithromycin was given by nurse once pulled from Omnicell. The resident has been assessed; no current adverse reaction noted. Resident #253 Coumadin and INR have been discontinued. Resident #303 has been discharged from the facility. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was performed of current residents receiving antibiotics and the NP will be notified of any potential allergy concerns. An audit has been performed of current residents and there are no current residents receiving Coumadin to have INRs ordered.	

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F 658	Continued From page 57 A review of R6's allergies listed on the electronic medical record revealed, in part: "Allergies: Erythromycin (1)." A review of R6's provider's orders revealed the following order, written 8/1/23: "Azithromycin (2) Oral Tablet 250 MG (milligrams)...Give 1 tablet by mouth at bedtime for copd (chronic obstructive pulmonary disease) exacerbation for 5 Days. 2 tabs today, 1 tab days 2-5." A review of R6's August 2023 MAR (medication administration record) revealed R6 received Azithromycin as ordered on 8/1/23 and 8/2/23. A review of R6's progress notes revealed the following note dated 8/1/23: "Order Note Text: The system has identified a possible drug allergy for the following order: "Azithromycin Oral Tablet 250 MG (milligrams)...Give 1 tablet by mouth at bedtime for copd exacerbation for 5 Days. 2 tabs today, 1 tab days 2-5." Further review of R6's clinical record failed to reveal evidence that any staff member followed up on the alert regarding R6's possible allergy to Azithromycin. On 8/30/23 at 1:38 p.m., OSM (other staff member) #11, a registered pharmacist and director of quality for the facility's pharmacy, was interviewed. When asked what should be done if a resident has a documented allergy to Erythromycin and is prescribed Azithromycin, she stated: "They are in the same antibiotic class. We do not dispense it." After checking the facility's pharmacy records and documented communication with the facility on 8/1/23 and 8/2/23, she stated: "Someone from the facility	F 658	3. DON/Designee to educate licensed nursing staff regarding provider notification of any potential allergy alerts. DON/Designee to educate licensed nursing staff regarding obtaining orders to monitor PT/INR for resident receiving coumadin. DON/Designee to educate licensed nursing staff regarding administration of medications within the allowable timeframe and notify provider if medications are given out of timeframe. 4. DON/Designee to audit newly ordered antibiotics to monitor for potential allergy and provider notification 3x week x4weeks. DON/Designee to audit current residents receiving coumadin to ensure PT/INR orders are in place weekly x4weeks. DON/designee to audit current residents for medications given outside of the timeframe to ensure provider notification 5x week x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of compliance 10/16/2023.	

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took it out of their Omicell (machine containing commonly used medications)." She stated the pharmacy records indicated a facility staff member entered the resident's information into the Omnicell (automated medication dispensing system) machine and removed the medication to administer to R6, even after the pharmacy had sent the alert regarding a possible allergy. She stated the pharmacy is not required to give an approval code for a nurse to access a medication that is not a narcotic in Omnicell. She stated: "Our records show we received the order on 8/1 and we held it due to the allergy. I don't have any evidence anyone from the facility followed up with us to say the allergy information had been resolved. We would not dispense the medication unless that had happened."

On 8/30/23 at 4:39 p.m., LPN (licensed practical nurse) #2, the nurse who administered the Azithromycin on 8/1/23, was interviewed. LPN #2 stated if a medication is not available, they check to see if it is available in Omnicell. After looking at R6's August 2023 MAR, LPN #2 stated they had administered the Azithromycin as ordered. He stated he could not remember whether or not he removed it from Omnicell, and he stated he did not remember seeing the pharmacy alert regarding a possible allergy.

On 8/31/23 at 7:05 a.m., LPN #10, who administered the Azithromycin on 8/2/23, stated if there is a problem with a potential allergy for a medication, "the pharmacy will alert you." She stated if there is possible allergy, the NP (nurse practitioner) should be contacted. Often, the NP will override the allergy and the nurse will inform the pharmacy about the override. At that point, the pharmacy will dispense the medication. She

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stated she documents the phone call with the NP in the progress notes. She stated one of the nurses told her that the NP had given permission for the Azithromycin to be administered to R6. She stated she could not recall which nurse told her this.

On 8/31/23 at 11:11 a.m., ASM (administrative staff member) #5, the NP, was interviewed. She stated she did not remember being notified about the potential allergy for R6 until 8/30/23. She stated: "I can't remember all of the nurses who contact me. If I had known about this allergy, I would have changed it. I consider it a mistake on my part ordering it."

On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

No further information was provided prior to exit.

NOTES
(1) "Erythromycin is used to treat certain infections caused by bacteria, such as infections of the respiratory tract, including bronchitis, pneumonia, Legionnaires' disease (a type of lung infection), and pertussis (whooping cough; a serious infection that can cause severe coughing); diphtheria (a serious infection in the throat); sexually transmitted diseases (STD), including syphilis; and ear, intestine, gynecological, urinary tract, and skin infections. It also is used to prevent recurrent rheumatic fever. Erythromycin is in a class of medications called macrolide antibiotics. It works by stopping the

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growth of bacteria." This information was taken from the website https://medlineplus.gov/druginfo/meds/a682381.html#:~:text=Erythromycin%20is%20used%20to%20treat,a%20serious%20infection%20in%20the.

(2) "Azithromycin is used to treat certain bacterial infections, such as bronchitis; pneumonia; sexually transmitted diseases (STD); and infections of the ears, lungs, sinuses, skin, throat, and reproductive organs. Azithromycin also is used to treat or prevent disseminated Mycobacterium avium complex (MAC) infection [a type of lung infection that often affects people with human immunodeficiency virus (HIV)]. Azithromycin is in a class of medications called macrolide antibiotics. It works by stopping the growth of bacteria." This information was taken from the website https://medlineplus.gov/druginfo/meds/a697037.html.

2. For Resident #253 (R253), the facility staff failed to follow a provider's orders to obtain a blood test and failed to assess the resident's use of blood testing equipment at the bedside.

A review of R253's progress notes revealed, in part (all notes written by ASM (administrative staff member) #5, the nurse practitioner (NP), unless otherwise noted:
"8/14/23 Hx (history) of DVT (deep vein thrombosis) (2). Continue with Warfarin (3). Start INR."

"8/17/23 Hx DVT. Stop Warfarin. Start INR Saturday. Start bridge to Xarelto (4) 10 [milligrams] when INR < 3."

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"8/19/23 Have pt (patient) check INR with her machine supplies."

"8/21/23 Hx DVT...Stop warfarin. INR done on Saturday? not reported to NP or recorded in progress notes."

"8/25/23 INR reported to be 1.3." This note was written by a nurse who was unavailable for interview at the time of the survey.

A review of R253's provider's orders revealed, in part:
"8/14/23 PT/INR One time for bridge to Xarelto when INR > 3."

"8/19/23 Have patient check INR with her machine/supplies. One time only."

"8/28/23 PT/INR One time only."

Further review of R253's clinical record revealed no evidence that PT/INR was done on 8/14/23, 8/17/23, 8/19/23, or 8/28/23.

A review of R253's MARs (medication administration record) for August 2023 revealed she received Warfarin 2.5 mg (milligrams) on 8/15/23 and 8/16/23, and Warfarin 3 mgs on 8/23/23 through 8/29/23.

On 8/31/23 at 3:06 p.m., LPN (licensed practical nurse) #9 was interviewed. She stated the NP usually gives verbal orders to the staff. She stated she is responsible for putting the order in as the NP has given it to her, and getting another staff member to verify the order. She stated if a resident is taking Warfarin, the resident needs a

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PT/INR test at least weekly. She stated the facility has a point of care INR test machine that enables staff members to get this test done quickly at the resident's bedside.

On 9/1/23 at 8:33 a.m., LPN #8 was interviewed. She stated she usually puts in the verbal orders given to her by the nurse practitioner. She stated she was not aware of any orders for Warfarin for R253. After checking the resident's orders, she stated: "Oh, I see some now. I'm not sure why they weren't done." She stated she was aware that the resident was to use her own machine for obtaining the INR level, but did not think the facility did any kind of assessment to determine the resident's competency to use the machine or to determine the machine's accuracy.

On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. ASM #2 stated the resident should have been evaluated for her competence to use the INR machine correctly prior to obtaining her own INR level on 8/25/23. She stated the resident's machine also needed to be calibrated prior to usage to ensure the reading was accurate.

No further information was provided prior to exit.

NOTES
(1) "Prothrombin time (PT) and the associated international normalized ratio (INR) are routinely tested to assess the risk of bleeding or thrombosis and to monitor response to anticoagulant therapy in patients." This information is taken from the National Institutes of

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Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569083/.

(2) "Thrombosis is the medical term for the formation of a blood clot in a blood vessel. In deep vein thrombosis (DVT), the blood clot forms in one of the larger, deeper veins that run through the muscles. Deep vein thrombosis usually occurs in the lower leg. It often goes unnoticed and dissolves on its own. But it may cause symptoms like pain and swelling. If someone is diagnosed with DVT, they will need treatment to avoid serious complications such as pulmonary embolism. This can occur if the blood clot breaks away from its original site and is carried to the lungs in the bloodstream. The risk of deep vein thrombosis increases after more major operations such as knee or hip replacement surgery. Because of this, people who have had this kind of surgery are usually given medication to prevent blood clots from forming. This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/books/NBK425364/.

(3) "Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood." This information is taken from the National Institutes of

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Health website https://medlineplus.gov/druginfo/meds/a682277.html.
3. For Resident #303 (R303), the facility staff failed to administer Apixaban within professional standards of medication administration practice timeframes.

The physician orders for R303 documented in part, "Apixaban Tablet 5 MG (milligram) Give 1 tablet by mouth two times a day for prevent blood clots. Order Date: 08/25/2022."

The eMAR for R303 dated 12/1/2022-12/31/2022 documented the Apixaban scheduled for administration at 9:00 a.m. and 5:00 p.m. each day.

On 8/30/2023 at 1:12 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of medication administration with administration times for R303 from 12/1/2022-12/31/2022.

Review of the facility provided "Medication Admin Audit report" for R303 dated 12/1/2022-12/31/2022 documented the Apixaban scheduled for 9:00 a.m. administered at 3:15 p.m. on 12/11/2022, at 10:42 a.m. on 12/16/2022, at 10:48 a.m. on 12/18/2022 and 10:38 a.m. on 12/24/2022. It further documented the Apixaban scheduled for 5:00 p.m. administered at 6:39 p.m. on 12/1/2022, at 6:29 p.m. on 12/7/22, at 7:06 p.m. on 12/8/2022, at 7:35 p.m. on 12/11/2022, at 6:57 p.m. on 12/12/2022, at 6:33 p.m. on 12/15/2022, at 6:49 p.m. on 12/21/2022 and at 10:42 p.m. on 12/23/2022.

The progress notes failed to evidence notification

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of the physician of the late administrations on the dates listed above.

On 9/1/2023 at 8:39 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that medications should be administered within an hour before or an hour after the scheduled time. She stated that if the medication was given outside of these timeframes then they notified the nurse practitioner and the responsible party and documented it in the progress notes.

According to Fundamentals of Nursing (made incredibly easy) Lippincott Williams and Wilkins, 2007 page 172, "Regardless of the administration times established for a patient, you'll need to follow these times carefully...administer all medications as ordered by the physician..."

On 9/1/2023 at 8:53 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the findings.

No further information was provided prior to exit.

Reference:
(1) Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and

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F 658	Continued From page 66 may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613032.html	F 658		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676	1.Resident #72 shower schedule updated to reflect assigned shower days, resident has received showers as scheduled. Resident #303 has discharged from the facility. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was performed of current residents for the current week to ensure the shower has been completed. 3. DON/designee will educate all Nursing staff on providing shower/bathing according to resident requests and preferences and documenting accordingly. 4. DON/designee to audit for shower completion 5x week x4 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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F 676	Continued From page 67 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of providing ADLs (activities of daily living) for two of 45 residents in the survey sample, Residents #72 and #303. The findings include: 1. For Resident #72 (R72), the facility staff failed to evidence a bath or shower was provided on 7/20/2023, 7/27/2023, 8/7/2023, 8/17/2023 or 8/28/2023. On the most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 6/16/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The assessment documented R72 requiring supervision of one person for personal hygiene and being independent in bathing with assistance of one person. On 8/29/2023 at 12:32 p.m., an interview was conducted with R72. R72 stated that there were	F 676		

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times when they did not get their showers when they were scheduled. R72 stated that they were supposed to get showers twice a week and there were days when they were scheduled and the staff would tell them that they did not have time or were going on break and could not do it.

Review of the ADL documentation for R72 from 7/1/2023-7/31/2023 failed to evidence a bath or shower was provided on 7/20/2023, 7/27/2023. The documentation for 7/20/2023 was blank and 7/27/2023 had an "X" in the area.

Review of the ADL documentation for R72 from 8/1/2023-8/31/2023 failed to evidence a bath or shower was provided on 8/7/2023, 8/17/2023 or 8/28/2023. The documentation for 8/7/2023 and 8/28/2023 was blank and 8/17/2023 documented "NA." The documentation key evidenced "NA-Not applicable."

The clinical record for R72 failed to evidence refusals for baths/showers on the dates above.

The comprehensive care plan for R72 documented in part, "(Name of R72) has an ADL (activities of daily living) self-care performance deficit r/t (related to) Activity Intolerance. Date Initiated: 11/11/2021. Revision on: 06/10/2022." Under "Interventions" it documented in part, "Bathing/Showering: The resident is able to perform with staff assistance. Date Initiated: 11/11/2021. Revision on: 11/12/2021."

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a bath or shower for R72 on the dates listed above.

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On 8/31/2023 at 3:49 p.m., ASM #2, the interim director of nursing stated that they did not have evidence of a bath or shower for R72 on the dates listed above to provide.

On 8/31/2023 at 10:19 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that showers were given twice a week and more often if needed or requested. She stated that baths or showers were documented in the computer in the ADL documentation and if the resident refused the bath or shower they documented that also and notified the nurse. She stated that "NA" on the ADL documentation meant that the activity did not happen.

On 8/31/2023 at 11:01 a.m., an interview was conducted with CNA #5. CNA #5 stated that they evidenced the care they provided by documenting what was done on the ADL documentation. She stated that "NA" meant that the computer had scheduled the shower or bath on the wrong day so it was not given and should be documented in the prn (as needed) shower area.

The facility policy, "Activities of Daily Living (ADLs)" dated 10/1/2021 documented in part, "Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene... 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care,

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including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); i. Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly or as required by state law. Residents preference and/or whose medical conditions prohibit tub or shower baths shall have a sponge bath daily..."

On 8/31/2023 at 4:31 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

2. For Resident #303 (R303), the facility staff failed to evidence a bath or shower was provided on 12/12/2022, 12/15/2022, 12/19/2022, 12/26/2022, 12/29/2022 and 1/2/2023.

On the most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 12/15/2022, the resident was assessed as requiring supervision of one person for personal hygiene and bathing.

Review of the ADL documentation for R303 from 12/1/2022-12/31/2022 failed to evidence a bath or shower was provided on 12/12/2022, 12/15/2022, 12/19/2022, 12/26/2022 or 12/29/2022. The documentation for 12/12/2022, 12/15/2022, 12/19/2022, and 12/29/2022 was blank and 12/26/2022 had an "NA" in the area. The documentation key evidenced "NA-Not applicable."

Review of the ADL documentation for R303 from 1/1/2023-1/31/2023 failed to evidence a bath or

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shower was provided on 1/2/2023. The documentation for 1/2/2023 documented "NA." The documentation key evidenced "NA-Not applicable."

The clinical record for R303 failed to evidence refusals for baths/showers on the dates above.

The comprehensive care plan for R303 documented in part, "(Name of R72) has an ADL selfcare performance deficit AEB (as evidenced by) Acute and chronic CHF (congestive heart failure), Type 2 DM (diabetes mellitus), Atrial fibrillation, ETOH (alcohol) abuse, H/O (history of) falling, COPD (chronic obstructive pulmonary disease), Homelessness, non compliance with medical treatment. Date Initiated: 08/25/2022. Revision on: 01/12/2023."

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a bath or shower for R303 on the dates listed above.

On 8/31/2023 at 3:49 p.m., ASM #2, the interim director of nursing stated that they did not have evidence of a bath or shower for R303 on the dates listed above to provide.

On 8/31/2023 at 10:19 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that showers were given twice a week and more often if needed or requested. She stated that baths or showers were documented in the computer in the ADL documentation and if the resident refused the bath or shower they documented that also and notified the nurse. She stated that "NA" on the ADL documentation meant that the activity did not

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F 676	Continued From page 72 happen. On 8/31/2023 at 11:01 a.m., an interview was conducted with CNA #5. CNA #5 stated that they evidenced the care they provided by documenting what was done on the ADL documentation. She stated that "NA" meant that the computer had scheduled the shower or bath on the wrong day so it was not given and should be documented in the prn (as needed) shower area. On 8/31/2023 at 4:31 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 676		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for dependent residents for three of 45 residents in the survey sample, Residents #6, #60, and #28. The findings include: 1. For Resident #6 (R6), the facility staff failed to provide showers/baths and personal hygiene on multiple dates in July and August 2023.	F 677	1. Resident #6 received showers as scheduled. Resident #60 prefers to wash at the sink instead of shower, careplan updated to reflect preference. Resident #28 received showers as scheduled. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit was performed of current residents for the current week to ensure the shower has been completed. 3. DON/designee will educate all Nursing staff on providing shower/bathing according to resident requests and preferences and documenting accordingly.	

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F 677	Continued From page 73 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/3/23, R6 was coded as being cognitively intact for making daily decisions. She was coded as requiring the extensive assistance of staff for toileting and personal hygiene, and as being completely dependent on staff assistance for bathing. On 8/29/23 at 11:57 a.m., R6 was interviewed. She stated the staff has not "been very good about getting me cleaned up in the mornings." She stated she does not always get a shower on her scheduled shower days. A review of R6's POC (point of care) records for July and August 2023 revealed no evidence of the following ADLs on the following dates: Bathing: 7/7, 7/9, 7/11, 7/13, 7/16, 7/20, 7/21, 7/23, 7/25, 7/26, 7/27, 7/28, 8/9, 8/10, 8/13, 8/14, 8/20, 8/25, 8/26, and 8/27. Morning Personal Hygiene: 7/7, 7/13, 7/20, 7/21, 7/22, 7/23, 7/28, 7/30, 7/31, 8/13, 8/20, and 8/27. Evening Personal Hygiene: 7/7, 7/13, 7/14, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21, 7/23, 7/24, 7/25, 7/26, 7/27, 7/28, 8/11, 8/12, 8/13, 8/14, 8/15, 8/16, 8/17, 8/19, 8/20, 8/21, 8/22, 8/23, 8/24, 8/25, 8/26, 8/27. Shower (as scheduled twice a week): 7/6, 7/13, 7/20, 7/27, 7/31. On 8/31/23 at 10:26 a.m., CNA (certified nursing assistant) #8 was interviewed. When asked what tasks are included in morning and evening care, she stated she changes incontinence briefs if	F 677	4. DON/designee to audit for shower completion 5x week x4 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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needed, giving a sponge bath, including washing the resident's face, hands, legs, feet, and private parts, applying deodorant in the mornings, combing hair, applying lotion to dry skin, and brushing the resident's teeth. She stated she provides evidence of what she has done by signing off the task on the POC record on the computer. She stated: "I try to get to everybody, every shift. Sometimes it's hard, depending on what's going on with other residents on the unit."

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated the CNAs are primarily responsible for ADL care. She stated if a resident refuses or the CNA has a concern, the CNA will report it to her. Otherwise, the CNAs sign off their work on the POC record on the computer.

On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

A review of the facility policy, "Activities of Daily Living (ADLs)," revealed, in part: "Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene...Each resident shall be given proper daily personal attention and care, including skin, nail, hair, and oral hygiene...Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly or as required by state law...Residents will be

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assisted with dressing and grooming as appropriate...Residents shall be assisted with oral care as needed."

No further information was provided prior to exit.

2. For Resident #60 (R60), the facility staff failed to evidence a bath or shower was provided on 7/4/2023, 7/18/2023, 7/21/2023, 7/28/2023, 8/1/2023, 8/18/2023 and 8/29/2023.

On the most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 7/21/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The assessment documented R60 requiring limited assistance of one person for personal hygiene and extensive assistance of one person for bathing.

On 8/29/2023 at 1:03 p.m., an interview was conducted with R60. R60 stated that they received showers sometimes but not as often as they were supposed to. R60 stated that they felt like some of the staff did not care very much and they just had to go to the sink and wash themselves up sometimes.

Review of the ADL documentation for R60 from 7/1/2023-7/31/2023 failed to evidence a bath or shower provided on 7/4/2023, 7/18/2023, 7/21/2023, or 7/28/2023. The documentation for 7/18/2023 was blank and 7/4/2023, 7/21/2023 and 7/28/2023 had an "NA" in the area. The documentation key evidenced "NA-Not applicable."

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Review of the ADL documentation for R60 from 8/1/2023-8/31/2023 failed to evidence a bath or shower provided on 8/1/2023, 8/18/2023 and 8/29/2023. The documentation for 8/1/2023, 8/18/2023 and 8/29/2023 documented "NA." The documentation key evidenced "NA-Not applicable."

The clinical record for R60 failed to evidence refusals for baths/showers on the dates above.

The comprehensive care plan for R60 documented in part, "(Name of R72) has an ADL (activities of daily living) self-care performance deficit r/t (related to) recent hospitalization compromising function mobility. Date Initiated: 11/04/2022. Revision on: 11/17/2022."

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a bath or shower for R60 on the dates listed above.

On 8/31/2023 at 3:49 p.m., ASM #2, the interim director of nursing, stated that they did not have evidence of a bath or shower for R60 on the dates listed above to provide.

On 8/31/2023 at 10:19 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that showers were given twice a week and more often if needed or requested. She stated that baths or showers were documented in the computer in the ADL documentation and if the resident refused the bath or shower they documented that also and notified the nurse. She stated that "NA" on the ADL documentation meant that the activity did not

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happen.

On 8/31/2023 at 11:01 a.m., an interview was conducted with CNA #5. CNA #5 stated that they evidenced the care they provided by documenting what was done on the ADL documentation. She stated that "NA" meant that the computer had scheduled the shower or bath on the wrong day so it was not given and should be documented in the prn (as needed) shower area.

On 8/31/2023 at 4:31 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

3. For Resident #28 (R28), the facility staff failed to evidence a shower and/or a complete bed bath completed on 7/10/2023, 7/20/2023, 7/24/2023, 7/27/2023, 7/31/2023, 8/10/2023, 8/14/2023, and 8/28/2023.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/23/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that they were cognitively intact for making daily decisions. Section G coded R28 as requiring extensive assistance of two or more persons for transfers and totally dependent on one person for bathing.

On 8/29/2023 at 12:33 p.m., an interview was conducted with R28. R28 stated that they had resided at the facility for over a year and really wanted to get a shower. R28 stated that they had only received bed baths since they were at the

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facility and there were only certain CNA's (certified nursing assistants) who would do their bath due to their size so they had to wait until they were working to get their baths. R28 stated that it made them mad and they had never been to the shower or been offered a shower because of their size. R28 stated that no one should have to go without a shower and they were looking to transfer to another facility in the Richmond area.

Review of the ADL documentation for R28 from 7/1/2023-7/31/2023 failed to evidence a complete bed bath or shower provided on 7/10/2023, 7/20/2023, 7/24/2023, 7/27/2023, and 7/31/2023. The documentation for 7/20/2023, 7/27/2023 and 7/31/2023 was blank. The documentation for 7/10/2023 and 7/24/2023 documented "PB." The documentation key evidenced "PB- Partial bath."

Review of the ADL documentation for R28 from 8/1/2023-8/31/2023 failed to evidence a complete bed bath or shower provided on 8/10/2023, 8/14/2023, 8/21/2023 and 8/28/2023. The documentation for 8/10/2023 and 8/28/2023 was blank. The documentation for 8/14/2023 and 8/21/2023 documented "PB." The documentation key evidenced "PB- Partial bath."

The clinical record for R28 failed to evidence refusals for baths/showers on the dates above.

The comprehensive care plan for R28 documented in part, The resident has an ADL self-care performance deficit AEB (as evidenced by). Date Initiated: 11/11/2022."

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a bath or shower for

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R28 on the dates listed above.

On 8/31/2023 at 3:49 p.m., ASM #2, the interim director of nursing stated that they did not have evidence of a bath or shower for R28 on the dates listed above to provide.

On 8/31/2023 at 10:19 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that showers were given twice a week and more often if needed or requested. She stated that baths or showers were documented in the computer in the ADL documentation and if the resident refused the bath or shower they documented that also and notified the nurse. She stated that "NA" on the ADL documentation meant that the activity did not happen.

On 8/31/2023 at 10:50 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that showers were twice a week and the CNA's documented them in the computer. LPN #7 stated that there were several CNA's who worked with R28 the most because they knew their routine and preferences. LPN #7 stated that R28 only received bed baths as far as they knew.

On 8/31/2023 at 11:01 a.m., an interview was conducted with CNA #5. CNA #5 stated that they evidenced the care they provided by documenting what was done on the ADL documentation. She stated that "NA" meant that the computer had scheduled the shower or bath on the wrong day so it was not given and should be documented in the prn (as needed) shower area. CNA #5 stated that R28 was totally dependent on staff for bathing and always got bed baths. She stated

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F 677	Continued From page 80 that they were supposed to be getting R28 a shower chair so they could go to the shower but it had not come in yet. She stated that R28 was one of two obese residents who needed the shower chair and the facility was working to buy the chair for them to use for the residents. She stated that the head of therapy had been working to get the chair. She stated that R28 received bed baths from her and one other aide twice a week when they were working because some of the other CNA's were intimidated by the resident's size but she did not mind. She stated that R28 had been here over a year and had always wanted showers. On 8/31/2023 at 4:31 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 677		
F 684 SS=G	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 observation, family interview, staff interview, facility document review, and clinical record review, the facility staff failed to assess	F 684	1. Resident #254 has been discharged from the facility. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. The most recent skin assessments of current residents were reviewed for skin impairments to ensure treatments are ordered as indicated. 3. DON/Designee to educate licensed nursing staff regarding assessment and provider notification requirements related to change of conditions.	

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F 684	Continued From page 81 and/or monitor a change in a resident's condition for one of 45 residents in the survey sample, Residents #254. For Resident #254, the facility staff failed to assess and monitor a diabetic resident's right great toe after identifying a skin tear. Three days after identifying the skin tear, the resident was transferred to the hospital with a necrotic right great toe and received treatment with antibiotics. The lack of assessment and monitoring resulted in harm to Resident #254. The findings include: For Resident #254 (R254), the facility staff identified a skin tear on her right great toe on 8/26/23. The facility staff failed to evidence further assessment or monitoring of the skin tear until the resident was sent to the hospital in the late afternoon of 8/29/23 with a necrotic (1) right great toe. The lack of assessment and monitoring resulted in harm to the resident. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/11/23, R254 was coded as being severely cognitively impaired for making daily decisions, having scored one out of 15 on the BIMS (brief interview for mental status). R254 was admitted to the facility with diagnoses including diabetes, dementia, and polyneuropathy (2). On 8/29/23 at 12:08 p.m., R254 was observed sitting in a wheelchair beside her bed. R254's daughter was seated beside the resident. R254's right leg was elevated, and a blanket covered the leg down to the ankle. R254's right great toe was red/purple/black, and toe was shiny with fluid on it. There was no dressing on the toes. R254's	F 684	4. DON/Designee to perform an audit of current residents' skin assessments for skin impairments and corresponding treatment/monitor order 5x week x 4 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance10/16/2023.	

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daughter stated: "[R254] had a bloody sock over the weekend and I showed it to a nurse." She stated the weekend nurse told her that the nurse would put R254 on the list to be seen by the nurse practitioner on Monday, 8/28/23. She stated she visits R254 every day, and there has never been any type of dressing on the toe. R254's daughter stated she was waiting for the nurse to come in and look at the toe.

On 8/29/23 at 3:28 p.m., R254 was lying in her bed. Her right great toe was visible, and was still red/purple/black, and wet.

A review of R254's clinical record revealed the following progress notes:
"8/26/2023 14:18 (2:18 p.m." Nursing Note Text: Skin tear found on Resident's great toe on right foot. Tear measures <0.5cm (centimeters) x <0.5cm x <0.5cm. Resident stated that she does not remember how skin tear happened. Cleansed w/ (with) wound cleanser and applied bacitracin. NP(nurse practitioner)...and [name of primary physician] informed. Will continue to monitor." This note was written by RN (registered nurse) #2.

"8/26/2023 15:21 (3:21 p.m.) Nursing Note Text: skin assessment documented. weekly wound assessment triggered."

"8/29/2023 1635 (4:35 p.m.) Transfer to hospital."

"8/29/2023 22:11 (10:11 p.m.) eINTERACT...Summary for Providers Situation: The Change In Condition/s reported on this...Evaluation are/were: Tired, Weak, Confused, or Drowsy Change in skin color or condition...Outcomes of Physical Assessment:

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Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Increased confusion (e.g. disorientation)...Skin Status Evaluation: Discoloration...Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:
A. Recommendations: to send the resident to the emergency [room]."

"8/29/2023 22:41 (10:41 p.m.) Nursing Note Text: Nursing assistant was giving the resident shower and noticed changes on her toe. upon assessment necrotic toe was observed. physician was notified instructions was given to send the resident to the ER (emergency room). RP (responsible party) was in the building and escorted the resident. phone call follow-up was made, resident admitted for hypernatremia (high sodium level), narcotic [sic] toe, dehydration, UTI (urinary tract infection)."

A review of R254's Weekly Skin Observation dated 8/26/23 revealed, in part: "Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? Yes. Skin Tear. Skin Tear Location: Right Toes. Is this a new skin condition? Yes."

A review of R254's clinical record (orders, provider notes, MAR [medication administration record] and TAR [treatment administration record]) revealed no evidence of an order for care of the skin tear, and no evidence of any assessment or monitoring of the resident's right great toe between 8/26/23 and when she was sent to the hospital with a necrotic right great toe on 8/29/23.

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A review of the Emergency Room records from the local hospital where R254 was admitted on 8/29/23 revealed, in part: "The patient...who is seen in the Emergency Department for concerns of black toes on her right foot, unsure how long it has been going on. Daughter first noticed it four days prior ....Physical Examination ...MSK (musculoskeletal): Black first and second right toes ...The patient presents with altered mental status, concerning for acute infection, possibly sepsis, although ongoing for three weeks per daughter. Concerns for foot ulceration vs. gangrenous changes on right toes ...Presentation most consistent with foot infection, UTI."

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated if she identifies that a resident has a skin tear, she assess the injury and notifies the NP to obtain treatment orders. She completes a skin assessment form, and enters the treatment order so it will show up on the TAR for follow up. She stated skin tears should be monitored by the facility staff until they are resolved. She stated this is especially important for resident who have diabetes and neuropathy.

On 8/31/23 at 11:11 a.m., ASM (administrative staff member) #5, a nurse practitioner, was interviewed. She stated RN #2 texted her about the skin tear by way of the facility's electronic medical record software on Saturday, 8/26/23. She stated: "I don't respond to those routine notifications." She stated she did not see the resident on 8/28/23 or 8/29/23. She stated: "I never looked at [R254's] toes."

On 8/31/23 at 12:36 p.m., ASM #1, the administrator, ASM #2, the director of nursing,

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and ASM #3, the regional nurse consultant, were informed of these concerns, and of the concern for harm to R254. ASM #2 stated the facility does not have standing orders for skin tears.

On 8/31/23 at 4:13 p.m., RN #2 was interviewed. She stated R254's daughter notified her on Saturday, 8/26/23, that the resident's right sock was bloody. She stated the daughter assisted her in removing the resident's sock. There was a skin tear on the top of the right great toe, extending around toward the side of the toe. The toenail was still intact, but there was dried blood on the toe. She stated she cleaned the dried blood with wound cleanser and applied an antibiotic ointment but no bandage. She put a clean sock on the resident and made the required notes in the clinical record. She stated she notified ASM #5 by a routine text. She stated it is her understanding that the electronic medical record software triggers a formal wound assessment for follow up, and the wound nurse would look at the injury and determine a proper treatment. She stated there is no list of residents for the NP to see on the NP's next visit to the facility. She stated: "I figured with me notifying the NP, that would trigger a visit."

On 9/1/23 at 8:14 a.m., ASM #2, the director of nursing, was asked if the facility had additional evidence to present regarding R254. She stated the hospital had determined the resident had peripheral vascular disease, of which the facility was not previously aware. When asked if the facility staff was aware that R254 had diabetes and peripheral neuropathy, she stated: "Yes, we were aware of that." When asked what was put in place to monitor this diabetic resident, who had a skin tear on her toe, ASM #2 did not answer.

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A review of the facility policy, "Skin Tears, Abrasions, and Bruises Management," revealed, in part: "Skin Tear...is a traumatic wound caused by mechanical forces...Severity may vary by depth...Staff will be encouraged to promptly report any observation of a change in the resident's skin integrity including presence of a skin tear, abrasion, or bruise...Observations of new areas of impaired skin integrity will be reported to the physician/practitioner for further evaluation and treatment...Treatments will be ordered by the physician/practitioner...Resident centered interventions and treatments will be prescribed by the physician/practitioner and administration of the treatments will be documented in the resident's medical record...Treatments, including preventive interventions, will be documented in the resident's medical record."

No further information was provided prior to exit.

References:
(1) "Necrosis is the death of body tissue. It occurs when too little blood flows to the tissue. This can be from injury, radiation, or chemicals. Necrosis cannot be reversed."
This information is taken from the website https://medlineplus.gov/ency/article/002266.htm
(2) "Peripheral neuropathies are diseases of the peripheral nervous system that can be divided into mononeuropathies, multifocal neuropathies, and polyneuropathies. Symptoms usually include numbness and paresthesia. These symptoms are often accompanied by weakness and can be painful." This information is taken from the website https://pubmed.ncbi.nlm.nih.gov/27637963/.

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F 686	Continued From page 87	F 686	1. Resident #7 order for heels up at all times has been discontinued. Resident #87 and Resident #98 have discharged from the facility. 2. All residents have the potential to be affected by the alleged deficient practice. An audit of current residents with orders to float heels has been conducted to ensure an offloading device is in place. An audit of current residents with pressure injuries has been conducted to ensure a treatment order is in place and said treatment order corresponds with recent provider written communication. 3. DON/Designee will educate licensed nursing staff regarding obtaining, transcribing, and implementing treatment orders. 4. DON/Designee will perform an audit of residents with orders to float heels to ensure an offloading device is in place 3x week x 4 weeks. DON/designee will perform an audit to ensure residents with pressure injuries to ensure there is a treatment order in place and said treatment order corresponds to the recent provider communication 3x week x 4 weeks. 5. Date of Compliance 10/16/2023.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement treatments and/or interventions to prevent and treat a pressure injury for three of 45 residents in the survey sample, Residents #7, #87, and #98. The findings include: 1. For Resident #7 (R7), the facility staff failed to elevate the resident's heels to prevent a pressure injury. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/30/23, R7 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was	F 686		

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coded as being at risk for a pressure injury, and as having no unhealed pressure injuries.

On the following dates and times, R7 was observed lying in bed, with bed heels in direct contact with the mattress surface: 8/29/23 at 12:25 p.m. and 3:41 p.m.; 8/30/23 at 8:46 a.m. and 1:07 p.m.

A review of R7's Braden Scale assessment to identify pressure injury risk dated 7/3/23 revealed R7 scored 19, indicating she was at low risk of developing a pressure injury.

A review of R7's orders revealed the following order, written 1/17/23: "Skin prep to bilateral heels and float off bed every shift for preventive."

On 8/31/23 at 10:26 a.m., CNA (certified nursing assistant) #8 was interviewed. She stated: "All residents' heels need to be floated if they have an order for it." She stated floating heels is especially important for residents who are in the bed. When asked about R7's need to have her heels floated, she stated: "I don't think she needs her heels to be floated because she is not in the bed all the time." She stated the nurses inform CNAs about which residents have orders for heels to be floated.

On 8/31/23 at 12:56 p.m., LPN (licensed practical nurse) #5, the wound nurse, was interviewed. She stated if a resident is in bed and has a risk for developing a pressure injury, the resident's heels should be floated. She stated the physician or NP (nurse practitioner) will often write an order for a resident's heels to be floated. She stated the orders should be followed.

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On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

A review of the facility policy, "Pressure Injury Prevention and Management," revealed, in part: "Findings from the pressure ulcer/injury risk assessment will be incorporated into the resident's plan of care...Preventative interventions will be implemented based on the...risk assessment, other related factors and resident preferences. Such interventions may include...Use of pressure reducing/relieving support surfaces or devices that assist with pressure redistribution and tissue load."

No further information was provided prior to exit.

2. For Resident #87 (R87), the facility staff failed to implement treatment for a pressure injury until four days after it was identified.

A review of R87's progress note revealed the following note dated 6/10/23 at 11:06 p.m.: "Resident presented today at [6:00 p.m.] from [name of local hospital]...Skin has scattered bruising all over the body, stage 4 sacral pressure wound (1) reported by discharging facility."

Further review of the resident's clinical record, including orders, skin assessments, MARs (medication administration records) and TARs (treatment administration records) failed to reveal evidence for orders for the treatment of the pressure injury until 6/14/23.

A review of the nurse practitioner's note dated

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6/12/23 at 2:08 p.m. revealed, in part: "...Endorses pain secondary to sacral ulcer...A&P (assessment and physical) decubitus ulcer - wound care."

A review of R87's care plan dated 6/10/23 revealed, in part: [R87] has actual impairment to skin integrity...Follow facility policies/protocols for the prevention of skin breakdown."

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated if she is the admitting nurse for a resident who comes in with a pressure injury, she notifies the NP (nurse practitioner) or physician. She states if a treatment order comes from the discharging hospital, she will let the NP know that and initiate the recommended treatment. She stated the treatment for the wound should be initiated as soon as possible.

On 8/31/23 at 11:11 a.m., ASM (administrative staff member) #5, a nurse practitioner, was interviewed. She stated if a resident is admitted with a pressure injury, the resident should ideally come with orders to treat the pressure injury from the hospital. She stated if there is a time lapse between when the resident is admitted to the facility and when the NP first sees the resident, there should be wound care happening. She stated: "That's something I expect the facility to do." She stated she often sees the resident before the physician comes in to do the admission history and physical, and she does not participate in that process. She stated she did not assess or write treatment orders for R87's pressure injury when she saw the resident on 8/12/23.

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On 8/31/23 at 12:56 p.m., LPN #5, the wound nurse, was interviewed. She stated if a resident is admitted with a pressure injury, "they should come with orders from the hospital." She stated the order from the hospital should be implemented immediately at the facility until the resident can be seen by the resident's wound nurse or doctor. She stated if the resident does not come with orders from the hospital, the NP should be notified and should give the admitting nurse an order for the pressure injury treatment. She stated: "It's not okay to wait a few days before pressure injury treatment."

On 9/1/23 at 8:33 a.m., LPN #8, who was R87's admitting nurse, was interviewed. She stated if a resident is admitted with a pressure injury, orders should come with the resident from the hospital. She stated she would find those orders and contact the NP to communicate that the resident had a pressure injury. She stated if there are no orders from the discharging hospital, she calls the NP to get orders in place until the resident can be seen by a facility provider. She stated: "It is not okay to wait a few days. The admitting nurse is responsible for this."

On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

A review of the facility policy, "Pressure Injury Prevention and Management," revealed, in part: "Treatments will be ordered by the physician/practitioner...unless established and approved under standing orders by an individual physician/practitioner, orders for pressure

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ulcer/injury treatment will be specific for each resident."

No further information was provided prior to exit.

NOTES
(1) "Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This information was obtained from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .

3. For Resident #98 (R98), the facility staff failed to transcribe a physician's order for a change in pressure injury (1) treatment in a timely manner.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/6/2023, the resident was assessed as being at risk for pressure injury but not having any current pressure injuries.

The physician orders for R98 documented in part,
- "Cleanse right and left buttocks open areas with wound cleanser and apply Calcium Alginate with foam
dressing QD (every day). Every day shift for skin impairment. Order Date: 08/15/2023. Start Date: 08/16/2023. End Date: 08/30/2023."
- "Cleanse buttock open areas with wound cleanser and apply honey with foam dressing

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every day. Every day
shift for skin impairment. Order Date: 08/30/2023. Start Date: 08/30/2023."

The eTAR (electronic treatment administration record) for R98 dated 8/1/2023-8/31/2023 documented the Calcium Alginate treatment to the right and left buttocks completed each day 8/16/2023-8/29/2023 and discontinued on 8/30/2023. The eTAR documented the honey with foam dressing treatment to the open area on the buttocks beginning on 8/30/2023.

The wound physician assessment dated 8/15/2023 documented in part, "...Wound #2 Right Buttock is a Deep Tissue Pressure Injury (2) Persistent non-blanchable deep red, maroon or purple discoloration...Initial wound encounter measurements are 2cm (centimeter) length x 2cm width with no measurable depth, with an area of 4 sq (square) cm...Wound #3 Left Buttock is a Deep Tissue Pressure Injury (2) Persistent non-blanchable deep red, maroon or purple discoloration...Initial wound encounter measurements are 3cm length x 2cm width with no measurable depth, with an area of 6 sq (square) cm..." The assessment further documented, "Wound Orders: Wound #2 Right buttock: ...Wound dressing: Apply: - Calcium Alginate/foam/QD (every day)... Wound Orders: Wound #3 Left buttock: ...Wound dressing: Apply: - Calcium Alginate/foam/QD..."

The wound physician assessment dated 8/21/2023 documented in part, "...Wound #2 Sacral is an unstageable pressure injury observed... Subsequent wound encounter measurements are 3cm length x 8cm width with no measurable depth, with an area of 24 sq cm...

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Note: this wound is from L and R buttock DTI wounds that evolved into one sacral wound. Wounds have joined now thus one wound... Wound Orders: Wound #2 Sacral: Wound Dressing- Apply: - honey foam daily..."

The wound physician assessment dated 8/29/2023 documented in part, "...Wound #2 Sacral is an Unstageable Pressure Injury... Subsequent wound encounter measurements are 3.5cm length x 7cm width with no measurable depth, with an area of 24.5 sq cm... Wound Orders: ...Wound #2 Sacral... Wound Dressing- Apply: - honey foam daily..."

On 8/31/2023 at 12:29 p.m., an interview was conducted with LPN #4, wound nurse. LPN #4 stated that the wound physician came in weekly and rounded with residents that they kept on a list. LPN #4 stated that the physician documented the measurements and any changes that they wanted to make to treatments on the list that they carried with them during rounds and they used that list to make changes to orders the same day or the next day. She stated that the wound physician dictated their wound notes and uploaded them into their system where medical records pulled them into the medical record. She stated that only medical records had access to the wound physicians system to get the notes and she was not sure if anyone reviewed the notes to see if there was any changes to the orders in the notes. She reviewed the wound physician's note dated 8/21/2023 and stated that the physician did not mention changing the treatment on that day and they had not reviewed the written note. She stated that she had reviewed the 8/29/2023 wound physician note and noticed that the treatment order had changed so she had clarified

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it with the wound physician and made the change on 8/30/2023. She stated as far as she knew there was no check in place to review the wound physician's notes when they came in, that medical records just put them in the chart.

The facility policy "Pressure Injury Prevention and Management" documented in part, "... 3. If a referral is made to a wound consultant: ... d. The wound consultant will provide timely and accurate information to the nursing facility on the status of the pressure ulcer/injury and will provide recommendation for change in treatment and care of the pressure ulcer/injury..."

On 8/31/2023 at 4:31 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the findings.

No further information was provided prior to exit.

Reference:

(1) Pressure injury
A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to

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F 686	Continued From page 96 see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm. (2) DTI- deep tissue injury Pressure sores that develop in the tissue deep below the skin. This is called a deep tissue injury. The area may be dark purple or maroon. There may be a blood-filled blister under the skin. This type of skin injury can quickly become a stage III or IV pressure sore. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to implement interventions for resident safety related to falls for one of 45 residents in the survey sample; Resident #7.	F 689	1.Resident #7 foam helmet has been discontinued; a new order was written for “Encourage Soft shell helmet when out of bed.” 2. All residents have potential to be affected by the alleged deficient practice. An audit was performed of current residents with helmets to ensure an order is in place. 3. DON/Designee will educate licensed nursing staff regarding implementing helmet orders.	

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F 689	Continued From page 97 The findings include: For Resident #7 (R7), the facility staff failed to apply a physician-ordered helmet to the resident. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/30/23, R7 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as having had two falls without injuries during the look back period. On the following dates and times, R7 was observed lying in bed, without a helmet: 8/39/23 at 12:25 p.m. and 3:41 p.m.; 8/30/23 at 8:46 a.m. and 1:07 p.m. A review of R7's orders revealed the following order, dated 6/14/23: "Foam helmet on at all times. Check placement and document refusal." A review of R7's care plan dated 1/18/23 and updated 6/14/23 revealed, in part: "[R7] has had an actual fall...Foam helmet at all times per family request. Document removal/refusals. Patient non-compliant with wearing foam helmet at times." On 8/31/23 at 10:26 a.m., CNA (certified nursing assistant) #8 was interviewed. She stated: "[R7] is supposed to have a helmet on all the time. Even in bed." She stated she "always" puts a helmet on R7 because the resident's family has asked for it. On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated R7 is	F 689	4. DON/Designee will perform an audit of residents with orders to ensure helmet is in place as ordered 3x week x 4 weeks. DON/designee will perform an audit to ensure residents with pressure injuries to ensure there is a treatment order in place and said treatment order corresponds to the recent provider communication 3x week x 4 weeks. 5. Date of Compliance 10/16/2023.	

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F 689	Continued From page 98 supposed to wear a helmet at all times "because her family thinks it will help." She stated the resident wears it and still falls and hits her head. She stated: "The helmet is not working, and it is what the family wants." On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. No further information was provided prior to exit.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692	1. Resident #10 fluid restrictions have been discontinued. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents with fluid restrictions has been conducted to ensure the provider has been notified of noncompliance since 9/1/2023. 3. DON/Designee will educate licensed nurses regarding reporting resident noncompliance with fluid restriction to the provider.	

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F 692	Continued From page 99 by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to report non-compliance with fluid restrictions to the physician for one of 45 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to report non-compliance with fluid restrictions to the physician. The physician orders for R10 documented in part, "Fluid Restriction 2000cc per day: 600cc breakfast, 120cc morning medpass, 480cc lunch, 120cc afternoon medpass, 480cc dinner, 120cc evening meds, 80cc extra every shift related to Acute On Chronic Diastolic (Congestive) heart failure. Order Date: 09/02/2021." Review of the eTAR (electronic treatment administration record) dated 6/1/2023-6/30/2023 for R10 documented intake amounts totaled for each shift. The eTAR documented a total amount of 2700cc on 6/4/2023, 2340cc on 6/19/2023 and 2360cc on 6/28/2023. The eTAR failed to evidence notification of the physician of non-compliance with the 2000cc per day fluid restrictions. Review of the eTAR dated 7/1/2023-7/31/2023 for R10 documented intake amounts totaled for each shift. The eTAR documented a total amount of 2700cc on 7/19/2023, 2910cc on 7/26/2023, 3000cc on 7/28/2023, and 3000cc on 7/29/2023. The eTAR failed to evidence notification of the physician of non-compliance with the 2000cc per	F 692	4. DON/Designee will perform an audit of residents with fluid restrictions to ensure any identified noncompliance is reported to the provider 3x week x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 10/16/2023.	

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F 692	Continued From page 100	F 692		

day fluid restrictions.

Review of the eTAR dated 8/1/2023-8/31/2023 for R10 documented intake amounts totaled for each shift. The eTAR documented a total amount of 2520cc on 8/2/2023 and 3600cc on 8/29/2023. The eTAR failed to evidence notification of the physician of non-compliance with the 2000cc per day fluid restrictions.

The clinical record for R10 failed to evidence notification of the physician/provider for the non-compliance of the fluid restrictions on the dates listed above.

The comprehensive care plan for R10 documented in part, "Noncompliance with fluid restriction. Noncompliance with keeping non skid socks on with eucerine [sic] cream. Date Initiated: 04/27/2023. Revision on: 04/27/2023." Under "Interventions" it documented in part, "...Report non compliance to MD (medical doctor). Date Initiated: 04/27/2023."

On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. She stated that when residents were on fluid restrictions they reviewed them daily and notified the nurse practitioner if they went over the limit and educated the resident. She stated that there should be documentation in the progress notes regarding notification of the nurse practitioner of the non-compliance with fluid restrictions.

The facility policy "Resident Hydration and Prevention of Dehydration" dated 10/01/2021 failed to evidence guidance on monitoring residents with fluid restrictions ordered.

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F 692	Continued From page 101 On 8/31/2023 at 4:31 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain respiratory equipment in a sanitary manner for two of 45 residents, Residents #6 and #253. The findings include: 1. For Resident #6 (R6), the facility staff failed to store the nebulizer mask in a sanitary manner. On the following dates and times, R6's nebulizer mask was observed to be uncovered and lying across the nebulizer machine: 8/29/23 at 11:57 a.m. and 3:36 p.m.; and 8/30/23 at 8:19 a.m. A review of R6's orders revealed the following	F 695	1. Resident #6 and Resident #253 nebulizer masks were placed in storage bags during the time of survey. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current resident with ordered nebulizers has been performed to ensure proper storage of the nebulizer mask. 3. DON/designee will educate licensed nurses regarding the appropriate storage of nebulizer masks. 4. DON/designee will perform an audit of current residents with ordered nebulizers to ensure proper storage of the nebulizer mask 3xweek x 4 weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 10/16/2023.	

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F 695	Continued From page 102	F 695		

order dated 8/10/23: "Ipratropium-Albuterol Solution (1) 0.5-2.5 MG/3ML (milligrams per milliliter) 3 ml inhale orally three times a day for SOB (shortness of breath)/respiratory failure/COPD (chronic obstructive pulmonary disease."

A review of R6's August 2023 MAR (medication administration record) revealed she had received the medication as ordered.

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated nebulizer equipment, and especially the nebulizer mask, should be washed after each use and stored in a plastic bag. She stated this is necessary to prevent the mask from collecting bacteria and possibly resulting in an infection for the resident.

On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

A review of the facility policy, "Oral Inhalation Administration," revealed, in part: "When treatment is complete...rinse and disinfect the nebulizer equipment...allow the components to air dry completely on a paper towel...When equipment is completely dry, store in a plastic bag marked with the resident's name and the date."

No further information was provided prior to exit.

Reference:
(1) "Ipratropium oral inhalation is used to prevent wheezing, shortness of breath, coughing, and chest tightness in people with chronic obstructive

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pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs)...Ipratropium comes as a solution (liquid) to inhale by mouth using a nebulizer (machine that turns medication into a mist that can be inhaled)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a695021.html#:~:text=Ipratropium%20oral%20inhalation%20is%20used,to%20the%20lungs)%20and%20emphysema%20(.

2. For Resident #253 (R253), the facility staff failed to store the nebulizer mask in a sanitary manner.

On the following dates and times, R253's nebulizer mask was observed to be uncovered and lying across the nebulizer machine: 8/29/23 at 12:01 p.m. and 3:29 p.m.; and 8/30/23 at 8:40 a.m.

A review of R253's orders revealed the following order dated 8/15/23: Albuterol Sulfate Nebulization Solution (1) (2.5 MG/3ML) (milligrams/milliliter) 0.083% 3 ml inhale orally via nebulizer four times a day."

A review of R253's August 2023 MAR (medication administration record) revealed the resident had received the medication as ordered.

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated nebulizer equipment, and especially the nebulizer mask, should be washed after each use and stored in a

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F 695	Continued From page 104 plastic bag. She stated this is necessary to prevent the mask from collecting bacteria and possibly resulting in an infection for the resident. On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. No further information was provided prior to exit. Reference: (1) Albuterol is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways)...Albuterol comes as a solution (liquid) to inhale by mouth using a special jet nebulizer (machine that turns medication into a mist that can be inhaled)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682145.html.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record reviews and facility document	F 697	1. Resident #28 non-pharmacological intervention monitoring has been added to MAR (Medication Administration Record). 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents receiving pain medication as needed will be performed to ensure non-pharmacological intervention monitoring is available on MAR.	

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F 697	Continued From page 105 reviews it was determined that the facility staff failed to provide a complete pain management program for one of 45 residents in the survey sample, Resident #28. The findings include: For Resident #28 (R28), the facility staff failed to implement a complete pain management program including non-pharmacological interventions prior to administration of as needed pain medications. Resident #28's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/23/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The assessment documented R28 receiving as needed pain medication, not receiving non-medication interventions for pain and not having any pain. On 8/29/2023 at 12:33 p.m., an interview was conducted with R28. R28 stated that they took medications for pain. R28 stated that they asked the nurses for pain medication when they needed it and sometimes they tried to reposition them before they gave them the medications and sometimes it made it hurt a little less. The physician orders for R28 documented in part, "Hydrocodone-Acetaminophen Tablet 5-325 MG (milligram) Give 1 tablet by mouth every 6 hours as needed for Pain. Order Date: 01/03/2023." Review of the eMAR (electronic medication administration record) for R28 dated	F 697	3. DON/ designee will educate licensed nursing staff regarding the providing nonpharmacological interventions prior to administration of PRN pain medications. 4. DON/designee will perform an audit of residents receiving pain medication as needed to ensure non-pharmacological intervention monitoring is available on MAR. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 10/16/2023.	

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7/1/2023-7/31/2023 failed to evidence non-pharmacological interventions prior to administration of the as needed Hydrocodone-Acetaminophen on 7/2/2023 at 4:26 a.m. for a pain level of 9, on 7/6/2023 at 10:41 a.m. for a pain level of 5, on 7/9/2023 at 2:39 a.m. for a pain level of 9, on 7/14/2023 at 4:55 a.m. for a pain level of 9, on 7/19/2023 at 3:55 a.m. for a pain level of 3, on 7/25/2023 at 11:20 a.m. for a pain level of 5, on 7/28/2023 at 4:59 a.m. for a pain level of 9, on 7/30/2023 at 5:01 a.m. for a pain level of 9 and 7/31/2023 at 6:07 a.m. for a pain level of 9.

Review of the eMAR for R28 dated 8/1/2023-8/31/2023 failed to evidence non-pharmacological interventions prior to administration of the as needed Hydrocodone-Acetaminophen on 8/1/2023 at 2:07 a.m. for a pain level of 2, on 8/2/2023 at 4:00 a.m. for a pain level of 3, on 8/6/2023 at 1:16 a.m., for a pain level of 9, on 8/7/2023 at 2:05 a.m. for a pain level of 2, on 8/11/2023 at 11:36 a.m. for a pain level of 8, on 8/13/2023 at 9:39 a.m. for a pain level of 7, on 8/14/2023 at 8:55 a.m. for a pain level of 5, on 8/21/2023 at 3:43 a.m. for a pain level of 9, and on 8/23/2023 at 9:02 a.m. for a pain level of 5.

Review of the progress notes failed to evidence non-pharmacological interventions prior to administration of the as needed Hydrocodone-Acetaminophen on the dates and times listed above.

The comprehensive care plan for R28 documented in part, "The resident has chronic pain r/t (related to) ADL (activities of daily living), mobility. Date Initiated: 11/11/2022. Revision on:

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01/10/2023." Under "Interventions" it documented in part, "Provide Non-pharmacological interventions such as redirection, distraction, repositioning, visualization, etc. Date Initiated: 11/11/2022..."

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of non-pharmacological interventions offered prior to administration of the as needed Hydrocodone-Acetaminophen on the dates and times documented above in July and August of 2023.

On 8/31/2023 at 3:14 p.m., ASM #2, the interim director of nursing stated that they did not have evidence of non-pharmacological interventions offered prior to administration of the as needed Hydrocodone-Acetaminophen on the dates and times documented above in July and August of 2023 to provide.

On 8/31/2023 at 10:50 a.m., an interview was conducted with LPN #7. LPN #7 stated that non-pharmacologic interventions were attempted prior to as needed pain medications. She stated that residents pain level was assessed and then the non-pharmacologic pain intervention was offered prior to the medication. She stated that at times R28 would refuse and just ask for the medication. She stated that the refusal should be documented. She stated that she did not think that the non-pharmacologic interventions were documented.

On 9/1/2023 at 8:53 a.m., ASM #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse

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F 697	Continued From page 108 consultant were made aware of the findings. No further information was provided prior to exit. On 9/1/2023 at 2:59 p.m., ASM #1 provided the policy "Fall Protocols" dated 10/1/2021 as their pain management policy. The policy failed to evidence guidance on pain management and use of non-pharmacological interventions.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to monitor weights as ordered for a resident receiving dialysis, for one of 45 residents in the survey sample, Resident #25. The findings include: For Resident #25 (R25), who was receiving dialysis, the facility staff failed to obtain weights per the provider's order. A review of R25's orders revealed the following orders: "7/28/23 Notify primary clinician for Weight gain of 2 or more pounds in 1 day or 5 pounds or more in 5 days."	F 698	1. Resident #25 daily weights have been discontinued and weight monitoring is now ordered to be completed Monday, Wednesday, and Friday. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents was performed and there are no current residents with daily weights ordered. 3. DON/designee will educate licensed nursing regarding obtaining weights per provider orders. 4. DON/designee will perform an audit of residents receiving dialysis to ensure weights are obtained per order 3xweek x 4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 10/16/2023.	

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"7/29/23 Hemodialysis at [name of dialysis center]...MWF (Monday, Wednesday, Friday."

A review of R25's weights revealed weights recorded on the following dates in August 2023: 8/2, 8/4, 8/10, 8/13, 8/18, 8/21, and 8/23. The clinical record revealed no other weights recorded for R25 in August 2023.

A review of R25's care plan dated 6/26/23 revealed, in part: "The resident has ESRD (end stage renal disease) and receives dialysis...Pre-Post dialysis weights."

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. After reviewing R25's order for notifying the provider for weight gain, she looked at the weights recorded in the medical record. She stated: "If the order is to notify the physician for weight changes over one day, then we should be weighing the resident every day." She stated there was no way to follow the provider's order unless the resident had been weighed every day.

On 8/31/23 at 3:45 p.m., ASM (administrative staff member) #2, the interim director of nursing, provided weights from the dialysis center. When asked if these weights were a part of R25's clinical record, she stated: "No. We don't get these unless I request them." She stated she had received the weights that day.

On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

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F 698	Continued From page 110 A review of the facility policy, "Weight Assessment and Intervention," revealed no information related to obtaining daily weights as ordered by the provider. No further information was provided prior to exit.	F 698		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide physician/provider supervision of a resident's condition for two of 45 residents in the survey sample, Residents #254 and #87. The findings include:	F 710	1. Resident #87 and Resident #254 have been discharged from the facility. 2. All residents have the potential to be affected by this deficient practice. An audit of current residents with skin tears/pressure injuries to ensure the provider completed an assessment of the impairment and a treatment order is in place. 3. Medical Director/designee will educate the Nurse Practitioner regarding the need for assessment and treatment order for skin tears and pressure injuries. 4. DON/designee will perform an audit of current residents with new onset of skin tears/pressure injuries to ensure the NP has completed an assessment and a treatment order is in place. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of compliance: 10/16/2023.	

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1. For Resident #254, the facility NP (nurse practitioner) failed to respond to notification about a resident who had received a skin tear, and failed to assess the resident following the skin tear.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/11/23, R254 was coded as being severely cognitively impaired for making daily decisions, having scored one out of 15 on the BIMS (brief interview for mental status). R254 was admitted to the facility with diagnoses including diabetes, dementia, and polyneuropathy (1).

On 8/29/23 at 12:08 p.m., R254 was observed sitting in a wheelchair beside her bed. R254's daughter was seated beside the resident. R254's right leg was elevated, and a blanket covered the leg down to the ankle. R254's right great toe was red/purple/black, and toe was shiny with fluid on it. There was no dressing on the toes. R254's daughter stated: [R254] had a bloody sock over the weekend and I showed it to a nurse." She stated the weekend nurse told her that the nurse would put R254 on the list to be seen by the nurse practitioner on Monday, 8/28/23. She stated she visits R254 every day, and there has never been any type of dressing on the toe. R254's daughter stated she was waiting for the nurse to come in and look at the toe.

On 8/29/23 at 3:28 p.m., R254 was lying in her bed. Her right great toe was visible, and was still red/purple/black, and wet.

A review of R254's clinical record revealed the following progress notes:

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"8/26/2023 14:18 (2:18 p.m." Nursing Note Text: Skin tear found on Resident's great toe on right foot. Tear measures <0.5cm (centimeters) x <0.5cm x <0.5cm. Resident stated that she does not remember how skin tear happened. Cleansed w/ (with) wound cleanser and applied bacitracin. NP(nurse practitioner)...and [name of primary physician] informed. Will continue to monitor." This note was written by RN (registered nurse) #2.

"8/26/2023 15:21 (3:21 p.m.) Nursing Note Text: skin assessment documented. weekly wound assessment triggered."

"8/29/2023 22:11 (10:11 p.m.) eINTERACT...Summary for Providers Situation: The Change In Condition/s reported on this...Evaluation are/were: Tired, Weak, Confused, or Drowsy Change in skin color or condition...Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Increased confusion (e.g. disorientation)...Skin Status Evaluation: Discoloration...Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:
A. Recommendations: to send the resident to the emergency [room]."

"8/29/2023 22:41 (10:41 p.m.) Nursing Note Text: Nursing assistant was giving the resident shower and noticed changes on her toe. upon assessment necrotic toe was observed. physician was notified instructions was given to send the resident to the ER (emergency room). RP (responsible party) was in the bulling and escorted the resident. phone call follow-up was

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made, resident admitted for hypernatremia (high sodium level), narcotic [sic] toe, dehydration, UTI (urinary tract infection."

A review of R254's Weekly Skin Observation dated 8/26/23 revealed, in part: "Are there any bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted? Yes. Skin Tear. Skin Tear Location: Right Toes. Is this a new skin condition? Yes."

A review of R254's clinical record (orders, provider notes, MAR [medication administration record] and TAR [treatment administration record]) revealed no evidence of an order for care of the skin tear, and no evidence of any assessment or monitoring of the resident's right great toe between 8/26/23 and when she was sent to the hospital with a necrotic right great toe on 8/29/23.

A review of the notebook with information regarding which residents on the unit needed to be seen did not reveal any evidence that R254 had been flagged by the facility staff for the NP to see on 8/28/23 when the NP was in the building.

A review of the Emergency Room records from the local hospital where R254 was admitted on 8/29/23 revealed, in part: "The patient is a 79 year old female who is seen in the Emergency Department for concerns of black toes on her right foot, unsure how long it has been going on. Daughter first noticed it four days prior ....Physical Examination ...MSK (musculoskeletal): Black first and second right toes ...The patient presents with altered mental status, concerning for acute infection, possibly sepsis, although ongoing for three weeks per daughter. Concerns for foot

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ulceration vs. gangrenous changes on right toes ...Presentation most consistent with foot infection, UTI."

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated if she identifies that a resident has a skin tear, she assess the injury and notifies the NP to obtain treatment orders. She completes a skin assessment form, and enters the treatment order so it will show up on the TAR for follow up. She stated skin tears should be monitored by the facility staff until they are resolved. She stated this is especially important for resident who have diabetes and neuropathy.

On 8/31/23 at 11:11 a.m., ASM (administrative staff member) #5, a nurse practitioner, was interviewed. She stated RN #2 texted her about the skin tear by way of the facility's electronic medical record software on Saturday, 8/26/23. She stated: "I don't respond to those routine notifications." She stated she did not give any orders for care of R254's skin tear. She stated she did not see the resident on 8/28/23 or 8/29/23. She stated: "I never looked at [R254's] toes." She stated there was nothing in the notebook on the unit regarding any concerns about R254. She stated she was not aware that R254's toe had become necrotic until a facility nurse sent her a picture of the toes on the evening of 8/29/23. She stated: "As soon as I saw that picture, I sent her out."

On 8/31/23 at 12:36 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

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On 8/31/23 at 4:13 p.m., RN #2 was interviewed. She stated R254's daughter notified her on Saturday, 8/26/23, that the resident's right sock was bloody. She stated the daughter assisted her in removing the resident's sock. There was a skin tear on the top of the right great toe, extending around toward the side of the toe. The toenail was still intact, but there was dried blood on the toe. She stated she cleaned the dried blood with wound cleanser and applied an antibiotic ointment but no bandage. She put a clean sock on the resident and made the required notes in the clinical record. She stated she notified ASM #5 by a routine text. She stated it is her understanding that the electronic medical record software triggers a formal wound assessment for follow up, and the wound nurse would look at the injury and determine a proper treatment. She stated there is no list of residents for the NP to see on the NP's next visit to the facility. She stated: "I figured with me notifying the NP, that would trigger a visit."

On 9/1/23 at 8:58 a.m., a policy regarding physician/provider supervision of resident care was requested. No further information was provided prior to exit.

NOTES
(1) "Peripheral neuropathies are diseases of the peripheral nervous system that can be divided into mononeuropathies, multifocal neuropathies, and polyneuropathies. Symptoms usually include numbness and paresthesia. These symptoms are often accompanied by weakness and can be painful." This information is taken from the website https://pubmed.ncbi.nlm.nih.gov/27637963/.

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2. For Resident #87 (R87), the nurse practitioner (NP) failed to assess and provide treatment orders for a pressure injury.

A review of R87's progress note revealed the following note dated 6/10/23 at 11:06 p.m.: "Resident presented today at [6:00 p.m.] from [name of local hospital]...Skin has scattered bruising all over the body, stage 4 sacral pressure wound (1) reported by discharging facility."

Further review of the resident's clinical record, including orders, skin assessments, MARs (medication administration records) and TARs (treatment administration records) failed to reveal evidence for orders for the treatment of the pressure injury until 6/14/23.

A review of the nurse practitioner's note dated 6/12/23 at 2:08 p.m. revealed, in part: "[Age and gender]...Endorses pain secondary to sacral ulcer...A&P (assessment and physical) decubitus ulcer - wound care."

On 8/31/23 at 10:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated if she is the admitting nurse for a resident who comes in with a pressure injury, she notifies the NP (nurse practitioner) or physician. She states if a treatment order comes from the discharging hospital, she will let the NP know that, and initiate the recommended treatment. She stated the treatment for the wound should be initiated as soon as possible.

On 8/31/23 at 11:11 a.m., ASM (administrative staff member) #5, a nurse practitioner, was interviewed. She stated if a resident is admitted

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with a pressure injury, the resident should ideally come with orders to treat the pressure injury from the hospital. She stated if there is a time lapse between when the resident is admitted to the facility and when the NP first sees the resident, there should be wound care happening. She stated: "That's something I expect the facility to do." She stated she often sees the resident before the physician comes in to do the admission history and physical, and she does not participate in that process. She stated she did not assess or write treatment orders for R87's pressure injury when she saw the resident on 8/12/23.

On 8/31/23 at 12:56 p.m., LPN #5, the wound nurse, was interviewed. She stated if a resident is admitted with a pressure injury, "they should come with orders from the hospital." She stated the order from the hospital should be implemented immediately at the facility until the resident can be seen by the resident's wound nurse or doctor. She stated if the resident does not come with orders from the hospital, the NP should be notified and should give the admitting nurse an order for the pressure injury treatment. She stated: "It's not okay to wait a few days before pressure injury treatment."

On 9/1/23 at 8:33 a.m., LPN #8, who was R87's admitting nurse, was interviewed. She stated if a resident is admitted with a pressure injury, orders should come with the resident from the hospital. She stated she would find those orders and contact the NP to communicate that the resident had a pressure injury. She stated if there are no orders from the discharging hospital, she calls the NP to get orders in place until the resident can be seen by a facility provider. She stated: "It is not

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F 710	Continued From page 118 okay to wait a few days. The admitting nurse is responsible for this." On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Pressure Injury Prevention and Management," revealed, in part: "Treatments will be ordered by the physician/practitioner...unless established and approved under standing orders by an individual physician/practitioner, orders for pressure ulcer/injury treatment will be specific for each resident." No further information was provided prior to exit. NOTES (1) "Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury." This information was obtained from the website https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf .	F 710		
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	F 732		

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F 732	Continued From page 119 must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to post the required nursing staffing information on one	F 732	1. The deficient practice could not be retroactively corrected. 2. NHA/designee will perform an audit of 30-days of nursing staffing posting to ensure completion. Findings will be presented to the Quality Assurance/Process Improvement for review and analysis. 3. NHA/designee will reeducate the staffing coordinator on the requirement to post staffing. 4. NHA/designee will perform an audit of the nursing staffing information to ensure it is posted three (3) times a week for one (1) month and then once (1) a week for three (3) months. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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F 732	Continued From page 120 of four days of the survey, 8/29/23. The findings include: On 8/29/23 at 10:45 a.m., observation was made of the posted nursing staffing information. The posting was located at the front receptionist's desk. The posted staffing information was dated 8/28/23. No staffing information for 8/29/23 could be seen. On 8/31/23 at 10:21 a.m., ASM (administrative staff member) #1, the administrator, was interviewed. She stated she is filling in for the staffing coordinator, and that a new staffing coordinator had just started training on 8/28/23. She stated: "I am responsible for posting the staffing information. During the week, I put it up myself first thing in the morning. I try to get it up before 8:00 [a.m.]. It should be up before them." She stated corporate staff had arrived at the facility on the morning of 8/29/23 and she had gotten distracted from posting the staffing information. No further information was provided prior to exit.	F 732		
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	F 757	1. Resident #253 Coumadin and INR have been discontinued. 2. All current residents have the potential to be affected by the alleged deficient practice. An audit was performed, and no current residents are receiving Coumadin or require an INR at this time.	

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F 757	Continued From page 121 §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 staff interviews, facility document review, and clinical record review, the facility staff failed to complete laboratory testing to prevent administration of an unnecessary medication for one of 45 residents in the survey sample, Resident #253. The findings include: For Resident #253 (R253), the facility staff failed obtain INR (international normalized ratio) (1) levels for Resident #253, as ordered by the physician. A review of R253's progress notes revealed, in part (all notes written by ASM (administrative staff member) #5, the nurse practitioner (NP)), unless otherwise noted: "8/14/23 Hx (history) of DVT (deep vein thrombosis) (2). Continue with Warfarin (3). Start INR." "8/17/23 Hx DVT. Stop Warfarin. Start INR Saturday. Start bridge to Xarelto (4) 10	F 757	3. DON/Designee to educate licensed nursing staff regarding performing lab tests to include INRS per order. 4. DON/Designee to audit current residents receiving coumadin to ensure PT/INR is completed per order weekly x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 10/16/2023.	

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[milligrams] when INR < 3."

"8/19/23 Have pt (patient) check INR with her machine supplies."

"8/21/23 Hx DVT...Stop warfarin. INR done on Saturday? not reported to NP or recorded in progress notes."

"8/25/23 INR reported to be 1.3." This note was written by a nurse who was unavailable for interview at the time of the survey.

A review of R253's provider's orders revealed, in part:

"8/14/23 PT/INR One time for bridge to Xarelto when INR > 3."

"8/19/23 Have patient check INR with her machine/supplies. One time only."

"8/28/23 PT/INR One time only."

Further review of R253's clinical record revealed no evidence that PT/INR was done on 8/14/23, 8/17/23, 8/19/23, or 8/28/23.

A review of R253's MARs (medication administration record) for August 2023 revealed she received Warfarin 2.5 mg (milligrams) on 8/15/23 and 8/16/23, and Warfarin 3 mgs on 8/23/23 through 8/29/23

On 8/31/23 at 3:06 p.m., LPN (licensed practical nurse) #9 was interviewed. She stated the NP usually gives verbal orders to the staff. She stated she is responsible for putting the order in as the NP has given it to her, and getting another staff

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member to verify the order. She stated if a resident is taking Warfarin, the resident needs a PT/INR test at least weekly. She stated the facility has a point of care INR test machine that enables staff members to get this test done quickly at the resident's bedside.

On 9/1/23 at 8:33 a.m., LPN #8 was interviewed. She stated she usually puts in the verbal orders given to her by the nurse practitioner. She stated she was not aware of any orders for Warfarin for R253. After checking the resident's orders, she stated: "Oh, I see some now. I'm not sure why they weren't done."

On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

No further information was provided prior to exit.

NOTES
(1) "Prothrombin time (PT) and the associated international normalized ratio (INR) are routinely tested to assess the risk of bleeding or thrombosis and to monitor response to anticoagulant therapy in patients." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569083/.

(2) "Thrombosis is the medical term for the formation of a blood clot in a blood vessel. In deep vein thrombosis (DVT), the blood clot forms in one of the larger, deeper veins that run through the muscles. Deep vein thrombosis usually

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F 757	Continued From page 124 occurs in the lower leg. It often goes unnoticed and dissolves on its own. But it may cause symptoms like pain and swelling. If someone is diagnosed with DVT, they will need treatment to avoid serious complications such as pulmonary embolism. This can occur if the blood clot breaks away from its original site and is carried to the lungs in the bloodstream. The risk of deep vein thrombosis increases after more major operations such as knee or hip replacement surgery. Because of this, people who have had this kind of surgery are usually given medication to prevent blood clots from forming. This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/books/NBK425364/. (3) "Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood." This information is taken from the National Institutes of Health website https://medlineplus.gov/druginfo/meds/a682277.html.	F 757		
F 758 SS=E	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	F 758		

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F 758	Continued From page 125 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 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.	F 758	1. Resident #98 discharged from the facility. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. An audit of current residents receiving psychotropic medications has been conducted to ensure there are orders in place to monitor for adverse effects, as well as behaviors. 3. DON/designee to educate licensed nursing staff regarding monitoring adverse effects and targeted behavioral symptoms for residents receiving psychotropic medication. 4. DON/designee will perform an audit of 10% of residents receiving psychotropic medications to ensure there are orders in place to monitor for adverse effects, as well as targeted behavioral symptoms 3xweek x 4weeks.These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance: 10/16/2023.	

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§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 staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence monitoring of psychotropic medication adverse effects and behavior monitoring for one of 45 residents in the survey sample, Resident #98.

The findings include:

For Resident #98 (R98), the facility staff failed to monitor for adverse effects and record targeted behavioral symptoms related to anti-psychotic medication use.

On the most recent MDS (minimum data set) a significant change assessment with an ARD (assessment reference date) of 7/6/2023, the resident scored 5 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The assessment documented R98 receiving an antipsychotic medication 6 of the 7 days during the assessment period.

The physician orders for R98 documented in part,
- "Risperidone Oral Tablet 2 MG (milligram) (Risperidone) Give 1 tablet by mouth one time a day for Anxiety. Order Date: 7/1/2023."

The clinical record for R98 failed to evidence

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monitoring for side effects, effectiveness or target behavior symptoms for psychotropic medication use.

The comprehensive care plan for R98 documented in part, "(Name of R98) uses psychotropic medications r/t (related to) Anxiety. Date Initiated: 06/09/2023. Revision on: 08/09/2023." Under "Interventions" it documented in part, "Administer Psychotropic medications as ordered by physician. Monitor for side effects and effectiveness Q-Shift. (every shift). Date Initiated: 06/01/2023... Monitor/record occurrence of for target behavior symptoms and document per facility protocol. Date Initiated: 06/09/2023. Revision on: 08/30/2023."

On 8/31/2023 at 2:15 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of behavior and adverse effect monitoring for R98 from 6/1/2023 to the present.

On 8/31/2023 at 4:00 p.m., ASM #2, the interim director of nursing stated that they did not have any evidence of behavior or adverse effect monitoring for R98 to provide and they had put something in place at that point.

On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that residents who received psychotropic medications were monitored for behaviors and any changes in their baseline. She stated that the monitoring was documented in the clinical record, typically on the medication administration record and done every shift.

The facility policy "Behavioral Assessment,

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F 758	Continued From page 128 Intervention and Monitoring" dated 10/2/2021 documented in part, "...10. When medications are prescribed for behavioral symptoms, documentation may include: a. Rationale for use; b. Potential underlying causes of the behavior; c. Other approaches and interventions tried prior to the use of antipsychotic or psychoactive medications; d. Potential risks and benefits of medications as discussed with the resident and/or family; e. Specific target behaviors and expected outcomes; f. Dosage; g. Duration; h. Monitoring for efficacy and adverse consequences; and i. Plans (if applicable) for gradual dose reduction..." On 8/31/2023 at 4:31 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern. No further information was provided prior to exit.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		

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F 812	Continued From page 129 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to maintain the kitchen in a sanitary manner. The facility staff failed to date and dispose of opened food in one of one kitchen areas. The findings include: The facility staff failed to date and dispose of opened food identified during the facility task-kitchen observation. On 8/29/23 at 11:00 AM, an observation was conducted in the main kitchen. In the freezer, one bag of approximately 12 hamburger patties was torn open. There was no label on bag of date opened or expiration date. In the dry storage area, there was approximately three pounds of dried medium size noodles in a plastic bag that had been torn open. There was no label on bag indicating the date opened or when it expired. An interview was conducted on 8/29/23 at 11:20 AM with OSM (other staff member) #1, the dietary manager. When asked to review the opened bag	F 812	1. The Dietary Services Manager (DSM) immediately disposed of both items that were not labeled. 2. The DSM conducted an audit of the dry storage as well as the walk-in refrigerator and freezer to confirm food was labeled per policy and procedure. 3. DSM reeducated all dietary staff on the facility's policy entitled "Receiving and Storage of Food," specifically as it relates to dating and labeling food. 4. DSM/designee will conduct an audit three (3) times a week for one (1) week and then weekly for four (4) weeks to confirm that food is dated and labeled according to policy. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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F 812	Continued From page 130 of hamburger patties and noodles, OSM #1 stated, they should not have opened these bags like this, they should have a date and be secured with a tie closure. The ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant was made aware of the finding on 8/30/23 at 5:00 PM. The facility's "Receiving and Storage of Food" policy, revealed the following, "Dry foods that are stored in bins will be removed from original packaging, labeled and dated ("use by" date). Such foods will be rotated using a "first in - first out" system. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)." No further information was provided prior to exit.	F 812		
F 813 SS=C	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to evidence a policy regarding the use and storage of food brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption. The findings include:	F 813	1. Facility policy entitled “Resident Right to Make Personal Dietary, Food and Meal Choices” located on September 21, 2023. 2. All residents have the potential to be affected by this deficient practice. No residents affected at this time. 3. The NHA/designee will reeducate all staff on the facility policy entitled “ Resident Right to Make Personal Dietary, Food and Meal Choices.”	

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F 813	Continued From page 131 On 8/29/23 at 11:00 AM during entrance conference, and on 8/30/23 at 9:00 AM, a request was made for the facility's policy on "Food Brought From Home". On 8/30/23 at approximately 12:00 PM, ASM (administrative staff member) #1, the administrator, stated they do not have a policy but will ask dietary services if they had a policy. On 8/30/23 at approximately 3:00 PM, ASM #1, the administrator, stated there is no policy. The ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant was made aware of the finding on 8/30/23 at 5:00 PM. No further information was provided prior to exit.	F 813	4. The NHA or designee will review resident access to food from outside of the facility monthly during resident council for three months. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5.Date of Compliance 10/16/2023.	
F 838 SS=D	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population,	F 838	1. The Interdisciplinary Team (IDT) met on 9/26/2023 to review and update the Facility Assessment to incorporate care of residents over 500 lbs. 2. IDT reviewed the entire Facility Assessment. Findings forwarded to the Quality Assurance/Process Improvement for review and analysis. 3. NHA reeducated the IDT on the Facility Assessment, specifically as it relates to documenting the resources necessary to care for residents completely.	

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F 838	Continued From page 132 including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing	F 838	4. IDT will review the Facility Assessment monthly for three (3) months. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review and facility document , it was determined that the facility staff failed to maintain an accurate and complete facility assessment for care of one of 45 residents in the survey sample, Resident #28.

The findings include:

For Resident #28 (R28), the facility staff failed to maintain an accurate and complete facility assessment for care of bariatric residents greater than 500 lbs.

R28 was admitted to the facility on 2/4/2022 with diagnoses that included but were not limited to severe morbid obesity (1) and body mass index [BMI] 70 or greater, adult (2).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/23/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that they were cognitively intact for making daily decisions.

On 8/29/2023 at 12:33 p.m., an interview was conducted with R28. R28 stated that they had resided at the facility for over a year. R28 stated that they had a bariatric bed and wheelchair but had never been able to use the shower because of their size and the facility not having a shower

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chair for them.

Review of R28's weight summary documented an admission weight of 573.5 lbs on 2/4/2022 and a current weight of 559.5 lbs on 8/2/2023.

Review of the facility assessment provided on entrance dated 5/27/2021 with an update on 1/12/2023 and QAPI (quality assurance performance improvement) review date of 7/19/2023 documented in part, "...Part 1: Our Resident Profile: Clinical Skill... Bariatric Care-300lbs to 500lbs..." The assessment documented an "x" in a column labeled "Red." The "Skill Identification" key documented in part, "Red- The facility is unable to provide these services..."

On 8/31/2023 at 4:30 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that when they reviewed the facility assessment it reflected the current residents in the facility at that time. She stated that the current facility assessment should reflect the residents that were in the building.

On 8/31/2023 at 4:31 p.m., ASM #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the concern.

No further information was provided prior to exit.

References:
(1) Obesity means weighing more than what is healthy for a given height. Obesity is a serious, chronic disease. It can lead to other health problems, including diabetes, heart disease, and

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F 838	Continued From page 135 some cancers. This information was obtained from the website: https://medlineplus.gov/ency/article/007297.htm (2) Your BMI estimates how much you should weigh based on your height... There are three classes of obesity: Class 1: BMI of 30 to less than 35. Class 2: BMI of 35 to less than 40. Class 3: BMI of 40 or higher. Class 3 is considered "severe obesity." This information was obtained from the website: https://medlineplus.gov/ency/article/007196.htm	F 838		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842	1. Resident #353 and #98 have been discharged from the facility. 2. All residents have the potential to be affected by the alleged deficient practice. An audit of current residents has been conducted to identify lack of Bowel and Bladder, Bed Mobility, and Personal Hygiene documentation from 9/29/2023; the provider and resident representative notified of discrepancies. An audit was performed of current residents' progress notes since 9/29/2023 to assure falls have been added under Risk management for IDT to review. 3. DON/designee to educate nursing staff regarding ADL documentation; as well as educate licensed nursing staff regarding documenting falls in the resident clinical record.	

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F 842	Continued From page 136 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F 842	4. DON/designee will perform an audit of POC compliance 5x week x 4 weeks. Audit progress notes 5x week x4weeks to ensure falls have been added under Risk management for IDT to review. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide complete and accurate documentation for two of 45 residents, Resident #353 and #98.

The findings include:

1. For Resident #353, the facility staff failed to evidence complete and accurate documentation for bladder and bowel elimination, bed mobility, and personal hygiene.

Resident #353 was admitted to the facility on 4/3/23 with diagnoses that include but are not limited to: pacemaker, Afib (atrial fibrillation), DM (diabetes mellitus) and bipolar.

Resident #353's most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an assessment reference date of 4/8/23, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. MDS Section G- Functional Status: coded the resident as total dependence with bathing, extensive assistance with bed mobility, transfers, locomotion, dressing and hygiene; supervision for eating. A review of MDS Section H- Bowel and Bladder: coded the resident as always incontinent for bowel and bladder.

A review of the comprehensive care plan dated 12/29/22, revealed, "FOCUS: Resident has

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potential/actual impairment to skin integrity of the (SPECIFY location) related to: __. The resident has bladder incontinence. Patient has MASD (moisture associated skin damage) to coccyx area. INTERVENTIONS: Follow facility protocols for treatment of injury. Clean peri-area with each incontinence episode. Apply zinc oxide to coccyx area per treatment."

A review of the ADL (activities of daily living) record for April 2023 revealed missing bladder and bowel elimination, bed mobility and personal hygiene documentation for 1 out of 14 day shifts, 2 out of 15 evening shifts and 3 out of 13 night shifts.

An interview was conducted on 8/31/23 at 3:25 PM with CNA (certified nursing assistant) #3. When asked where bladder and bowel elimination, bed mobility, and personal hygiene was documented, CNA #3 stated it is documented on the ADL form. Asked what it means if there is missing documentation, CNA #3 stated it just means they did not have time to document. When asked if the record was complete, CNA #3 stated, no, it is not complete.

An interview was conducted on 9/1/23 at 10:15 AM with CNA #4. When asked where bladder and bowel elimination, bed mobility, and personal hygiene was documented, CNA #4 stated they document in the computer on the CNA/ADL form. Asked what it means if there is missing documentation, CNA #4 stated, it only means that it was not documented, probably because they did not have time to document. When asked if the record was complete, CNA #4 stated, no, it is not complete.

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On 9/1/23 at 9:55 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant was made aware of the findings.

A review of the facility's "Charting and Documentation" policy, which revealed, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, will be documented in the resident's medical record. The medical record will facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate."

No further information was provided prior to exit.

2. For Resident #98 (R98), the facility staff failed to document a fall in the clinical record.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/6/2023, the resident was assessed as not having any falls since the previous assessment.

The progress notes for R98 documented in part,
- "6/27/2023 08:00 (8:00 a.m.) Note Text : X ray results confirm left hip fx (fracture) without dislocation. Order from NP (nurse practitioner) send to ER (emergency room) via 911. Resident sent to (Name of hospital) with face sheet, current orders and bed hold policy. RP (responsible party)/ sister/ (Name of sister) notified via phone call."

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- "6/26/2023 11:08 (11:08 a.m.) Note Text : Resident visited by NP and complains of left hip pain. New order of STAT X-ray pelvis with left hip received. STAT X-ray scheduled with Dispatch health imagery. RP (Name of responsible party) notified."
- "6/26/2023 10:01 (10:01 a.m.) Note Text : IDT (interdisciplinary team) met to review care plan post fall. Adding intervention to have therapy review goals, visual cue to be placed on walker."

The progress notes failed to evidence documentation of the fall discussed in the note 6/26/2023.

The assessments failed to evidence documentation of the fall discussed in the IDT meeting on 6/26/2023.

On 8/30/2023 at 1:12 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of a fall investigation for the fall discussed in the IDT meeting 6/26/2023.

The fall investigation dated 6/24/2023 documented in part, "6/24/2023 Resident was placed in bed by CNA (certified nursing assistant) on duty and later resident came to the nursing station fell in front of nursing station lying on his left side. Staff's came and assessed no injury noted helped into wheel chair. Active ROM (range of motion) done to upper and lower extremities denies pain. Resident was placed in wheel chair for continuous monitoring. No acute distress noted. (Name of physician) notified by text. R/P (responsible party) (Name of RP) notified... 6/26/2023 Per nurse resident fell in front of the nursing station on North Wing. IDT

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F 842	Continued From page 141 met to review fall. Adding intervention to have therapy review goals. Visual cue to be placed on walker... Not Part of the medical record..." On 8/31/2023 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that when a resident has a fall the nurse assessed the resident and based on the assessment they notified the family and the nurse practitioner. She stated that they put any new interventions in place and updated the care plan. She stated that they documented the fall in the medical record and completed the risk assessment. She stated that all falls should be documented in the medical record and a post fall assessment should also be included in the medical record for it to be accurate. On 8/31/2023 at 10:50 a.m., an interview was conducted with LPN #7. LPN #7 stated that after a resident had a fall they assessed the resident for any injury and notified the physician and the family. She stated that after they got the resident up they documented the fall in the progress notes and completed a change in condition assessment in the medical record. On 8/31/2023 at 4:31 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing and ASM #3, the regional nurse consultant were made aware of the findings. No further information was provided prior to exit.	F 842		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		

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F 883	Continued From page 142 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883	1. The deficient practice could not be retroactively corrected. 2. All current residents have the potential to be affected by the alleged deficient practice. An audit was performed of current residents who have received the Influenza and/or Pneumococcal vaccination at the facility in the past 30 days to ensure education has been provided. 3. DON/designee will educate licensed nursing staff regarding providing education when offering a vaccination. All current residents and/or responsible parties will be educated and information regarding the Influenza and Pneumococcal vaccine will be provided to the resident and/or Responsible representative. 4. DON/designee will perform an audit of current residents offered the Influenza and Pneumococcal vaccine to ensure education was provided weekly x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence that education and information regarding risks vs benefits of the influenza and/or pneumonia vaccines were provided to the resident and/or resident representative, prior to the vaccines being administered or refused, for four of five residents reviewed for immunizations; Residents #82, #93, #16, and #46.

The findings include:

The facility policy, Influenza Vaccination" was reviewed. This policy documented, "....The facility will provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives); for example, risk factors that have been identified for specific age groups or individuals with risk factors....2. Before offering influenza immunization, each resident or the resident's legal representative or employee will receive education regarding the benefits and

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potential side effects of the immunization...4. Consent for the administration of the influenza vaccination will be obtained from the resident and/or resident's representative or employee prior to administration of the vaccine. A copy of the consent form will be maintained in the resident's clinical record....6.a. If a resident or resident's representative refuses to have the influenza vaccine administered, the attending physician will be notified, and documentation of the refusal and physician notification will be documented in the nursing notes...." A review of a blank copy of the facility's "Influenza Vaccination - Informed Consent/Declination" form documented side effects of the vaccine, whether or not the resident has an allergy to eggs, a statement that the resident had received education about the vaccine, and whether or not the resident accepted or declined the vaccine.

The facility policy, "Pneumococcal Vaccine" was reviewed. This policy documented, "....3. Before offering pneumococcal immunization, each resident or the resident's legal representative will receive education regarding the benefits and potential side effects of the immunization....6. Consent for the administration of the pneumococcal vaccination will be obtained from the resident and/or resident's representative prior to administration of the vaccine. A copy of the consent form will be maintained in the clinical record....8. If a resident or resident's representative refuses to have the pneumonia vaccine administered, the attending physician will be notified, and the documentation of the refusal and physician notification will be documented in the nursing notes...." A review of a blank copy of the facility's "Pneumococcal and Vaccination - Informed Consent" form documented side effects

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of the vaccine, a statement that the resident had received education about the vaccine, and whether or not the resident accepted or declined the vaccine.

1. For Resident #82, the facility staff failed to evidence that education and information regarding the influenza and pneumonia vaccines were provided to the resident and/or resident representative prior to the influenza vaccine being administered and the pneumococcal vaccine being refused

A review of the clinical record revealed an influenza vaccine administration dated 11/16/22. This record documented that consent was given on 11/15/22. However, the box for "Education Provided to Resident/Family" was not marked to evidence that the education was provided. There was no other documentation either that would have evidence that education was provided prior to the administration of the vaccine.

Further review of the clinical record revealed that a pneumococcal vaccine was refused by the resident's representative on 1/11/23. However, the box for "Education Provided to Resident/Family" was not marked to evidence that the education was provided. There was no other documentation either that would have evidence that education was provided prior to the refusal of the vaccine.

On 8/31/23 at 1:38 PM, an interview was conducted with ASM #4 (Administrative Staff Member) the Assistant Director of Nursing and Infection Preventionist. She stated that if the box for education was not checked, she did not have

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any other evidence as the facility did not utilize written consent forms, which contained evidence that education was provided. She stated that going forward, the facility would be using such forms.

On 8/31/23 at 4:30 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Nurse Consultant were made aware of the findings. No further information was provided.

2. For Resident #93, the facility staff failed to evidence that education and information regarding the influenza and pneumonia vaccines were provided to the resident and/or resident representative prior to the vaccines being administered.

A review of the clinical record revealed an influenza vaccine administration dated 1/10/23. This record documented that consent was given on 1/10/23. However, the box for "Education Provided to Resident/Family" was not marked to evidence that the education was provided. There was no other documentation either that would have evidence that education was provided prior to the administration of the vaccine.

Further review of the clinical record revealed a pneumococcal vaccine administration dated 1/12/23. This record documented that consent was given on 1/10/23. However, the box for "Education Provided to Resident/Family" was not marked to evidence that the education was provided. There was no other documentation either that would have evidence that education was provided prior to the administration of the

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vaccine.

On 8/31/23 at 1:38 PM, an interview was conducted with ASM #4 (Administrative Staff Member) the Assistant Director of Nursing and Infection Preventionist. She stated that if the box for education was not checked, she did not have any other evidence as the facility did not utilize written consent forms, which contained evidence that education was provided. She stated that going forward, the facility would be using such forms.

On 8/31/23 at 4:30 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Nurse Consultant were made aware of the findings. No further information was provided.

3. For Resident #16, the facility staff failed to evidence that education and information regarding the influenza vaccine was provided to the resident and/or resident representative prior to the vaccine being administered.

A review of the clinical record revealed an influenza vaccine administration dated 10/12/22. This record documented that consent was given on 9/14/22. However, the box for "Education Provided to Resident/Family" was not marked to evidence that the education was provided. There was no other documentation either that would have evidence that education was provided prior to the administration of the vaccine.

On 8/31/23 at 1:38 PM, an interview was conducted with ASM #4 (Administrative Staff Member) the Assistant Director of Nursing and

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Infection Preventionist. She stated that if the box for education was not checked, she did not have any other evidence as the facility did not utilize written consent forms, which contained evidence that education was provided. She stated that going forward, the facility would be using such forms.

On 8/31/23 at 4:30 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Nurse Consultant were made aware of the findings. No further information was provided.

4. For Resident #46, the facility staff failed to evidence that education and information regarding the influenza vaccine was provided to the resident and/or resident representative prior to the vaccine being administered.

A review of the clinical record revealed an influenza vaccine administration dated 10/11/22. This record documented that consent was given on 10/10/22. However, the box for "Education Provided to Resident/Family" was not marked to evidence that the education was provided. There was no other documentation either that would have evidence that education was provided prior to the administration of the vaccine.

On 8/31/23 at 1:38 PM, an interview was conducted with ASM #4 (Administrative Staff Member) the Assistant Director of Nursing and Infection Preventionist. She stated that if the box for education was not checked, she did not have any other evidence as the facility did not utilize written consent forms, which contained evidence that education was provided. She stated that

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F 883	Continued From page 149 going forward, the facility would be using such forms. On 8/31/23 at 4:30 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Nurse Consultant were made aware of the findings. No further information was provided.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;	F 887	1. The deficient practice could not be retroactively corrected. 2. All current residents have the potential to be affected by the alleged deficient practice. An audit was performed of current resident who have received a COVID vaccination provided at the facility in the past 30 days to ensure education has been provided. 3. DON/designee will educate licensed nursing staff regarding providing education when offering a vaccination. All current resident's and/or responsible parties will be educated and information regarding the COVID vaccine will be provided to the resident and/or Responsible representative.	

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F 887	Continued From page 150 (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence that education and information regarding the COVID-19 vaccine was provided to the resident and/or resident representative prior to the vaccine being refused, for one of five residents reviewed for immunizations; Resident #82. The findings include:	F 887	4. DON/designee will perform an audit of current residents offered the COVID vaccine to ensure education was provided weekly x4weeks. These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. 5. Date of Compliance 10/16/2023.	

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The facility policy, "COVID-19 Vaccination for Residents" was reviewed. This policy documented, "...2. Resident / resident representatives will be educated on: a) risks / benefits of COVID-19 vaccination. The education will be specific to vaccine being offered/administered and; b) current CDC guidelines for vaccination or residents for COVID-19 and; c) Symptoms, risks and benefits associated with the COVID-19 virus...5. Prior to administration of the COVID-19 vaccine, consent will be obtained from the resident / resident representative and will be documented in the resident's medical record...."

For Resident #82, the facility staff failed to evidence that education and information regarding the COVID-19 vaccine was provided to the resident and/or resident representative prior to the vaccine being refused.

A review of the clinical record revealed that a COVID-19 vaccine was refused by the resident's representative on 12/17/22. However, the box for "Education Provided to Resident/Family" was not marked to evidence that the education was provided. There was no other documentation either that would have evidence that education was provided prior to the refusal of the vaccine.

On 8/31/23 at 1:38 PM, an interview was conducted with ASM #4 (Administrative Staff Member) the Assistant Director of Nursing and Infection Preventionist. She stated that if the box for education was not checked, she did not have any other evidence as the facility did not utilize written consent forms, which contained evidence that education was provided. She stated that

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F 887	Continued From page 152 going forward, the facility would be using such forms. On 8/31/23 at 4:30 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, and ASM #3 the Regional Nurse Consultant were made aware of the findings. No further information was provided.	F 887		