STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. BUILDING _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD SOUTHWEST HEALTH AND REHABILITATION	324 KING GEORGE AVE SW ROANOKE, VA 24016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 10/30/2023 through 11/01/2023. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Two complaints were investigated during the survey. VA00059912-Non-compliant with regulations deficient practice cited. VA00059799-Non-compliant with regulations deficient practice cited The census in this 130 certified bed facility was 56 at the time of the survey. The survey sample consisted of 33 resident reviews.	F 000		
F 584 SS=E	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.	F 584	1. The rooms/floors/windowsills/walls for residents #15, 23 and 24 were all addressed. Both observed shower rooms were cleaned and the odors addressed. 2. All residents have the potential to be impacted by the alleged deficient practice. A baseline quality monitoring audit was completed of all rooms and common areas for cleanliness and issues addressed. 3. Housekeeping staff will be educated on cleaning practices and expectations. The Housekeeping supervisor/designee will conduct a quality monitoring audit of 5 rooms a shower room and a common area per day to ensure a comfortable homelike environment.. 4. The Administrator/designee will complete a quality monitoring audit of 5 rooms and a common area/week for 6 weeks to ensure proper cleaning process are being followed. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	11/19/23

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

Administrator | 11/17/2023

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

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §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 observation and staff interview, the facility staff failed to ensure a clean, comfort homelike environment for 3 of 33 Residents (#15, #23, and #24) and in 2 of 2 shower rooms. The findings included: Residents #15 and #23's room was observed to have debris scattered on the floor, a white substance that resembled milk and dried brown areas on the floor. The floor was sticky and there was debris in the windowsill. The wall behind Resident #24's bed had a brown substance splattered on the wall. The shower rooms were observed with debris present in floors and the shower room on the 100 hall had a musty odor.	F 584		

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F 584	Continued From page 2	F 584		

Resident #15's diagnoses included respiratory failure and chronic obstructive pulmonary disease. Section C (cognitive patterns) of Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/29/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points.

Resident #23's diagnoses included respiratory failure and diabetes. Section B (hearing/speech/vision) of Resident #23's quarterly MDS assessment with an ARD of 09/02/23 was coded to indicate this resident was in a persistent vegetative state. Section K (swallowing/nutrition) was coded to indicate this resident had a feeding tube.

Resident #15 and #23 resided in the same room.

On 10/30/23 at 10:50 a.m., during an observation of this room the surveyor observed a white liquid substance that resembled milk between the beds, scattered debris throughout the floor, and the floor was observed to be sticky. When asked about the items in the floor Resident #15 stated they had dropped some M&M's (candy) last night. Beside of bed B (Resident #23's bed) and the window the surveyor observed a brown dried substance, a washcloth, and a package that was labeled de-clogger that was partially open lying in the floor. The floor was also observed to be sticky.

On 10/30/23 at 2:10 p.m. the surveyor completed an observation of Resident #15 and #23's room. The room was observed to have debris in the floor, dried substance in the floor between the beds and beside bed B, the washcloth remained

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F 584	Continued From page 3	F 584		

in the floor. The windowsill beside of Bed B contained plastic pieces and paper, the white liquid substance that was in the floor previously was now observed to be dry in appearance. The floor remained sticky.

On 10/31/23 at 8:13 a.m., the surveyor observed a dried brown substance in floor beside of bed B. The white dried substance remained between the beds; debris scattered under Bed A.

Upon leaving this room the surveyor entered Resident #24's room. The surveyor observed a dried substance splattered on the wall behind Resident #24's bed.

Resident #24's diagnoses included cerebrovascular accident (stroke) and respiratory failure. Section B of Resident #24's quarterly MDS assessment with an ARD of 08/30/23 was coded to indicate Resident #24 was in a persistent vegetative state. Section K was coded to indicate this resident had a feeding tube.

On 10/31/23 at 8:23 a.m., the surveyor entered the shower room on 300 hall. The surveyor observed a glove and shoes that resembled Croc's in the floor, a wet sponge dressing on the shower chair that was dated 10/31/23, and the commode had a brown dried substance on the back of the toilet between the tank and the seat. Respiratory Therapist #1 entered the shower room with the surveyor and acknowledged the dressing on the shower chair. There was no resident or staff member in the shower room when the surveyor entered the room.

While the surveyor was still in the shower room the Director of Environmental

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F 584	Continued From page 4 Service/Maintenance entered the shower room and stated they were going to have a complete renovation. On 10/31/23 at 8:34 a.m., the surveyor and Maintenance Assistant entered the shower room on 100 hall. This shower room was observed to have a musty smell, a surgical mask and washcloths were observed in the floor. On 10/31/23 at 3:30 a.m., the surveyor entered Resident's #15 and #23's room. The white dried substance remained in the floor between the beds as well as a dried brown substance beside of bed B. Debris was again observed in the floor. The unit manager stated they would have the room cleaned. On 10/31/23 at 4:00 p.m., during an end of the day meeting with the Administrator and Regional Nurse Consultant the issues with the residents rooms and shower rooms were reviewed. On 11/01/23 at 8:30 a.m., the surveyor observed brown splattered areas behind Resident #24's bed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 584		
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	F 655	1. The facility recognizes that the base line care plan for resident #21 was not completed. Resident #21 no longer resides in the facility. 2. All new residents have the potential to be impacted by the alleged deficient practice. A quality monitoring audit was completed of new admissions in the last two weeks to verify that a base line care plan had been initiated as expected.	

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F 655	Continued From page 5 that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 655	3. The MDS nurse and nurses will be educated regarding the base line care plan expectations. The IDT will review new admissions in the am clinical meeting to ensure that base line care plans have been initiated as expected. 4. The DON/designee will complete a quality monitoring audit of all new admits weekly for 6 weeks to ensure that base line care plans are implemented as expected. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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F 655	Continued From page 6	F 655		

Based on staff interview and clinical record review, the facility staff failed to develop a baseline care plan for 1 of 33 Residents, Resident #21.

The findings included:

The facility staff failed to develop a baseline care plan when the resident was admitted to the facility.

This was a closed record review.

Resident #21's diagnoses included, but were not limited to, bacteremia, pyogenic arthritis, diabetes, severe sepsis, and cutaneous abscess.

Section C (cognitive patterns) of Resident #21's admission minimum data (MDS) assessment with an assessment reference date (ARD) of 09/25/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points.

During a review of the clinical record the surveyor was unable to locate a baseline care plan.

On 10/31/23 at 8:36 a.m., during an interview with the MDS nurse this nurse stated the baseline care plan was in progress but it was never completed.

On 10/31/23 at 4:00 p.m., during an end of the day meeting with the Administrator and Regional Nurse Consultant the issue with the missing baseline care plan was reviewed.

No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	1. The facility recognizes that there was no comprehensive care plan for resident #21. Resident #21 no longer resides in the facility. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality monitoring audit was completed to ensure that all residents that met the criteria for a comprehensive care plan had one. 3. The MDS nurse will be educated to the comprehensive care plan expectations. The IDT will verify that each resident that qualifies for has a comprehensive care plan at least quarterly in the resident specific care plan meeting. 4. The DON/designee will conduct a quality monitoring audit of 10 residents per week for 6 weeks to ensure that each that meets the criteria for a comprehensive care plan in fact has one. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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F 656	Continued From page 8	F 656		

plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop and implement a comprehensive care plan (CCP) for 1 of 33 Residents, Resident #21.

The findings included:

The facility staff failed to develop and implement a CCP.

This was a closed record review.

Resident #21's diagnoses included, but were not limited to, bacteremia, pyogenic arthritis, diabetes, severe sepsis, and cutaneous abscess.

Section C (cognitive patterns) of Resident #21's admission minimum data (MDS) assessment with an assessment reference date (ARD) of 09/25/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points.

During a review of the clinical record the surveyor was unable to locate a CCP.

On 10/31/23 at 8:36 a.m., during an interview with the MDS nurse this nurse stated there was not a CCP for Resident #21.

On 10/31/23 at 4:00 p.m., during an end of the

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F 656	Continued From page 9 day meeting with the Administrator and Regional Nurse Consultant the issue regarding the missing CCP was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	1. The care plan for resident #26 was up dated to reflect the isolation status. 2. All residents requiring isolation are at risk for being impacted by the alleged deficient practice. A quality monitoring audit was completed to ensure that residents requiring isolation were care planned for such. 3. The MDS nurse will be educated regarding the care plan revision expectations. The IDT will review new isolation orders in the am clinical meeting and ensure that the care plan is updated at this time. 4. The DON/designee will conduct a quality monitoring audit of residents on isolation weekly for 6 weeks to ensure the care plan reflects the isolation status. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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F 657	Continued From page 10	F 657		

by:
Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the residents care plan for 1 of 33 Residents, Resident #26.

The findings included:

The facility staff failed to review and revise Resident #26's care plan. Resident #26 was on contact isolation.

Resident #26's diagnoses included, but were not limited to, severe sepsis, ventilator associated pneumonia, chronic respiratory failure, and diabetes.

Section C (cognitive patterns) of Resident #26's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/14/23 included a brief interview for mental status (BIMS) summary score of 00 out of a possible 15 points.

Resident #26's clinical record included a provider order dated 10/30/23 for contact isolation for candida auris fungemia.

During a review of Resident #26's care plan the surveyor was unable to locate any information to indicate this resident was on contact isolation. There was no signage posted on the door to indicate this resident was on isolation. The surveyor did observe a cart outside the door that contained personal protective equipment (PPE).

On 10/31/23 at 4:00 p.m., during an end of the day meeting with the Administrator and Regional Nurse Consultant the missing information

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F 657	Continued From page 11 regarding Resident #26's isolation status on the care plan was reviewed. A review of Resident #26's care plan on 11/01/23 at 10:40 a.m. revealed the care plan had still not been updated to include the residents isolation status. No further information regarding this issue was provided to the survey team prior to the exit conference.	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 interview, facility document review, clinical record review, and during a medication pass and pour observation the facility staff failed to follow standards of practice in regards to medication administration for 2 of 33 residents, Resident #19, and Resident #33. The findings included: 1. For Resident #19 the facility staff documented vital signs, enteral feedings, and medications as administered when the resident was not in the facility. Resident #19's face sheet listed diagnoses which included but not limited to malignant neoplasm of right lung, malignant neoplasm of oropharynx,	F 658	1. The facility recognizes that the documentation for resident #19 was erroneous for 9/4/23 and 9/5/23 and that the medication borrowed for resdient #33 was erroneous. RN #2 was educated immediately regarding borrowing medications. 2. All residents have the potential to be impacted by the alleged deficient practice. 3. All nurses will be educated on medication administration, not borrowing medications and documentation in the medical record. The IDT will review Emar documentation in the daily am clinical meeting to verify that documentation is accurate. The UMs will verify medication availability by inspecting the medication carts weekly 4. The DON/designee will complete a quality monitoring audit of 5 Emar records weekly for accuracy and 1 cart weekly for medication availability for 6 weeks. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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tracheostomy, and anxiety.

Resident #19's most recent minimum data set with an assessment reference date of 09/17/23 assigned the resident a brief interview for mental status score of 13 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #19's clinical record was reviewed and contained a census report which indicated that the resident was discharged on 09/02/11 and readmitted on 09/11/22.

Resident #19's electronic medication administration record for the month of September 2023 was reviewed and revealed that the residents enteral feed was initialed as being administered on 09/04/23, night shift and 09/05/23, day shift. Resident #19 had a set of vital signs (blood pressure, temperature, pulse, respirations, oxygen saturation) recorded on 09/04/23, night shift. Resident #19's medications were initialed as being administered on 09/05/23 at 8 am.

Surveyor requested and was provided with a facility policy entitled "Documentation in Medical Record", which read in part "Policy: Each resident's medical record shall contain and accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guideline: 3. Principles of documentation include but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not

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be documented."

The concern of documenting the resident's clinical record when the resident was not in the facility was discussed with the administrator and regional nurse consultant on 11/01/23 at 12:10 pm.

No further information was provided prior to exit.

2. For Resident #33 the facility staff borrowed medications from another resident to administer to Resident #33.

Resident #33's face sheet listed diagnoses which included but not limited to acute and chronic respiratory failure, end stage renal disease, and atrial fibrillation.

Resident #33's most recent minimum data set with an assessment reference date of 10/09/23 coded the resident as 10 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively intact.

Resident #33's physician's order summary was reviewed and contained an order for "Eliquis Oral Tablet 5 mg. Give one tablet by mouth twice a day for non-valvular atrial fibrillation."

On 10/31/23 at 10:05 am, surveyor observed registered nurse (RN) #2 during a medication pass and pour. While preparing Resident #33's medications, RN #1 was observed removing an Eliquis tablet from another resident's medication stock, and administering it to Resident #33, stating, "She has to have her Eliquis."

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F 658	Continued From page 14 Surveyor spoke with RN #2 on 10/31/23 at 1:55 pm. Surveyor asked RN #2 if they were supposed to borrow meds from one resident to give to another, and RN #2 stated, "Not supposed to do that, but I wanted to make sure she got it. Her's is still on order. Eliquis is an important medication." Surveyor asked RN #1 if the medication was in the facility's emergency supply, and RN #1 stated, "Not sure if it's in the stat box, might be in the Cubex." Surveyor was provided with a facility document entitled "Medication Administration" which read in part, "Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination of infection." During a meeting with the administrator and regional nurse consultant (RNC) on 11/01/23 at 11:30 am, surveyor asked if medications should be borrowed from one resident to administer to another resident, and the RNC stated that medications should not be borrowed. No further information was provided prior to exit.	F 658		
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	F 686	1. The facility recognizes there were omissions in the TARS for wound treatments for resident's #18 and #25. 2. All residents with wounds have the potential to be impacted by the alleged deficient practice. A full house skin sweep was completed to ensure no unidentified skin conditions were present. 3. Nurses will be educated on wound care expectations and documentation to include signing off on the TAR and completing	

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F 686	Continued From page 15 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 resident interview, staff interview, clinical record review and facility document review, the facility staff failed to provided pressure ulcer treatment for two of 33 residents in the survey sample, Resident # 18 and Resident # 25. The findings included: 1. For Resident # 18, the facility staff failed to perform wound care as ordered by the physician multiple days in the months of September 2023 and October 2023. Resident # 18's clinical record was reviewed and indicated that they have a diagnosis of quadriplegia. The most recent minimum data set (MDS) assessment with an assessment reference date of 8/18/23 indicated that resident is dependent on staff for most activities of daily living (ADL's) including bed mobility, transfers, and toileting. Resident is non-ambulatory, has contractures of both upper and lower extremities, and uses an electric wheelchair to self-propel on and off unit independently. The resident was coded as being at risk of developing pressure ulcers and as having pressure ulcers. The care plan for resident # 18 was reviewed and a problem statement that read, "(name omitted) has a hx (history) of impaired skin breakdown.	F 686	weekly skin assessments and ordered treatments. The IDT will review weekly skin assessments and the TAR in the daily am clinical meeting to verify compliance. 4. The DON/designee will complete a quality monitoring audit of weekly skin assessments/ TARs/treatments for 10 residents weekly for 6 weeks to ensure compliance. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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(they) is at risk for further pressure ulcer development quadriplegia. Once (name omitted) is up in w/c will not allow staff to put back in bed. Education has been provided about the continued pressure. (they) has an air mattress and heel protectors in place. (Name omitted) has two acquired pressure wounds with treatments in place. - Stage 3 on L (left) lateral back - Stage 4 on R (right) Gluteal fold." Other portions of the care plan stated that resident # 18 has been non-compliant with many aspects of care including turning and positioning for pressure reduction.

Resident # 18's physician's orders were reviewed. An order read, "L (left) lateral back: Cleanse with w.c. (wound cleanser), pat dry, apply honey fiber and cover with bordered foam dressing every day shift." The TAR for this wound treatment had holes for 9/8, 9/11, 9/12, 9/21, 9/23, 10/12, 10/15, 10/18. An order for the right gluteal fold order with a start date of 9/6/23 and an end date of 9/19/23 read, "Cleanse with Dakin's, pat dry, apply santyl followed by calcium alginate then cover with foam bordered dressing every day shift. There were holes on the TAR for this order on 9/18, 9/11, and 9/12. An order for the right gluteal fold with a start date of 10/12/23 read, "Cleanse with w.c., pat dry, apply collagen particles followed by honey fiber then cover with foam bordered dressing every day shift." The TAR had holes for this treatment on 10/12, 10/15, 10/18, 10/28.

On 10/31/23 at 10:25 AM this surveyor interviewed LPN # 7. When asked who does wound care, they stated that the wound nurse does most of the wound care, but they were on vacation, so the floor nurses were doing their own treatments. When asked why there would be

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holes on the TAR for a particular resident, they stated, "Well, if there's holes, it wasn't done, right? When I do my treatments, just like passing medicine, I sign off I did it so if it isn't signed, chances are it wasn't done".

On 10/31/23 at 10:31 AM surveyor interviewed the regional Nurse Consultant. They explained that the expectation for wound care is that the assigned nurse is to do wound care if the wound nurse isn't there. Whoever does the treatment is who should be signing off the TAR.
The surveyor requested and received the policy entitled, "Wound Treatment Management" with a revised date of 12/1/22. The policy read in part, "1. Wound treatments will be provided in accordance with physician's orders, including the cleansing method, type of dressing, frequency of dressing change." And "7. Treatments will be documented on the Treatment Administration Record."

On 11/1/23 at 11:30 AM the survey team met with the Administrator and the Regional Nurse Consultant and this concern was discussed.

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

2. For Resident # 25, the facility staff failed to provide wound care as ordered by the physician on multiple days in September and October 2023.

This surveyor interviewed resident # 25 on 10/30/23 at 3:51 PM. They stated that they had a pressure area on their thigh and that the staff were putting "cream and a patch on it." When asked if the treatment was done every day, they stated, "no, not every day. I don't know how often

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they are supposed to do it, but they do it a few times a week usually. If the wound nurse isn't here, it doesn't get done, only days that she's here." When asked if the wound is getting better, they stated, "yes I think so, it feels better anyway."

The clinical record for resident # 25 was reviewed. The most recent MDS assessment assigned the resident a brief interview for T status (BIMS) score of 15 indicating resident is cognitively intact. The were coded as being at risk for pressure ulcers and being admitted with a stage 3 pressure ulcer. They are incontinent of bowel and bladder and require extensive assistance of staff for bed mobility and transfers, they are not ambulatory. The care plan was reviewed with a problem statement that read, "(name omitted) has a potential for pressure ulcer development r/t impaired mobility, incontinent of bowel/bladder, impaired circulation, T2DM (Diabetes). Has 3 stage 3 PU with yeast to abdominal folds and hips." One of the interventions was, "administer treatment as ordered and monitor for effectiveness."

On 10/31/23 at 10:25 AM this surveyor interviewed LPN # 7. When asked who does wound care, they stated that the wound nurse does most of the wound care, but they were on vacation, so the floor nurses were doing their own treatments. When asked why there would be holes on the TAR for a particular resident, they stated, "Well, if there's holes, it wasn't done, right? When I do my treatments, just like passing medicine, I sign off I did it so if it isn't signed, chances are it wasn't done".

On 10/31/23 at 10:31 AM surveyor interviewed

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F 686	Continued From page 19 the regional Nurse Consultant. They explained that the expectation for wound care is that the assigned nurse is to do wound care if the wound nurse isn't there. Whoever does the treatment is who should be signing off the TAR. The surveyor requested and received the policy entitled, "Wound Treatment Management" with a revised date of 12/1/22. The policy read in part, "1. Wound treatments will be provided in accordance with physician's orders, including the cleansing method, type of dressing, frequency of dressing change." And "7. Treatments will be documented on the Treatment Administration Record." On 11/1/23 at 11:30 AM the survey team met with the Administrator and the Regional Nurse Consultant and this concern was discussed. No further information was provided to the survey team prior to the exit conference.	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced	F 687	1. The facility recognizes that resident #23 had not received podiatry services. Resident #23 has scheduled podiatry services in place. 2. All residents have the potential to be impacted by the alleged deficient practice.. A quality monitoring audit was completed to determine which residents needed to be seen by the podiatrist. 3. Nurses will be educated on the podiatry services process and how to ensure the podiatrist sees the resident. The UMs will review all new admits to determine their need for podiatry services and all other residents on a monthly basis to determine their need for podiatry services. 4. The DON/designee will complete a quality monitoring audit of 5 residents	

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F 687	Continued From page 20 by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide foot care for a dependent care resident for 1 of 33 Residents, Resident #23. The findings included: Resident #23's toenails were observed to be long, thick, and jagged. The residents feet were observed to be dry and flaky. Resident #23's diagnoses included, but were not limited to, diabetes and acute respiratory failure with hypoxia. Resident #23's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 09/02/23 was coded to indicate Resident #23 was in a persistent vegetative state/no discernible consciousness. Section G (functional status) was coded (4/2) for personal hygiene to indicate the resident was totally dependent on 1 staff for this task. Resident #23's comprehensive care plan included the focus areas activity of daily living self-care performance deficit and has diabetes mellitus. Interventions included but were not limited to, refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. On 10/31/23 at 3:30 p.m., the surveyor observed Resident #23's toenails to be long, thick, and jagged. Resident #23's feet were observed to be dry with flaky skin. The Unit Manager was in room and made aware of the issue regarding Resident #23's toenails and feet. The Unit Manager	F 687	weekly for 6 weeks to determine their need for podiatry services. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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F 687	Continued From page 21 acknowledged the residents toenails were long and thick and stated Other Employee #8 made the appointments for podiatry. On 10/31/23 at 3:35 p.m., during an interview with Other Employee #8 this staff stated the podiatrist would be at the facility on 11/16/23. On 10/31/23 at 4:00 p.m., during an end of the day meeting with the Administrator and Regional Nurse Consultant the issue with Resident #23's foot care was reviewed. On 11/01/23 at 9:20 a.m., during an interview with Other Employee #8 this staff stated Resident #23 had not been seen by podiatry since their admission to the facility (March 2023), but they were on the list to be seen 11/16/23. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 687		
F 689 SS=E	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 and staff interview, the facility staff failed to ensure the facility was free of accident hazards in 2 of 2 shower rooms.	F 689	1. The facility recognizes that the shower rooms had missing floor tiles. 2. All residents that use the shower rooms have the potential to be impacted by the alleged deficient practice. A quality monitoring audit was completed of the shower rooms for needed repairs. 3. The maintenance director/staff will be educated on identifying and repairing items to prevent hazards. The IDT will utilize the quality monitoring rounding tool to identify potential hazards and share with the maintenance team for repair in the am IDT meeting. 4. The Administrator/designee will complete a quality monitoring audit of shower rooms weekly for 6 weeks to ensure issues are identified and repaired timely.	

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F 689	Continued From page 22 The findings included: The shower rooms were observed to have missing tiles in the floor. On 10/31/23 at 8:23 a.m., the surveyor entered the shower room on 300 hall. The surveyor observed missing tiles under the shower chair. The Director of Environmental Service/Maintenance entered the shower room and stated they were going to have a complete renovation. On 10/31/23 at 8:34 a.m., the surveyor and Maintenance Assistant entered the shower room on 100 hall. This shower room was observed to have a musty smell and the surveyor observed missing tiles around the area where the shower chair was sitting. On 10/31/23 at 4:00 p.m., during an end of the day meeting with the Administrator and Regional Nurse Consultant the issues with the missing tiles in the shower rooms was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 689	The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	
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	F 692		

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F 692	Continued From page 23 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 by: Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to ensure 1 of 33 residents (Resident #23) tube feeding was set on the rate that was ordered by the provider. The findings included: Resident #23's tube feeding rate was set at the incorrect amount. The provider order read 50 ml/hour when the tube feeding was set to run at 65 ml/hour. Resident #23's diagnoses included respiratory failure and diabetes. Section B (hearing/speech/vision) of Resident #23's quarterly minimum data set (MDS) assessment with an ARD of 09/02/23 was coded to indicate this resident was in a persistent vegetative state. Section K (swallowing/nutrition) was coded to indicate this resident had a feeding tube.	F 692	1. The facility recognizes that the tube feeding rate for resident #23 was running at the wrong rate. The RD was consulted for claification and the rate was set to run at the correct setting. 2. All residents receiving tube feeding are at risk for the alleged deficient practice. A quality monitoring audit was completed of residents receiving tube feeding, comparing orders against pump settings. 3. Nurses will be educated to medication administration process and to verify that feeding pumps are set to physician orders. UMs will review the pump settings in their daily rounding schedules to ensure compliance. 4. The DON/designee will complete a quality monitoring audit on 5 residents receiving tube feeding per week for 6 weeks to verify that pump rates are set to physician orders. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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Resident #23's comprehensive care plan included the focus area all nutritional support is via tube feeding. Interventions included registered dietician to evaluate quarterly and as needed and make changes to tube feeding as needed.

Resident #23's clinical record included the following order in reference to their tube feeding. Enteral Feed-Glucerna 1.5 administer via peg tube at 50 ml/hour until Glucerna 1.2 available. Administer Glucerna 1.2 (65ml) per hour via G-Tube continuously.

On 10/30/23 at 2:10 p.m., the surveyor entered Resident #23's room and observed Glucerna 1.5 running at 65 ml/hour.

On 10/30/23 at 2:37 p.m., the surveyor interviewed Licensed Practical Nurse (LPN) #2 regarding Resident #23's tube feeding. LPN #23 entered Resident #23's room and confirmed the rate was set at 65 ml/hour and that the formula was Glucerna 1.5. LPN #2 called the Nurse Practitioner (NP) in the presence of the surveyor and confirmed the tube feeding should have been set to run at 50 ml/hour when the Glucerna 1.5 ml/hour was in use.

On 10/30/23 at 2:45 p.m., after speaking with the NP LPN #2 called the Registered Dietician (RD). After the phone call LPN #2 stated the RD instructed them to change the rate of Glucerna that was currently running (1.5) to 50 ml/hour.

On 10/30/23 at 3:19 p.m., LPN #2 documented the following in Resident #23's clinical record. Clarification to Glucerna 1.5 tube feeding. RD and NP clarified that Glucerna 1.5 is to run at 50 ml/hour and continue order if needed to use

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F 692	Continued From page 25 Glucerna 1.2 to run at 65 ml/hour. Pump corrected. Responsible party made aware. On 10/31/23 at 4:00 p.m., during an end of the day meeting with the Administrator and Regional Nurse Consultant the issue regarding Resident #23's tube feeding rate was reviewed. No further information regarding this issue was provided by the survey team prior to the exit conference.	F 692		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755	1. The facility recognizes that various medications were not signed as administered for residents # 1, 10, 31, 32 and 21. and/or not available during med pass observation. The medical team was notified with no new orders. 2. All residents are at risk for the alleged deficient practice. A quality monitoring audit was completed to ensure medications were available as ordered. 3. Nurses will be educated to medication administration, medication re-ordering and documentation. The UMs will complete a quality monitoring audit of the medication carts weekly to ensure that medications are re-ordered timely and are available for administration. 4. The DON/designee will complete a quality monitoring audit of one cart per week for 6 weeks to ensure that medications are available as ordered. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, clinical record review and during a medication pass and pour observation the facility staff failed to ensure that physician ordered medications were available for administration for 5 of 33 residents, Resident #1, Resident #10, Resident #31, Resident #32 and Resident #21.

The findings included:

1. For Resident #1 the facility staff failed to ensure the medications Saccharomyces boulardii and Zyprexa Zydis were available for administration.

Resident #1's face sheet listed diagnoses which included but not limited to anxiety, depression, and schizophrenia.

Resident #1's most recent minimum data set with an assessment reference date of 08/03/23 assigned the resident a brief interview for mental status score of 12 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #1's comprehensive care plan was reviewed and contained a care plan for "... has had episodes of delusions and hallucinations.

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Recent dosage reduction FAILED." Interventions for this care plan include "Administer medications as ordered."

Resident #1's clinical record was reviewed and contained a physician's order summary which read in part, "Saccharomyces boulardii Capsule 250mg. Give 1 capsule by mouth two times a day for probiotic for 30 days", and "Zyprexa Zydis Tablet Dispersible 5 mg (olanzapine). Give one tablet by mouth twice a day related to anxiety disorder."

Resident #1's electronic medication administration record (eMAR) for the month of September 2023 was reviewed and contained entries as above. The entry for Saccharomyces was coded "9" on 09/13/23 and 09//20/23, and coded "5" on 09/14/23, 09/15/23, 09/20/23 and 09/25/23. The entry for Zyprexa Zydis was coded "9" on 09/13/23. Chart code "9" is equivalent to "Other/See Nurse Notes". Chart code "5" is equivalent to "Hold/See Nurse Notes."

Resident #1's nurses' progress notes were reviewed and contained notes which read in part, "9/13/2023 08:06 Note Text: Saccharomyces boulardii Capsule 250 mg. Give 1 capsule by mouth two times a day for probiotic for 30 days. Arrival pending via pharmacy. NP [nurse practitioner] aware", "9/13/2023 08:03 Note Text: Zyprexa Zydis Tablet Dispersible 5 mg. Give 1 tablet by mouth two times a day related to anxiety disorder...Arrival pending via pharmacy. NP aware", "0/14/2023 Note Text: Saccharomyces boulardii Capsule 250 mg. Give 1 capsule by mouth two times a day for probiotic for 30 days one time hold per np. rp [responsible party] made aware", "9/16/2023 Note Text: Saccharomyces

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boulardii Capsule 250 mg. Give 1 capsule by mouth two times a day for probiotic for 30 days. Medication not available. Orders to hold doses, resume as scheduled once it arrives", "9/16/2023 Note Text: 16:28 Saccharomyces boulardii Capsule 250 mg....Orders to hold dose and resume as scheduled on arrival", "9/20/23 10:11 Note Text: Saccharomyces boulardii Capsule 250 mg... Medication on order."

Surveyor requested and was provided with a facility policy entitled "Unavailable Medications" which read in part, "1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn [as needed], and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications.

Surveyor requested and was provided with a list of medications available in the facility's STAT supply. Neither Saccharomyces boulardii nor Zyprexa Zydis were listed as available.

The concern of not having the resident's medications available for administration was discussed with the administrator and regional nurse consultant on 11/01/23 at 11:30 am.

No further information was provided prior to exit.

2. For Resident #10 the facility staff failed to ensure the medications Zyprexa and Seroquel were available for administration.

Resident #10's face sheet listed diagnoses which included but not limited to bipolar disorder, schizophrenia, and delusional disorders.

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Resident #10's most recent minimum data set with an assessment reference date of 09/22/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #10's comprehensive care plan was reviewed and contained a care plan for "Psychiatric/Mood disorder: Schizoaffective DO [disorder], bipolar." Interventions for this care plan included "Administer medications and observe for effectiveness of treatment and side effects as orders."

Resident #10's clinical record was reviewed and contained a physician's order summary which read in part, "Seroquel XR Tablet Extended Release 24 Hour (QUEtiapine Fumarate ER). Give 200 mg by mouth one time a day related to SCHIZOPHRENIA", "Seroquel XR Tablet Extended Release 24 Hour (QUEtiapine Fumarate ER). Give 300 mg by mouth at bedtime related to SCHIZOPHRENIA", and "Zyprexa Oral Tablet 5 mg (Olanzapine). Give 5 mg by mouth one time a day related to SCHIZOPHRENIA."

Resident #10's electronic medication administration record (eMAR) for the month of September 2023 was reviewed and contained entries as above. The entry for Seroquel 200 mg was coded "9" on 09/13/22. the entry for Seroquel 300 mg was coded "9" on 09/11/23, and coded "5" on 09/12/23, 09/13/23, and 09/25/23. The entry for Zyprexa was coded "9" on 09/23/23 and 09/23/23. Chart code "9" is equivalent to "Other/See Nurse Notes." Chart code "5" is equivalent to "Hold/See Nurse Notes."

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Resident #10's nurse's progress notes were reviewed and contained notes which read in part, "9/7/2023 20:41 Note Text: Seroquel XR Tablet Extended Release 24 Hour. Give 300 mg by mouth at bedtime related to schizophrenia. drug unavailable", "9/11/2023 09:18 Note Text: Seroquel XR Tablet Extended Release 24 Hour. Give 200 mg by mouth one time a day related to schizophrenia. awaiting pharmacy", "9/11/2023 20:36 Note Text: Seroquel XR Tablet Extended Release 24 Hour. Give 300 mg by mouth at bedtime related to schizophrenia. unavailable", "9/12/2023 21:04 Note Text: Seroquel XR Tablet Extended Release 24 Hour. Give 300 mg by mouth at bedtime related to schizophrenia. order rec'd [received]. med on hold", "9/13/2023 09:54 Note Text: Seroquel XR Tablet Extended Release 24 Hour. Give 200 mg by mouth one time a day related to schizophrenia. Arrival pending pharmacy. np [nurse practitioner] aware", "9/13/2023 09:54 Note Text: Zyprexa Oral Tablet 5 mg. Give 5 mg by mouth one time a day related to schizophrenia. Arrival pending via pharmacy. NP aware". "9/13/2023 20:10 Note Text: Seroquel XR Tablet Extended Release 24 Hour. Give 300 mg by mouth at bedtime related to schizophrenia", "9/23/2023 12:45 Note Text: Zyprexa Oral Tablet 5 mg. Give 5mg by mouth one time a day related to schizophrenia. Awaiting arrival via pharmacy. NP aware", and "9/25/2023 21:36 Note Text: Seroquel XR Tablet Extended Release 24 Hour. Give 300 mg by mouth at bedtime related to schizophrenia."

Surveyor requested and was provided with a facility policy entitled "Unavailable Medications" which read in part, "1. The facility maintains a contract with a pharmacy provider to supply the

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facility with routine, prn [as needed], and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications.

Surveyor requested and was provided with a list of medications available in the facility's STAT supply. Neither Zyprexa nor Seroquel XR were available.

The concern of not having the resident's medications available for administration was discussed with the administrator and regional nurse consultant on 11/01/23 at 11:30 am.

No further information was provided prior to exit.

3. For Resident #31 the facility staff failed to ensure the medication Sorbitol was available for administration.

Resident #31's face sheet listed diagnoses which included but not limited to acute and chronic respiratory failure and constipation.

Resident #31's most recent minimum data set with an assessment reference date of 10/16/23 assigned the resident a brief interview for mental status score of 00 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired.

Resident #31's clinical record was reviewed and contained a physician's order summary which read in part, "Sorbitol Solution 70% [Sorbitol]. Give 15 ml via G-tube one time a day for bowel regimen."

Resident #31's electronic medication

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administration record was reviewed and contained an entry as above. This entry was coded "5" on 10/27/23, 10/30/23 and 10/31/23. Chart code "5" is equivalent to "Hold/See Nurse Notes."

Resident #31's nurse's progress notes were reviewed and read in part, "10/27/2023 12:26 Note Text: Sorbitol Solution 70%. Give 15 ml via G-Tube one time a day for bowel regimen. Medication on order", "10/30/2023 10:34 Note Text: Sorbitol Solution 70%. Give 15 ml via G-Tube one time a day for bowel regimen. one time hold per np [nurse practitioner]. rp [responsible party] made aware", "10/31/2023 08:44 Note Text: Sorbitol Solution 70%. Give 15 ml via G-Tube one time a day for bowel regimen. Per Dr. ... [name omitted] may hold x 1 dose...", and "10/31/2023 11:19 Note Text: New orders per Dr. ... [name omitted] ... D/C [discontinue] Sorbitol and start Lactulose 15 gm via peg tube QHS [bedtime] ..."

Surveyor observed licensed practical nurse (LPN) #1 on 10/31/23 at 8:35 am during a medication pass and pour. LPN #1 was preparing Resident #31's medications, and stated to surveyor that the medication, Sorbitol was not on the medication cart. LPN #1 later informed surveyor that medication had been discontinued.

Surveyor requested and was provided with a facility policy entitled "Unavailable Medications" which read in part, "1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn (as needed), and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications.

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Surveyor requested and was provided with a list of medications available in the facility's STAT supply. Sorbitol Solution was not available in the STAT supply.

The concern of not having the resident's medication available for administration was discussed with the administrator and regional nurse consultant on 11/01/23 at 11:30 am.

No further information was provided prior to exit.

4. For Resident #32 the facility staff failed to ensure the medication Baclofen was available for administration.

Resident #32's face sheet listed diagnoses which included but not limited to spinal stenosis, low back pain and other chronic pain.

Resident #32's most recent minimum data set with an assessment reference date of 10/23/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #32's clinical record was reviewed and contained a physician's order summary which read in part, "Baclofen Oral Tablet 10 mg. give 1 tablet by mouth three times a day for muscle spasms."

Resident #32's electronic medication administration record for the month of October 2023 was reviewed and contained an entry as above. This entry was coded "5" on 10/31/23 at 8 am, and "9" on 10/31/23 at 12 pm. Chart code "5"

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is equivalent to "Hold/See Nurse Notes" and chart code "9" is equivalent to "Other/See Nurse Notes."

Surveyor observed licensed practical nurse (LPN) #5 on 10/31/23 at 8:00 am during a medication pass and pour. LPN #5 prepared Resident #5's medications but stated to this surveyor that the resident's Baclofen was not in the cart. LPN #5 stated they pull the medication from the Cubex (STAT supply). LPN #5, along with this surveyor went to the Cubex, located in the medication room. LPN #5 attempted to retrieve the Baclofen from the Cubex, but the Cubex would not open. LPN #5 stated they would try again later. Surveyor asked LPN #3 to let them know once they had the Baclofen. Surveyor spoke with LPN #5 on 10/31/23 at 3p and asked them if they had gotten the Baclofen, and LPN #5 stated that they had just gotten the Cubex fixed, and they would administer the Baclofen with the 4 pm med pass.

Surveyor requested and was provided with a facility policy entitled "Unavailable Medications" which read in part, "1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn (as needed), and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications.

The concern of not having the resident's medication available for administration was discussed with the administrator and regional nurse consultant on 11/01/23 at 11:30 am.

No further information provided prior to exit.
5. For Resident #21, the facility staff failed to ensure the provider ordered antibiotic Cefazolin

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was available for administration.

This was a closed record review.

Resident #21's admitting diagnoses included, but were not limited to, type 2 diabetes with mellitus with ketoacidosis without coma, cutaneous abscess, bacteremia, and severe sepsis.

Section C (cognitive patterns) of Resident #21's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 09/25/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points.

The clinical record included an order for the antibiotic Cefazolin 1 gram every 8 hours until 10/26/23. The start date was documented as 09/20/23. On 09/21/23 Licensed Practical Nurse (LPN) #9 documented a "9" for the antibiotic at midnight. Per the preprinted code on the medication administration record (MAR) a 9=Other/see nurses note. A review of the nursing progress notes revealed LPN #9 documented "Medication unavailable. Dose not available in IV STAT BOX. new order, awaiting arrival from pharmacy. Dose will need to be rescheduled." The previous nurse had documented that they had administered this medication on 09/20/23 at 8:00 a.m. and again at 4:00 p.m.

On 10/30/23 at 12:20 p.m., during an interview with LPN #3 this nurse stated Resident #21 had stated there were times where night shift didn't give them their antibiotic.

On 10/30/23 the facility administrative staff provided the survey team with their policy titled,

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F 755	Continued From page 36 "Unavailable Medications." This policy read in part, "...Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold..." On 10/31/23 at 12:00 p.m., the Regional Nurse Consultant provided the survey team a copy of a policy titled, "Medication Administration." This policy read in part, "Medications are administered....as ordered by the physician..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and a medication pass and pour observation the facility staff failed to ensure a medication error rate of less than 5 %. There were 6 errors in 34 opportunities for a medication error rate of 17.6 %. These errors affected Resident #30, Resident #32, and Resident #33. The findings included. 1. For Resident #30 the facility staff administered	F 759	1. The facility recognizes that residents # 30, 32, and 33 did not receive medications as ordered. The medical team was notified with no new orders. 2. All residents have the potential to be impacted by the alleged deficient practice. 3. Nurses will be educated on medication administration, physician orders and documentation. Unit managers/designee will validate medication med errors are less than 5% by utilizing direct observation during medication administration. 4. DON/designee will complete a quality monitoring audit of 2 medication passes weekly for 6 week to validate compliance. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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incorrect doses of docusate sodium and sertraline HCl and failed to administer the resident's insulin with meals as ordered by the physician.

Resident #30's face sheet listed diagnoses which included but not limited to type II diabetes mellitus, depression, anxiety, and constipation.

Resident #30's most recent minimum data set with an assessment reference date of 09/30/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Surveyor observed licensed practical nurse (LPN) #5 during a medication pass and pour on 10/31/23 at 7:30 am. Surveyor observed LPN #4 check the resident's blood sugar. LPN #4 then returned to the medication cart and surveyor observed them prepare docusate 100 mg, one capsule and sertraline 25 mg, 1/2 tablet. LPN #4 then found a discrepancy with one of Resident #30's medications, and stated, "I'll have to get this clarified before I can give it." LPN #4 labeled Resident #30's medications and secured them in the medication cart at this time. At 10:35 am, LPN #4 informed surveyor they were ready to administer Resident #30's medications at this time. Surveyor observed LPN #4 prepared and administer the resident's insulin injection and other medications.

Surveyor reconciled Resident #30's medications with the clinical record. Resident #30's physician's order summary contained orders which read in part, "Docusate sodium Oral Tablet 100 mg (Docusate Sodium). Give 2 tablets by mouth two

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times a day related to constipation", "Sertraline HCL Oral Tablet 25 mg (Sertraline HCl). Give 1 tablet by mouth one time a day related to mood" and "Humalog KwikPen Solution Pen-injector 100 unit/ml (Insulin Lispro (Human)). Inject 5 units subcutaneously three times a day with meals."

Surveyor spoke with LPN #4 on 10/31/23 at 3 pm. Surveyor asked LPN #4 how many docusate tablets they had administered to Resident #30, and LPN #4 looked at the medication administration record and stated, "I gave him two." Surveyor then asked LPN #4 if they had administered 1/2 of a sertraline tablet and LPN #4 again looked at the medication administration record and stated, "I gave him a whole one." Surveyor asked LPN #4 to see the medication card for the sertraline, and LPN #4 retrieved it from the medication cart. The card for sertraline contained 1/2 tablets. LPN #4 then stated, "I guess I gave him 1/2 tablet."

Surveyor requested and was provided with a facility policy entitled "Medication Administration" which read in part, "11. Compare medication source (bubble pack, vial, etc.) with MAR [medication administration record] to verify resident name, medication name, form, dose, route, and time. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician." Surveyor was also provided with a policy entitled "Timely Administration of Insulin" which read in part, "1. All insulin will be administered in accordance with physician's orders. 4. Insulin administration will be coordinated with meal times and bedtime snacks unless otherwise specified in the physician order. 5e. Administer insulin at appropriate times."

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2. For Resident #32 the facility staff failed to administer the medication Baclofen.

Resident #32's face sheet listed diagnoses which included but not limited to spinal stenosis, low back pain and other chronic pain.

Resident #32's most recent minimum data set with an assessment reference date of 10/23/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Surveyor observed LPN #4 on 10/31/23 at 8:00 am during a medication pass and pour. Surveyor observed LPN #4 prepared Resident #32's medications for administration. LPN #4 informed the surveyor that the resident's baclofen was not in the medication cart, and that they would pull it from the Cubex (emergency supply). LPN #4 went to the medication room and attempted to retrieve the baclofen from the Cubex. The Cubex was not operational at this time. LPN #4 then stated they would get someone else to check the Cubex, to see if they could pull the medication. LPN #4 then administered Resident #32's other medications. Surveyor asked LPN #4 to inform them when they were ready to prepare the baclofen for administration.

Surveyor reconciled Resident #32's medications with the clinical record. Resident #32's clinical record contained a physician's order summary which read in part, "Baclofen Oral Tablet 10 mg (Baclofen). Give 1 tablet by mouth three times a day for muscle spasms."

Surveyor spoke with LPN #4 on 10/31/23 at 3 pm

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regarding Resident #4's baclofen, and LPN #4 stated they had just got the Cubex fixed so they could retrieve the baclofen. LPN #4 stated, "I just got it, and I will give it with his 4 pm meds."

3. For Resident #33 the facility staff administered Nephro-Vite instead of Nepro.

Resident #33's face sheet listed diagnoses which included but not limited to acute and chronic respiratory failure, end stage renal disease, and atrial fibrillation.

Resident #33's most recent minimum data set with an assessment reference date of 10/09/23 coded the resident as 10 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively intact.

Surveyor observed registered nurse (RN) # 2 on 10/31/23 at 10:05 am during a medication pass and pour. RN #2 prepared Resident #33 medications including Nephro-Vite.

Surveyor reconciled Resident #33's medications with the clinical record. Resident #33's clinical record contained a physician's order summary which read in part, "Nepro 1 can supplement PO [by mouth] BID [twice daily] two times a day for supplement" and "Nephro-Vite Oral Tablet 0.8MG (B-Complex w/ C and Folic Acid). Give 1 tablet by mouth one time a day for supplement."

Resident #33's electronic medication administration record was reviewed and listed entries as above. The entry for Nepro was listed for administration times of 9 am and 9 pm. The entry for Nephro-Vite was listed for administration at 9 pm.

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F 759	Continued From page 41 Surveyor spoke with RN #2 on 10/31/23 at 1:55 pm regarding the resident's medications. Surveyor asked RN #2 to review the medications with the surveyor. Surveyor asked RN #2 if they had administered the resident's Nepro, and RN #1 stated they had, and pulled the bottle of Nephro-Vite from the medication cart and showed to surveyor. Surveyor asked RN #1 to review the resident's medication administration record, and RN #1 did so, then stated, "What is Nepro? I've never even heard of that." Surveyor then asked RN #1 at what time did Resident #33 get Nephro-Vite, and RN #2 stated, "She doesn't, I looked at it wrong." Surveyor requested and was provided with a facility policy entitled "Medication Administration" which read in part, "11. Compare medication source (bubble pack, vial etc.) with MAR [medication administration record] to verify resident name, medication name, form, dose, route, and time. a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects." The concern of not ensuring a medication error rate of less than 5 % was discussed with the administrator and regional nurse consultant on 11/0123 at 11:30 am. No further information was provided prior to exit.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		

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F 760	Continued From page 42 medication errors. 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 ensure 2 of 33 residents were free of significant medication errors, Resident #30, and Resident #21. The findings included: 1. For Resident #30 the facility staff failed to administered insulin within the physician ordered timeframe. Resident #30's face sheet listed diagnoses which included but not limited to type II diabetes mellitus, depression, anxiety, and constipation. Resident #30's most recent minimum data set with an assessment reference date of 09/30/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Surveyor observed licensed practical nurse (LPN) #5 during a medication pass and pour on 10/31/23 at 7:30 am. Surveyor observed LPN #4 check the resident's blood sugar. LPN #4 then returned to the medication cart and surveyor observed them prepare docusate 100 mg, one capsule and sertraline 25 mg, 1/2 tablet. LPN #4 then found a discrepancy with one of Resident #30's medications, and stated, "I'll have to get this clarified before I can give it." LPN #4 labeled Resident #30's medications and secured them in the medication cart at this time. At 10:35 am, LPN #4 informed surveyor they were ready to	F 760	1. The facility recognizes that residents # 30 and 21 did not receive their insulin per MD orders. The medical team was notified with no new orders. Resident #21 no longer resides in the facility. 2. All residents receiving insulin are at risk for being impacted by the alleged deficient practice. 3. Nurses will be educated on medication administration, MD orders and documentation. Unit Managers will review the Emar in the am clinical meeting for validation that insulin was administered timely and per MD orders. 4. The DON/designee will complete a quality monitoring audit of 5 residents that receive insulin per week for 6 weeks to ensure compliance with timely insulin administration. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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administer Resident #30's medications at this time. Surveyor observed LPN #4 prepared and administer the resident's insulin injection and other medications.

Surveyor reconciled Resident #30's medications with the clinical record. Resident #30's physician's order summary contained an order which read in part, "Humalog KwikPen Solution Pen-injector 100 unit/ml (Insulin Lispro (Human)). Inject 5 units subcutaneously three times a day with meals."

Surveyor requested and was provided with a policy entitled "Timely Administration of Insulin" which read in part, "1. All insulin will be administered in accordance with physician's orders. 4. Insulin administration will be coordinated with meal times and bedtime snacks unless otherwise specified in the physician order. 5e. Administer insulin at appropriate times."

The concern of not administering the resident's insulin within the ordered timeframe was discussed with the administrator and regional nurse consultant on 11/01/23 at 11:30 am.

No further information was provided prior to exit.
2. For Resident #21, the facility staff failed to administer insulin as ordered by the provider.

This was a closed record review.

Resident #21's clinical record included the diagnosis type 2 diabetes.

Section C (cognitive patterns) of Resident #21's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of

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09/25/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points.

The facility did not complete a baseline care plan or a comprehensive care plan for this resident.

The clinical record included the following provider orders.
09/19/23-Insulin Glargine 45 units at bedtime. This order was changed to 50 units on 09/27/23.
09/19/23-Humalog insulin 24 units with meals.

A review of Resident #21's clinical record revealed the following.

On 09/19/23 at 5:00 p.m., Licensed Practical Nurse (LPN) # 8 documented a "9" for the administration of Resident #21's insulin. Per the preprinted code on the medication administration record (MAR) a 9=Other/see nurses note. LPN #8 had documented a progress note that read this drug was unavailable. A review of the stat box list revealed this insulin was available in the stat box for administration.

On 09/19/23 at 10:00 p.m., 10/02/23 and 10/13/23 at 5:00 p.m. no nursing staff had signed for the administration of Resident #21's insulin the administration blocks were blank.

The facility staff provided the survey team with a copy of their policy titled, "Timely Administration of Insulin." This policy read in part, "It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a residents condition...All insulin will be administered in accordance with physician's

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F 760	Continued From page 45 orders..." On 10/30/23 at 12:20 p.m., during an interview with LPN #3 this nurse stated if a medication was not signed for it "didn't happen." On 10/30/23, during an interview with LPN #1 this nurse stated if a medication was not signed for it either didn't get done or it was missed. On 10/31/23 at 4:00 p.m., during a meeting with the Administrator and Regional Nurse Consultant (RNC) the issue with Resident #21's insulin not being administered per the providers orders was reviewed. On 10/31/23 at 12:00 p.m., the RNC provided the survey team a copy of a policy titled, "Medication Administration." This policy read in part, "Medications are administered....as ordered by the physician..." No further information regarding the insulin was provided to the survey team prior to the exit conference.	F 760		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761	1. The facility recognizes that various insulin pens were discovered in medication carts not labeled/dated/store appropriately, additionally that an aspirin bottle had no dosage on it. The facility removed the insulin pens in question and held the aspirin dose until verified. 2. All residents receiving insulin and aspirin are at risk for being impacted by the alleged deficient practice. A quality monitoring audit was completed of all carts focusing on proper insulin storage and aspirin dosage. 3. Nurses will be educated on insulin pen storage, the storage/labeling of drugs and medication administration including verifying dosage of	

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F 761	Continued From page 46 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review the facility staff failed to properly label and store medications in 4 of 4 medications carts and for 1 of 33 resident's, Resident #30. The findings included: 1. The facility staff failed to ensure that opened insulin vials/pens were labeled with an "opened on/discard by" date, failed to discard insulin pens/vials 28 days after opening, and failed to correctly store unopened insulin vials/pens. On 10/30/23 at 10:55 am, surveyor observed the medication cart for unit 4 of the facility. Inside the medication cart, surveyor observed an insulin glargine pen dated with a "use by" date of 10/25/23, an insulin lispro pen with a "use by" date of 10/18/23, and an unopened insulin pen inside a plastic bag with a label reading, "refrigerate until opened."	F 761	medications. Unit Managers will review their carts three times per week focusing on proper insulin storage and labeling and aspirin dosage. 4. The DON/designee will complete a quality monitoring audit of 2 carts weekly for 6 weeks to validate compliance with medication storage/labeling. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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On 10/30/23 at 11:10 am, surveyor observed the medication cart on unit 3 of the facility. Inside the medication cart, surveyor observed a basaglar insulin pen with a "use by" date of 10/23/23, a basaglar insulin pen with an illegible "use by" date, and an unopened insulin glargine vial labeled "refrigerate until opened."

On 10/30/23 at 11:20 am, surveyor observed the medication cart on unit 1 of the facility. Inside the medication cart, surveyor observed a basaglar insulin pen with an illegible "use by" date.

On 10/30/23 at 11:25 am, surveyor observed the medication cart on unit 2 of the facility. Inside the medication cart, surveyor observed an open basaglar insulin pen with no date on it, a lispro insulin pen with no date, and a Levemir insulin pen with no date. Surveyor also observed an admelog insulin vial with no date, two unopened Humalog insulin pens label "refrigerate until open", and a lispro insulin pen with no date.

Surveyor requested and was provided with a facility policy entitled "Medication Storage" which read in part, "It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations..." and "6. Refrigerated Products: a. All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room."

Surveyor was also provided a facility policy entitled "Insulin Pen" which read in part, "7. Store unopened insulin pens in a refrigerator. 8. Once opened, clearly labeled insulin pens may be

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stored at room temperature in a locked medication cart. 9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation."

The concern of not properly labeling, storing, or disposing of insulin pens/vials was discussed with the administrator and regional nurse consultant on 11/01/23 at 11:30 am.

No further information was provided prior to exit.

2. For Resident #30 the facility staff failed to ensure the medication aspirin was labeled with the correct dosage.

Resident #30's face sheet listed diagnoses which included but not limited to type II diabetes mellitus, depression, anxiety, and constipation.

Resident #30's most recent minimum data set with an assessment reference date of 09/30/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Surveyor observed licensed practical nurse (LPN) #5 during a medication pass and pour on 10/31/23 at 7:30 am. While preparing Resident #30's medications, LPN #4 stated, "This aspirin doesn't have a dosage on it. I'll have to get this clarified before I can give it."

Surveyor reconciled Resident #30's medications with the clinical record. The clinical record contained a physician's order summary which read in part, "Aspirin Tablet. Give 1 tablet by

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F 761	Continued From page 49 mouth one time a day for Post Cardiac Stent." This order did not contain a dosage. The concern of not ensuring Resident #30's aspirin was labeled with the correct dosage was discussed with the administrator and regional nurse consultant on 11/01/23 at 11:30 am. No further information was provided prior to exit.	F 761		
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, 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;	F 842	1. The facility recognizes that the documentation for resident #20 was erroneous and missing for resident #21. The medical team was notified with no new orders. Resident #20 and 21 no longer resides at the facility. 2. All residents receiving medications and accu-checks are at risk for being impacted by the alleged deficient practice. 3. Nurses will be educated to medication administration, MD orders and documentation. The clinical team will review Emars and accu-checks in the am clinical meeting to validate accuracy with documentation. 4. The DON/designee will complete a quality monitoring audit of 5 residents with accu-checks and/or receiving meds each week for 6 weeks to validate accuracy of documentation. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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F 842	Continued From page 50 (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 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:	F 842		

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Based on staff interview, clinical record review and facility document review the facility staff failed to maintain a complete and accurate clinical record for 2 of 33 residents, Resident #20, and Resident #21.

The findings included:

1. For Resident #20 the facility staff documented that medications were administered when the resident was not in the facility.

Resident #20's face sheet listed diagnoses which included but not limited to acute respiratory failure with hypoxia, gastrostomy status, hypertension, and anxiety.

Resident #20 was admitted and discharged on the same day; therefore, no minimum data set was completed.

Resident #20's electronic medication administration record (eMAR) for the month of September 2023 was reviewed and contained entries which read in part, "Losartan Potassium Oral Tablet 50 mg (Losartan Potassium). Give 1 tablet via PEG [percutaneous endoscopic gastrostomy)-Tube one time a day related to essential (primary) hypertension", "Sertraline HCl Oral Tablet 100 mg (Sertraline HCl). Give 1 tablet via PEG-Tube one time a day for depression", and "Vitamin B-1 Tablet 100 mg (Thiamine HCl). Give 1 tablet via PEG-Tube one time a day for supplement". Each of the entries had been initialed as being administered on 09/11/23 at 8 am. Resident #20's eMAR also contained enteral feed orders including amount, rate, residuals, and placement. These orders were initialed as administered/completed on 09/09/23 on day shift.

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Surveyor requested and was provided with a facility policy entitled "Documentation in Medical Record", which read in part "Policy: Each resident's medical record shall contain and accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guideline: 3. Principles of documentation include but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented."

The concern of not ensuring an accurate clinical record for Resident #20 was discussed with the administrator and regional nurse consultant during a meeting on 11/01/23 at 11:30 am.

No further information was provided prior to exit.
2. For Resident #21, the facility staff failed to document they had obtained blood sugars (BS) per the providers orders.

This was a closed record review.

Resident #21's clinical record included the diagnosis type 2 diabetes.

Section C (cognitive patterns) of Resident #21's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 09/25/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points.

The facility did not complete a baseline care plan

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F 842	Continued From page 53 or a comprehensive care plan for this resident. The clinical record included an order for BS's before meals and at bedtime. The start date was documented as 09/19/23. A review of the clinical record revealed the facility staff did not document the results of the BS's on 09/26/23 at 6:30 a.m., 10/02/23 at 6:30 a.m., 10/13/23 at 4:30 p.m. and again on 10/15/23 at 10:00 p.m. The facility provided the survey team with a copy of their policy titled, "Documentation in Medical Record." Implementation date 11/01/20 date reviewed/revised 12/01/22. This policy read in part, "...Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred..." On 10/31/23 at 4:00 p.m., during an end of the day meeting with the Administrator and Regional Nurse Consultant the missing documentation regarding Resident #21's BS was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880	1. The facility recognizes that RN #2 did not wear the correct PPE when entering resident #2's room and also that proper signage was not placed outside resident's #26 room. RN #2 was immediately addressed/educated regarding PPE. The correct sign of placed on the door of room for resident #26. 2. All residents have the potential to be impacted by the alleged deficient practice. A qualtiy monitoring audit was conducted for proper signage of isolation precautions.	

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F 880	Continued From page 54 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	3. Nurses will be educated on infection control practices, PPE use and signage. Unit Managers will verify that the correct isolation sign is placed on the doors of residents requiring isolation daily on their quality monitoring rounds. Unit Managers will also validate that staff are entering isolation rooms with the proper PPE daily while conducting their quality monitoring rounds. 4. The DON/designee will review 5 residents in isolation each week for 6 week for proper signage and also observe staff entering those rooms to validate proper PPE use. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review the facility staff failed to establish and follow an effective infection control program for 2 of 32 residents, Resident #12, and Resident #26.

The findings included:

For Resident #12 the facility staff failed to don proper personal protective equipment (PPE) upon entering the resident's room. Resident was on droplet precautions.

Resident #12's face sheet listed diagnoses which included, but not limited to diabetes mellitus, anxiety, and depression.

On 10/31/23 at 09:55 am, surveyor observed a

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"Droplet Precautions" sign located on Resident #12's door. This sign read in part, "Everyone must: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit." Surveyor observed an isolation cart located outside Resident #12's room, containing gowns, gloves, and masks. Surveyor did not observe any type of face/eye covering, however, an isolation cart located outside a nearby room contained face shields.

Surveyor observed registered nurse (RN) #2 preparing medications for Resident #12. Once RN #2 prepared the medications, they donned a gown and gloves prior to entering Resident #12's room. RN #2 was already wearing a face mask. RN #2 entered the resident's room, went to the resident's bed, leaned over, and spoke with resident. RN #2, then went over to sink, removed gown and gloves, washed their hands, and exited the room with Resident #2's medications. RN #2 returned to the medication cart, crushed the medications, placed in pudding, and went back to Resident #2's doorway to begin donning PPE. Surveyor asked RN #2 to read the sign on the door, which RN #2 did. Surveyor then asked RN #2 if they had worn eye protection when they had previously entered the room, and RN #2 stated, "No, I'd like to see some goggles around here." RN #2 then entered Resident #12's room, after donning gown and gloves, but no eye protection.

Surveyor requested and was provided with a facility policy entitled "Standard Precautions Infection Control" which read in part, "2. Using Personal Protective Equipment: a. All staff who have contact with resident and/or their

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environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely."

The concern of facility staff not wearing proper PPE was discussed with the administrator and regional nurse consultant on 11/01/23 at 11:30 am.

No further information was provided prior to exit.
2. For Resident #26, the facility staff failed to identify the type of precautions and the appropriate personal protective equipment (PPE) to be used prior to entering the residents room. Resident #26 was on contact precautions.

Resident #26's diagnoses included, but were not limited to, severe sepsis, ventilator associated pneumonia, chronic respiratory failure, and diabetes.

Section C (cognitive patterns) of Resident #26's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/14/23 included a brief interview for mental status (BIMS) summary score of 00 out of a possible 15 points.

On 10/31/23 at approximately 1:30 p.m., the surveyor approached Resident #26's room and observed a plastic cart beside the doorway that contained PPE. The surveyor did not observe any signage on the door that stated to see the nurse prior to entering or to define what type of isolation this resident was on and what type of PPE was required before entering the room.

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On 10/31/23 at 1:35 p.m., the surveyor asked Licensed Practical Nurse (LPN) #1 what type of isolation this resident was on. LPN #1 checked Resident #26's orders and stated Resident #26 was on contact isolation. LPN #1 acknowledged there was no signage outside the door. The Unit Manager placed an isolation sign on the door that read contact isolation. The Unit Manager stated the nurse working when the resident was admitted should have put some type of signage on the door.

A review of Resident #26's clinical record revealed that this resident was on contact isolation for candida auris fungemia. The date of the provider order was documented as 10/30/23.

Resident #26's comprehensive care plan did not include any information regarding Resident #26's isolation status.

On 10/31/23 at 2:00 p.m., the Administrator provided the survey team with a copy of their policy titled, "Infection Prevention and Control Program date reviewed and revised 12/01/22." This policy read in part, "...All staff are responsible for following all policies and procedures related to the program...Isolation signs are used to alert staff, family members, and visitors of isolation precautions..."

On 10/31/23 at 4:00 p.m., during an end of the day meeting with the Administrator and Regional Nurse Consultant (RNC) the missing information regarding Resident #26's isolation status was reviewed. The RNC was currently filling in for the infection preventionist and stated there should have been some type of signage regarding the residents isolation status.

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F 880	Continued From page 59 No further information regarding this issue was provided to the survey team prior to the exit conference.	F 880		