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	345520	A. BUILDING _____ B. WING _____	C 04/22/2021

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PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

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E 000	Initial Comments An unannounced recertification,complaint and revisit survey were conducted on 04/13/2021 through 04/22/2021. The facility was found in complaince with requirement CFR 483.73, Emergency Preparedness. Event ID # VXXD11.	E 000		
F 000	INITIAL COMMENTS A recertification, complaint and revisit survey was conducted from 04/13/2021 through 04/22/2021. Immediate Jeopardy was identified at CFR 483.45 at tag F760 at a scope and severity (K). Event ID # VXXD11. The tag F 760 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/27/2021 and was removed on 4/16/2021 . An extended survey was conducted on 04/19/2021. An unannounced on - site recertification, complaint and revisit survey was conducted from 04/13/2021 through 04/22/2021. Tag F 563 was corrected as of 04/22/2021. Repeat tags (F 550 and F 580) were cited. New tags were also cited as a result of the complaint and recertification survey conducted at the same time as the revisit survey. The facility is still out of compliance. Event ID # OCZ412.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		5/18/21

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

Electronically Signed | 05/09/2021

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to promote dignity by failing to provide a privacy cover for the urinary	F 550	Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 550	Continued From page 2 drainage bag for one of three sampled residents reviewed for dignity (Resident #54). Findings included: Resident #54 was admitted to the facility on 3/6/21 with multiple diagnoses which partly included: Dementia with behaviors, neurogenic bladder, cognitive decline and an open wound to the left hip. The Minimum Data Set (MDS) admission comprehensive assessment with an Assessment Reference Date (ARD) of 3/13/21 indicated Resident #54 had severe cognitive loss. The resident was coded as having had an indwelling urinary catheter. Resident #54 was observed out in the resident smoking area on 4/13/21 at 11:16 AM. There were multiple residents around Resident #54. Resident #54 was in a reclined type rolling chair and his urinary drainage bag did not have a privacy cover on it. The resident ' s yellow urine in the drainage bag with a clear side was visible to the residents and staff member who were out at the smoking area. Resident #54 was observed in the resident dining area for the 100-hall side of the building on 4/13/21 at 12:44 AM. There were other multiple residents around Resident #54 who were eating lunch. Resident #54 was in a reclined type rolling chair and his urinary drainage bag did not have a privacy cover on it. The resident ' s yellow urine in the drainage bag with a clear side was visible to the residents eating lunch and staff members who were assisting residents with lunch.	F 550	practice. A privacy cover was immediately placed over the urinary drainage bag of resident # 54 on 4/22/21 by the charge nurse " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents with a urinary drainage bag have the potential to be affected by the deficient practice. On 4/22/2021 a visual audit was conducted by the Director of nursing and no other urinary drainage bags were without privacy covers. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/6/2021 the Administrator and the Director of Nursing (DON) initiated re-education to all staff including licensed nurses, certified nursing assistants, rehabilitation staff, Housekeeping staff and administrative staff regarding resident rights and the need to have a privacy cover placed over all urinary drainage bags at all times. New admissions with urinary drainage bags without covers will have them covered or replaced with self-covered bags by the admitting nurse at the time of admission.	

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F 550	Continued From page 3 Resident #54 was observed to be in his room in his bed on 4/15/21 at 8:22 AM. The resident ' s urinary drainage bag was hung on the side of the bed facing the hallway, was visible from the hallway, and did not have a privacy cover on it. The resident ' s yellow urine in the drainage bag with a clear side was visible to the residents and staff member who passed the resident ' s room and peered inside of the resident ' s room. Resident #54 was observed to be in his room in his bed on 4/15/21 at 8:40 AM. The resident ' s urinary drainage bag was hung on the side of the bed facing the hallway, was visible from the hallway, and did not have a privacy cover on it. The resident ' s yellow urine in the drainage bag with a clear side was visible to the residents and staff member who passed the resident ' s room and peered inside of the resident ' s room. An interview was conducted on 4/15/21 at 8:44 AM with Nursing Assistant (NA) #3 stated Resident #54 should have had a privacy cover for his urinary drainage bag. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated it was her expectation for a resident ' s urinary drainage bag to be covered to maintain dignity. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator said he wanted a cover on a resident ' s urinary drainage bag to provide dignity for the resident. Due to Resident #54 ' s severe cognitive loss he was unable to be interviewed regarding his	F 550	" Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and An audit sheet will be done by the Administrator, DON, Nursing Supervisor or Department Manager to visually monitor and ensure that all residents with a urinary drainage bag will have the appropriate privacy covering. This monitoring process will take place 5x weekly for 4 weeks then 3x weekly for 4 weeks, then monthly for 1 months. The Administrator, or DON, will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan at any time.	

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F 550	Continued From page 4 feeling about the lack of a privacy cover on his urinary drainage bag.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced	F 553		5/18/21

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F 553	Continued From page 5	F 553		

by:
Based on record reviews, observations, resident and staff interviews, the facility failed to invite one of two residents reviewed for care plan meeting invitations (Resident # 67).

Findings included:

Resident # 67 was originally admitted to the facility on 06/21/2005 with diagnoses that included quadriplegia, chronic pain, neuromuscular dysfunction and muscle wasting.

A review of a quarterly Minimum Data Set (MDS) dated 04/04/2021 revealed that Resident # 67 was cognitively intact and was able to make daily care decisions.

An interview conducted with Resident # 67 on 04/13/2021 at 12:42 PM revealed that he did not recall the last care plan meeting was held that he was invited to. Resident # 67 revealed that the last care plan invitation he received was most likely a year ago or longer. Resident # 67 also explained that he had attended more care plan meetings than he had refused in the past.

A review of the medical record of Resident # 67 revealed that Resident # 67 was his own responsible party (RP) and the last documented care plan meeting that he attended was 03/14/2018.

On 04/15/2021 at 12:15 PM an interview was conducted with the facility social worker (SW). The SW explained that she scheduled care plan meetings and invited all residents and the resident's RP to the meeting based off a calendar schedule of dates provided to her by the MDS

" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident # 67 was invited by the Social Worker or Minimum data set nurse (MDS) to review the plan of care on 5/6/2021 and this was documented in the medical record.

" Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

Residents that require a plan of care have the potential to be affected by the same deficient practice. The MDS nurse will review the list of care plan reviews weekly to ensure that an invitation has been sent to the resident and responsible party. The MDS nurse will also ensure that the documentation of this invitation is in the medical record.

" Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

On 5/7/2021 the Administrator and the Director of Nursing (DON) initiated re-education to the Social worker and MDS nurse to review resident rights regarding invitations to care plan meetings. This re-education including

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F 553	Continued From page 6 nurse. The SW revealed that she did invite Resident # 67 to a care plan meeting scheduled for 04/14/2021 but the meeting had been cancelled and she was not certain when the meeting would be rescheduled. The SW was not able to locate any documentation that Resident # 67 had been invited to attend a care plan meeting since 03/14/2018. The SW confirmed that Resident # 67 was listed as his own RP and she explained that she had only taken on the role as care plan meeting facilitator during the past year. The MDS nurse was interviewed on 04/16/2021 at 1: 50 PM and revealed that she had been the facility MDS nurse for about one year and had recently started to give the SW a calendar of MDS dates and that the SW was responsible to invite all residents and the family or responsible party of the meetings. The MDS nurse was not able to locate any documentation that Resident # 67 had been invited to his care plan meeting since 03/14/2018 and she believed that a care plan meeting invitation for the current month had been extended to Resident # 67 but she was not able to confirm the exact date or time with the meeting as scheduled by the SW. The MDS nurse explained that care plan meetings were to be scheduled on admission, quarterly and annually for all residents in the facility. The facility administrator was interviewed on 04/16/2021 at 2:23 PM and he explained that he expected all resident's to have scheduled care plan meetings as dictated by the schedule set in the Resident Assessment Manual (RAI) or as requested by the resident or the resident RP.	F 553	ensuring the documentation is present in the medical record showing the invitation was sent to the resident and responsible party. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and An audit sheet will be done by the Administrator, DON, or Nurse Manager to audit care plan schedules to ensure residents have been invited and the documentation of the invitation is present in the medical record. This auditing process will take place weekly for 8 weeks, then monthly for 1 month. The Administrator, or DON, will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan at any time.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		5/18/21

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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide

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F 578	Continued From page 8 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to obtain an order and document the resident ' s advanced directives in the resident ' s electronic medical record (EMR) for 1 of 21 residents (Resident #58) reviewed for advanced directives. The findings included: Resident #58 was admitted to the facility on 3/22/21 with diagnoses which included: Pneumonia, sepsis, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), renal failure, dependence on oxygen, and chronic respiratory failure. A review of Resident #58's EMR conducted on 4/13/21 revealed no physician ' s order to establish the resident ' s code status which would indicate the resident was a Full Code (cardiopulmonary resuscitation (CPR) to be initiated if the heart stopped beating) or a Do Not Resuscitate (DNR). Further review of Resident #58's EMR revealed there were no indications of an Advanced Directive on the resident's profile page or on the resident ' s face sheet. The care plan for Resident #58 was reviewed on 4/16/21 and there was no information contained in the resident ' s care plan, or focus areas, regarding the resident ' s code status. An interview was conducted on 4/16/21 at 1:34	F 578	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. For resident # 58 the Advanced Directive form was signed by the resident/POA on and the Physician order was in the electronic medical record on 5/5/2021 and resident # 58 remains a Full Code " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current facility residents have the potential to be affected by the alleged deficient practice of failure to clarify code status. The Social Workers completed an audit of Advanced Directives for current facility residents on 5/10/2021, to validate Advanced Directive form, Physician orders and the canary transport form are consistent and available in the resident□s chart. No other discrepancies were identified " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 5/14/21 The Director of nursing/ Unit manager provided re- education for the licensed nursing staff and social workers	

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F 578	Continued From page 9 PM with the Medical Records Director. She said she believed Resident #58 was a full code based on her hospital paperwork. She said sometimes she will enter a resident ' s code status and sometimes the nurse who admits the resident, or writes the code status order, will put the code status into the resident ' s EMR. She reviewed the resident ' s EMR, including the resident ' s orders, and stated she did not see the resident ' s code status in the resident ' s EMR. She said the facility did not have any hard charts, so everything should be in the resident ' s EMR. She said the facility does keep the Stop Sign or goldenrod sheet for residents which were DNRs at each nurses ' station. She proceeded to check a notebook at each nurses ' station to see if the resident had such records indicating the resident was a DNR and did not discover evidence indicating the resident was a DNR. The Medical Records Director stated she was not aware of the process worked to get an order or establish the code resident for a resident because that was a task which the nurses completed. During an interview conducted with the evening supervisor on 4/16/21 at 1:45 PM he stated he believed Resident #58 was a full code based on her hospital paperwork. He stated sometimes he will enter the resident ' s code status when he ' s working on an admission and sometimes someone else will enter the resident ' s code status. He reviewed the resident ' s physician ' s orders and stated he did not see the resident ' s code status in the physician ' s orders or documented elsewhere in the resident ' s EMR. He reviewed the resident ' s hospital History and Physical (H and P) and the resident was a full code at the hospital and a full code order should have been written at the facility to establish the	F 578	regarding completion of Advanced Directives upon admission to include Advanced Directives form, Physician order and the canary transport form if applicable. The Licensed Nurses/ Admissions Director or the Social worker will assist the resident and/or the family to complete the Advanced Directive form upon admission. If the resident wishes are for a Do not resuscitate (DNR), the Physician will be notified and an order written to support the resident wishes, and the canary transport form will be completed and signed by the physician. The forms will be placed in the resident□s medical record upon completion. The Physicians order will be included in the order section of the resident□s electronic medical record. If the resident and /or family wish for a full code status the order will be obtained from the physician by the licensed nurse and placed in the medical record. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Social worker/ Unit Manger/ Admissions Director or Staff development Coordinator will complete an audit weekly for 4 weeks then monthly for 2 months to ensure each resident has a code status order and advance directive along with canary form if indicated and that all are in the medical record and signed by physician. The Director of Nursing or Administrator will review audits and present to the Quality assurance performance improvement committee to identify patterns/trends and will adjust	

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resident ' s code status in the resident ' s EMR. He stated if the resident were to be in an emergency situation the facility staff would treat the resident as a full code, and he would go the resident ' s hospital records to see what her code was at the hospital. He stated he had assisted with the admission, but he believed it was something he missed.

An interview was conducted with the MDS Coordinator on 4/16/21 at 2:23 PM. She said the Social Worker handled the resident ' s code status and nursing enters the resident ' s code status when they do the admission if the resident does not come with a DNR. The MDS Coordinator reviewed Resident #58 ' s EMR and stated she was unable to find information in the facility ' s EMR regarding the resident ' s code status and there was no order for the resident ' s code status. She stated the resident would be a full code due to not having a physician ' s order for a full code, but there should be a physician ' s order for the resident ' s code status. She stated the resident ' s code status should have been on the resident ' s care plan, as well as her baseline care plan, but she has been trying to keep up with MDS assessments and had not had an opportunity to work on the resident ' s baseline care plan or her permanent care plan. The MDS Coordinator stated she would talk with Resident #58 and validate with her what she wanted her code status to be.

An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated it was her expectation for each resident to have an order for their desired advanced directive and for the resident ' s advanced directive to be documented in the

plan as necessary to maintain compliance each month for 3 months. The QAPI committee can modify this plan to ensure a facility remains in compliance.

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PELICAN HEALTH THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

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F 578	Continued From page 11 resident ' s EMR. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator said each resident ' s advanced directives needed to be completed and entered in the resident ' s EMR. The Social Worker was unavailable for interview on 4/16/21.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		5/18/21

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F 580	Continued From page 12 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, family, staff, and physician the facility failed to notify a resident ' s representative of a change in condition that included administration of an incorrect type and dose of insulin injection for 1 of 1 residents (Resident # 25) reviewed for notification of changes. Findings included: Resident # 25 was admitted to the facility on 12/28/2018 with diagnoses that included type 2 diabetes mellitus (DM) and polyneuropathy. The electronic profile of Resident # 25 indicated	F 580	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The resident representative (RP) was notified about # 25 change in condition that included administration of an incorrect type and dose of insulin. on 5/7/21 the RP was notified by the Director of Nursing and this notification was documented in the medical record. On 4/22/2020 the physician reassessed resident□ #25 medication regimen. On 4/15/2021 the Director of Nursing	

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F 580	Continued From page 13 that a family member was listed as the emergency contact, responsible party (RP) and power of attorney (POA) of Resident # 25. A review of a quarterly minimum data set (MDS) dated 02/24/2021 included that Resident # 25 had no cognitive impairment, made daily care decisions, was understood and was able to understand. Resident # 25 received 7 days of insulin injections during the review period. A nurse note dated 12/11/2020 at 2:24 AM revealed that a medication aid (MA # 4) notified the nurse (nurse # 7) earlier in the evening of 12/10/2020 that MT # 4 had given Resident # 25 the incorrect insulin that was prescribed to be administered at 10:00 PM. Resident # 25 was to receive 96 units of Lantus (slow acting) insulin but MA # 4 administered 96 units of NovoLog (fast acting) insulin instead. On 04/14/2021 at 11:02 AM a phone interview was conducted with the RP of Resident # 25. The RP explained that he had always been notified by the facility for changes of the status for Resident # 25 until 12/10/2020. The RP explained that Resident # 25 had told him about the insulin a day or so after it happened that the RP called the facility and spoke with a staff member (he was not able to recall the name) and asked the staff member why he had not been called about Resident # 25 and an insulin injection error because he was always made aware of any and all changes that involved Resident # 25. The RP explained that the staff member was not able to explain why he had not been notified and expressed that he would never experience that again. The RP revealed that it was the nurse's responsibility to notify him not Resident # 25.	F 580	(DON) re-educated the licensed nurses # 6 and # 7 on the protocol of notification of the (RP) with a change of condition that included administration of an incorrect medication or dosage. Medication Aide #4 is no longer employed with this facility Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Audit completed on Current residents medical records starting 5/1/21 by the Director of Nursing to ensure if a change of condition occurred that involved administration if an incorrect medication or dosage that the RP was notified. No other residents were found to have had a change of condition regarding medications or dosage. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 5/7/2021 the DON began re-education with Licensed nurses on RP notification of a residents change of condition. New employees will receive education during orientation. On SDC and5/7/21 DON began re-education with Medication Aides on Medication administration and complete the competency check offs for each one will be completed by an Registered nurse	

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F 580	Continued From page 14 A phone interview was conducted with nurse # 7 on 04/14/2021 at 4: 30 PM. Nurse # 7. Nurse # 7 revealed that she failed to notify the RP of the insulin error made on 12/10/2020 even though she knew she should have. Nurse # 6 was interviewed at 8:16 AM on 04/15/2021. Nurse # 6 revealed that she did not notify the RP of Resident # 25 because she was not present when the change in resident status was identified. Nurse # 6 revealed that the licensed nurse present at the time of a significant change was the nurse responsible to notify the RP of change in resident status when it happened. On 04/16/2021 at 2:44 PM an interview was conducted with the DON. The DON revealed that it was expected that licensed nurses notify resident's RP as soon as a change in status was identified	F 580	prior to working. New medication Aide employees will education and competency check offs during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Director of Nursing/ Unit Manager/Supervisors will review each change of condition regarding an incorrect medication or dosage in the medical record daily for 4 weeks then weekly for 8 weeks to ensure the RP has been notified and that this notification is documented in the medical record. The Director of nursing will present the results of the reviews to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		5/18/21

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discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email),

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and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of

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F 623	Continued From page 17 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the emergency contact of a discharge from the facility for 1 of 3 residents reviewed for discharge. (Resident #68) Findings Included: Resident #68 was admitted to the facility on 2/18/21 with a diagnosis which included schizophrenia, COVID-19, dementia with behavioral disturbance and anxiety disorder. Resident #68 admission Minimum Data Set (MDS) dated 2/18/21 coded the resident's cognition as moderately impaired. A review of the progress dated 2/21/21 revealed Resident #68 was attempting to exit out an emergency door and was re-directed by staff and his behaviors escalated with his fists clenched yelling obscenities at staff. A review of a progress note dated 2/26/21 revealed Resident #68 behaviors had escalated to threatening of staff and had barricaded himself in his room with a couch from the common area. The Director of Nursing (DON) obtained involuntary commitment orders and the police came to transfer him out of the facility. A record review revealed no written or verbal communication was completed to Resident #68 emergency contact regarding his involuntary	F 623	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 68 is no longer in the facility. Discharge date 2/26/21 " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents who have been transferred or discharge have the potential to be affected. An audit was completed by the administrator on discharges since 5/1/2021 to ensure the emergency contact was notified of the discharge from the facility. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 5/11/21 the Administrator re-educated the Licensed nursing staff and Social worker on the policy for notification of the resident and responsible parties or emergency contacts upon transfer and discharge from the facility. The notification of those parties must be documented in the medical record and a copy of the	

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F 623	Continued From page 18 commitment order (IVC) and transfer out of the facility. A phone call was placed to Resident #68's family member and emergency contact to see if she was notified of his transfer out of the facility. The family member stated that no one had called her to let her know and she called the facility on 2/28/21 to see how her brother was doing. She did not remember who she spoke to, but the staff member she spoke to stated to her that he had been discharged and was taken to the hospital. The family member contacted the hospital and they had no admission of Resident #68. The family member called the facility again to make sure he was discharged to the hospital and the facility replied "yes". The family member was able to locate her brother at the hospital but in the psychiatric ward. The family member stated she never received anything in writing relating to his transfer. An interview was completed with the Director of Nursing (DON) on 4/16/21 at 1:08 PM who stated that staff were unable to approach Resident #68 due to his behaviors. The DON stated we needed to shut all the resident's doors to secure their safety the day Resident #68 was IVC'd. The DON stated she felt that any change in condition or transfer out of the facility the emergency contact should be made aware. During the interview the DON placed a telephone call to the Social Worker (SW) who was not available for an interview and the SW stated to her knowledge she was not aware if Resident #68's sister was notified. An interview was completed with the	F 623	written notice must also be in the medical record. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The administrator or Director of Nursing will review each transfer or discharge chart weekly for 12 weeks to ensure the record includes a copy of the transfer/ discharge notice in writing. Also, to ensure the documentation is present of notification to all parties of the transfer/discharge. The administrator or Director of Nursing will interview by phone 5 discharge/ transfer residents RP or EC weekly for 12 weeks to ensure notification took place regarding the transfer/discharge. A transfer/discharge log will be sent to the State Ombudsman Office Monthly Via certified mail to prove delivery. A copy of these audits will be given to the Administrator for review weekly. The administrator will review audits and present to the Quality assurance performance improvement committee to identify patterns/trends and will adjust plan as necessary to maintain compliance each month for 3 months. The QAPI committee can modify this plan to ensure facility remains in compliance.	

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F 623	Continued From page 19 Administrator on 4/16/21 at 3:53 PM who stated all responsible parties should be notified of a discharge.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments for pressure ulcers for one of two sampled residents reviewed for pressure ulcers (Resident #43). The findings included: Resident #43 was admitted to the facility on 2/12/16. Resident #43 ' s cumulative list of diagnoses included: Diabetes, chronic kidney disease, and a stage IV pressure ulcer of the sacrum. The MDS annual comprehensive assessment with an Assessment Reference Date (ARD) of 3/2/21 indicated Resident #43 was coded as not having had a pressure ulcer (of any stage) during the assessment period. Review of the Medication Administration Record (MAR) for the month of March 2021 was completed. The review revealed the resident had an order dated 11/24/20 for Hydrofera Blue (wound dressings) apply to left posterior thigh topically every day shift for wound care and cover with a dry protective dressing. The treatment was	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 43 minimum data set (MDS) was modified by the minimum data set nurse (MDS) to indicate the stage IV pressure injury and transmitted Address how the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of(MDS) of current residents with pressure injuries section M on the MDS was completed on 5/18/21 by the regional nurse consultant/ MDS nurse consultant/ Director of nursing and no other coding corrections were warranted. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; MDS staff, will be re-educated by the Regional MDS consultant on 5/11/21 regarding the importance of accurately	5/18/21

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F 641	Continued From page 20 discontinued on 3/11/21 and replaced with another treatment. During an interview and observation with Resident #43 conducted on 4/13/21 at 12:13 PM the resident was observed to have been on an air mattress for pressure relief. The resident stated she had a pressure ulcer to her sacrum. A review of the care plan for Resident #43, which was most recently updated on 4/14/21 revealed the following focus area: Resident #64 had an actual pressure ulcer related to the disease process of paraplegia, history of ulcers, immobility, and antiplatelet medication use. Further review revealed an intervention regarding the resident having indwelling urinary catheter related to incontinence and a stage IV injury to the sacrum. On observation was conducted on 4/15/21 at 9:48 AM of the dressing change for Resident #43 by Nurse #2. During the dressing change the resident was observed to have had a wound on her sacrum and was grape sized both in length/width and in depth. The wound was ulcerated below the skin surface to the point where pink tissue was exposed. The nurse completed the dressing change as ordered. During a phone interview conducted on 4/16/21 at 9:47 AM with wound physician he stated he has seen Resident #43 weekly or every other week for an extended period of time. He said he was treating her in March for the stage IV pressure ulcer and continued to treat the resident because the pressure ulcer has not yet healed. During an interview conducted with the MDS	F 641	coding the MDS, specifically, section M skin conditions. Regional MDS consultant and MDS coordinators will audit section M of 5 Minimum data sets per week x 12 weeks to ensure accuracy. After the 12 weeks the regional MDS consultant and MDS coordinators will review section M of 2 completed MDS□s during visits to ensure the facility maintains compliance Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee by MDS coordinator monthly x 3 months. At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 641	Continued From page 21 Coordinator on 4/16/21 at 2:40 PM she stated Resident #43 did have a stage IV pressure ulcer at the time of the 3/2/21 annual assessment and it was not coded correctly. She said the assessment should have been coded the resident had a pressure ulcer, and then it should have been coded the resident had a stage IV pressure ulcer. She said she had not completed the assessment due to having been out of the facility and an MDS nurse from another building had completed the assessment. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated it was her expectation for MDS assessments to be correct. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator said the MDS assessments needed to be accurate.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655		5/18/21

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F 655	Continued From page 22 (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: Based on record reviews and staff interviews the facility failed to initiate a baseline care plan for one of one resident (Resident #58) reviewed for baseline care plan. The findings included: Resident #58 was admitted to the facility on 3/22/21 with diagnoses which included:	F 655	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 58 did not have a baseline care plan completed but does have an initial care plan initiated on 3/22/21 and this has been updated to	

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F 655	Continued From page 23 Pneumonia, sepsis, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), renal failure, dependence on oxygen, and chronic respiratory failure. A review of Resident #58's Electronic Medical Record (EMR) conducted on 4/13/21 revealed her care plan at the time had two focus areas. One of the focus areas was the resident having been on restriction for visitation due to the COVID-19 pandemic, with an initiation date of 3/22/21, and the second was regarding the resident having had little or no activity involvement related to the resident ' s wishes not to participate, with an initiation date of 3/26/21. Further review of Resident #58 ' s EMR revealed no areas regarding a baseline care plan. An interview was conducted with the Minimum Datat Set (MDS) Coordinator (MDSC) and the regional nurse consultant on 4/16/21 at 2:31 PM. The MDS Coordinator said she had been out of the facility and had become behind on keeping up with the care plans. She said her corporate consultant helped as much as she could. She said there should be another person who would help her in the facility, but they don ' t have anyone in the building right now to help her. She said Resident #58 did not have a baseline care plan and she had just entered the information in the resident ' s care plan a couple of days ago. The MDS nurse said she was out of the facility when Resident #58 was admitted, and she had not worked on the resident ' s care plan. The MDS nurse stated the facility utilized the resident's regular care plan for the resident's baseline care plan. She further clarified the facility did not have a separate section,	F 655	reflect resident # 58 current status on 5/10/21 by the interdisciplinary team. " Address how the facility will identify other residents having the potential to be affected by the same. deficient practice. On 5/06/21 a review of baseline care plans for admissions starting 4/30/21 has been completed by the Director of Nursing (DON) and the minimum data set nurse (MDS) of current residents to ensure the baseline care is in place. No other residents have admitted to the facility. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 05/06/2021 The Minimum Data Set (MDS) nurse/Director of Nursing (DON) re-educated the licensed nurses to start the baseline care plan on admission with completion to reviewed and signed by an administrative nurse. Starting on 05/07/21 the MDS nurse will review the completion of the baseline care plan with the interdisciplinary team each morning meeting 5 x week for review to ensure the base line is reflective of the resident□s status and has been closed by an administrative nurse. The DON will audit all baseline care plans on admissions weekly for 12 weeks to ensure the care plan is reflective of the resident□s status.	

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F 655	Continued From page 24 assessment, or a notebook at the nurses' station with a baseline care plan for newly admitted residents. The regional nurse consultant stated she had opened the MDS assessment for Resident #58 but had not completed the baseline care plan. The consultant further added it was the expectation for each resident to have an up to date and accurate baseline care plan within 2 days of admission. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated the MDS nurse or her backup should have developed a baseline care plan for the resident. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator said the MDS nurse or her backup needed to develop a baseline care plan in a timely manner.	F 655	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The DON will report the results of the data collected by the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations and to determine the need for further auditing beyond the three (3) months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		5/18/21

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F 656	Continued From page 25 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop and implement a comprehensive care plan for one of two residents (Resident #58) reviewed for care plans. The findings included: Resident #58 was admitted to the facility on 3/22/21 with diagnoses which included: Pneumonia, sepsis, chronic obstructive pulmonary disease (COPD), congestive heart	F 656	1. Corrective action accomplished for those residents found to have been affected by the deficient practice. The care plan for resident #58 has been reviewed and updated by the Interdisciplinary Team. The Scheduled Care Plan meeting with the resident is on 5/11/21. 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken.	

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F 656	Continued From page 26 failure (CHF), renal failure, dependence on oxygen, and chronic respiratory failure. A review Resident #58 ' s admission comprehensive Minimum Data Set (MDS) assessment dated 3/30/21 revealed Resident #58 was cognitively intact. She had received speech, physical, occupational, and oxygen therapy, and dialysis. The resident pain interview indicated she had rated her pain as a 10 (on a scale of 1-10 with 10 indicating the worst pain) and had pain frequently. Medications noted as received included: antipsychotic, antidepressant, anticoagulant, antibiotic, and opioid. A review of Resident #58's care plans conducted on 4/13/21 revealed she had two focus areas. One of the focus areas was the resident having been on restriction for visitation due to the COVID-19 pandemic, with an initiation date of 3/22/21, and the second was regarding the resident having had little or no activity involvement related to the resident ' s wishes not to participate, with an initiation date of 3/26/21. During an interview conducted in conjunction with an observation on 4/13/21 at 2:53 PM Resident #58 stated she did smoke and had been out to smoke frequently since she was admitted. The resident was observed to be receiving oxygen via a nasal cannula from an oxygen concentrator in the room. The resident stated she used oxygen as needed since she was readmitted from the hospital. An interview was conducted with the Minimum Data Set (MDS) Coordinator (MDSC) and the regional nurse consultant on 4/16/21 at 2:31 PM. The MDSC said she had been out of the facility	F 656	A review has been completed on 5/7/2021 by the Director of Social Services on all current residents to ensure care plans are in place and have been updated. Any resident identified as not having a care plan will have one completed by 5/18/21. 3. Measure/ systemic changes put in place to ensure the deficient practice does not reoccur. The Licensed Staff will also be educated on 5/10/21 by the Director of Nursing on adding changes to the care plan as they occur. The Minimum data set nurse (MDS) and the interdisciplinary team will be re-educated on 5/7/21 by the regional MDS nurse regarding the completion of the care plan by the interdisciplinary team. 4. Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Director of Nursing, Nurse Manager or MDS consultant will audit 5 care plans per week for 4 weeks than 3x per week for 2 months. The Director of Nursing or MDS nurse will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance.	

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F 656	Continued From page 27 and had become behind on keeping up with the care plans. The MDSC said Resident #58 ' s care plan had not been developed within 7 days after the admission assessment. The MDSC further clarified the facility did not have a separate section, assessment, or a notebook at the nurses ' station with additional care plans and everything for a resident ' s care plan was in the computer. The regional nurse consultant stated she had opened the MDS assessment for Resident #58 but had not developed a full care plan for the resident. The consultant further added it was the expectation for each resident to have an up to date and accurate care plan within 7 days of the completion of the admission assessment. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated the MDS nurse or her backup should have developed a comprehensive care plan for the resident. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator stated it was his expectation for each resident ' s comprehensive care plan to be developed timely.	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.	F 657		5/18/21

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F 657	Continued From page 28 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to revise a care plan after completion of a quarterly assessment for 1 of 5 care plans reviewed for accidents (Resident #7). Findings included: Resident #7 was readmitted to the facility 1/4/2021 with diagnoses to include stroke, paralysis related to stroke. A care plan dated 3/21/2018 and revised 7/8/2019 addressed Resident #7 ' s need for help with bed mobility and specified that 1-person assistance was required for bed mobility. The most recent quarterly Minimum Data Set	F 657	1. Immediate action(s) taken for the resident(s) found to have been affected include: The bed mobility related care plans and the comprehensive care plan was updated for resident #7 on 5/7/2021 by the MDS Coordinator to reflect their current needs of 2-person assistance with bed mobility 2. Identification of other residents having the potential to be affected was accomplished by: On 5/7/2021, the MDS Coordinator reviewed the bed mobility related care plan and the comprehensive care plan for all current residents to ensure that each	

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F 657	Continued From page 29 (MDS) assessment dated 1/15/2021 assessed Resident #7 to be cognitively intact and to have range of motion impairment on one side of his body, both upper and lower extremities. The MDS assessed Resident #7 to require 2-person extensive assistance with bed mobility. The MDS documented Resident #7 ' s height as 75 inches (6 foot, 3 inches). Resident #7 ' s weight was documented at 348 pounds on 3/3/2021. No revisions were made to the care plan to reflect Resident #7 ' s need for 2-person assistance with bed mobility. Resident #7 was observed on 4/13/2021 at 2:23 PM. Resident #7 was noted to be in a bariatric bed. Resident #7 was noted to have left-sided paralysis. Resident #7 reported he required 2-person assistance to turn in bed, but the facility staff usually used only 1 person, especially during the evening and night shifts. An interview was conducted with the MDS nurse on 4/15/2021 at 3:44 PM. The MDS nurse reported some MDS assessments had been completed by a MDS nurse from another building and she was not certain if the care plan had been updated. The Regional MDS nurse was interviewed on 4/15/2021 at 4:00 PM. The Regional MDS nurse reported she did not know why the MDS and the care plan did not agree for Resident #7. The Regional MDS nurse reported the care plan should be updated after every comprehensive assessment and she was not certain why Resident #7 ' s care plan did not accurately reflect his need for 2-person assistance with bed	F 657	resident□s current needs for bed mobility was reflected in the care plan. No other care plans needed to be updated to reflect bed mobility. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Regional Director of Clinical reimbursement re-educated the Interdisciplinary team including the MDS Coordinator on care plan timing and revision requirements on 5/7/2021 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Starting on 5/18/21 The Director of Nursing or Nurse Manger will review the comprehensive care plan to ensure the care plans are reviewed and updated by the Interdisciplinary Team following the completion of each comprehensive and quarterly review assessment for five residents each week times two weeks, then three residents each week times two weeks, then two resident each week times eight weeks. The results of the comprehensive timing and revision audit will be presented by the Director of Nursing monthly times three months to the Quality Assurance Performance Improvement Committee, the committee. If issues are identified during the committee meeting, then additional education will be provided and modification of the plan of correction will be made to address the alleged deficient	

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F 657	Continued From page 30 mobility.	F 657	practice.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to provide nail care (Resident #8 and Resident #54), failed to provide a scheduled shower (Resident #8), failed to clear ear wax from a resident ' s ear (Resident #54) and failed to ensure residents facial hair was groomed (Residents #8 and #54). This was for 2 of 6 residents reviewed for Activities of Daily Living (ADL's) or personal hygiene. The findings included: 1. Resident #54 was admitted to the facility on 3/6/21 with multiple diagnoses which partly included: Dementia with behaviors, neurogenic bladder, cognitive decline, and an open wound to the left hip. The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 3/30/21 indicated Resident #54 had severe cognitive loss. The resident was coded as requiring extensive assistance of two people for all Activities of Daily Living (ADLs) or personal hygiene, including bathing, except for eating, in which he required extensive assistance of one person.	F 677	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 54 no longer in the facility and #8 have had all personal hygiene concerns addressed (showers, nail care, toenail care, facial hair trimmed, and ear cleaning) on 4/21/2021 by direct care staff. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that current residents that require assistance with personal hygiene have the potential to be affected. The Director of Nursing, Activities Director, Social workers and Administrator completed a visual inspection on 5/7/21 of all resident to ensure all personal hygiene needs had been met per their personal preferences (showers, nail care, toe nail care, facial hair trimmed, and ear cleaning) on 5/7/2021 Residents requiring specialized toenail care due to high risk conditions will	5/18/21

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F 677	Continued From page 31 Review of the facility resident shower schedule revealed Resident #54 was scheduled to receive a shower on second shift (3:00 PM to 11:00 PM) each Tuesday and each Friday. A review of the nursing progress notes from 4/8/21 through 4/15/21 revealed no refusals of nail care or personal care assistance documented. Resident #54 ' s care plan, which was most recently updated on 4/15/21, contained a focus area for the resident having an ADL or personal hygiene self-care performance deficit related to activity intolerance, aggressive behavior, confusion, and dementia. The interventions included: Check nail length, trim, and clean on bath day and as necessary. Report any changes to the nurse. Provide a sponge bath when a full bath or shower cannot be tolerated. The resident required extensive assistance by one staff with personal with personal hygiene and oral care. An observation of Resident #54 while he was in the smoking area was conducted on 4/13/21 at 11:10 AM. The resident was observed to have extensive, untrimmed, and ungroomed facial hair. Further observation revealed a raisin sized piece of brown ear wax visible in the resident ' s external right ear canal. Resident #54 was observed on 4/13/21 at 12:44 PM while in the dining area of the 100 hall. The resident was observed to have had extensive, untrimmed, and ungroomed facial hair. Further observation revealed a raisin sized piece of brown ear wax remained visible in the resident ' s external right ear canal. The resident ' s left hand	F 677	be referred to a podiatrist for appropriate care and treatment. All residents requiring in-depth ear cleaning were referred to the physician. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Direct care staff were educated on 5/10/2021 by the Director of Nursing - addressing the proper care of nails and toenails including resident preferences and high-risk conditions. The direct care staff were also provided education on the process for requesting podiatrist for residents that are in need to toenail care. The education included the resident preference on showers, facial hair removal, ear cleaning and overall hygiene. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/ supervisor/Assistant director of nursing or unit manager will complete a visual inspection of the residents personal hygiene (showers, Nail care, toe nail care, facial hair trimmed, and ear cleaning) for 10 residents weekly x 4 weeks, then 5 residents per week x4 weeks, then 2 residents per week x4 weeks or until compliance is achieved or as otherwise determined by the Quality Assurance Committee. The findings of the inspections will be presented to Quality assurance performance improvement committee monthly by the Director of	

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F 677	Continued From page 32	F 677		

was visible. The free edge of resident ' s fingernails was observed to extend beyond the end of the resident ' s fingers for all five fingers on the left hand and there was dark matter under the free edge for each finger on the left hand except for the pinky finger.

On 4/14/21 at 12:25 PM Resident #54 was observed while in bed in his room. The resident was observed to have had extensive, untrimmed, and ungroomed facial hair. Further observation revealed a raisin sized piece of brown ear wax remained visible in the resident ' s external right ear canal. The free edge of resident ' s fingernails was observed to extend beyond the end of the resident ' s fingers for all ten fingers and there was dark matter under the free edge for eight of the ten fingers. Inspection of the resident ' s toenails revealed the free edge of the toenail extended beyond the tip of 10 of 10 toenails.

Resident #54 was observed while in bed in his room on 4/14/21 at 4:29 PM. The resident was observed to have had extensive, untrimmed, and ungroomed facial hair. Further observation revealed a raisin sized piece of brown ear wax remained visible in the resident ' s external right ear canal. The free edge of resident ' s fingernails was observed to extend beyond the end of the resident ' s fingers for all ten fingers and there was dark matter under the free edge for eight of the ten fingers. Inspection of the resident ' s toenails revealed the free edge of the toenail extended beyond the tip of 10 of 10 toenails.

An observation was conducted on 4/15/21 at 8:22 AM of Resident #54 while in bed in his room. The

nursing monthly

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resident was observed to have had extensive, untrimmed, and ungroomed facial hair. Further observation revealed a raisin sized piece of brown ear wax remained visible in the resident ' s external right ear canal. The free edge of resident ' s fingernails was observed to extend beyond the end of the resident ' s fingers for all ten fingers and there was dark matter under the free edge for eight of the ten fingers. Inspection of the resident ' s toenails revealed the free edge of the toenail extended beyond the tip of 10 of 10 toenails.

An interview with Nursing Assistant (NA) #3 was conducted in conjunction with an observation of Resident #54 on 4/15/21 at 8:44 AM. The NA stated she usually had the resident but did not have the resident every day. The resident was observed to have extensive, untrimmed, and ungroomed facial hair. The NA stated the resident ' s beard appeared to need to be trimmed or shaved. Further observation revealed a raisin sized piece of brown ear wax remained visible in the resident ' s external right ear canal. The NA stated while performing daily care the resident ' s care, part of the care should include cleaning the resident ' s face and ears. The free edge of resident ' s fingernails were observed to extend beyond the end of the resident ' s fingers for all ten fingers and there was dark matter under the free edge for eight of the ten fingers. The NA stated nail care was usually provided on shower days, but she did not know when the resident ' s shower was. She stated regardless of when the resident ' s shower was, he needed fingernail care. Inspection of the resident ' s toenails revealed the free edge of the toenail extended beyond the tip of 10 of 10 toenails. The NA stated she would need to check with the

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nurse to see if the resident was a diabetic and if she could trim his toenails or not, but she stated if she could not trim them, she would request they be trimmed because they needed to be trimmed. Additionally, the resident was observed to have had what appeared to have been food around his mouth and in his beard and visible flakes of skin and dandruff in his hair. The NA stated the resident ' s face needed to be cleaned as well as his hair needed to be washed.

An observation was conducted in conjunction with an interview on 4/15/21 at 8:55 AM with the evening supervisor regarding Resident #54. He stated the resident ' s beard needed to be shaved or trimmed due to its appearance. He further stated the resident needed nail care to his fingernails and toenails due to the length of the nails and having many fingernails with dark matter under the nails. He said he was not aware if the resident was a diabetic or not, but regardless, he needed toenail care. He clarified it was the responsibility of the NAs to provide care for the residents such as trimming or shaving a resident ' s beard, providing nail care, and general bathing of the resident. He explained it would also be expected for the resident ' s ears to be cleaned as part of bathing as well as washing the resident ' s hair.

An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated it was her expectation for a resident ' s personal hygiene to be completed.

An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator said he expected for residents to receive personal hygiene.

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Due to Resident #54 ' s severe cognitive loss he was unable to be interviewed regarding his feeling about the lack of a privacy cover on his urinary drainage bag.
2. Resident #8 was admitted to the facility 10/30/2019 and readmitted 1/19/2021 with diagnoses to include lung disease, weakness and hypertension. The most recent annual Minimum Data Set (MDS) assessment dated 10/16/2020 assessed Resident #8 to be cognitively intact and he required extensive assistance with dressing, hygiene and total assistance with toileting and bathing.

A care plan dated 11/24/2019 and revised on 3/4/2021 addressed Resident #8 ' s need for bathing, dressing, hygiene, and toileting assistance. Interventions included to check nail length and trim and clean on bath day and as necessary. Additional interventions included to provide extensive assistance with personal hygiene and showering.

The shower schedule for the facility was reviewed and Resident #8 was scheduled to receive a shower on Tuesday and Friday during 2nd shift (3:00 PM to 11:00 PM) each week.

The bathing record for Resident #8 was reviewed from 2/28-3/15/2021 and 3/23-4/16/2021. It was documented Resident #8 received a shower on 3/9/2021, 3/23/2021 and 4/9/2021. Bathing documentation for 3/15-22/2021 was not available for review.

Resident #8 was observed on 4/13/2021 at 12:22 PM. Resident #8 was unshaven and had facial hair approximately ¼ inch long covering his face,

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chin, and neck. The hair on his head appeared to be oily and uncombed. Resident #8 ' s fingernails extended beyond the tip of his fingers approximately 1/8 of an inch and a dark brown substance was under each nail. Resident #8 reported he had not had a shower for several days and he reported he rarely was given a shower. Resident #8 reported he wanted his face shaved and he did not like the facial hair. Resident #8 reported he felt his nails needed to be clipped and he thought that should be done with his shower. Resident #8 reported he would like a shower at least twice per week.

Resident #8 was observed on 4/14/2021 at 9:53 AM in bed. Resident #8 face was not shaved, his hair was disheveled and oily appearing and all the nails on both hands extended past his fingertips on all fingers and had a dark brown substance under all nails.

Resident #8 was observed on 4/14/2021 at 4:53 PM. Resident #8 ' s hair was clean, but not combed, his face was shaved, but his chin and neck had ¼ inch long beard. Resident #8 ' s fingernails extended 1/8 inch beyond his fingertips on all fingers, and there was a faint brown substance noted under each of the nails. Resident #8 reported he had received a shower that afternoon. Resident #8 reported he had asked to have his nails trimmed. Resident #8 reported he had told the nursing assistant (NA) to stop shaving his neck and chin because the razor was pulling, and he wanted his family to bring in an electric beard trimmer to clip the hair shorter to be shaved. Resident #8 reported he felt cleaner and enjoyed his shower.

An interview was conducted with NA #8 on

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4/14/2021 at 4:38 PM. NA #8 reported he checked the list of showers when his shift started and offered showers to the residents during his shift. He reported he had not showered Resident #8 on 4/14/2021 and he was not certain why Resident #8 was showered on a Wednesday instead of his shower day Tuesday.

NA #4 was interviewed on 4/15/2021 at 7:50 AM. NA #4 reported Resident #8 received a shower on Tuesday and Friday and she did not know why he received a shower on 4/14/2021 (Wednesday). NA #4 reported she had shaved Resident #8 during the day shift on 4/14/2021 and because the beard hair was so long on his neck and chin, Resident #8 had requested she stop and wait for his family to bring in the electric beard trimmer. NA #4 reported she shaved male residents when they had facial hair and when they requested to be shaved.

NA #7 was interviewed on 4/15/2021 at 3:05 PM. NA #7 reported she shaved Resident #8 often, but it had been several days since she had been assigned to Resident #8.

The NA assigned to Resident #8 on 4/13/2021 was not available to interview.

The Director of Nursing (DON) was interviewed on 4/16/2021 at 3:47 PM. The DON reported she did not know why Resident #8 had only 3 showers documented since 2/28/2021. The DON reported she had not been told that residents were not being showered. The DON reported she was not aware that Resident #8 wanted to receive 2 showers per week. The DON reported she expected nails to be cleaned and trimmed and facial hair to be shaved according to the resident

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to provide evidence of treatments provided as ordered for 1 of 2 sampled residents (Resident #54) reviewed for wound care. Findings included: Resident #54 was admitted to the facility on 3/6/21 with multiple diagnoses which partly included: Dementia with behaviors, neurogenic bladder, cognitive decline, and an open wound to the left hip. The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 3/30/21 indicated Resident #54 had severe cognitive loss. The resident was coded as requiring extensive assistance of two people for all Activities of Daily Living (ADLs) except for eating, in which he required extensive assistance of one person. The resident was receiving applications of non-surgical dressings other than	F 684	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 54 was discharged on 4/14/2021. 2. Identification of other residents having the potential to be affected was accomplished by: Current residents receiving wound treatments have the potential to be affected. Current residents receiving wound treatments were assessed and documentation will be reviewed by the Director of Nursing/Unit manager or Assistant director of nursing by 5/14/21 to ensure wound care is completed per physician orders. 3. Actions taken/systems put into place to reduce the risk of future occurrence	5/18/21

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F 684	Continued From page 39 to feet, applications of ointments/medications other than to feet, and application of dressing to feet (with or without topical medications). Resident #54 ' s care plan, which was most recently updated on 4/15/21, contained a focus area for the resident was admitted to the facility with an unspecified open wound to the left hip. The listed interventions included to administer the treatments as ordered and to monitor for effectiveness. A review of Resident #54 ' s electronic medical record (EMR) revealed the following: · An order dated 3/6/21 which read, apply protective ointment to buttocks and coccyx every shift. · An order dated 3/7/21 which read, Clotrimazole-Betamethasone 1-0.05%, apply to groin and inner thigh topically every day and evening shift for irritation until healed. Review of Resident #54 ' s April Treatment Administration Records (TAR ' s) from 4/1/21 to 4/15/21 revealed the following days with documentation of the prescribed wound care: · An order dated 3/6/21 which read, apply protective ointment to buttocks and coccyx every shift. Treatment was documented as provided for 27 of the 43 opportunities. The other opportunities were blank. · An order dated 3/7/21 which read, Clotrimazole-Betamethasone 1-0.05%, apply to groin and inner thigh topically every day and evening shift for irritation until healed. Treatment was documented as provided for 13 of the 29 opportunities. The other opportunities were blank.	F 684	include: On 5/10/21 the Director of Nursing or Nurse Manager started re-education of all licensed nurses on completing treatments as ordered and proper documentation of treatments provided to residents. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing/unit manager or Assistant director of nursing will verify by watching treatments being completed and reviewing documentation of treatments on 10 residents per week for 4 weeks, then 5 residents a week for 8 weeks. The Director of Nursing will present the results of visual watching of the treatments and review of documentation to the Quality assurance and performance improvement committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent compliance has been met.	

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An interview was conducted on 4/16/21 at 8:51 AM with Nurse #2. She said she had not seen where treatments from the previous days for treatments to Resident #54 were not signed off until she reviewed the April 2021 TAR. She said she was taught if the if the treatment was not signed off, it was not done, but she did not know if the treatments which were not signed off for the resident were completed or not. She said she did not know how come the treatments were not signed off. She said there was some confusion because there was a lack of consistency as to where the treatments for residents were located. She stated Resident #43 ' s treatment was located in the Medication Administration Record (MAR), but Resident #54 ' s treatments were located in the TAR.

Through record review of the schedules Nurse #5 was observed to have worked on several of the days including 4/14/21.

A phone interview was conducted with Nurse #5 on 4/16/21 at 10:28 AM. She stated there were no dressings or treatments due for Resident #54 when she had worked and hadn ' t completed any dressings or treatments on him. She said she was unable to do dressing changes or treatments because she frequently had to stop her medication pass to assist with bed baths and resident care. She said there was a heavy workload on the 100 hall side and she was unable to do dressing changes or treatments. She said there were several residents who would frequently yell on the 100 hall and there were not enough staff available because the staff who working were helping other residents. She said the Medication Aide (MA) may stay till 8:00 PM but then she has to do the evening medication

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pass and the treatments on her own. She further explained she felt like she had to help the Nursing Assistants (NAs) because they needed more help.

During a second interview conducted with the evening supervisor on 4/16/21 at 1:56 PM he stated he had done the treatments on Resident #54 the morning of 4/15/21 before the resident went out to the hospital, but Nurse #2 had signed them off. He explained he went to go sign off the treatments in the TAR that he had completed them, but when he checked the TAR Nurse #2 had already signed them off and once someone signs out a treatment as completed, it cannot be undone.

A second interview was conducted with Nurse #2 on 4/16/21 at 2:06 PM. During the interview she stated she had completed the wounds on Resident #54 prior to him going out to the hospital on 4/15/21 and had signed off in the MAR the dressings were completed. When she reviewed the MAR, she stated she had signed off for a dressing change to the resident ' s right hip, but she had not done that dressing change. She further explained she usually worked on the 200 side of the facility, but when she worked on the 100 side of the facility, she would often notice treatments which weren ' t completed or signed off. She added, she believed if the treatments were ordered, the treatments should be completed, and signed off. She said on the 100 hall side, there was usually one nurse, and two medication aides (MAs). She explained, the nurse should be able to complete and sign off the treatments because the MAs were passing out all of the medications.

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F 684	Continued From page 42 During a phone interview conducted on 4/16/21 with the wound physician he stated he had not seen where any of Resident #54 ' s wounds had declined since he was admitted. The physician further stated it was his expectation for dressings to be applied as ordered. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated it was her expectation for treatments to be provided as ordered as well as the appropriate charting and documentation of the treatment. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator said it was his expectation for treatments to be provided as ordered. Due to Resident #54 ' s severe cognitive loss he was unable to be interviewed regarding when his dressings were changed. Attempts to interview Nurse #4 who was assigned to provide treatment during the day shift on 4/14/21 to Resident #54 were unsuccessful.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		5/18/21

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F 686	Continued From page 43 (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 record review, observation, and staff interviews, the facility failed to provide evidence of treatments provided as ordered for 1 of 2 sampled residents (Resident #54) reviewed for pressure ulcers. Findings included: Resident #54 was admitted to the facility on 3/6/21 with multiple diagnoses which partly included: Dementia with behaviors, neurogenic bladder, cognitive decline, and an open wound to the left hip. The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 3/30/21 indicated Resident #54 had severe cognitive loss. The resident was coded as requiring extensive assistance of two people for all Activities of Daily Living (ADLs) except for eating, in which he required extensive assistance of one person. The resident was coded as having had one or more stage I or greater pressure ulcers. The resident ' s pressure ulcers included: A stage IV pressure ulcer, 3 unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar (one of which present upon admission), and 1 unstageable pressure ulcers with suspected deep tissue injury in evolution which was present upon admission. The resident was receiving pressure ulcer care, applications of non-surgical dressings other than	F 686	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 54 was discharged from the facility and did not return. 2. Identification of other residents having the potential to be affected was accomplished by: Current residents receiving wound treatments have the potential to be affected. Current residents receiving wound treatments will assessed and documentation will be reviewed by the Director of Nursing/unit manager or assistant director of nursing by 5/14/21 to ensure wound care has completed per physician orders 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 5/11/21 the Director of Nursing / Nurse Manager will start the education of all licensed nursing staff on proper wound care and documentation of treatments provided to residents per physician orders.	

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F 686	Continued From page 44 to feet, applications of ointments/medications other than to feet, and application of dressing to feet (with or without topical medications). Resident #54 ' s care plan, which was most recently updated on 4/15/21, contained a focus area for the resident having the potential for pressure ulcer development related to immobility and the resident was admitted to the facility with an unspecified open wound to the left hip. The listed interventions included to administer the treatments as ordered and to monitor for effectiveness. A review of Resident #54 ' s electronic medical record (EMR) revealed the following: 1. An order dated 3/6/21 which read, cleanse area to the left hip with wound cleanser/Normal Saline (NS), pat dry, prep surrounding skin with protective barrier wipe, apply absorbent foam dressing. Change every 3 days. There was no discontinue date for this order. 2. An order dated 3/7/21 which read, cleanse area to the left heel with wound cleanser/Normal Saline (NS). Apply protective ointment to wound edges. Apply wound gel to wound bed. Cover the wound with saline moist gauze. Unfluff gauze and fold over wound bed. Cover with petroleum jelly gauze and an ABD pad (a large absorbent dressing). Wrap to ankle with woven gauze. Change daily. There was no discontinue date for this order. 3. An order dated 3/7/21 which read, cleanse area to the right ankle with wound cleanser. Apply protective ointment liberally to intact skin and wound bed. Apply wound gel to wound bed. Cover the wound with saline moist gauze. Cover open area with petroleum jelly gauze. Wrap toe to above ankle with woven gauze. Change daily,	F 686	4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or unit manager will monitor wound care / dressings on 10 residents per week for 4 weeks, then 5 residents every week for 8 weeks. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent compliance has been met.	

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every evening shift. There was no discontinue date for this order.
4. An order dated 4/13/21 which read, cleanse left heel, apply full strength hypochlorite solution soaked gauze for packing, cover with an ABD pad and wrap with woven gauze, every day shift for wound care.
5. An order dated 4/13/21 which read, cleanse left lateral ankle, apply full strength hypochlorite solution and cover with a dry dressing, every day for wound care.
6. An order dated 4/13/21 which read, cleanse left lateral hip, apply crushed flagyl (an antibiotic) to the wound bed, then apply full strength hypochlorite solution soaked gauze for packing, cover with an ABD pad and then skin prep periwound (around the wound bed), every day shift for wound care.
7. An order dated 4/13/21 which read, cleanse left medial ankle, apply full strength hypochlorite solution and a dry dressing, every day shift for wound care.
8. An order dated 4/13/21 which read, cleanse right hip, apply crushed flagyl (an antibiotic) to the wound bed, then apply full strength hypochlorite solution soaked gauze for packing, cover with an ABD pad and then skin prep periwound (around the wound bed), every day shift for wound care.
9. An order dated 4/13/21 which read, Hypochlorite solution (full strength) 0.05% apply to wounds as ordered topically, every day shift for wound care.
10. An order dated 4/13/21 which read, skin prep left lateral foot daily, every day shift for wound care.
11. An order dated 4/13/21 which read, skin prep right lateral ankle daily, every day shift for wound care.

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Review of Resident #54 ' s April Treatment Administration Records (TAR ' s) from 4/1/21 to 4/15/21 revealed the following days with documentation of the prescribed wound care:

1. An order dated 3/6/21 which read, cleanse area to the left hip with wound cleanser/Normal Saline (NS), pat dry, prep surrounding skin with protective barrier wipe, apply absorbent foam dressing. Change every 3 days. There was no discontinue date for this order. Treatment was documented as provided for 0 of the 3 opportunities from the order date of 3/6/21.

2. An order dated 3/7/21 which read, cleanse area to the left heel with wound cleanser/Normal Saline (NS). Apply protective ointment to wound edges. Apply wound gel to wound bed. Cover the wound with saline moist gauze. Unfluff gauze and fold over wound bed. Cover with petroleum jelly gauze and an ABD pad (a large absorbent dressing). Wrap to ankle with woven gauze. Change daily. There was no discontinue date for this order. Treatment was documented as provided for 4 of the 14 opportunities. The treatment was to be provided during the evening shift. The other opportunities were blank.

3. An order dated 3/7/21 which read, cleanse area to the right ankle with wound cleanser. Apply protective ointment liberally to intact skin and wound bed. Apply wound gel to wound bed. Cover the wound with saline moist gauze. Cover open area with petroleum jelly gauze. Wrap toe to above ankle with woven gauze. Change daily, every evening shift. There was no discontinue date for this order. Treatment was documented as provided for 4 of the 14 opportunities. The treatment was to be provided during the evening shift. The other opportunities were blank.

4. An order dated 4/13/21 which read, cleanse left heel, apply full strength hypochlorite solution

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soaked gauze for packing, cover with an ABD pad and wrap with woven gauze, every day shift for wound care. Treatment was documented as provided for 2 of the 3 opportunities. The treatment was to be provided during the day shift. The other opportunity was blank.
5. An order dated 4/13/21 which read, cleanse left lateral ankle, apply full strength hypochlorite solution and cover with a dry dressing, every day for wound care. Treatment was documented as provided for 2 of the 3 opportunities. The treatment was to be provided during the day shift. The other opportunity was blank.
6. An order dated 4/13/21 which read, cleanse left lateral hip, apply crushed flagyl (an antibiotic) to the wound bed, then apply full strength hypochlorite solution soaked gauze for packing, cover with an ABD pad and then skin prep periwound (around the wound bed), every day shift for wound care. Treatment was documented as provided for 2 of the 3 opportunities. The treatment was to be provided during the day shift. The other opportunity was blank.
7. An order dated 4/13/21 which read, cleanse left medial ankle, apply full strength hypochlorite solution and a dry dressing, every day shift for wound care.
8. An order dated 4/13/21 which read, cleanse right hip, apply crushed flagyl (an antibiotic) to the wound bed, then apply full strength hypochlorite solution soaked gauze for packing, cover with an ABD pad and then skin prep periwound (around the wound bed), every day shift for wound care. Treatment was documented as provided for 2 of the 3 opportunities. The treatment was to be provided during the day shift. The other opportunity was blank.
9. An order dated 4/13/21 which read, Hypochlorite solution (full strength) 0.05% apply

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to wounds as ordered topically, every day shift for wound care. Treatment was documented as provided for 2 of the 3 opportunities. The treatment was to be provided during the day shift. The other opportunity was blank.
10. An order dated 4/13/21 which read, skin prep left lateral foot daily, every day shift for wound care. Treatment was documented as provided for 2 of the 3 opportunities. The treatment was to be provided during the day shift. The other opportunity was blank.
11. An order dated 4/13/21 which read, skin prep right lateral ankle daily, every day shift for wound care. Treatment was documented as provided for 2 of the 3 opportunities. The treatment was to be provided during the day shift. The other opportunity was blank.

Resident #54 was observed to be in his room in his bed on 4/15/21 at 8:22 AM. The resident was observed to have a dressing on his left foot/ankle which was dated 4/13/21.

An interview with the evening supervisor was conducted in conjunction with an observation of Resident #54 on 4/15/21 at 8:55 AM. He stated the dressing on the left foot/ankle was dated 4/13/21, however, he did not know when the dressing had last been changed. Further observation revealed the resident had a pressure ulcer wound to the left hip, the diameter of a ping pong ball, with packing remaining in the wound, with no dressing covering the packing, and serosanguinous (yellow with some pink tinge) drainage on his incontinence brief which was near the wound. He stated the resident's condition had declined and they were awaiting communication from hospice regarding a possible discharge to the local hospital. He further stated

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he was not familiar with the orders for the resident ' s dressings, but the left foot/ankle dressing appeared to need to be changed, and the wound to the left hip also needed to be changed because there was nothing covering the wound packing. He further stated hospice nursing provided no wound care to the resident, the wound care was provided by the facility nurses.

An interview was conducted on 4/16/21 at 8:51 AM with Nurse #2. She said she had not seen where treatments for pressure ulcers and other wounds from the previous days for treatments to Resident #54 were not signed off until she reviewed the April 2021 TAR. She said she was taught if the if the treatment was not signed off, it was not done, but she did not know if the treatments which were not signed off for the resident were completed or not. She said she did not know how come the treatments were not signed off. She said there was some confusion because there was a lack of consistency as to where the treatments for residents were located. She stated Resident #43 ' s treatment was located in the Medication Administration Record (MAR), but Resident #54 ' s treatments were located in the TAR.

Through record review of the schedules, Nurse #5 was observed to have worked on several of the days including 4/14/21.

Review of Resident #54 ' s progress notes for a period of 4/8/21 through 4/15/21, revealed one nursing progress note which documented wound care provided for the resident. The entry was on 4/13/21 and was timed at 3:58 PM. The entry documented the resident ' s right hip was

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cleansed, and the prescribed treatment of applying full strength hypochlorite solution soaked gauze for packing and then covering with an ABD pad was applied. However, the prescribed application of crushed flagyl was not completed due to the medication not having arrived from the pharmacy.

A phone interview was conducted with Nurse #5 on 4/16/21 at 10:28 AM. She stated there were no dressings due for Resident #54 when she had worked and hadn ' t completed any dressings on him. She said she was unable to do dressing changes because she frequently had to stop her medication pass to assist with bed baths and resident care. She said there was a heavy workload on the 100 hall side and she was unable to do dressing changes. She said there were several residents who would frequently yell on the 100 hall and there were not enough staff available because the staff who working were helping other residents. She said the Medication Aide (MA) may stay till 8:00 PM but then she has to do the evening medication pass on her own and do the treatments. She further explained she felt like she had to help the Nursing Assistants (NAs) because they needed more help.

During a second interview conducted with the evening supervisor on 4/16/21 at 1:56 PM he stated he had done the treatments to the pressure ulcers and other wounds on Resident #54 the morning of 4/15/21 before he went out to the hospital, but Nurse #2 had signed them off. He explained he went to go sign off the treatments in the TAR that he had completed them, but when he checked the TAR Nurse #2 had already signed them off and once someone signs out a treatment as completed, it cannot be

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undone.

A second interview was conducted with Nurse #2 on 4/16/21 at 2:06 PM. During the interview she stated she had completed the treatment to the pressure ulcers and other wounds on Resident #54 prior to him going out to the hospital on 4/15/21 and had signed off in the MAR the dressings were completed. When she reviewed the MAR, she stated she had signed off for a dressing change to the resident ' s right hip, but she had not done that dressing change. She further explained she usually worked on the 200 side of the facility, but when she worked on the 100 side of the facility, she would often notice treatments which weren ' t completed or signed off. She added, she believed if the treatments were ordered, the treatments should be completed, and signed off. She said she did do the treatment to the left hip of Resident #54 because the dressing had fallen off but she could not sign off the dressing as having been completed, because the dressing was ordered to be changed every 3 days and it was not due to be changed. She said the order should have been written to change the dressing every 3 days and as needed, then she would have been able to sign off the dressing as having been changed. She further stated she did remove the dressing on the left foot/ankle of Resident #54 which was dated 4/13/21, she did see the treatment was not signed off for the dressing on 4/14/21, and she stated the dressing did not appear to have been changed as ordered. She said on the 100 hall side, there was usually one nurse, and two medication aides (MAs). She explained, the nurse should be able to complete and sign off the treatments because the MAs were passing out all of the medications.

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F 686	Continued From page 52 During a phone interview conducted on 4/16/21 with the wound physician he stated he had not seen where any of Resident #54 ' s wounds had declined since he was admitted. The physician further stated it was his expectation for dressings to be applied as ordered. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated it was her expectation for pressure ulcers to be treated to be treated as ordered as well as the appropriate charting and documentation of the treatment. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator said it was his expectation for pressure ulcers to be treated as ordered. Due to Resident #54 ' s severe cognitive loss he was unable to be interviewed regarding when his dressings were changed. Attempts to interview Nurse #4 who was assigned to provide treatment during the day shift on 4/14/21, the day the treatments were not signed off as provided, to Resident #54 were unsuccessful.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		5/18/21

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F 689	Continued From page 53 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, facility staff, dialysis staff, and physician interviews, the facility failed to repair a broken bed side rail that was missing from a bariatric bed for 1 of 5 residents reviewed for accidents (Resident #7). Additionally, 1-person assistance for bed mobility was used for Resident #7 who was assessed to require 2-person assistance. The facility failed to conduct a root cause analysis related to the fall and implement interventions to prevent further occurrences. Findings included: Resident #7 was readmitted to the facility 1/4/2021 with diagnoses to include stroke, paralysis related to stroke and obesity. The most recent quarterly Minimum Data Set (MDS) assessment dated 1/15/2021 assessed Resident #7 to be cognitively intact and to have range of motion impairment on one side of his body, both upper and lower extremities. The MDS assessed Resident #7 to require 2-person extensive assistance with bed mobility. The MDS documented Resident #7 ' s height as 75 inches (6 foot, 3 inches). Resident #7 ' s weight was documented at 348 pounds on 3/3/2021. A care plan dated 3/21/2018 and revised 7/8/2019 addressed Resident #7 ' s need for help with bed mobility and specified that 1-person assistance was required for bed mobility. A nursing change in condition form written by Nurse #6 dated 3/3/2021 was reviewed. The	F 689	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #7 had the side rail on the bed replaced on 4/14/2021 by maintenance. The Certified nursing assistants that are assigned to resident # 7 was educated by the Director of Nursing that resident #7 require 2-person extensive assistance with bed mobility. The Minimum data set nurse (MDS)/ Staff development nurse or Director of nursing updated the CNA task section and the nursing Care Plan to reflect the assistance requirements and bed mobility for resident # 7/ 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that current residents that require assistance with bed mobility have the potential to be affected along with residents that require side rails. Director of Maintenance audited all resident beds with side rails for proper placement and function on 5/12/21 The MDS Coordinator/unit manager reviewed the Plan of care to develop a list of residents that have been assess and require side rails. The Minimum data set nurse (MDS)/ Staff development nurse or Director of nursing updated the CNA task section and the nursing Care Plan to	

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F 689	Continued From page 54 form documented a fall out of bed at 9:00 PM on 3/3/2021. The note documented that Resident #7 rolled off the bed during incontinence care. Nurse #7 notified the physician and a mobile x-ray was ordered of the right hip and elbow. The radiology report dated 3/3/2021 reported no fracture due to the fall. Work orders and records of completed repairs for the facility were not available. The dialysis center social worker was interviewed on 4/13/2021 at 11:37 AM. The dialysis center social worker reported Resident #7 had told the dialysis center staff the bed side rail was broken on his bed and the facility staff were using 1 person to turn him in the bed and he had fallen out of the bed on 3/3/2021. The dialysis center social worker reported Resident #7 had bruising on the right side of his body on 3/5/2021 when he came to dialysis. The dialysis center social worker reported that Resident #7 told the dialysis center staff he had reported the broken bed side rail to facility staff, but it had not been repaired. Resident #7 was observed on 4/13/2021 at 2:23 PM. Resident #7 was noted to be in a bariatric bed. A bed side rail was in place on the right side of the upper portion of the bed and on the left lower portion of the left side of the bed. The side rail area on the left upper side of the bed did not have a side rail and the rail was noted to be sitting on the floor beside the bed. Resident #7 was interviewed during the observation. Resident #7 reported the upper left bed rail had been broken "for months." Resident #7 was not able to give a specific date that the bedrail broke, but reported he had an incident in March when he slid	F 689	reflect the assistance requirements and bed mobility for all residents 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Director of Maintenance placed a maintenance repair binder at each nurse's station to allow the nurses and any other staff to communicate any issues with side rails or any other maintenance issues. The maintenance director will review the book Monday thru Friday. Director of Maintenance audited all resident beds with side rails for proper placement and function on 5/12/21 and every two weeks thereafter for 1 month, then monthly for 2 months. Upon completion of the audit sheet will be submitted to the Administrator for review. MDS to update the CNA task upon resident admission and as change indicates. As of 5/18/21 The Director of Nursing will be review documentation after a fall to ensure a root cause analysis is conducted to determine the cause and to ensure interventions are implemented. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance will check 5 residents that require beds with side rails to ensure placement and function of the rails. The	

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F 689	Continued From page 55 out of the bed during care because the bedrail was not in place. Resident #7 reported he had rolled out of bed and hit his right hip and elbow. Resident #7 reported he was bruised from the fall, but nothing was fractured. Resident #7 reported he had told multiple staff members the side rail was broke, but it had not been repaired. An interview was conducted with nursing assistant (NA) #4 on 4/15/2021 at 7:50 AM. NA #4 reported she had provided care to Resident #7 frequently and the upper left side rail had been broken "for months", but she was unable to report a specific date. NA #4 reported Resident #7 was able to turn in bed and hold himself to the side for care. NA #4 stated there was a clipboard with a repair request form attached and if equipment was broken and needed repaired, staff were supposed to fill out the form. NA #4 reported that usually staff told the maintenance staff about repairs that needed to be done and did not use the clipboard repair request form. NA #5 was interviewed on 4/15/2021 at 7:50 AM. NA #5 reported the maintenance repair log was on the wall, but she usually told the housekeeping manager if something needed repaired. The housekeeping director (HK) was interviewed on 4/15/2021 at 8:02 AM. The HK reported he repaired minor things in the facility. The HK reported bed repair was usually given to the maintenance director to address. Resident #7 was observed on 4/15/2021 at 12:30 PM. The left upper side rail was attached. Resident #7 reported the bed rail was repaired when he returned from dialysis on 4/14/2021. NA #1 was interviewed on 4/15/2021 at 12:34	F 689	administrator will review 5 medical records of residents with falls weekly to ensure a root cause analysis is completed and interventions are in place for 12 weeks. The This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent compliance has been met.	

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PM. NA #1 reported Resident #7 ' s bed side rail had been broken for "months", but she was unable to give an exact time frame. NA #1 reported Resident #7 was able to turn himself in bed with 1-person assistance, but she used a 2nd person for his safety.
The maintenance director (MTD) was interviewed on 4/15/2021 at 1:33 PM. The MTD reported he had been working at the facility for 1 month and he checked the repair request log daily, but usually staff verbally notified him of equipment needing repairs and he would fix it. The MTD reported he repaired Resident #7 ' s bed on 4/14/2021. The MTD reported 4/14/2021 was the first time he had repaired Resident #7 ' s bed.

The Regional MDS nurse was interviewed on 4/15/2021 at 4:00 PM. The Regional MDS nurse reported she did not know why the care plan had not been updated after Resident #7 ' s fall out of bed on 3/3/2021 and she did not know why the MDS and the care plan did not match.

Nurse #7 was interviewed on 4/15/2021 at 11:14 PM. Nurse #7 reported she was working the night of 3/3/2021 when Resident #7 rolled out of the bed during care. Nurse #7 reported she was called to the room by NA #6 when Resident #7 rolled out of the left side of the bed and hit his right hip and elbow. Nurse #7 reported Resident #7 was able to roll in the bed and hold himself to the side by using the bed side rail and only one staff member would assist him with care. Nurse #7 reported she was not aware the bed side rail was broken until Resident #7 fell. Nurse #7 reported she wrote a note for the bed side rail on a sticky note at the nursing station and reported the broken bed side rail to the next shift. Nurse #7 reported she did not know if the repair had been

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F 689	Continued From page 57	F 689		

completed.

NA #6 was interviewed on 4/15/2021 at 11:19 PM. NA #6 reported she had been providing care to Resident #7 on 3/3/2021 when he rolled out of the bed and hit his right arm and hip. NA #6 reported she provided care to Resident #7 by herself because he was able to hold himself on his side. NA #6 reported was not aware Resident #6 required 2-person assistance with bed mobility. NA #6 reported the bed side rail had been broken "for a long time" prior to his accident. NA #6 reported Resident #7 used the left lower side rail to hold on to when she provided care to him, but on 3/3/2021 he had slid out of bed. NA #6 reported the bed side rail remained broken after 3/3/2021.

The certified occupational therapist aide (COTA) was interviewed on 4/16/2021 at 12:37 PM. The COTA explained she had provided occupational therapy to Resident #7 from 10/9-12/7/2020. The COTA reported she had communicated to nursing staff the bed side rail was broken during Resident #7 ' s treatment period from 10/9-12/7/2020, but she did not recall the staf or the date she reported the broken rail.

The facility physician (MD) was interviewed on 4/16/2021 at 2:14 PM. The MD reported Resident #7 had reported the broken and missing bed side rail to her. The MD reported she had told nursing staff but did not recall the staff member ' s name or the date.

The Administrator was interviewed on 4/16/2021 at 4:08 PM. The Administrator reported the facility did not have a MTD for 2 months and during that time, MTD and maintenance staff visited from

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F 689	Continued From page 58 other facilities to assist with repairs. The Administrator reported during the time without a MTD he would have a written list of repairs that needed completed and the visiting maintenance staff would complete as much as possible. The Administrator reported he was not aware Resident #7 ' s bed side rail was broken, or that Resident #7 slid out of the bed during care on 3/3/2021 due to the broken bed side rail. The Administrator reported he expected repair requests be kept on the log and the MDT to check the log daily and make timely repairs to broken equipment.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		5/18/21

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F 690	Continued From page 59 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, resident and physician interviews, the facility failed to obtain orders regarding indwelling catheter care in 2 of 3 residents reviewed, orders to change the catheter in 2 of 3 residents reviewed and failed to secure the urinary catheter drainage tubing for 1 of 3 residents reviewed for indwelling urinary catheter (Residents #43, #45, #54). The findings included: 1. Resident #45 was admitted to the facility on 03/12/21 with diagnoses that included paraplegia, neuromuscular dysfunction of bladder, acute kidney failure, diabetes and muscle weakness. The care plan dated 03/12/21 indicated Resident #45 had a urinary catheter due to the diagnosis of neuromuscular dysfunction of the bladder. There were no interventions listed to change the urinary catheter, provide catheter care or a leg strap to secure the catheter or empty the drainage bag. Resident #45's admission Minimum Data Set (MDS) assessment dated 03/24/21 noted she was cognitively intact. She was totally dependent	F 690	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #45 had orders for catheter care, leg strap and frequency for catheter changes written on 4/20/21. Resident #45 treatment plan was updates with urinary catheter interventions on 3/24/21. Resident #54 orders were corrected on 4/14/21 to reflect urinary catheter in place with size and balloon size, provide catheter care, secure the drainage tubing with a leg strap, and empty the drainage bag. Resident #54 treatment plan was updates with urinary catheter interventions on 3/11/21. Resident #43 had an order written to secure the drainage tubing to a leg strap on 4/14/2021. 2. Identification of other residents having the potential to be affected was accomplished by:	

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F 690	Continued From page 60 with bed mobility, transfers and toileting and required the assistance of 2 people. The MDS assessment noted she required extensive assistance and 2 people for personal hygiene. It indicated Resident #45 was always incontinent and had an indwelling catheter. Review of Resident #45's hospitalization from 01/25/21-02/07/21 indicated she was treated for a Urinary Tract Infection (UTI) and sepsis. A review of the physician orders for Resident #45 revealed there were no orders for catheter care, leg strap or when to change the catheter. A review of the treatment plan for Resident #45 for March 2021 and April 2021 revealed no urinary catheter interventions were ordered. The Admission History and Physical completed on 03/16/21 by the Medical Director addressed the need for a chronic urinary catheter for neurogenic bladder. An observation on 4/14/21 at 5:00 PM of Resident #45 revealed amber colored urine with sediment in the catheter bag. The catheter tubing was cloudy and white, and this observer was unable to see the color or clarity of the urine through the tubing. An observation on 04/15/21 at 8:41 PM indicated the catheter tubing was cloudy and the urine in the catheter bag was amber colored with sediment. Resident #45 was interviewed on 04/16/21 at 10:37 AM regarding the urinary catheter. She said she was at another facility for a month before she came to the current facility on 3/12/21, and	F 690	The facility has determined that current residents that have a urinary catheter have the potential to be affected. The Director of Nursing/ unit manager completed an audit on current residents to determine who had a urinary catheter on 5/11/2021 to ensure orders are written correctly and leg straps are in place. No other residents were found to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All licensed nursing staff were educated on 5/11/21 by the Director of Nursing/Unit manager on assessment of urinary catheters, writing orders for urinary catheters that include the size and balloon size, orders for catheter care, securing device for tubing, emptying the drainage bag, and updating the care plan for the resident as needed. The MDS Coordinator was educated by the Director of nursing on 5/11/2021 updating the plan of care with appropriate interventions for residents with urinary catheters. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services/Assistant director of nursing will complete a visual audit and medical records audit weekly x 12 weeks on 5 residents with urinary catheters, to ensure all orders are correct and plan of care with	

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F 690	Continued From page 61 she had recently been in the hospital for a UTI. She stated her catheter had not been changed for a long time since she was in the hospital in January 2021 and she thought it was due to be changed. An interview was completed with Nurse #2 on 04/16/21 at 1:49 PM regarding urinary catheter care. She had provided care for the resident for 2 days and was not aware if catheter care had been completed. She stated if a resident was admitted with an indwelling catheter, the orders for catheter care and when to change the catheter would be obtained with admission. She noted they should have ensured the tubing was free and clear, a catheter strap was on, catheter care was done and orders to change the foley or send the resident out to the Urologist had been obtained. She stated the facility doctor usually gave orders for flushing the catheter, catheter care and to change it every 28 days and as necessary. An interview was completed on 04/22/21 at 2:54 PM with Nurse #7 that completed the admission orders for Resident #45. She was asked about admission orders and stated she did not know what the admission order process was, and she followed what she normally did at other facilities. She said she reviewed the orders and the admission assessment, verified the orders with the on-call physician and entered the orders in the computer. She stated other places had a second nurse to check the orders and was not aware of that facility's process. She noted she had asked another nurse to check the orders, but she was not sure if the nurse did it or not. She was asked about orders for Resident #45 and the indwelling catheter and said normally there was a catheter batch order set to choose from and it	F 690	interventions are in place. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent compliance has been met.	

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included the change of the indwelling catheter every 30 days. She did not recall the resident or why the catheters were not entered. She also was not familiar with the order process to validate with a second nurse at that facility.

The evening Supervisor was interviewed on 04/15/21 at 9:07 PM regarding Resident #45's catheter. He stated the catheter care orders and treatments should have been initiated with admission. The supervisor said treatments that should have been included were to ensure peri care was done, the drainage bag had a privacy cover, a leg strap was used, the bag was emptied every shift, the bag changed every 29-30 days and orders to change the urinary catheter.

An interview was conducted with the Director of Nursing (DON) on 04/15/21 at 9:11 PM regarding urinary catheter care. The DON stated the urinary catheter was to be changed monthly. She said the treatment that should be included was frequent peri-care, changing the bag normally when the catheter was changed or if the urine had sediment or was cloudy, the bag should be kept low and have a privacy cover.

A follow up interview was conducted with the Director of Nursing on 04/16/21 at 2:15 PM regarding the urinary catheter for Resident #45. She stated the catheter was usually changed every 28 days and as needed and the nurse that obtained the admission orders should have obtained an order. The DON stated that on admission the nurse reviewed the hospital discharge orders and entered the other orders needed with the Physician and verified them in the computer and also a second nurse was supposed to have verified that the orders were

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correct.

The Medical Director was interviewed on 4/16/21 at 11:02 AM regarding Resident #45 admission with a urinary catheter. She stated the catheter should have been changed every month and prn if it was clogged or if staff noticed any changes with the drainage to reduce the risk of urinary tract infection. She stated the catheter should be irrigated as needed and care completed to reduce the risk of infection. She stated usually the nurse put in the indwelling catheter orders and she reviewed and signed them.

An interview was completed with the Administrator on 4/16/21 at 3:16 PM regarding urinary catheter care. He stated he would have expected the catheter to be changed once a month and as needed. If there were no orders, he would have expected an order would be obtained or to follow the policy.

2. Resident #54 was admitted to the facility on 3/6/21 with multiple diagnoses which partly included: Dementia with behaviors, neurogenic bladder, cognitive decline, and an open wound to the left hip.

The Minimum Data Set (MDS) admission comprehensive assessment with an Assessment Reference Date (ARD) of 3/13/21 indicated Resident #54 had severe cognitive loss. The resident was coded as having had an indwelling urinary catheter.

Review of Resident #54 ' s Medication

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Administration Record (MAR) revealed the resident received ceftriaxone sodium, reconstituted, 1 gram (gm), inject 1 gm intramuscularly (IM) one time per day for a urinary tract infection (UTI) for 7 days. The first dose was administered on 4/3/21 and the last dose was administered on 4/9/21.

Resident #54 ' s care plan, which contained a focus area dated 3/11/21 for the resident having an indwelling urinary catheter, infection/UTI, and a neurogenic bladder. There were no interventions listed to change the urinary catheter, provide catheter care, secure the drainage tubing with a leg strap, or empty the drainage bag.

Resident #54 was observed out in the resident smoking area on 4/13/21 at 11:16 AM. The resident ' s yellow urine in the drainage bag with a clear side was observed to be clear, yellow, and had no sediment.

Resident #54 was observed in the resident dining area for the 100-hall side of the building on 4/13/21 at 12:44 AM. The resident ' s yellow urine in the drainage bag with a clear side was observed to be clear, yellow, and had no sediment.

Resident #54 was observed to be in his room in his bed on 4/15/21 at 8:22 AM. The resident ' s yellow urine in the drainage bag with a clear side was observed to be clear, yellow, and had no sediment.

A review of the physician orders for Resident #54 revealed an order with a start date of 4/20/21 regarding an indwelling urinary catheter every day shift starting on the 20th and ending on the 20th

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of every month for catheter care and the order had a discontinue date of 4/14/21. Further review revealed a second physician ' s order with a start date of 4/20/21 regarding an indwelling urinary catheter every day shift starting on the 20th and ending on the 20th of every month for catheter care and the order had a discontinue date of 4/14/21. There were no current orders regarding catheter care, leg strap, or when to change the catheter.

A review of the Treatment Administration Record (TAR) for Resident #54 for April 2021 revealed the following treatments: An order with a start date of 4/20/21 regarding an indwelling urinary catheter every day shift starting on the 20th and ending on the 20th of every month for catheter care and the order had a discontinue date of 4/14/21. There were no initials on the TAR indicating catheter care had been provided. Further review of the TAR revealed a second treatment with a start date of 4/20/21 regarding an indwelling urinary catheter every day shift starting on the 20th and ending on the 20th of every month for catheter care and the order had a discontinue date of 4/14/20. There were no initials on the TAR indicating catheter care had been provided. There were no treatments regarding catheter care, leg strap, or when to change the catheter.

An interview was completed with Nurse #2 on 04/16/21 at 1:49 PM regarding urinary catheter care. She stated if a resident was admitted with an indwelling catheter, the orders for catheter care and when to change the catheter would be obtained with admission. She noted the facility

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staff should ensure the tubing was free and clear, a catheter strap was on, catheter care was done, orders to change the foley or send the resident out to the urologist for tubing change. She stated the facility doctor usually gave orders for flushing the catheter, catheter care, and to change it every 28 days and as necessary.

The evening Supervisor was interviewed on 04/15/21 at 9:07 PM. He stated the catheter care orders and treatments should have been initiated with admission. The supervisor said treatments that should have been included were to ensure peri care was done, the drainage bag had a privacy cover, a leg strap was used, the bag was emptied every shift, the bag changed every 29-30 days and orders to change the urinary catheter.

An interview was conducted with the Director of Nursing (DON) on 04/15/21 at 9:11 PM regarding urinary catheter care. The DON stated the urinary catheter was to be changed monthly. She said the treatment that should be included was frequent peri-care, changing the bag normally when the catheter was changed or if the urine had sediment or was cloudy, the bag should be kept low and have a privacy cover.

A follow up interview was conducted with the Director of Nursing on 04/16/21 at 2:15 PM. She stated the indwelling urinary catheter was usually changed every 28 days and as needed. She explained the nurse who obtained the admission orders should have obtained an order regarding care for the indwelling urinary catheter. The DON stated that on admission the admitting nurse reviews the hospital discharge orders and enters the other orders needed with the physician. She

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said the nurse will then verify the orders in the computer and also a second nurse was supposed to have verified the orders were correct.

The Medical Director was interviewed on 4/16/21 at 11:02 AM. Regarding urinary indwelling catheter care, she stated the catheter should be irrigated as needed and care completed to reduce the risk of infection. She stated usually the nurse put in the indwelling catheter orders and she reviewed and signed them.

An interview was completed with the Administrator on 4/16/21 at 3:16 PM regarding urinary catheter care. He stated he would have expected the catheter to be changed once a month and as needed. If there were no orders, he would have expected an order would be obtained or to follow the policy.

3. Resident #43 was admitted to the facility on 2/12/16. Resident #43 ' s cumulative list of diagnoses included: Diabetes, chronic kidney disease, chronic pain, neurogenic bladder, and a stage IV pressure ulcer of the sacrum.

The MDS annual comprehensive assessment with an Assessment Reference Date (ARD) of 3/2/21 indicated Resident #43 was coded as having an indwelling urinary catheter on the assessment.

Review of the Treatment Administration Record (TAR) for Resident #43 for the month of April 2021 was completed. There was no mention of securing the drainage tubing to a leg strap.

Review of the Medication Administration Record (TAR) for Resident #43 for the month of April

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2021 was completed. There was no mention of securing the drainage tubing to a leg strap.

A review of the care plan for Resident #43, which was most recently updated on 4/14/21 revealed the following focus area: There was no mention of securing the drainage tubing to a leg strap.

On observation was conducted on 4/15/21 at 9:48 AM, the resident ' s urinary catheter drainage tubing was observed to have been not secured to the resident ' s leg.

On observation was conducted on 4/15/21 at 2:51 PM of Resident #43 in conjunction with an interview with Nursing Assistant NA #10 and Resident #43. During the interview the resident stated she used to have a leg strap for the tubing, but it came off. The resident was observed to not have her drainage tubing secured with a leg strap. The NA stated she did not apply the leg strap unless the resident was going out of the facility somewhere. The NA further explained they did not keep extra leg straps for the residents in their rooms and the leg straps were not available in the supply room. The NA further explained some residents who had indwelling urinary catheters on the tubing had leg straps and some did not.

During an interview conducted on 4/15/21 at 3:00 PM with the central supply coordinator, which was conducted in conjunction of an observation of the central supply room, she stated she did assure there were supplies to secure urinary drainage tubing to a resident ' s leg. She proceeded to find a hook and loop fastener leg strap in the central supply room and stated they were available. She stated the NAs did not have access to the supply

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F 690	Continued From page 69 room, but the nurses did have access. She stated if a resident needed a leg strap for urinary drainage tubing, they were available. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated urinary drainage tubing needed to be secured. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator stated urinary drainage tubing needed to be secured.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff, dialysis staff and Director of Nursing interviews, the facility failed to communicate significant medication errors with dialysis staff for 1 of 1 resident reviewed for dialysis (Resident #42). Findings included: Resident #42 was readmitted to the facility 2/27/2021 with diagnoses to include chronic kidney disease and dependence on renal dialysis. The most recent quarterly Minimum Data Set assessment dated 3/15/2021 assessed Resident #42 to moderately cognitively impaired.	F 698	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility reviewed resident # 42 medications on 3/2/21. The facility notified the Medical Director and the correct Medications were ordered on 3/2/21. The dialysis center was aware of the medication error and medication changes on 3/8/21. 2. Identification of other residents having the potential to be affected was accomplished by:	5/18/21

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F 698	Continued From page 70 A review of the medical record for Resident #42 revealed he was scheduled for dialysis Tuesday, Thursday and Saturday of each week. A physician (MD) note dated 3/2/2021 documented incorrect medications had been ordered for Resident #42. The note further documented the medications had been corrected. A phone interview was conducted with the dialysis center nurse on 4/15/2021 at 9:28 AM. The dialysis nurse reported the facility faxed a medication list to the facility on 3/1/2021. The medication list was dated 3/1/2021. The dialysis nurse reported on 3/8/2021 the dialysis facility reviewed the monthly medication list and discovered Resident #42 had medications listed that were incorrect. The dialysis center nurse reported she called the facility and was told by a facility staff nurse there had been a transcription error for Resident #42. The dialysis center nurse reported the facility had not called or faxed the dialysis center with an updated or corrected medication list for Resident #42 after the facility discovered the error. An interview was conducted with the facility MD on 3/15/2021 at 9:49 AM. The MD reported she was not aware the medication errors had not been communicated to the dialysis center. An interview was conducted with Nurse #2 on 4/16/2021 at 11:45 AM. Nurse #2 reported she was the charge nurse for the facility. Nurse #2 reported the dialysis center will call and request the monthly medication orders to be faxed to the dialysis center. Nurse #2 reported she was not aware of the medication errors for Resident #42	F 698	The facility has determined that current residents who receive dialysis which is 5 have the potential to be affected and their Medication lists will be reviewed by Nursing and approved by the Medical Director on 5/11/21. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Re - education will be conducted by the Director of Nursing Services or Nurse manager starting on 5/7/21 with all licensed staff regarding communication with the resident□s dialysis centers. This in-service included faxing updates to the dialysis center when medications have changed for the resident. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Starting the week of May 23 The Director of Nursing Services/unit manager will review the orders for 5 dialysis resident and verify with the dialysis center that changes were communicated to them weekly x 12 weeks. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 698	Continued From page 71 and she did not know she should have sent another medication list to the dialysis center. The DON was interviewed on 4/16/2021 at 3:47 PM. The DON reported the dialysis center should have been notified of Resident #42 ' s medication errors. The DON reported she did not notify the dialysis center of the medication errors. The DON reported she expected the communication between the facility and the dialysis center to be ongoing and that dialysis is notified of any resident changes. The Administrator was interviewed on 4/16/2021 at 4:08 PM. The Administrator reported he was not aware dialysis had not been provided an updated medication list for Resident #42 after medication errors had been discovered by the physician.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide	F 725		5/18/21

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F 725	Continued From page 72 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide sufficient nursing staff to provide evidence of treatments provided as ordered for pressure ulcers and for skin treatments for 1 of 3 residents reviewed for wound care (Resident #54). The findings included: This tag is cross referenced to F684 Quality of Care and F686 Treatment of Pressure Ulcers: 1a. F684-Based on record review, observation, and staff interviews, the facility failed to provide evidence of treatments provided as ordered for 1 of 2 sampled residents (Resident #54) reviewed for wound care. 1b. F686-Based on record review, observation, and staff interviews, the facility failed to provide evidence of treatments provided as ordered for 1 of 2 sampled residents (Resident #54) reviewed for pressure ulcers. During an interview with the scheduler conducted on 4/15/21 at 10:13 AM she stated the nurses on	F 725	For affected resident(s): Resident # 54 was discharged on 4/14/21 For other residents with the potential to be affected: Current residents that receive wound care have the potential to be affected by this alleged non-compliance Facility plan to prevent re-occurrence: On 5/5/2021 the Director of Nursing initiated re-education to the nursing staff on the importance of completing all wound treatments as order by physician. Education will be completed on 5/10/2021. On 5/5/2021 the Administrator initiated re-education to the Director of Nursing, regarding the need to maintain sufficient nursing staffing levels to ensure that staff are able to complete wound treatments as ordered by physician. The Administrator and Director of Nursing review the staffing sheets weekly and daily to ensure sufficient staffing is	

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F 725	Continued From page 73 the floors were responsible to provide treatments and wound care. She further clarified the facility did not have a wound nurse or a treatment nurse. She stated the facility had one unit manager, who was an agency nurse. She said he was the evening supervisor but often worked more than just evenings. She explained she would have liked to have had 2 nurses on the 100 hall side (the side where Resident #54 resided), two nurses for day shift, and two nurses for evening shift, but she has been unable to get two nurses. She said she has been typically scheduling one nurse on day shift, and one nurse on evening shift. She then said she will try to get two medication aides to work with the one nurse. She said the medication aides can pass pills and check blood sugars. She explained it was up to the nurses to do the treatments, administer insulin, and administer as needed (PRN) medications. She said there were typically about 49 residents on the 100 hall side and she would like to have 5 NAs on first shift and 4 NAs on second shift. She said she had typically had 4 NAs for day shift and 3 NAs for evening shift. The scheduler said the facility currently did not have a Nursing Assistant who was assigned to give showers. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated no nurses had come to her and informed her they didn ' t have time to dressings, provide wound care, or provide treatments which were ordered. She further stated it was her expectation for dressings to be changed and treatments to be applied as ordered. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The	F 725	available at all times to meet the needs of the residents. Facility plan to monitor its performance to make sure that solutions are sustained: Starting the week of May 16th A monitor sheet will be done by the Administrator, or Director of Nursing to monitor and ensure that all shifts have the appropriate staffing levels to perform and complete their necessary tasks. This monitoring process will take place daily for 4 weeks, weekly for 4 weeks, then monthly for 1 month. The Administrator and Director of Nursing will interview 2 staff and 4 residents with wounds weekly for 12 weeks to ensure there is sufficient nursing staff to provide treatments for pressure ulcers and skin treatments. The Administrator, or Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in compliance.	

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F 725	Continued From page 74 Administrator said he felt staffing was sufficient and the facility was staffed accordingly.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, mandatory training	F 726	For affected resident(s):	5/18/21

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F 726	Continued From page 75 review, and staff interview, the facility failed to ensure that of 3 of 3 Medication Aides (MAs) who worked for the facility and were required to demonstrate competency skills for medication administration completed observed skilled competencies by the facility. MA # 4, MA # 1, and MA # 2. Residents identified included Resident # 25 (MA # 4) and Resident # 46 (MA #1 and MA #2). Findings included: 1.A nurse note dated 12/11/2020 at 2:24 AM revealed that a medication aid (MA # 4) notified the nurse earlier in the evening of 12/10/2020 that Resident # 25 had been given 96 units of NovoLog (fast acting) insulin and not the ordered 96 units of Lantus (slow acting) insulin by MA # 4 as scheduled at 10:00 PM. Resident # 25 had no signs of hypoglycemia or hyperglycemia; his blood sugar was 223 and his skin was warm and dry. A phone interview with MA # 4 was conducted on 04/15/2021 at 2:59 PM. MA # 4 explained she did administer an insulin injection to Resident # 25 at around 10:00 PM on 12/10/2020. On 04/16/2021 at 2:44 PM an interview was conducted with the Director of Nurses (DON). The DON explained that the previous DON employed at the facility on 12/10/2020 had discontinued MA # 4's medication pass responsibilities and that since that time MA # 4 had only worked as a nurse assistant (NA). On 04/22/2021 at 4:26 PM a phone interview was conducted with the administrator and current DON. The administrator revealed that the facility	F 726	Resident #25 and Resident #46 had no noted ill effects and have had been assessed by the Medical Director or Nurse Practioner. Medication Aid # 4 no longer worked at the facility and all current Medication Aids were re-education prior to returning to medication carts. This was started on 4/23/21. For other residents with the potential to be affected: Current residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: On 4/23/2021 the Director of Nursing initiated re-education to the medication aids staff on the importance of adhering to their scope of practice and following the physician orders. Education on regarding anti- hypertensive completed by pharmacist for all nursing and med-aid staff. Education will be completed on 5/18/2021. On 5/7/21 the Director of Nursing began re-education with Medication Aides on Medication administration and complete the competency check offs for each one will be completed by an Registered nurse prior to working. New medication Aide employees will education and competency check offs during orientation and any new agency medication Aide will complete the competency check off with a registered	

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F 726	Continued From page 76 was not able to locate any skilled competency check lists for MA # 4. He also explained that MA # 4 was not able to administer any medications after 12/10/2020 and for that reason a medication pass competency had not been performed because medication administration was no longer a part of her job description. The DON explained that she had not given MA # 4 a skills competency review and that she did not have a formal skills competency form in place at present. The DON also revealed that she was also the staff development coordinator for the facility. 2. The physician orders for Resident #46 were reviewed. An order dated 4/11/2021 for carvedilol 3.125 milligrams (mg) by mouth twice per day. The order specified that the carvedilol was to be held if the (systolic) blood pressure was less than 130. The medication administration record (MAR) for Resident #46 was reviewed. The MAR documented that Medication aide (MA) #1 administered carvedilol to Resident #46 on 4/15/2021 with a blood pressure of 97/61. MA #1 was interviewed on 4/15/2021 at 11:58 AM. MA #1 reported she had misread the instructions and misunderstood the medication order for carvedilol. MA #1 reported she should have held the carvedilol and reported the low blood pressure to the nurse. The Director of Nursing (DON) was interviewed on 4/16/2021 at 3:47 PM. The DON reported MA #1 should have reported the blood pressure to the nurse on the floor for further direction related to the medication administration. On 04/22/2021 at 4:26 PM a phone interview was	F 726	nurse prior to working on the units Facility plan to monitor its performance to make sure that solutions are sustained: Starting the week of May 16th a med pass observation will be done by the Director of nursing , or assistant director of 3 licensed nurses and med aides weekly to ensure that all med aids and licensed nurses are passing medications within regulatory compliance and according to physician orders. This monitoring process will take place weekly times 12. The Administrator, or director of nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in compliance.	

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F 726	Continued From page 77	F 726		

conducted with the administrator and DON. The administrator revealed that the facility was not able to locate any skilled competency check lists for MA # 1. The DON explained that she had not given MA # 1 a skills competency review and that she did not have a formal skills competency form in place at present. The DON also revealed that she was also the staff development coordinator for the facility.

3. The MAR for Resident #46 was reviewed. The MAR documented that Resident #46 had been administered carvedilol on by MA #2 on 4/12/2021 with a blood pressure of 104/65; 4/13/2021 with a blood pressure of 100/79 and on 4/14/2021 with a blood pressure 105/75.

MA #2 was interviewed on 4/16/2021 at 2:05 PM. MA #2 reported she had administered carvedilol to Resident #46 on 4/14/2021. MA #2 reported she documented Resident #46 ' s blood pressure after she administered the carvedilol. MA #2 reported she was not aware she should have documented the blood pressure prior to administering the medication. MT #2 reported she checked Resident #46 ' s blood pressure before and after the carvedilol administration and documented the blood pressure after it was given. MT #2 reported she had been trained to administer blood pressure medications and to document the blood pressure after the medication was given.

The DON was interviewed on 4/16/2021 at 3:47 PM. The DON reported that MA #2 should not have documented the blood pressure after the medication was administered. The DON reported that documentation of the blood pressure after

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F 726	Continued From page 78 medication administration was not a standard of care. On 04/22/2021 at 4:26 PM a phone interview was conducted with the administrator and DON. The administrator revealed that the facility was not able to locate any skilled competency check lists for MA #2. The DON explained that she had not given MA #2 a skills competency review and that she did not have a formal skills competency form in place at present. The DON also revealed that she was also the staff development coordinator for the facility.	F 726		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		5/18/21

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F 732	Continued From page 79 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to post accurate staffing information as compared to the Staff Schedule/ Assignment Sheets for 7 days of the 7 days reviewed. Findings included: The Daily Staffing Form for 4/5/21 revealed the posted staffing for first shift (7:00 AM to 3:00 PM) had 3 Medication Aides (MAs) for a total of 24 hours. Further review revealed the second shift (3:00 PM to 11:00 PM) had 1 Registered Nurse (RN) for a total of 8 hours, Licensed Practical Nurses (LPNs) was blank, Nursing Assistants (NAs) was blank, and 1 MA for a total of 8 hours. The facility nursing schedule for 4/5/21 revealed for first shift there were 2 MAs for a total of 16 hours. Further review revealed for second shift there was 1 RN for 8 hours, 1 LPN for 8 hours, 2 MAs for a total of 16 hours, and 7 NAs for a total of 36 hours (several NAs worked abbreviated shifts).	F 732	For affected resident(s): No residents were directly affected. For other residents with the potential to be affected: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: On 5/5/2021 the Administrator initiated re-education to the Director of Nursing, regarding the daily nurse staffing information requirements and that all required areas must be filled out. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, Director of Nursing, or unit	

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F 732	Continued From page 80 The Daily Staffing Form for 4/6/21 revealed the posted staffing for second shift RNs was blank, LPNs was blank, NAs was blank, and MAs was blank. The facility nursing schedule for 4/6/21 revealed for second shift there was no RN, 3 LPNs for 16 hours (1 worked 8 hours and the other 2 worked 4 hours each), 4 MAs for a total of 28 hours (2 CMAs each worked 8 hours each and another 2 worked 6 hours each), and 7 NAs for a total of 38.5 hours (several NAs worked abbreviated shifts). The Daily Staffing Form for 4/7/21 revealed the posted staffing for second shift NAs for NAs had 9 staff for a total of 67.5 hours and MAs had a total of 16 hours for 3 total MAs. The facility nursing schedule for 4/7/21 revealed for second shift there were 3 MAs for a total of 22 hours (2 MAs worked 16 hours, and another worked 6 hours). Further review revealed there were 9 NAs for a total of 56.5 hours (several NAs worked abbreviated shifts). The Daily Staffing Form for 4/8/21 revealed the posted staffing for second shift RNs was blank, LPNs was blank, NAs was blank, and MAs was blank. The facility nursing schedule for 4/8/21 revealed for second shift there was no RN, 2 LPNs for 16 hours, 2 MAs for a total of 14 hours (one MA worked for 6 hours), and 9 NAs for a total of 51.5 hours (several NAs worked abbreviated shifts). The Daily Staffing Form for 4/9/21 revealed the	F 732	manager to monitor and ensure that all of the required daily nurse staffing information matches the schedule and assignments and that it is complete, accurate and displayed appropriately. The administrator and Director of Nursing will review the previous days posted staffing to ensure all the information that was displayed was accurate. This monitoring process will take place daily for 4 weeks, and weekly for 9 weeks. The Administrator, or Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan (QAPI). The QAPI Committee can modify this plan to ensure the facility remains in compliance.	

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posted staffing for second shift RNs was blank, LPNs was blank, NAs was blank, and MAs was blank.

The facility nursing schedule for 4/9/21 revealed for second shift there was no RN, 2 LPNs for 16 hours, 2 MAs for a total of 16 hours, and 8 NAs for a total of 53 hours (several NAs worked abbreviated shifts).

The Daily Staffing Form for 4/10/21 was not available for review.

The facility nursing schedule for 4/10/21 revealed for first shift there were no RNs, 2 LPNs for 16 hours, 2 MAs for 16 hours, and three NAs for 22.5 hours. For second shift there was 1 RN for 8 hours, 3 LPNs for 16 hours (2 LPNs worked 4 hour shifts), 1 MAs for 8 hours, and 7 NAs for a total of 35 hours (several NAs worked abbreviated shifts). Further review revealed third shift (11:00 PM to 7:00 AM) there was 1 RN for 8 hours, 2 LPNs for 16 hours, no MAs, and 5 NAs for 37.5 hours.

The Daily Staffing Form for 4/11/21 revealed the posted staffing for first shift (7:00 AM to 3:00 PM) to have 1 MA for a total of 8 hours. Further review revealed second shift to have 6 NAs for a total of 31 hours.

A review was completed of the facility nursing schedule for 4/11/21. The review revealed for first shift revealed there were 2 MAs for 16 hours. Further review revealed for second shift there were 7 NAs for a total of 37 hours (several NAs worked abbreviated shifts).

An interview was conducted in conjunction with a

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F 732	Continued From page 82 record review on 4/15/21 at 10:13 AM with the scheduler. She said she updated the Daily Staffing Form when she arrived in the morning and posted it. She then explained for first and second shift it was the responsibility of one of the nurses to update the form for second and third shifts. The Daily Staffing Forms from 4/5/21 through 4/11/21 were then compared with the facility nursing schedule and multiple discrepancies were found on the Daily Staffing forms for each day when compared to the facility nursing schedule for the same period. The scheduler repeated it was the responsibility of the nurses from second and third shift to update and revise the Daily Staffing Forms and she could see after reviewing the forms that the updates regarding staffing had not been completed as they should have been. An interview was conducted on 4/16/21 at 4:10 PM with the Director of Nursing (DON). The DON stated it was her expectation for the Daily Staffing Forms to be accurate, current, updated, and completed. An interview was conducted on 4/21/21 at 4:32 PM with the facility Administrator. The Administrator said he expected for the Daily Staffing Forms to be updated and accurate.	F 732		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident,	F 760	For those Residents with potential to be	5/18/21

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F 760	Continued From page 83 facility staff, dialysis staff, and physician interviews, the facility failed to prevent significant medication errors for 1 of 8 residents reviewed for medication administration (Resident #42). The facility administered heart medication, insulin, blood thinner, blood pressure and diabetic medications to Resident #42 after Resident #68 ' s medications were transcribed in error for Resident #42. The facility failed to administer prescribed antipsychotic medication, heart medication, pain medication, tremor medication and insulin to Resident #42. Resident #42 had the high likelihood of additional adverse consequences to the medications he received that were not intended for him. Resident #42 experienced low blood sugar levels and increased tremors. Additionally, the facility failed to prevent significant medication errors for 2 of 8 residents reviewed for medication administration (Resident #46 and Resident #25) Medication aide (MA) #1 administered a blood pressure medication outside of prescribed parameters to Resident #46. and a MA administered an incorrect amount of insulin to Resident #25. Immediate Jeopardy began on 2/27/2021 when Resident #42 missed his first dose of carvedilol 12.5 milligrams (mg) for blood pressure, gabapentin 300 mg for pain, primidone 50 mg for tremors, aripiprazole 5 mg for mood, and received metoprolol 25 mg (blood pressure), metformin 1000 mg (diabetes), and Humalog insulin 32 units (elevated blood sugar). Immediate Jeopardy was removed on 4/16/2021 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and	F 760	affected. Residents Admitted/Readmitted since 2/1/21 had all Medications verified with Hospital Discharge Summary and current Physician orders to assure no medication errors and audit will be documented on Quality Improvement Audit Tool. Director of Nursing and Nurse managers started audit 4/15/21 and will be completed by 4/16/21. No other transcription issues were noted Specify the Action the Entity will take to Alter the Process or System Failure to Prevent a Serious Outcome from occurring reoccurring and when the action will be complete. ON 4/15/21-4/16/21 the Director of Nursing did in-service with all Nurses regarding: Admission/readmission and required procedures; Licensed Nurse will verify all orders with the physician, enter the orders after physician verification for the admitted resident and then have orders verified with second nurse to ensure the orders match the resident admission orders verified by physician. The following morning the new admissions/readmission will be reviewed by the Director of Nursing or Nurse manager to ensure the residents orders verified by the physician is the same set of orders for the same resident in the Medication Administration record. The hospital discharge summary for a newly admitted or readmitted resident with the orders from the hospital will be uploaded	

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F 760	Continued From page 84 severity of "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) due to examples #2 and #3 to ensure monitoring systems put into place are effective. 1. Resident #68 was admitted to the facility on 2/26/2021 from the hospital. The medical record for Resident #68 was reviewed and hospital discharge orders dated 2/26/2021 had the following medications ordered for Resident #68: Amiodarone 400 mg (milligram) 1 tablet oral daily Ceftriaxone 2 grams in sodium chloride 100 milliliters intravenous every 12 hours Digoxin 0.125 mg oral daily Eliquis 5 mg oral twice per day Fenofibric acid 45 mg oral daily Fluoxetine 40 mg oral daily Insulin lispro 32 units subcutaneously 3 times per day Insulin lispro sliding scale insulin before meals and bedtime Metformin 1000 mg oral 2 times per day Metoprolol tartrate 25 mg oral 2 times per day Tresiba flextouch 120 units injected subcutaneously at bedtime Victoza 1.8 mg injected subcutaneously daily Resident #42 was admitted to the facility on 10/9/2010 and readmitted on 2/27/2021. Diagnoses for Resident #42 included chronic kidney disease, diabetes, chronic pain. The most recent quarterly Minimum Data Set (MDS) assessment dated 3/15/2021 assessed Resident #42 to be moderately cognitively impaired and he was receiving renal dialysis. The MDS documented Resident #42 received insulin, antipsychotic medications, antidepressant, diuretic and opioids during the 7-day lookback	F 760	into point click care by the admissions director at the time of admission to be available for the physician to review to verify. Any Nurse that has not received the training will not work until training is received. Newly hired nurses will receive training during orientation by the Director of Nursing or Nurse manager. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Administrator, Director of Nursing, or Manager will audit compliance of new admissions daily for 2 month and then weekly for 1 month. The results of these audits will be reported and reviewed by the Quality Assurance Committee.	

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period.

The medical record for Resident #42 was reviewed and included the hospital discharge orders. The orders were dated 2/27/2021 and had following medications listed for Resident #42:
Amlodipine 5 mg oral daily
Aripiprazole 5 mg oral daily
Basaglar insulin 35 units subcutaneously daily
Carvedilol 12.5 mg 2 tablets oral 2 times per day
Duloxetine 20 mg oral daily
Duragesic 25 micrograms/hour patch, apply topically every 3rd day
Furosemide 40 mg oral 2 times per day
Gabapentin 300 mg oral 2 times per day
Insulin lispro 4 units subcutaneously 3 times per day before meals
Primidone 50 mg oral 2 times per day

Review of the physician orders for Resident #42 dated 2/27/2021 revealed the medications that had been ordered for Resident #68 on 2/26/2021 were transcribed for Resident #42 ' s physician orders. These orders were transcribed in error by Nurse #1.

A review of the medication administration record (MAR) for Resident #42 revealed the following medications Resident #42 received in error, which were prescribed to Resident #68:
Amiodarone 400 milligrams (mg) 3 doses (used for irregular heart rate)
Digoxin 125 micrograms (mcg) 3 doses (used for heart failure and irregular heart rate)
Tresiba 120 units 1 dose (long-acting insulin)
Victoza 1.8 mg 2 doses (used to control blood sugar)
Eliquis 5 mg 5 doses (blood thinner)
Metoprolol 25 mg 6 doses (slows heart rate,

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decreases blood pressure)
Metformin 1000 mg 7 doses (used to control blood glucose)

Review of the MAR revealed the following medications Resident #42 missed:
Amlodipine 5 mg 4 doses (blood pressure)
Allopurinol 100 mg 4 doses (gout)
Aripiprazole 5 mg 4 doses (antipsychotic medication for mood stabilization)
Carvedilol 12.5 mg 7 doses (blood pressure)
Furosemide 40 mg 7 doses (heart failure)
Gabapentin 300 mg 7 doses (used for pain control)
Primidone 50 mg 7 doses (for tremors)
Admelog 4 units 10 doses (short-acting insulin)
Fentanyl (Duragesic) patch: removed 2/27/2021, was not replaced until 3/3/2021.

A review of the MAR revealed Ceftriaxone 1 gram intravenous (IV) every 12 hours (antibiotic) was ordered but not administrated. Resident #42 refused the medication due to a known penicillin allergy.

The medical record was reviewed, and Resident #42 received a dialysis treatment on 3/2/2021.

The MAR was reviewed and blood glucose levels for Resident #42 were: 3/1/2021 were documented 67 at 8:00 AM, 63 at 4:00 PM, 55 at 8:00 PM. Blood glucose levels on 3/2/2021 were 67 at 4:00 PM.

A physician order dated 2/27/201 for Glucagon 1 mg intramuscularly as needed for blood glucose less than 60. The MAR was reviewed, and Glucagon 1 mg was administered 3/1/2021 at 10:00 PM for a blood sugar documented as 55 in

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the medical record.

A nursing note dated 3/1/2021 written by the Unit Manager (UM) documented Resident #42 had episodes of low blood glucose during the shift and Glucagon 1 mg was administered at 10:00 PM for blood glucose results of 55. The note did not document the physician had been notified of the low blood glucose levels.

A handwritten communication form from nursing staff to the physician dated 3/1/2021 reported "several episodes of low blood glucose" and questioned the amount of insulin prescribed for Resident #42. The physician initialed and signed the note on 3/2/2021.

An interview was conducted with the UM on 4/15/2021 at 7:45 AM. The UM reported he had held the insulin for Resident #42 on 3/1/2021 and had given Resident #42 Glucagon on 3/1/2021 because he was shaking tremoring and had weakness and sweating. The UM reported he checked Resident #42 ' s blood glucose and it was low, but he was unable to recall the results. The UM reported he did not remember if he called the physician with Resident #42 ' s low blood glucose results.

Resident #42 was interviewed on 4/13/2021 at 2:00 PM. Resident #42 reported that he returned from the hospital and he had many different medications. Resident #42 reported that he felt bad and his blood sugar dropped, but he wasn ' t certain of the date. Resident #42 reported he was told he had to take an intravenous antibiotic, but he was allergic to the medication and he refused to take the antibiotic. Resident #42 reported that when he took penicillin type of

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medications, he became very sick to his stomach.

The medical record was reviewed and lab work for Resident #42, performed on 3/4/2021 at the dialysis center revealed a glucose level of 43.

Nurse #1 was interviewed on 4/19/2021 at 1:37 PM. Nurse #1 reported she completed the readmission for Resident #42 on 2/27/2021. Nurse #1 reported when Resident #42 was readmitted to the facility after hospitalization on 2/27/2021, the transporters handed her a packet with all of Resident #42 ' s paperwork, including medication orders. Nurse #1 reported she had contacted the on-call physician to review the medications. Nurse #1 reported she did not know why Resident #68 ' s medications were transcribed for Resident #42.

The dialysis nurse was interviewed on 4/14/2021 at 10:55 AM. The dialysis nurse reported Resident #42 had weakness related to the low blood sugar lab result on 3/4/2021.

The dialysis nurse was interviewed on 4/15/2021 at 9:27 AM. The dialysis nurse reported Resident #42 was not very symptomatic with the low blood sugar on 3/4/2021, but the dialysis center nurses noticed that he was having more tremors and shaking. The dialysis nurse reported the dialysis center received the medication MAR for Resident #42 on 3/1/2021 but it was 3/8/2021 before dialysis was able to review the MAR. The dialysis nurse reported she had called the facility on 3/8/2021 to notify them there were medication discrepancies on the MAR, and she was told the facility corrected the medication errors and orders on 3/2/2021. The dialysis nurse reported that the facility had not called the dialysis center to notify

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of the medication errors for Resident #42.

The facility physician (MD) was interviewed on 4/14/2021 at 12:49 PM. The MD reported she had visited Resident #42 on 3/2/2021 and when she reviewed his medications, she noted that medications were ordered for him that he had not had in the past and the orders did not match his hospital discharge note. The MD reported she contacted the Director of Nursing (DON) on 3/2/2021 and the DON came into the facility to make the order corrections. The MD reported because Resident #42 was on dialysis and had received the amiodarone, digoxin and other oral medications were most likely removed by the dialysis treatment. The MD reported that the most significant adverse reaction Resident #42 had was a low blood sugar that was treated with glucagon (treats low blood sugar) on 3/1/2021. The MD reported that Resident #42 was allergic to the IV antibiotic, and Resident #42 had refused to take the medication. The MD reported the correct medication had been ordered and administered for Resident #42 effective 3/2/2021.

An interview was conducted with the DON on 4/14/2021 at 2:57 PM. The DON reported she was called by the MD on 3/2/2021 to report transcription errors for Resident #42. The DON reported she had made the corrections to the medication orders on 3/2/2021 but she was not aware of the specific medications Resident #42 had received between 2/27/2021 and 3/2/2021. The DON reported she had not completed an incident report or medication error report for Resident #42.

The DON was interviewed on 4/15/2021 at 1:09 PM. The DON reported she was not aware of the

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number of medications Resident #42 had received in error. The DON reported after she corrected the orders for Resident #42, she implemented a system to check for transcription errors on new admission residents, but she was not monitoring the process. The DON reported she was aware Resident #42 had experienced low blood sugars.

The administrator was notified of the immediate jeopardy on 4/15/2021 at 2:54 PM.

The facility provided a credible allegation for immediate jeopardy removal on 4/16/2021 that read:

Credible Allegation of Removal of Immediate Jeopardy:

Identify those residents who have suffered or are likely to suffer a serious adverse outcome because of the non-compliance. Immediate Action for those affected and potential to be affected.
On 2/26/21, Resident #68 was admitted to the facility from the hospital. On 2/27/21 Resident #42 was readmitted to the facility from the hospital. Resident #68 medications were transcribed for Resident #42 resulting in medication errors. These medication errors caused Hypoglycemia with a low blood glucose of 43. Resident #42 Diagnosis include: Chronic Kidney Disease, Diabetes, Respiratory Failure and Heart Failure. The most recent Minimum Data Set Assessment dated 3/15/21 assessed Resident #42 as Moderately Cognitively Impaired. Resident #68 did receive the correct medication administration.

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The Medical Director reported that she had visited Resident #42 on 3/2/21 and noted that the medications ordered for him did not match his previous orders. The Medical Director notified the Director of Nursing and the Director of Nursing made the order corrections. The Medical Director reported the resident was on Dialysis and most like the medications were removed by the Dialysis Treatment. Resident #42 experienced low blood glucose levels and increased tremors. Resident #42 had the high likelihood of additional adverse consequences to the medications he received that were not intended for him.

For those Residents with potential to be affected:

Residents Admitted/Readmitted since 2/1/21 had all Medications verified with Hospital Discharge Summary and current Physician orders to assure no medication errors and audit will be documented on Quality Improvement Audit Tool. Director of Nursing and Nurse Designees started audit 4/15/21 and will be completed by 4/16/21.

Specify the Action the Entity will take to Alter the Process or System Failure to Prevent a Serious Outcome from occurring reoccurring and when the action will be complete:

ON 4/15/21-4/16/21 the Director of Nursing did in-service with all Nurses regarding: Admission/readmission and required procedures; Licensed Nurse will verify all orders with the physician, enter the orders after MD verification for the admitted resident and then have orders verified with second nurse to ensure the orders match the resident admission orders verified by MD. The following morning the new admissions/readmission will be reviewed by the

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Director of Nursing or Nurse Designee to ensure the residents orders verified by the MD is the same set of orders for the same resident in the Medication Administration record. Any Nurse that has not received the training will not work until training is received. Newly hired nurses will receive training during orientation by the Director of Nursing or Nurse Designee.

Director of Nursing and Nurse Designee will continue daily surveillance of implemented process to assure ongoing compliance.

Allegation of Immediate Jeopardy removal:
The facility alleges Immediate Jeopardy removal as of 4/16/21.

On 4/16/2021, the facility's credible allegation for immediate jeopardy removal was validated by the following:
- Review of the in-services provided to nursing regarding admission/readmission and the required procedures including nurse will verify all orders with the physician, enter the orders into the electronic documentation system and then verify with a 2nd nurse
- Audits of the admissions/readmissions medication verification with the hospital discharge orders
- Corrections to errors found by the facility (17 out of 22 residents reviewed)
-

The facility ' s date of the immediate jeopardy removal plan of 4/16/2021 was validated on 4/16/2021.

2. Medication administration for Resident #46 was observed 4/15/2021 at 8:02 AM. Medication aide (MA) #1 checked Resident #46 ' s blood

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pressure with a wrist cuff and stated out loud Resident #46 ' s blood pressure was low, and she needed to get another blood pressure cuff. MA #1 rechecked Resident #46 ' s blood pressure with a different wrist cuff and reported the blood pressure was 97/61 and she would administer carvedilol 3.125 milligrams (mg). MA #1 was observed administering carvedilol 3.125 milligrams (mg) to Resident #46.

The physician orders for Resident #46 were reviewed. An order dated 4/11/2021 for carvedilol 3.125 mg by mouth twice per day. The order specified that the carvedilol was to be held if the (systolic) blood pressure was less than 130.

The medication administration record (MAR) was reviewed. The MAR documented that Resident #46 had received carvedilol on 4/11/2021 with a blood pressure of 118/70, on 4/12/2021 with a blood pressure of 104/65; 4/13/2021 with a blood pressure of 100/79 and on 4/14/2021 with a blood pressure 105/75.

MA #1 was interviewed on 4/15/2021 at 11:58 AM. MA #1 reported she had misread the instructions and misunderstood the medication order for carvedilol. MA #1 reported she should have held the carvedilol and reported the low blood pressure to the nurse.

MA #2 was interviewed on 4/16/2021 at 2:05 PM. MA #2 reported she had administered carvedilol to Resident #46 on 4/14/2021. MA #2 reported she documented Resident #46 ' s blood pressure after she administered the carvedilol. MA #2 reported she was not aware she should have documented the blood pressure prior to administering the medication. MT #2 reported

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she checked Resident #46 ' s blood pressure before and after the carvedilol administration and documented the blood pressure after the carvedilol was given. MT #2 reported she had been trained to administer blood pressure medications and to document the blood pressure after the medication was given.

The Director of Nursing (DON) was notified of the medication error on 4/15/2021 at 10:56 AM. The DON checked Resident #46 ' s blood pressure and it was 130/78. The DON notified the physician and the Resident #46 ' s family.

The DON was interviewed on 4/15/2021 at 10:56 AM. The DON reported she did not know why Resident #46 received the carvedilol with low blood pressures.

The DON was interviewed again on 4/16/2021 at 3:47 PM. The DON reported MA needed to report changes and issues to the charge nurse. The DON reported that nurses on the floor should be providing active monitoring to the MA. The DON reported it was not a standard of care to document a blood pressure after a medication administration and MA #2 was incorrect. The DON reported she expected medications to be administered correctly and nurses to monitor MA activity with medication administration.

The Administrator was interviewed on 4/16/2021 at 4:08 PM. The Administrator reported he expected medications to be administered correctly.

3.Resident # 25 was admitted to the facility on 12/28/2018 with diagnoses that included type 2 diabetes mellitus (DM) and polyneuropathy.

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A review of a quarterly minimum data set (MDS) dated 02/24/2021 included that Resident # 25 had no cognitive impairment, made daily care decisions, was understood and was able to understand. Resident # 25 received 7 days of insulin injections during the review period.

A record review revealed a physician ' s (MD) order that was originated on 12/03/2020 to administer Lantus SoloStar insulin 96 units injected every day at 10:00 PM for diabetes type 2.

A review of Resident # 25 ' s Medication Administration Record (MAR) dated for 12/2020 revealed that Resident # 25 was administered the insulin as ordered every day except was administered the incorrect insulin on 12/10/2020.

A nurse note dated 12/11/2020 at 2:24 AM revealed that a medication aid (MA # 4) notified the nurse (nurse # 7) earlier in the evening of 12/10/2020 that Resident# 25 had been given 96 units of NovoLog (fast acting) insulin and not the ordered 96 units of Lantus (slow acting) insulin by MA # 4 as scheduled at 10:00 PM. Resident # 25 had no signs of hypoglycemia or hyperglycemia; his blood sugar was 223 and his skin was warm and dry.

A nurse note dated 12/11/2020 at 7:47 AM revealed that blood sugar checks of Resident # 25 the 11:00 PM to 7:00 AM shift were in normal limits and ranged as follows 164,163,115,130, 127, 111, 133,164 and 213. Resident # 25 did not show any adverse reaction after he received the incorrect insulin type.

Resident # 25 was interviewed on 04/14/2021 at

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10:48 AM. Resident # 25 revealed that one evening last December he was informed by the nurse staff that he received the incorrect insulin. Resident # 25 also reported that the nurse staff monitored him closely the entire night and he had no adverse effects from the insulin that he had been given.

A phone interview with nurse # 7 on 04/14/2021 at 4:30 PM revealed that MA # 4 administered insulin to Resident #25, and it was the incorrect type of insulin that was ordered for Resident # 25. Nurse #7 revealed that the MA staff was only to check resident blood sugars and report results to the nurse and the nurse was to administer insulin.

A phone interview was conducted with nurse # 6 on 04/14/2021 at 4:30 PM. Nurse # 6 revealed that Resident # 25 had ben administered the incorrect insulin on 12/10/2020 and that she monitored Resident # 25 closely through the night and that Resident # 25 showed no adverse medication effects and voiced no adverse effects. Resident # 25 remained stable.

The facility MD was interviewed via phone on 04/15/2021 at 9:51 AM. The MD revealed that Resident # 25 had not sustained any adverse effects from an injection of the incorrect insulin type on 12/10/2020 and that the licensed nurses monitored him very closely and if Resident # 25 had experienced any adverse effects that there were MD orders in place to administer glucagon if indicated and to call 911 to send Resident # 25 to the hospital immediately.

A phone interview with MA #4 was conducted on 04/15/2021 at 2:59 PM and explained she did administer an insulin injection to Resident # 25 at

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F 760	Continued From page 97 around 10:00 PM on 12/10/2020 and that it was approximately 10 minutes after she gave the insulin injection she realized she had not administered the insulin type that was ordered for Resident # 25 and she reported the error to the licensed nurse.	F 760		
F 761 SS=D	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 §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 observations, staff and Director of Nursing interviews, the facility failed to remove	F 761	For affected resident(s): No residents were effected by the	5/18/21

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F 761	Continued From page 98 expired promethazine rectal suppositories (medication used for nausea/vomiting) and expired lansoprazole liquid (medication used for heartburn) in 1 of 2 medication storage rooms. Findings included: An observation of the 100-hall medication storage room was conducted 4/14/2021 at 11:02 AM. A clear plastic zip-top bag was noted with multiple doses of promethazine suppositories in the door of the refrigerator. The expiration date on the medication label was 3/23/2021. A bottle of liquid lansoprazole was located inside of the refrigerator. The expiration date on the label was 9/24/2020. Medication technician (MT) #2 was interviewed on 4/16/2021 at 11:04 AM. MT #2 reported she did not remove expired medications from the refrigerator. Nurse #4 was interviewed on 4/14/2021 at 12:19 PM. Nurse #4 reported she had not been instructed to remove expired medications from the refrigerator. Nurse #5 was interviewed on 4/14/2021 at 4:07 PM. Nurse #5 reported she worked afternoon shift (3:00 PM to 11:00 PM) and she did not check the refrigerator for expired medications. Nurse #5 reported night shift (11:00 PM to 7:00 AM) was responsible for checking the refrigerator temperatures. Nurse #6 was interviewed on 4/15/2021 at 11:14 PM. Nurse #6 reported she worked night shift for the facility. Nurse #6 reported it was night shift ' s	F 761	deficient practice For other residents with the potential to be affected: Current residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: Review of the facility medication carts and medication rooms was conducted by the Director of Nursing on 5/5/2021 to ensure medications were not beyond their expiration date and no adverse effects found. License nurses including nurse #4, nurse #5, nurse #6, and medication Aide #2 were re-educated by the Director of Nursing on 5/8/2021 on checking expiration dates and discarding prior to expiration of medication. Facility plan to monitor its performance to make sure that solutions are sustained: Starting the week of May 16th the Director of Nursing, or licensed nurse will monitor medication carts and medication rooms via direct observation two times a week times 4, then one time a week times 8 to ensure medications are not expired. The Administrator, or Director of Nursing,will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI) for any	

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F 761	Continued From page 99 responsibility to check the temperature of the refrigerator every night and document the temperature, but she thought a pharmacy consultant came in and took out expired medications. The Director of Nursing (DON) was interviewed on 4/16/2021 at 3:47 PM. The DON reported she did not know why the expired medications were left in the refrigerator on the 100-hall. The DON reported she thought because the night shift nurse was checking the temperature of the refrigerator, they would remove expired medications. The DON reported she did not know if the task of removing expired medications was specific to the night shift nurse. The DON reported it was her expectation that expired medications would be removed and disposed.	F 761	additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and staff, pharmacist and physician interviews the facility failed to develop an Infection Control program that established an Antibiotic Stewardship Program that included the development of written protocols and a system to monitor infections and antibiotic	F 881	For affected resident(s): No residents were directly affected. For other residents with the potential to be affected: All residents have the potential to be	5/18/21

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F 881	Continued From page 100 use. This was evident for the 3 months reviewed (January 2021-March 2021) in the April 7, 2021 Quality Assessment and Process Improvement (QAPI) minutes and in interviews with the leadership team. Findings included: A review of the Antibiotic Stewardship Program (ASP) policy that was not dated, with the most recent attachment dated November 2017 revealed in part that the Infection Preventionist would oversee and fully implement the process with the Director of Nursing and the Leadership Team. The Medical Director would participate in data review and strategizing improvements, and the Consultant Pharmacist would actively review prescribing patterns for both individual patients and the facility overall and make recommendations to improve the process. Furthermore, it stated that nurses will review infection signs and symptoms against McGeer's criteria and question the appropriateness of dosing if it may not be clinically indicated. The policy for the antibiotic stewardship program indicated the goals were to be tracked and monitored and the ASP guidelines would be included in QAPI and analyzed against data for continuing improvement opportunities. A record review of the QAPI minutes from April 7, 2021 that included January 2021, February 2021 and March 2021 data, failed to address antibiotic stewardship, antibiotic usage or protocols, and did not have data included for infections for 10 of 12 months for 2020 in the minutes. An interview was completed with the Medical Director on 04/16/21 at 11:10 AM regarding the	F 881	affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: The Director of Nursing was educated on the Antibiotic Stewardship Program and its requirement by the Nurse consultant. The required monitoring is in place currently. On 4/29/2021 the Director of Nursing initiated the Antibiotic Stewardship Program. A licensed Nurse in the facility will register for the next SPICE training and complete the course and obtain certification by fall 2021 or a Nurse with a SPICE certification will be hired. . Audits of the required monitoring and documentation will be monitored x5 weekly for 1 month, 2 times weekly for 1 month then weekly for the 3rd month. After that time the program manager will report the monthly report to the Director of Nursing and Administrator. This will be reviewed at QAPI. The Administrator or DON will ensure the license nurse will complete the SPICE course in fall of 2021. The QAPI Committee can modify this plan to ensure the facility remains in compliance	

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Antibiotic Stewardship Program. She stated she had been involved with the facility's ASP in the past but due to a lot of staff turnover with the leadership team, it was difficult to put anything in place as there was no one to work on the process. She stated Antibiotic Stewardship was brought up at the QAPI meeting in the past, but due to no consistent DON it had not been done for a long time. She noted there was no antibiotic stewardship being done, and the facility had an opportunity with this. She said it was difficult to initiate monitoring or improvements because the DON leadership constantly changed.

An interview was conducted with the Facility Pharmacist that completed the monthly medication reviews on 04/16/21 at 1:00 PM. She stated she did not have any involvement with the Antibiotic Stewardship Program and that usually there was an Infection Prevention nurse at the facility that facilitated it. She noted there were no antibiotic protocols in place.

The Director of Nursing was interviewed on 04/15/21 at 11:49 AM regarding the Infection Control and Antibiotic Stewardship Program. She noted she had started working at the facility in late February and was currently also the Infection Prevention Nurse and the Staff Development Coordinator. She stated for the Antibiotic Stewardship Program, she spoke with the Medical Director about any concerns and the DON said she was mindful of antibiotic use. She said she had not kept any logs and no trending was being done right now. She noted they discussed antibiotics and the indications in QAPI now. She was informed this information was not in the minutes. She stated she was not aware of any antibiotic protocols.

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F 881	Continued From page 102 An interview was done on 04/16/21 at 3:16 PM with the Administrator regarding the Infection Control and the Antibiotic Stewardship program. He was not familiar with the criteria utilized for the Infection Control Program and said they probably mentioned infections in QAPI. He was not aware of the facility's Antibiotic Stewardship Program but stated they had talked about this in the past. He said the April minutes were for the March data. He was informed there were no protocols, trending or monitoring reported in the minutes of the April meeting and no minutes for Jan-March were in the QAPI book. It was reported to the Administrator that interviews with the Pharmacist, the Medical Director and the Director of Nursing had revealed that there was no trending of antibiotics or infections, and no follow up for antibiotics other than the monthly pharmacy review. He acknowledged the facility should have infection monitoring and the required Antibiotic Stewardship Program.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883		5/18/21

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F 883	Continued From page 103 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 883		

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F 883	Continued From page 104 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and review of the facility policy, the facility failed to administer the vaccine and provide the resident and their representative with education regarding the benefits and potential side effects of the pneumococcal immunization for 1 out of 5 residents reviewed for immunizations (Residents #63). Findings included: The facility policy titled "Pneumococcal Vaccine" dated 01/21, stated in part, "the resident's medical record shall include documentation that indicates at a minimum the following: -the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization Review of the medical record indicated a consent for the pneumococcal vaccine was signed by Resident #63's court appointed legal guardian on 07/07/20. Resident #63 was admitted to the facility on 07/08/20 with diagnoses that included, in part, Chronic Obstructive Lung Disease, liver failure and a history of falls. The Quarterly Minimum Data Set (MDS) assessment completed on 04/05/21 indicated Resident #63 was not cognitively intact. The medical record review for Resident #63 revealed that he had not received or had	F 883	For affected resident(s): Resident #63 was offered Pneumococcal vaccine and educated on the risks and benefits on 4/15/21. The resident refused the vaccine on 4/15/21. For other residents with the potential to be affected: Current residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. By 5/18/21 Current residents charts will be audited as to if they were educated on the risks and benefits and the Pneumococcal vaccine will be offered. Facility plan to prevent re-occurrence: On 5/11/2021 the administrator or Director of Nursing will ensure that the influenza and pneumococcal consent form will be added to the admission packet. Social worker or Admissions coordinator will notify each resident/Responsible party to acquire if they want the influenza and pneumococcal immunization. Social worker or Admissions coordinator will form a list of all residents that are consenting to the vaccine and give that list to the Director of Nursing to obtain an order from the physician for vaccine and the licensed nurse will administer the vaccine. Declination sheet will be kept in the file.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 105 documented refusal of the pneumococcal vaccine prior to the recertification survey in April 2021. Review of the pneumococcal vaccine administration record for Resident #63 completed by Nursing Supervisor #1 documented that risk and benefits education was reviewed and the resident refused the vaccine on 04/15/21. An interview was completed with the Regional Director of Quality Assurance on 04/15/21 at 1:27 PM regarding the lack of documentation for the pneumococcal vaccine education and administration for Resident #63. She noted they had opportunities for improvement with obtaining the consents, administration and the documentation of vaccine education. An interview was completed with the Director of Nursing/Infection Prevention Nurse/Staff Development Coordinator on 04/16/21 at 4:49 PM regarding the pneumovax vaccine administration. She was informed that education and administration was not documented on 1 resident and the example of the documentation was shown. She stated the facility should be compliant with the vaccine administration and providing the education to the resident or the resident's representative and the education and administration should be documented.	F 883	Facility plan to monitor its performance to make sure that solutions are sustained: Infection preventionist (IP) will monitor current residents yearly. Starting 5/18/21 Audits will be completed of new admissions medical records to verify that Pneumococcal and Flu vaccines (when in season) are offered and education is provided. The audits will be done Weekly for 3 months and then reviewed quarterly during care plans. The audit will be done by the Director of Nursing, Nurse Manger, IP or Medical records. The Administrator, or Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in compliance.	