STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 9/27/21 through 9/30/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# EKRC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/27/21 through 9/30/21. Event ID# EKRC11. 2 of the 2 complaint allegations were not substantiated.	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 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	F 550		10/26/21

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

Electronically Signed | 10/22/2021

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

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F 550	Continued From page 1 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 reviews, observations, staff and resident interviews, the facility failed to promote dignity by not providing privacy during an insulin injection (Resident #215) and by standing while assisting a dependent resident during a meal (Resident #59). This was for 2 of 2 residents reviewed for dignity. The findings included: 1. Resident #215 was admitted to the facility 3/17/2020 with diagnoses that included type two diabetes. Resident #215's most recent Minimum Data Set (MDS) dated 9/8/2021 indicated the resident was mildly cognitively impaired and had no moods or behaviors. The resident required extensive assistance with activities of daily living (ADL) and	F 550	F-550 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of	

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F 550	Continued From page 2 received insulin injections 7 out of 7 days during the assessment period. On 9/28/2021 at 8:08 AM Nurse #4 was observed asking Resident #215 to lift her gown so she could administer insulin in her abdomen. The resident was sitting on the side of her bed, visible from the door and visible to her roommate. Nurse #4 did not shut the door or pull the privacy curtain prior to administering insulin. The resident's lower abdomen and her incontinent brief were exposed during the insulin administration. An interview was conducted with Resident #215 on 9/28/2021 at 12:18 PM. She stated she did not want to "advertise". She wanted the nurse to close the door and pull the privacy curtain prior to administering insulin in her abdomen. When asked if the nurses routinely provided privacy during insulin administration, she stated some nurses did and others did not. On 9/29/2021 at 11:21 AM an interview was conducted with Nurse #4. She stated she typically does close the door and pull the curtain for privacy, but on that occasion, she just forgot. An interview was conducted with the Director of Nursing (DON) and the Administrator on 9/30/2021 at 12:39 PM. Both stated they expect staff to provide privacy and promote dignity for all residents. 2. Resident #59 was admitted on 9/4/20 with cumulative diagnoses of Diabetes and Dementia. Review of Resident #59's revised care plan dated 4/29/21 indicated she was dependent on staff to eat her meals.	F 550	Nursing (DON) discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the nursing staff regarding resident rights and that privacy must be given during injections and staff must be seated while assisting a resident during a meal. For affected resident(s): Resident #215 is ensured privacy during insulin injections and resident #59 is assisted during mealtimes with a staff member in a seated position. For other residents with the potential to be affected: On 10/21/2021 an audit (title: f-550) of all residents was done by the Director of Nursing to identify all residents that receive injections were provided privacy and that all residents that are dependent for meals were assisted by a staff member in a seated position. No other issues were noted during audit. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 10/13/2021 The Director of Nursing, Staff Development	

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F 550	Continued From page 3 Resident #59's annual Minimum Data Set (MDS) dated 9/13/21 indicated severe cognitive impairment and coded for extensive physical assistance for eating. In an observation on 9/28/21 at 8:50 AM, Resident #59 was sitting up in bed with Nurse #3 standing at the bedside feeding the resident. Observed was a chair in the room. Nurse #3 stated she normally does not stand while assisting a resident with eating because it was important to be at eye level when feeding Resident #59. In an interview on 9/30/21 at 12:39 PM, the Administrator stated it was his expectation that staff sit to assist residents with meals for dignity reasons.	F 550	Coordinator, and Unit Manager initiated re-education to all nursing staff regarding resident rights and the need to have privacy during injections and to assist with meals in a seated position. All nursing staff education will be completed by 10/25/2021. Any nursing employee that did not receive training by this date will receive it prior to the next shift scheduled. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by Administrator, DON, or designee to monitor and ensure that all residents that receive injections have the appropriate privacy and that all residents who require assistance with meals are assisted by staff in a seated position. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		10/26/21

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F 584	Continued From page 4	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

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

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

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

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

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F 584	Continued From page 5 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to ensure resident rooms were in good repair (Rooms #412, #414, #415, and #205) and failed to clean the Packaged Terminal Air Conditioner (PTAC) filters (Rooms #301, #303, #305 and #308). This was for 8 of 16 resident rooms reviewed for comfortable, clean, and homelike environment. The findings included: 1) On 9/27/21 at 10:50 AM, an observation of room 412 revealed damage to the plaster of the wall to the right of the window, exposing sheetrock. Observations were conducted during a round with the Maintenance Director on 9/29/21 at 11:10 AM. He observed the area of exposed sheetrock and indicated he was not aware of the damage to the wall. He acknowledged the area did require attention and would be repaired. The Administrator and Director of Nursing were interviewed on 9/30/21 at 9:15 AM, and stated it was important for the environment to be well repaired and homelike. 2) On 9/27/21 at 11:00 AM, an observation of room 414 revealed the top left dresser drawer was missing the drawer front. Observations were conducted during a round with the Maintenance Director on 9/29/21 at 11:15 AM.	F 584	F-584 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the maintenance staff regarding maintaining a safe/clean/comfortable/homelike environment. For affected resident(s): Resident room #s 412, 414, 415, and 205 were repaired on 9/30/2021 by the Maintenance Director. Resident room #s	

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F 584	Continued From page 6 He observed the missing top-drawer front to the dresser on the left side of the room and stated he was unaware it was missing but would address the issue. The Administrator and Director of Nursing were interviewed on 9/30/21 at 9:15 AM, and stated it was important for the environment to be well repaired and homelike. 3) On 9/27/21 at 11:15 AM, an observation of room 415 revealed the dresser to the right side of the room was missing the drawer front of the 2nd drawer. Observations were conducted with the Maintenance Director on 9/29/21 at 11:20 AM. He observed the missing second drawer front to the dresser on the right side of the room. He acknowledged knowing it was missing and stated he had the dresser part in his office but "just hadn't been back to replace it" but would address the issue. The Administrator and Director of Nursing were interviewed on 9/30/21 at 9:15 AM, and stated it was important for the environment to be well repaired and homelike. 4. On 9/27/21 at 9:55 AM, an observation of room 205 revealed the walls were patched in multiple areas with what appeared to be putty in preparation for painting. Observations were conducted during a round with the Maintenance Director on 9/30/21 at 12:00 PM. He observed the areas of patching in room 205. He acknowledged room 205 did require painting and the facility recently hired an assistant	F 584	301, 303, 305, and 308 air conditioner filters were cleaned on 9/30/2021 by the Maintenance Director. For other residents with the potential to be affected: A 100% audit (title: f-584) was completed by the Maintenance Director on 9/30/2021 to ensure that all rooms were in good repair and that all air conditioning filters were clean. No other occurrences were noted. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 9/30/2021 the Administrator completed re-education to the Maintenance Director and the Maintenance Assistant regarding maintaining rooms in good repair and maintaining clean air conditioner filters. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all resident rooms are in good repair and that all air conditioning filters remain clean. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be	

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F 584	Continued From page 7 to help get caught up on repairs. The Administrator and Director of Nursing were interviewed on 9/30/21 at 9:15 AM, and stated it was important for the resident rooms to be well repaired and homelike. 5. On 9/21/21 at 9:59 AM, an observation of Packaged Thermal Air Conditioning (PTAC) units in rooms 301, 303, 305 and 308 had a large amount of visible dust on the filters. Observations of rooms 301, 303, 305 and 308 were conducted during a round with the Maintenance Director on 9/30/21 at 12:00 PM. He stated normally all PTAC filters were cleaned monthly "but for some reason, I never even see those rooms and forget to clean the filters." He stated he had to ambulate down the 300 hall to get to his office in the secured unit, but stated not cleaning the PTAC filters on the 300 hall was an oversight. He stated facility recently hired an assistant to help get caught up on repairs and maintenance. The Administrator and Director of Nursing were interviewed on 9/30/21 at 9:15 AM, and stated it was important for the resident rooms to be well repaired and homelike.	F 584	addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		10/26/21

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respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman

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program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 10 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff and Responsible Party (RP) interviews and record review, the facility failed to provide a written notification with the grievance resolution to the resident, RP and/or family member. This was for 3 (Resident #41, Resident #24 and Resident #60) of 3 residents reviewed for grievances. The findings included: 1. Resident #41 was admitted on 9/9/20 with cumulative diagnoses of dysphagia, contractures and anxiety. Review of Resident #41's electronic medical record (EMR) indicated he had an RP listed as his first emergency contact. Review of a grievance dated 2/2/21 read Resident #41's RP had concerns regarding communication, customer service and Resident #41's care. The form read as the resolution, a follow up phone call was conducted with the RP informing her of the results/resolution of her grievance. The form did not indicate a verbal or written grievance resolution was provided. The grievance form was also not signed by any facility staff acknowledging the grievance had be resolved. In an interview on 9/29/21 at 4:32 PM, the Social Worker (SW) stated she was the facility	F 585	F-585 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the Social Service Director regarding the requirement of written notification of the grievance resolution to the resident, RP, and or family member.	

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F 585	Continued From page 11 grievance officer. She stated she and the department supervisor listed in the grievance completed the grievance investigations together to resolve any concerns. The SW stated she always communicated verbally with the individual who initiated the grievance and asked if they wanted a copy of the grievance. She stated she was not aware until 9/28/21 that a written grievance response was required. In a telephone interview on 9/30/21 at 11:41 AM, Resident #41's RP stated she did not recall ever receiving anything in writing regarding a grievance and did not recall being offered a written grievance resolution. In an interview on 9/30/21 at 1:47 PM, the Administrator and DON stated it was their expectation a written grievance resolution be provided to the party that initiated the grievance. 2. Resident #24 was admitted on 2/4/20 with a diagnosis of a Cerebral Vascular Accident. Review of a grievance dated 4/20/21 read Resident #24's family member was concerned about his rapid decline in function. A care plan meeting was completed with Resident #24's family to discuss his expected continued decline and prognosis. The form indicated the family member received verbal grievance resolution and was signed by the Administrator. The form did not include any documented evidence that the family member received a written grievance resolution. Review of a grievance dated 6/21/21 read Resident #24's family member went to the facility to cut Resident #24's hair and was unable to gain access by ringing the door bell or by phone. The	F 585	For affected resident(s): Written notification of the grievance resolution was sent to the resident, RP, and or family member as indicated for Resident #41, #24, and #60 by the Social Worker. Completed by 10/23/2021. For other residents with the potential to be affected: An audit was done by the social worker for all grievances in the past 6 months. Completed by 10/23/2021. Audit revealed additional individuals were affected. As a result, a written notification of the grievance resolutions was sent to the resident, RP, and or family member as indicated for any that were not previously provided. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 9/30/2021 the Administrator completed re-education to the Social Service director regarding the requirement of providing written notification of the grievance resolution to the resident, RP, and or family member even if verbally decline. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the	

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F 585	Continued From page 12 form read the receptionist was in the bathroom at the time he attempted to gain access. The form read the family member received verbal grievance resolution and was signed by the Social Worker. The form did not include any documented evidence that the family member received a written grievance resolution. In an interview on 9/29/21 at 4:32 PM, the SW stated she was the facility grievance officer. She stated she and the department supervisor listed in the grievance completed the grievance investigations together to resolve any concerns. The SW stated she always communicated verbally with the individual who initiated the grievance and asked if they wanted a copy of the grievance. She stated she was not aware until 9/28/21 that a written grievance response was required. A telephone interview was attempted on 9/30/21 at 11:00 AM with Resident #24's family member. There was no answer and surveyor was unable to leave a message. In an interview on 9/30/21 at 1:47 PM, the Administrator and DON stated it was their expectation a written grievance resolution be provided to the party that initiated the grievance. 3. Resident #60 was admitted to the facility on 3/4/2021 with diagnoses that included intervertebral disc degeneration of the lumbar region. Resident #60's quarterly Minimum Data Set (MDS) dated 9/15/2021 indicated the resident was mildly cognitively impaired, understood others, and could be understood by others. He	F 585	Administrator, DON, or designee to monitor and ensure that all grievances have a written notification of the grievance resolution sent to the appropriate party. The resident, RP, and or family member. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	

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required extensive assistance with activities of daily living.

The facility's grievance log revealed Resident #60 filed two grievances. On 3/15/2021 Resident #60 filed a grievance regarding the length of his quarantine being 14 days instead of 7 days. On 9/15/2021 Resident #60 filed a grievance regarding Nurse Aides (NAs) not getting him out of bed in the morning at his preferred time and his preference for his nurses to manage his colostomy and not the NAs.

On 9/29/2021 at 4:38 PM an interview was conducted with Resident #60. He stated he did meet with the social worker and the Director of Nursing (DON) regarding his grievances but he was not given or offered a written copy of resolutions for his grievances.

An interview was conducted with the facility's social worker on 09/28/2021 at 11:08 AM. She stated she addressed most of the grievances. She further stated the DON and the Administrator did handle some grievances as well. The social worker stated she and the department heads investigated the grievances and all grievances were discussed in the stand-up meeting held every morning. The social worker stated she followed up with the residents regarding resolutions. The follow up was verbal. The social worker stated she was not aware the regulation required a written response summary.

An interview was conducted with the Director of Nursing (DON) and the Administrator on 9/30/2021 at 12:39 PM. Both stated they expect residents to be given a written resolution regarding their grievances.

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F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, staff, Medical Director (MD), Physician #1 interviews and record review, the facility failed to recognize the use of an abdominal binder (a wide compression belt that encircles the abdomen) previously identified as	F 604	F-604 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of	10/26/21

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physical restraint and complete quarterly restraint assessments. The facility also failed to identify the use of a resident bed pushed up against a wall as a physical restraint. This was for 2 (Resident #32 and Resident #59) 2 residents reviewed for physical restraints. The findings included:

1. Resident #32 was admitted on 12/21/18 with a diagnosis of a Cerebral Vascular Accident.

Review of Resident #32's feeding tube care plan included the intervention of an abdominal binder around his feeding tube (a tube inserted directly into the stomach for nutrition) as tolerated by the resident. This intervention was last revised on 10/16/19.

Review of Resident #32' September 2021 Physician orders included an order dated 1/6/20 for an abdominal binder related to major depression disorder, poor safety awareness and a history of pulling out his feeding tube. Release the binder for activities of daily living (ADL) care and every 2 hours as needed every shift.

Review of Resident #32' electronic medical record (EMR) included a Physical Restraint Review for Reduction assessment dated 10/29/20 indicated an abdominal binder was in use. The determination section F of the assessment read as follows: Are the current or considered device(s) or bed placement for the resident considered a restraint? The form indicated the choice of "yes" was checked. The assessment indicated Resident #32 was not a candidate for a restraint reduction or elimination due to a history of removing his feeding tube.

correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

Root Cause:

The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the nursing staff regarding the recognition of an abdominal binder as a restraint as well as a bed pushed up against the wall.

For affected resident(s):

Resident #59’s bed was removed from against the wall by the Administrator and the Regional Director of Operations on 9/29/2021. A trial as conducted on 10/20/21 to use least restrictive device to secure medically needed feeding tube for resident #32. MD changed order from abdominal binder to secure lock on 10/20/2021 to secure feeding tube. Resident #32 will be assessed quarterly and as needed for any change in needs by the clinical team.

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F 604	Continued From page 16 Review of Resident #32's quarterly Minimum Data Set (MDS) dated 8/4/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total assistance with all his ADLs and coded as having no restraints. In a medication administration observation on 9/28/21 at 10:20 AM, Nurse #1 removed Resident #32's covers and lifted his gown. Observed around Resident #32's abdomen was an off-white stretchy abdominal binder that went completely around his torso and was secured with Velcro covering the feeding tube insertion site. Nurse #1 did not loosen the abdominal binder to access Resident #32's feeding tube but rather pulled the binder up to access his feeding tube. Nurse #1 stated Resident #32 had to wear the abdominal binder due to a history of pulling out his feeding tube. In an interview on 9/28/21 at 3:25 PM, Nursing Assistant (NA) #4 stated she did not recall Resident #32 making any effort to remove or unfastened his abdominal binder. She stated as far as she was aware, the only time the abdominal binder was released was during ADL care and maybe when the nurse performed his feeding tube care. In an interview on 9/29/21 at 10:07 AM, the Director of Nursing (DON) stated the abdominal binder was not considered a restraint but rather served as protection of Resident #32's surgical site. She clarified the surgical site was the insertion site of his feeding tube. The DON stated when a restraint was needed, the facility had to complete a restraint assessment, obtain consent from the resident or the responsible party and obtain Physician orders. She stated any restraint	F 604	For other residents with the potential to be affected: An audit was completed by the Director of Nursing on 9/30/2021 and no other abdominal binders were in use nor were there any other beds noted against the wall. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 10/13/2021 the Director of Nursing, Staff Development Coordinator, and Unit Manager initiated re-education to the nursing staff regarding what is considered a restraint, the proper process for restraint use that includes the need for a restraint reassessment, and reduction attempt along with supporting documentation. All nursing staff education will be completed by 10/25/2021 and will not return to work without this re-education. To protect residents from similar occurrences, on 9/30/2021 the Regional Clinical Reimbursement Consultant provided re-education to the Minimum Data Set (MDS) coordinator regarding the need for accurate coding on the MDS to reflect the use of an abdominal binder as a restraint. Facility plan to monitor its performance to make sure that solutions are sustained:	

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F 604	Continued From page 17 had to be reassessed at least quarterly to determine continued medical necessity or if a restraint reduction should be attempted. In an interview on 9/29/21 at 10:32 AM, the MD stated Resident #32' abdominal binder was not a restraint, medically necessary and was considered an article of clothing. In an observation on 9/30/21 at 9:30 AM, Nurse #1 asked Resident #32 to unfasten his abdominal binder. There was no response from the resident. Nurse #1 made multiple attempts to have Resident #32 unfasten his abdominal binder. Resident #32 never moved nor acknowledged understand of what Nurse #1 was asking of him. Nurse #1 stated he had not personally ever seen Resident #32 attempt to remove his abdominal binder but there had been instances where it would be loose. He stated he could not say that maybe a staff member did not adequately secure the binder. In an interview on 9/30/21 at 9:40 AM, NA #6 stated Resident #32 was unable to unfastened or remove his abdominal binder and she had never observed him making any attempt to do so. In an interview on 9/30/21 at 1:47 PM, the Administrator and DON stated Resident #32's abdominal binder was medically necessary and did not consider it as a restraint. 2. Resident #59 was admitted 9/4/20 with cumulative diagnoses of seizures, anxiety, insomnia, bilateral knee contractures and dementia with behavioral disturbance.	F 604	A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents are free from unnecessary restraints, accuracy of MDS coding of restraints along with supporting documentation, and that a restraint reassessment and reduction has been attempted at least quarterly for any resident that has a restraint. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	

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Review of Resident #59's two fall incidents in June 2021 (6/10/21 and 6/21/21) indicated she was found on the floor on the left side of her bed.

Review of Resident #59's annual Minimum Data Set (MDS) dated 9/13/21 indicated severe cognitive impairment and she exhibited both verbal and physical behaviors. She was coded for extensive to total assistance with her activities of daily living (ADLs). Resident #59 was coded as having no restraint.

Review of Resident #59's fall care plan last included an intervention dated 8/18/21 that read: Resident will have a fall mat to the right side of her bed with the left side of the bed to the wall per family request.

In an observation on 9/27/21 at 9:55 AM, Resident #59 was observed lying in her bed that was pushed up against the wall on her left side.

In an observation on 9/28/21 at 8:50 AM, Resident #59 was observed lying in her bed that was pushed up against the wall on her left side.

In an interview on 9/28/21 at 3:20 AM, the Staff Development Coordinator (SDC) stated recently Resident #59's family requested that her bed be pushed up against the wall on her left side because that was the side she had fallen from the bed in the past. The SDC stated Resident #59 would not be able to get out of her bed from the left side because the wall would prevent it.

In an interview on 9/28/21 at 3:25 PM, Nursing Assistant (NA) #4 stated she came in one day and the bed had been moved up against the wall. She stated she thought it was to prevent Resident

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F 604	Continued From page 19 #59's from falling out of the bed. In an interview on 9/29/21 at 10:07 AM, the Director of Nursing (DON) stated there had been no restraint assessment and no consent was obtained because it was the request of the family. The DON stated Resident #59's bed against a wall was a restraint. The DON stated when a restraint was needed, the facility had to complete a restraint assessment, obtain consent from the resident or the responsible party and obtain Physician orders. She stated any restraint had to be reassessed at least quarterly to determine medical necessity or an attempt in a reduction. In an interview on 9/29/21 at 2:34 PM, Physician #1 stated the staff moved her bed up against the wall on that side to keep her from falling out of the left side of her bed. He stated he did not think it was possible for Resident #59 to get out of the bed on the right side unless assisted by the staff. In an interview on 9/30/21 at 9:20 AM, NA #5 stated the Resident #59's bed was put against the wall on her left side because that was the side she had experienced previous falls. In an interview on 9/30/21 at 1:47 PM, the Administrator and DON stated unless Resident #59's bed was moved away from the wall, it would be considered a restraint.	F 604		
F 623 SS=B	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	F 623		10/26/21

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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 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

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F 623	Continued From page 21 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), 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.	F 623		

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F 623	Continued From page 22 §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 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 family and staff interviews, the facility failed to provide the resident and/or responsible party (RP) written notification of the reason for a hospital transfer for 3 of 3 residents reviewed for hospitalization (Residents #62, #64 and #54). The findings included: 1) Resident #62 was originally admitted to the facility on 10/25/19 with diagnoses that included dementia with Lewy Bodies, seizure disorder and diabetes. Resident #62's medical record revealed the following transfers and discharges: - Transferred to the hospital on 5/10/21 and readmitted back to the facility on 5/14/21. - Transferred to the hospital 7/19/21 and readmitted back to the facility on 7/23/21. - Transferred to the hospital on 8/19/21 and readmitted back to the facility on 8/26/21. There was no documentation that a written notice of transfer was provided to the resident and/or RP for any of the hospital transfers noted above.	F 623	F-623 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the Social	

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The quarterly Minimum Data Set (MDS) assessment dated 9/17/21 indicated Resident #62 had moderately impaired cognition.

During a phone call with Resident #62's RP, she indicated she had not received anything in writing regarding Resident #62's hospital transfers since the early part of 2021.

On 9/29/21 at 4:31PM, an interview was conducted with the Social Worker (SW), who stated she began employment with the facility on 5/17/21 and was unaware she was to send a written reason for the hospital transfer to the resident and/or RP.

The Administrator was interviewed on 9/30/21 at 12:39 PM and stated he was not aware the written notifications regarding hospital transfers were not being provided to the resident and/or RP. The Administrator further stated it was his expectation for the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation.

2) Resident #64 was originally admitted to the facility on 4/8/21 with diagnoses that included chronic obstructive pulmonary disease (COPD), seizure disorder and chronic pain.

A quarterly Minimum Data Set (MDS) assessment dated 7/15/21 indicated she was cognitively intact.

Resident #64's medical record revealed she was transferred to the hospital on 7/31/21 and did not return to the facility. There was no documentation of a written notice of transfer being provided to

Service Director regarding proper written notification requirements for the reason of a hospital transfer provided to the resident and/or responsible party.

For affected resident(s):

Resident #62 and #54 have returned to the facility and resident #64 now resides in another facility.

For other residents with the potential to be affected:

Social Worker conducted and audit (title: F-623) of all residents that were transferred and discharged in the last 30 days. Audit revealed that additional residents were affected. As a result, a written notification for the reason of a hospital transfer was provided to the resident and/or responsible party not previously provided. Audit completed 10/23/2021. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

Facility plan to prevent re-occurrence:

To protect residents from similar occurrences, on 9/30/2021 the Administrator re-educated the Social Service Director regarding the requirement to provide the resident and/or responsible party a written notification of the reason for a hospital transfer.

Facility plan to monitor its performance to make sure that solutions are sustained:

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F 623	Continued From page 24 the resident and/or RP for the hospital transfer. On 9/29/21 at 4:31PM, an interview was conducted with the Social Worker (SW), who stated she began employment with the facility on 5/17/21 and was unaware she was to send a written reason for the hospital transfer to the resident and/or RP. The Administrator was interviewed on 9/30/21 at 12:39 PM and stated he was not aware the written notifications regarding hospital transfers were not being provided to the resident and/or RP. The Administrator further stated it was his expectation for the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation. 3. Resident #54 was admitted on 4/23/21 with a diagnosis of a Cerebral Vascular Accident. His quarterly Minimum Data Set dated 9/6/21 indicated severe cognitive impairment. Resident #54 was sent to the hospital on 8/25/21 and was readmitted to the facility on 8/30/21. In an interview on 9/29/21 at 4:32 PM, the Social Worker stated it was her responsibility to send out the written reason Resident #54 was transferred to the hospital to his Responsible Party (RP). She stated she was unaware of the regulation until 9/29/21. A telephone interview was attempted on 9/30/21 at 11:00 AM with his RP. There was no answer and unable to leave a message. In an interview on 9/30/21 at 12:39 PM, the Administrator stated it was his expectation that	F 623	A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents and/or responsible parties are provided a written notification of the reason for a hospital transfer. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	

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F 623	Continued From page 25 anytime a resident transfers to the hospital, a written reason for the transfer was required.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident enrolled in the hospice program for 1 of 1 residents reviewed for hospice (Resident #62). The findings included: Resident #62 was originally admitted to the facility on 10/25/19 with multiple diagnoses that included dementia with Lewy Bodies, Parkinson's disease, and diabetes. Resident #62 was transferred to the hospital on 8/19/21 and returned to the facility on 8/26/21. The medical record for Resident #62 was	F 637	F-637 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause:	10/26/21

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F 637	Continued From page 26 reviewed and revealed a physician's order dated 8/26/21 to admit to hospice services due to a diagnosis of Alzheimer's disease. A review of Resident #62's care plan revealed a problem area initiated on 8/30/21 for Hospice services. A quarterly MDS assessment dated 9/17/21 indicated Resident #62 had moderately impaired cognition. Hospice was not coded. On 9/30/21 at 10:03 AM, the MDS Nurse was interviewed and stated a significant change in status MDS assessment should have been completed 14 days after Resident #62 enrolled in hospice services and she felt it was an oversight. An interview was completed with the Administrator and Director of Nursing on 9/30/21 at 12:39 PM and both stated it was their expectation for significant change in status MDS assessments to be completed as required.	F 637	The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the Minimum Data Set Coordinator (MDS) regarding the need for a significant change in status in the MDS assessment within 14 days after a resident is enrolled in a hospice program. For affected resident(s): Resident #62 had a significant change done in the MDS on 10/4/2021 by the MDS Coordinator. For other residents with the potential to be affected: A 100% audit (titled: F-637) of hospice residents was completed on 9/30/2021 by the MDS Coordinator to ensure that all significant changes were completed. All significant had been completed. the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 9/30/2021 the Regional Clinical Reimbursement Consultant provided re-education to the Minimum Data Set Coordinator (MDS) regarding the	

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F 637	Continued From page 27	F 637	need for a significant change in status in the MDS within 14 days after a resident is enrolled in a hospice program. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents newly enrolled in a hospice program have the required significant change assessment done in the MDS. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	
F 641 SS=E	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 record reviews, observations and staff	F 641	F-641	10/26/21

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interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of falls (Residents #31, #45, and #62), medications (Residents #63 and #59), nutrition (Resident #32), restraints (Resident #32), and demographics (Resident #58). This was for 7 of 17 residents reviewed.

The findings included:

1) Resident #31 was originally admitted to the facility on 2/3/20 with diagnoses that included dementia with Lewy Bodies, Atrial Fibrillation, and seizure disorder. Resident #31 transferred to the hospital on 7/22/21 and was readmitted to the facility on 7/28/21.

A review of Resident #31's medical record revealed he had no falls since readmission to the facility on 7/28/21.

The quarterly Minimum Data Set (MDS) assessment dated 8/1/21 indicated Resident #31 had severe cognitive impairment and was coded with 2 or more falls with no injury.

On 9/30/21 at 10:03 AM, an interview occurred with the MDS Nurse who reviewed the MDS assessment dated 8/1/21 as well as Resident #31's medical record. The MDS Nurse confirmed Resident #31 has had no falls since his readmission to the facility on 7/28/21 and falls should have been coded as no falls instead of 2 falls with no injury.

An interview was conducted with the Administrator and Director of Nursing on 9/30/21 at 12:39 PM and both stated it was their expectation for the MDS assessment to be coded

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Root Cause:

The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the MDS Coordinator regarding accurate coding of the MDS assessment in the areas of falls, medications, nutrition, restraints, and demographics.

For affected resident(s):

Resident #31, #45, #62, #63, #59, #32, and #58 all were corrected and coded accurately on the MDS by the MDS Coordinator. All changes were completed by 10/20/2021.

For other residents with the potential to be

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F 641	Continued From page 29 accurately. 2) Resident #45 was admitted to the facility on 12/24/12 with multiple diagnoses that included unsteadiness on feet, dementia, and Parkinson's disease. A review of Resident #45's medical record revealed she had 2 falls with no injury on 7/29/21 and 8/12/21 within the 8/27/21 MDS assessment look back period. The quarterly MDS assessment dated 8/27/21 indicated Resident #45 had moderately impaired cognition. She was coded with 2 or more falls with no injury and 2 or more falls with minor injury. On 9/30/21 at 10:03 AM, an interview occurred with the MDS Nurse who reviewed the MDS assessment dated 8/27/21 as well as Resident #45's medical record. The MDS Nurse stated it was an error that 2 falls with minor injury was coded. An interview was conducted with the Administrator and Director of Nursing on 9/30/21 at 12:39 PM and both stated it was their expectation for the MDS assessment to be coded accurately. 3) Resident #62 was originally admitted to the facility on 10/25/19 with diagnoses that included Parkinson's disease, dementia with Lewy Bodies and seizure disorder. He was most recently transferred to the hospital on 8/19/21 and readmitted to the facility on 8/26/21.	F 641	affected: Auditing (titled: F-641) by the MDS Coordinator on the accuracy of coding on the MDS for all residents over the past quarter to include falls, medications, nutrition, restraints, and demographics. Audit completed by 10/25/2021. Audit revealed additional coding discrepancies. All corrections were made as indicated. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 9/30/2021 the Regional Clinical Reimbursement Consultant provided re-education to the MDS Coordinator regarding the need for accurate coding on the MDS to reflect falls, medications, nutrition, restraints, and demographics. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all falls, medications, nutrition, restraints, and demographics are coded accurately on the MDS. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The	

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F 641	Continued From page 30 A review of Resident #62's medical record revealed he had falls on 9/1/21 with no injury, 9/11/21 with minor injury and 9/16/21 with minor injury since his return to the facility on 8/26/21. The quarterly Minimum Data Set (MDS) assessment dated 9/17/21 indicated Resident #62 had moderately impaired cognition and was coded with 2 or more falls with minor injury. On 9/30/21 at 10:03 AM, an interview occurred with the MDS Nurse who reviewed the MDS assessment dated 9/17/21 as well as Resident #62's medical record. The MDS Nurse stated it was an oversight not to code the fall with no injury. An interview was conducted with the Administrator and Director of Nursing on 9/30/21 at 12:39 PM and both stated it was their expectation for the MDS assessment to be coded accurately. 4) Resident #63 was admitted to the facility on 9/12/19 with diagnoses that included vascular dementia with behavioral disturbances, insomnia and depression. A review of Resident #63's September 2021 physician orders included Melatonin 10 milligrams (mg) 1 tab by mouth at bedtime for insomnia and Trazodone (an antidepressant medication that can used to aide in sleep) 25mg 1 tab by mouth at bedtime for sleep aid. The annual Minimum Data Set (MDS) assessment dated 9/17/21 indicated Resident	F 641	Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	

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#63 was cognitively intact and received 7 days of a hypnotic medication.

On 9/30/21 at 10:03 AM, an interview occurred with the MDS Nurse who reviewed the MDS assessment dated 9/17/21 as well as Resident #63's medical record. The MDS Nurse stated when she coded the MDS assessment she was looking at the use of Trazodone rather than classification of the drug. She stated Trazodone should not have been coded as a hypnotic.

An interview was conducted with the Administrator and Director of Nursing on 9/30/21 at 12:39 PM and both stated it was their expectation for the MDS assessment to be coded accurately.

5. Resident #32 was admitted on 12/21/18 with a diagnosis of a Cerebral Vascular Accident and a feeding tube (a tube inserted directly into the stomach for nutrition).

Review of Resident #32's September 2021 Physician orders included an order dated 8/11/21 for a mechanical soft texture diet with thin liquids and an order for a frozen nutritional cup three times daily dated 2/17/21. Resident #32's September 2021 Physician orders included an order dated 9/2/21 for tube feeding continuously for nutritional support. Resident #32's September 2021 Physician orders also included an order dated 1/6/20 for an abdominal binder related to a history of removing his feeding tube.

Review of Resident #32's quarterly Minimum Data Set (MDS) dated 8/4/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total assistance with all his activities of daily living. Review of section K

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(Swallowing/Nutritional Status) indicated he was not coded for the nutritional approach of his feeding tube and not coded for any nutrition taken by mouth. Review of section P (restraints) indicated he was not coded for the use of an abdominal binder as a restraint to prevent Resident #32 from removing his feeding tube.

During an medication observation with Nurse #1 on 9/28/21 at 10:20 AM, he stated Resident #32 took all medications through his feeding tube but did get a frozen nutritional supplement by mouth three times a day while on continuous tube feedings. Observed around Resident #32's abdomen was an off- white stretchy abdominal binder that went completely around his torso and was secured with Velcro covering the feeding tube insertion site.

In an interview on 9/30/21 at 10:15 AM, the MDS Nurse stated she did not code section K or section P accurately. She stated she should have coded Resident #32 for his tube feedings and oral intake but stated she did not think the abdominal binder was considered a restraint.

In an interview on 9/30/21 at 1:47 PM, the Administrator and Director of Nursing stated it was their expectation that the MDS be coded accurately.

6. Resident #59 was admitted 9/4/20 with cumulative diagnoses of seizures, anxiety, insomnia, bilateral knee contractures and dementia with behavioral disturbance.

Review of Resident #59's September 2021 Physician orders included an order for Trazadone (antidepressant) as bedtime for insomnia.

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Review of Resident #59's annual Minimum Data Set (MDS) dated 9/13/21 indicated she was not taking any antidepressants but was taking an hypnotic.

In an interview on 9/30/21 at 10:15 AM, the MDS Nurse stated she coded the Trazadone for what it was prescribed for rather than the medication classification. She stated it was inaccurate and an oversight.

In an interview on 9/30/21 at 1:47 PM, the Administrator and Director of Nursing stated it was their expectation that the MDS be coded accurately.

7. Resident #32 was admitted to the facility on 3/4/2021 with diagnoses that included hypertension, cardiovascular accident (stroke) and diabetes.

Resident #32's quarterly Minimum Data Set (MDS) dated 9/2/2021 indicated she was cognitively intact, understood by others and able to make herself understood. She was coded as male during the assessment period.

Review of Resident #32's previous quarterly MDS dated 6/15/2021 revealed the resident was coded as female.
An interview was conducted with Resident #32 on 09/28/21 at 12:25 PM. She stated she was female, her assigned gender at birth was female.

On 9/29/2021 at 3:00pm an interview was conducted with Nurse # 3. She stated she frequently provided care for Resident #32 and the

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F 641	Continued From page 34 resident's gender was female, and she lived as female. 09/29/21 at 3:09 PM an interview was conducted with the MDS nurse. She stated the demographic was an error on her part. Resident #32 should have been coded as female. On 9/30/2021 at 12:39pm and interview was conducted with the Director of Nursing and the facility Administrator. Both stated they expected the MDS to be coded correctly.	F 641		
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 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	F 656		10/26/21

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F 656	Continued From page 35 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 observation, staff interviews and record review, the facility failed to complete a comprehensive care plan in the areas of contractures and physical restraints. This was for 2 (Resident #24 and Resident #32) of 17 residents reviewed for comprehensive care plans. The findings included: 1. Resident #24 was admitted on 2/4/20 with a diagnosis of a Cerebral Vascular Accident. Resident #24's quarterly Minimum Data Set (MDS) dated 7/29/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total assistance with his activities of daily living and coded for impairment to his bilateral upper extremities. Review of Resident #24's care plan last revised on 6/30/21 did not include a care plan for	F 656	F-656 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI	

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F 656	Continued From page 36 contractures. In an interview on 9/30/21 at 10:15 AM, the MDS nurse stated she completed record review, interviews staff and completed observations with completing a comprehensive care plan. She stated Resident #24's bilateral hand contractures should have been care planned. She stated it was an oversight. In an interview on 9/30/21 at 1:47 PM, the Administrator and Director of Nursing (DON) stated they expected Resident #24's hand contractures would have been care planned. 2. Resident #32 was admitted on 12/21/18 with a diagnosis of a Cerebral Vascular Accident. Review of Resident #32's quarterly Minimum Data Set (MDS) dated 8/4/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total assistance with all his activities of daily living (ADLs) and coded as having no restraints. Review of Resident #32' September 2021 Physician orders included an order dated 1/6/20 for an abdominal binder (a wide compression belt that encircles the abdomen) related to major depression disorder, poor safety awareness and a history of pulling out his feeding tube. Release the binder for activities of daily living (ADL) care and every 2 hours as needed every shift. Review of Resident #32's care plan last revised 9/9/21 did not include a care plan for an abdominal binder as a physical restraint. In an observation on 9/30/21 at 9:30 AM, Nurse	F 656	committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the MDS Coordinator regarding the completion of a comprehensive care plan in the areas of contractures and physical restraints. For affected resident(s): Resident #24’s care plan was updated to reflect limited range of motion and resident #32’s care plan was updated to reflect change from abdominal binder to secure lock device. All updates were completed by the MDS Coordinator as of 10/20/2021. For other residents with the potential to be affected: An audit (titled: F-656) was completed by DON for all residents 10/21/21. No other residents were identified using abdominal binder. No other residents were identified to have new contractures or worsening limitations in Range of Motion (ROM). The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 9/30/2021 the Regional Clinical Reimbursement Consultant provided re-education to the MDS	

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F 656	Continued From page 37 #1 asked Resident #32 to unfasten his abdominal binder. There was no response from the resident. Nurse #1 made multiple attempts to have Resident #32 unfastened his abdominal binder. Resident #32 never moved nor acknowledged understand of what Nurse #1 was asking of him. Nurse #1 stated he had not personally ever seen Resident #32 attempt to remove his abdominal binder but there had been instances where it would be loose. He stated he could not say that maybe a staff member did not adequately secure the binder. In an interview on 9/30/21 at 10:15 AM, the MDS nurse stated she completed record review, interviews staff and completed observations with completing a comprehensive care plan. She stated she did not consider Resident #32's abdominal binder as a restraint. In an interview on 9/30/21 at 1:47 PM, the Administrator and DON stated they expected the residents to have a complete and comprehensive care plan.	F 656	Coordinator regarding the need for completion of the comprehensive care plan in the areas of contractures and restraints. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that residents with contractures and restraints are accurately reflected in a comprehensive care plan. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	
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.	F 657		10/26/21

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F 657	Continued From page 38 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise care plans in the area of falls (Residents #31 and #62) and in the area of isolation precautions (Resident #62). This was for 2 of 17 resident care plans reviewed. The findings included: 1) Resident #31 was originally admitted to the facility on 2/3/20 and most recently readmitted on 7/28/21. His diagnoses included dementia with Lewy Bodies, atrial fibrillation, history of falls and unsteadiness on feet. A quarterly Minimum Data Set (MDS)	F 657	F-657 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.	

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F 657	Continued From page 39 assessment dated 8/1/21 indicated Resident #31 had severe cognitive impairment and a wheelchair was used for mobility. Resident #31's care plan revealed a focus area for falls with interventions that included a referral for a high back wheelchair for positioning. This intervention was initiated on 4/23/21 and the care plan was most recently reviewed on 8/5/21. Observations were made of Resident #31 on 9/27/21 at 11:45 AM and 9/29/21 at 11:38 AM and he was sitting up in a regular wheelchair. An interview occurred with Nurse #2 and Nurse Aide (NA) #1 on 9/29/21 at 11:38 AM. Both verified Resident #31 used a regular wheelchair for mobility and was unable to recall if he had ever used a high back wheelchair. On 9/29/21 at 1:00 PM an interview was held with the Rehab Director who was familiar with Resident #31. She confirmed he was not using a high back wheelchair and was unaware if this had ever been used as an intervention for falls. The MDS Nurse was interviewed on 9/30/21 at 10:03 AM. She reviewed Resident #31's medical record and stated the intervention for a high back wheelchair should have been resolved when the care plan was reviewed, by her, on 8/5/21 as Resident #31 did not use this for mobility. An interview occurred with the Administrator and Director of Nursing on 9/30/21 at 12:39 PM. Both indicated it was their expectation for the care plan to be an accurate representation of the resident, when updated by the MDS Nurse.	F 657	Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the MDS Coordinator regarding care plan review and revision in the areas of falls and isolation precautions. For affected resident(s): Resident #31s care plan was revised for falls and resident #62s care plan was revised for isolation precautions by the MDS Coordinator on 9/30/2021. For other residents with the potential to be affected: A care plan review and revision audit (titled: f-657) was completed by the MDS Coordinator for residents that have falls and that have been under isolation precautions for the last quarter. Audit completed by 10/25/2021. No other inaccuracies were noted. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar	

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F 657	Continued From page 40 2 a) Resident #62 was originally admitted to the facility on 10/25/19 and most recently readmitted on 8/26/21. His diagnoses included Parkinson's disease, history of falling, dementia with Lewy Bodies and unsteadiness on feet. A review of Resident #62's September 2021 physician orders included the following: - An order dated 8/26/21 for Hospice services. - An order dated 9/2/21 for the bed to be in the lowest position possible when resident is in bed. - An order dated 9/13/21 for fall mats to both sides of the bed, winged mattress, and low bed in lowest position for safety promotion interventions. Hospice to provide durable medical equipment (DME). A quarterly Minimum Data Set (MDS) assessment dated 9/17/21 indicated Resident #62 had moderately impaired cognition, use of a wheelchair for mobility and 2 or more falls with minor injury. Resident #62's care plan, last reviewed on 9/20/21, revealed a focus area for falls with interventions that included: - New bed/crank bed in place. Remove electrical bed. This was initiated on 3/5/21. - Make a referral to therapy upon return from the hospital. This was initiated on 6/16/21 and revised on 9/28/21. - Remove fall mats due to resident ability to get up and stand without assistance. Ensure bed is low. This was initiated on 1/2/21 and revised on 9/16/21. - Floor mat to right side of bed with left side of bed to wall. Check placement of mat every shift. This was initiated on 9/17/21 and revised on 9/20/21.	F 657	occurrences, on 9/30/2021 the Regional Clinical Reimbursement Consultant provided re-education to the MDS Coordinator regarding the need for review and revision of care plans in the area of falls and isolation precautions. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that residents care plans are reviewed and revised as necessary in the areas of falls and isolation precautions. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	

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F 657	Continued From page 41	F 657		

On 9/27/21 at 10:46 AM, an observation occurred of Resident #62 while he was in bed. The electric bed was in the lowest position possible, winged mattress was present, fall mats were present to either side of the bed and the bed was not positioned against the wall.

An interview was held with Nurse #2 on 9/28/21 at 10:30 AM, who verified hospice had provided an electric low bed for Resident #62, fall mats were placed on either side of the bed and a winged mattress was present as part of falls interventions.

On 9/29/21 at 1:00 PM, an interview was conducted with the Rehab Director who was familiar with Resident #62. She explained since Resident #62 was active with Hospice services since 8/26/21, he would no longer be evaluated or treated for therapy services, unless hospice ordered it.

The MDS Nurse was interviewed on 9/30/21 at 10:03 AM. She reviewed Resident #62's medical record and stated the interventions for a crank bed, therapy referrals and left side of bed against the wall should have been resolved from the care plan. The use of the fall mats should have been revised and the winged mattress should have been added to the care plan. All of these changes should have occurred when she reviewed the care plan on 9/20/21.

An interview occurred with the Administrator and Director of Nursing on 9/30/21 at 12:39 PM. They both indicated it was their expectation for the care plan to be an accurate representation of the resident when updated by the MDS Nurse.

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F 657	Continued From page 42	F 657		

b) Resident #62 was originally admitted to the facility on 10/25/19 and most recently readmitted on 8/26/21. His diagnoses included Parkinson's disease, history of falling, dementia with Lewy Bodies and unsteadiness on feet.

A quarterly Minimum Data Set (MDS) assessment dated 9/17/21 indicated Resident #62 had moderately impaired cognition and isolation or quarantine for active infectious disease was not coded.

Resident #62's care plan revealed a focus area for isolation precautions due to resident has not had COVID vaccinations. This focus area was initiated on 9/1/21 and the care plan was most recently reviewed on 9/20/21.

On 9/27/21 at 10:46 AM, an observation occurred of Resident #62 while he was in bed. There was no indication Resident #62 was under isolation precautions and a roommate was present in the room.

An interview was held with Nurse #2 on 9/28/21 at 10:30 AM, who verified Resident #62 was under quarantine precautions shortly after his return from the hospital on 8/26/21 but was no longer under these precautions.

The MDS Nurse was interviewed on 9/30/21 at 10:03 AM. She reviewed Resident #62's medical record and stated the focus care plan for isolation precautions should have been resolved when she reviewed the care plan on 9/20/21.

An interview occurred with the Administrator and Director of Nursing on 9/30/21 at 12:39 PM. They

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F 657	Continued From page 43 both indicated it was their expectation for the care plan to be an accurate representation of the resident when updated by the MDS Nurse.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Physician #1 interviews and record review, the facility failed to ensure an air mattress ordered to promote wound healing was accurately set based on the resident's body weight. This was for 1 (Resident #59) of 2 residents reviewed for pressure ulcers. The findings included: Resident #59 was admitted on 9/4/20 with cumulative diagnoses of Diabetes, Dementia, contractures and a pressure ulcer to her sacrum. Resident #59's revised care plan dated 8/18/21 read she had a pressure ulcer to her sacrum. Interventions included an air mattress on her bed for pressure relief.	F 686	F-686 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.	10/26/21

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F 686	Continued From page 44 Review of Resident #59's September 2021 Physician orders included an order dated 2/16/21 for an air mattress to her bed to promote wound healing. There was no order regarding the assessment of the air mattress for proper function and/or settings. Resident #59's annual Minimum Data Set (MDS) dated 9/13/21 indicated severe cognitive impairment and extensive assistance with all her activities of daily living. Her weight was documented at 124 pounds. She was coded for one pressure ulcer present on admission with a pressure relieving mattress to her bed. The pressure ulcer Care Area Assessment read as follows: "Resident was admitted with stage 4 pressure wound to sacrum. Resident will receive proper treatment for pressure wound per MD orders with positive healing noted thru next review." In an observation completed on 9/27/21 at 10:12 AM, Resident #59 was lying on her left side on an air mattress with the mattress weight setting of 300 pounds. In an observation completed on 9/28/21 at 8:50 AM, Resident #59 was lying on her left side on an air mattress with the mattress weight setting of 300 pounds. A wound care observation was conducted on 9/28/21 at 10:10 AM with the Treatment Nurse. There were no observed concerns related to the wound care. The Treatment Nurse stated when using an air mattress on the bed of a resident with a pressure ulcer, the pressure setting were determined by the resident's weight. She stated	F 686	Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the treatment nurse to ensure an air mattress ordered to promote wound healing was accurately set based on the resident's body weight. For affected resident(s): Resident #59s air mattress was adjusted to the proper setting based on her weight on 9/29/2021 by the Administrator and the Regional Director of Operations. For other residents with the potential to be affected: A 100% audit (titled: f-686) was completed on 9/30/2021 by the Director of Nursing to ensure that all air mattresses ordered to promote wound healing were set accurately based on the resident's weight. All were accurately set. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 9/30/2021 the DON re-educated the treatment nurse	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 45 the nurses set the air mattress pressure based on the residents weight or unless otherwise specified by the Physician. In an observation and interview on 9/28/21 at 3:15pm, the Treatment Nurse and Nurse # 1 confirmed the air mattress weight setting was set for 300 pounds. The Treatment Nurse stated the setting should have been set to less than (<) 250 pounds and not 300 pounds. Nurse #1 stated Resident #59 did not weight much over 100 pounds and he adjusted the air mattress pressure to <250 pounds at this time. The Treatment Nurse stated the air mattress weight setting should be assessed weekly during the skin assessments. She stated she did not check the air mattress settings on a daily basis while completed wound care. She stated it was an oversight. In an interview on 9/29/21 at 2:34 PM, Physician #1 stated it was the nurses responsibility to ensure Resident #59's air mattress was set accurately based on her most recent weight of 124 pounds. In an interview on 9/30/21 at 12:29 PM, the Administrator and Director of Nursing stated it was their expectation that Resident #59's air mattress pressure setting were based on her weight of 124 pounds unless otherwise specified by the Physician.	F 686	regarding the process on how to accurately set an air mattress to promote wound healing based on the resident's body weight. On 10/13/2021 the Director of Nursing, Staff Development Coordinator, and Unit Manager initiated re-education to the nursing staff regarding the process on how to accurately set an air mattress to promote wound healing based on the resident's body weight. All nursing staff education will be completed by 10/25/2021 and will not return to work without this re-education. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all air mattresses ordered to promote wound healing are accurately set based on the resident's weight. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance.	

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F 686	Continued From page 46	F 686	The facility alleges compliance on 10/26/2021	
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, facility staff, rehabilitation staff and Physician #1 interviews and record review, the facility failed to assess a resident for the worsening of bilateral hand contractures (Resident #24) and also failed to obtain Physician orders for splint management (Resident #32). This was for 2 of 6 residents reviewed for range of motion. The findings included: 1. Resident #24 was admitted on 2/4/20 with a diagnosis of a Cerebral Vascular Accident. Review of Resident #24's	F 688	F-688 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate	10/26/21

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F 688	Continued From page 47 Admission/Re-Admission Screening dated 2/4/20 did not include any evidence that Resident #24 was admitted with bilateral hand contractures. Review of an Occupational Therapy (OT) Evaluation and Plan of Treatment report dated 3/4/21, under the musculoskeletal System Assessment, read Resident #24 did not have any contractures present. The evaluation read he was referred by nursing due to an increased need for assistance, decrease in strength and coordination. He was discharged from OT on 4/2/21 with no recommendations. Review of another OT Evaluation and Plan of Treatment report, dated 4/22/21, read OT would treat and address contractures by passive range of motion (PROM)/stretching, joint mobilization techniques and assess for upper bilateral orthotics. The reason for the OT referral was for decreased independence with self-feeding and decreased ROM in his bilateral upper extremities. Review of the OT Treatment encounter notes from 4/22/21 to 5/12/21 read, manual joint mobilization techniques and stretching of shortened connective tissue and PROM was provided to Resident #24' bilateral upper extremities to reduce stiffness and increase blood flow. The notes did not specify if the bilateral shoulders or hands were addressed. Review of the OT Discharge Summary dated 5/12/21 read the ROM performed was to his bilateral shoulders and did not mention his bilateral hand contractures. The goal of Resident #24 was to safely wear the least restrictive splinting/orthotic device during daily task without complaints of discomfort, in order to improve his	F 688	the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the nursing staff on the process of assessing worsening limitations in range of motion along with obtaining proper physician orders. For affected resident(s): Resident #24 is currently on therapy caseload (evaluated by Occupational Therapy on 10/11/2021) to address bilateral hand limitations and resident #32 had physician orders obtained on 9/30/2021. For other residents with the potential to be affected: An audit was completed on 10/21/2021 by the Director of Nursing to ensure that there were no other residents that exhibited worsening limitations in range of motion along with ensuring that all orders are in place for current splints/orthotics. Audit revealed additional residents were affected. As a result, orders were received for splints/orthotics as indicated and therapy referrals were made as indicated.	

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F 688	Continued From page 48 ability to participate in self-feeding. A scoop dish with a plate guard and divided plate was implemented. He was discharged with no change in his dependence and there was no documented evidence provided that the scoop dish with a plate guard and a divided plate were ever implemented. Review of Resident #24's care plan, last revised on 6/30/21, did not include a care plan for contractures or the risk for contracture development. Resident #24's quarterly Minimum Data Set (MDS) dated 7/29/21, indicated he had severe cognitive impairment and exhibited no behaviors. He was coded for total assistance with his activities of daily living as well as impairment to his bilateral upper extremities. An observation was conducted on 9/27/21 at 10:00 AM. There were no splints or protective devices observed to Resident #24's bilateral hand contractures. An observation was conducted on 9/28/21 at 8:43 AM, where wash clothes were noted to be inserted into Resident #24's bilateral hands. An observation was made on 9/28/21 at 12:10 PM. There were no splints or protective devices observed in Resident #24's bilateral hand contractures. An observation was conducted on 9/28/21 at 4:00 PM. There were no splints or protective devices observed in Resident #24's bilateral hand contractures.	F 688	The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 10/13/2021 the DON, Staff Development Coordinator, and the Unit Manager initiated re-education to the nursing staff regarding the process on how to identify worsening limitations in range of motion along with steps to follow if identified. This re-education also included obtaining the proper physician orders if splints/orthotics are necessary. All nursing staff education will be completed by 10/25/2021 and will not return to work without this re-education. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents have been assessed for contracture management and that the appropriate orders have been put in place if necessary. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for	

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F 688	Continued From page 49 An observation was conducted on 9/29/21 at 8:47 AM. There were no splints or protective devices observed in Resident #24's bilateral hand contractures. In an interview on 9/29/21 at 12:32 PM, the OT who treated Resident #24 stated she received a referral yesterday to evaluate Resident #24's hands. The OT stated when she discharged him from services on 5/12/21, he was using his hands and she only saw him to determine his eating skills and needs. She denied any contractures to his bilateral hands at that time and stated she assessed Resident #24 today and noted worsening of the ROM in his bilateral hands since May 2021. She stated she normally received a referral from nursing for any changes in a resident's ROM but had not received a referral for Resident #24. In an interview on 9/29/21 at 12:40 PM, the Rehabilitation Director stated the normal process was the nurse would fill out a referral form and give it to her and she would give the referral to the proper therapy discipline. She stated at one time, the therapist were completing a quarterly screening for changes in a resident, but it stopped. She continued to explain, she felt with the management transition, COVID-19, and staff turn-over, that was when the therapy screening stopped. She confirmed Resident #24 was being evaluated today by the OT. Review of the OT Evaluation and Plan of Treatment report dated 9/29/21, the reason for the referral was due to an exacerbation of decreased ROM in Resident #24's bilateral hands. It read Resident #24 would safely wear a resting hand splint on his right fingers, right hand,	F 688	any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/26/2021	

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F 688	Continued From page 50	F 688		

and right wrist for up to 2 hours with a target time of 6 hours, as well as would wear a resting hand splint on his left fingers, left hand, and left wrist for up to 2 hours with a target time of 6 hours.

In an interview on 9/30/21 at 9:00 AM, Nursing Assistant (NA) #5 stated Resident #24 had recently been transferred from the secured unit and had required total assistance with his meals in the unit and now on the 300 hall. She stated she did not recall any special plates or utensils delivered from dietary because he was unable to assist with eating due to his hand contractures. NA #5 stated she was uncertain when Resident #24's hand contractures developed but she had never seen any splints or protection in his hands until the past few days when wash clothes were added to his hands for protection.

In an interview on 9/30/21 at 9:30 AM, Nurse #1 stated Resident #24 required total staff assistance with his meals. He stated therapy picked him up yesterday for contracture management.
In an interview on 9/30/21 at 9:40 AM, NA #6 stated Resident #24 had to be fed and he did not use any adaptive equipment for his meals or for his bilateral hand contractures.

2. Resident #32 was admitted on 12/21/18 with a diagnosis of a Cerebral Vascular Accident.

Review of a Therapy Communication to Nursing form dated 7/29/21, read for the staff to apply Resident #32's resting hand splint as tolerated. The form was signed by the Occupational Therapist (OT), however, there were no signatures by the nurse acknowledging the need for a physician's order in order to ensure the

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F 688	Continued From page 51	F 688		

aides were aware of the need to apply Resident #32's right hand splint.

Attached to the communication form was a in-service education and training dated 8/5/21 of a right-hand resting hand splint but there was no documented resident's name, and there were no signatures by the Unit Manager (UM) or a nurse acknowledging the need for a physician's orders for splinting.

Review of Resident #32's quarterly Minimum Data Set (MDS) dated 8/4/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total assistance with all his activities of daily living and was not coded for any impairment to his bilateral upper extremities.

Review of an Occupational Therapy (OT) Discharge Summary dated 8/17/21 read Resident #32 would safely wear a resting hand splint on his right fingers, right hand, and right wrist for up to 4 with a target of 8 hours. The summary read he was discharged to staff, who were trained in his splinting program.

Review of Resident #32's care plan last revised on 9/9/21 did not include a care plan for any contractures.

Review of an undated Resident Care Guide did not include any instructions for the floor staff to put on and/or remove Resident #32's right hand splint.

Review of Resident #32's August 2021 and September 2021 physician orders did not include any orders for splinting of his right hand.

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F 688	Continued From page 52	F 688		

An observation was conducted on 9/27/21 at 10:00 AM. There was no splint observed to Resident #32's right hand.

An observation was conducted on 9/28/21 at 8:43 AM. There was observed a resting hand splint on Resident #32's right hand.

An observation was conducted on 9/28/21 at 12:10 PM. There were no resting hand splint observed on Resident #32's right hand.

In an interview on 9/28/21 at 3:25 PM, Nursing Assistant (NA) #4 stated she was under the impression that therapy was applying Resident #32' resting hand splint. NA #4 stated if there was nothing in the electronic task area or on the Resident Care Guide about a right-hand splint, the aides would have no way of knowing to apply, remove and document his right-hand splint.

An observation was conducted on 9/28/21 at 4:00 PM. There were no resting hand splint observed on Resident #32's right hand.

An observation was conducted on 9/29/21 at 8:47 AM. There was a resting hand splint on Resident #32's right hand.

In an interview on 9/29/21 at 12:32 PM, the OT stated Resident #32 was established with a splinting schedule in August 2021 and she notified the UM that she had completed the staff training and was discharging Resident #32 from OT services. The OT stated it was the responsibility of the UM or floor nurse to obtain the physician order and enter the order into the electronic medical record so the aides would

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F 688	Continued From page 53	F 688		

know to apply his right-hand splint daily.

In an interview on 9/29/21 at 2:00 PM, the Director of Nursing (DON) stated she was unable to locate any physician orders or documentation regarding Resident #32' right resting hand splint. She normally stated the therapy department would give the UM or the nurses the therapy communication form and the nurses or UM would enter the physician orders into the electronic medical record so that the aides would know to apply the splint. She stated she was uncertain as to why the process did not work for Resident #32.

In an interview on 9/29/21 at 3:29 PM, the UM stated when therapy discharged a resident from therapy services to the nursing staff with orders to implement a splinting program, the therapist was to complete a referral form and give it to her after the therapist educated the floor staff on any recommendations such as splinting. She stated after the therapist educated the staff, she was given the referral form along with the in-service sign in sheet. The UM stated at that point, the orders would be written and entered into the electronic medical record and added to the aide's task list. The UM stated the OT never gave her a referral form because she would have signed the form acknowledging the need for physician orders.

In an interview on 9/30/21 at 9:40 AM, NA #6 stated she was aware that Resident #32 wore a right-hand splint but there was no place to document that the staff were applying his splint.

In an interview on 9/30/21 at 1:47 PM, the Administrator and Director of Nursing stated it was their expectation that the facility would have

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F 688	Continued From page 54 obtained and entered Resident #32's right hand splinting orders into the electronic medical record to ensure his splint application.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview, the facility failed to provide a hazard free environment by utilizing a power strip for a window air conditioner unit for 1 of 14 rooms occupied by residents in the memory care unit (Room #411). The findings included: During an observation of Room 411 on 9/27/21 at 10:46 AM and 9/28/21 at 11:00 AM, a window air conditioner (AC) unit was plugged into a 6-receptacle power strip, by a resident's bed, not in use and easily accessible to residents. A review of the facility's undated policy titled, "Power Cords and Extension Cords" revealed, the use of "power strips for non-Patient Care Related Electrical Equipment (i.e., personal electronics) only in long term care resident rooms without Patient Care Related Electrical Equipment" and "Power strips in patient care room but outside	F 689	F-689 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged	10/26/21

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F 689	Continued From page 55 Patient Care Vicinity for non-related items are permitted". In addition, the policy stated, "the electrical and mechanical integrity of the assembly is regularly verified and documented". An interview occurred with the Administrator and Maintenance Director on 9/29/21 at 11:00 AM. The Administrator stated the central air conditioner for the memory care unit was not operating correctly at the end of 2019 and several window AC units were placed at that time. They both explained, they felt the power strip was used as the AC power cord was not long enough to reach the wall receptacle. The Maintenance Director stated he began employment at the facility January 2020 and was aware the window units were present as well at the power strip. He further stated the central air conditioner for the memory care unit was replaced June 2021 and the window AC units were no longer used. Both the Administrator and Maintenance Director stated they would not have expected the AC unit in the window to be plugged into a power strip, instead it should have been plugged directly into the wall receptacle or a receptacle should have been placed on the wall within the distance needed to plug the AC window unit in directly. On 9/29/21 at 11:10 AM an observation of Room 411 was made with the Maintenance Director where the window AC unit was plugged into a power strip, which was then plugged into the wall receptacle. The Maintenance Director stated power strips were allowed for items such as personal electronics in resident rooms and should be inspected and approved regularly. The Maintenance Director was unable to provide evidence of the facility regularly inspecting and approving the power strip observed in room 411.	F 689	non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the maintenance staff regarding providing a hazard free environment by utilizing a power strip for a window air conditioner occupied by residents in the memory care unit. For affected resident(s): Room #411 had the power strip removed by the Maintenance Director on 9/29/2021. For other residents with the potential to be affected: On 9/29/2021 the Maintenance Director audited (titled: f-689) all rooms to ensure no other power strips were utilized for a window air conditioner. No other power strips were identified. the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 9/29/2021 the Administrator re-educated the Maintenance Director and Maintenance regarding providing a hazard free environment and ensuring that power strips are not being utilized for window air conditioning units. Facility plan to monitor its performance to	

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F 689	Continued From page 56 The Maintenance Director stated he would remove the window AC unit and power strip.	F 689	make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all Window air conditioning units are free from power strip usage. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		10/26/21

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F 755	Continued From page 57 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff, pharmacist, the facility failed to obtain medication prescribed for pain which resulted in 10 missed doses for 1 of 5 (Resident #53) reviewed for unnecessary medications. The findings included: Resident #53 was admitted to the facility on 5/7/2021 with most recent readmission on 8/27/2021. Her admitting diagnoses included osteomyelitis (bone infection) of the vertebrae in the lower lumbar region. The resident's hospital discharge summary dated 8/27/2021 revealed Resident #53 was discharged with orders for oxycodone 10 milligrams (mg) orally every four hours as needed (prn) for pain, and pregabalin 75mg capsule three times daily	F 755	F-755 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause:	

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F 755	Continued From page 58 for pain. Resident #53's admission Minimum Data Set (MDS) dated 9/7/2021 indicated she was severely cognitively impaired with behaviors positive for disorganized thinking. Resident #53 required extensive assistance with activities of daily living (ADL) and received opioid 6 out of 7 days during the assessment period. The resident was on scheduled medication for pain and prn (as needed) medication for pain. She characterized her pain as frequent and rated her pain 7 out of 10 during the assessment period. The August 2021 Medication Administration Record (MAR) revealed Resident #53 had an order for pregabalin capsules, 75mg to be given orally three times daily for pain with a start date for this 8/27/2021. The medication was not administered from 8/27/2021 through 8/30/2021. There were 10 missed administrations during that time period. Each missed administration was documented as a 9, indicating the medication was not available for administration. . Further review of the August 2021 MAR revealed Oxycodone 10mg was administered orally every four hours 8/28/2021 through 8/30/2021. The August 2021 MAR revealed Resident #53's pain level was documented every shift. On 8/28/2021 her pain level was documented as 4-5 on a scale of 10 (with 10 being the worst pain ever experienced). Her pain level on 8/29/2021 was documented as zero every shift, and on 8/302021 her pain level was documented as low as 2 and as high as 7. Attempts to interview the resident were not successful. When asked to rate her pain level, she did not reply.	F 755	The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the nursing staff on the process of obtaining prescribed controlled medication. For affected resident(s): Resident #53 had other controlled pain medication available as needed that was administered to her and with every administration effectiveness was documented. Pregabalin was obtained and administrated on 8-31-21. For other residents with the potential to be affected: A 100% audit (titled: f-755) was completed on 10/21/2021 by the Director of Nursing to ensure all residents that are prescribed Pregabalin have an adequate supply. No other issues were noted. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 10/13/2021 the DON, Staff Development Coordinator, and Unit Manager initiated re-education to the nursing staff regarding the process on	

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F 755	Continued From page 59 A phone interview was conducted with Nurse # 5 on 9/29/2021 at 2:56 PM. She stated she worked Resident #53 on Saturday 8/28/2021 and Sunday 8/29/2021 and both days she called the pharmacy regarding the pregabalin. The pharmacist told her they had not received a hard script for the medication and could not fill it until the physician signed a hard script. She stated she sent a text to the facility's physician on 8/28/2021 and made him aware but she did not recall him texting her back. She called the pharmacy again on 8/29/2021 and was told the same thing. She could not recall if she called the physician again on 8/29/2021 to make him aware the pregabalin was not available. Nurse #5 felt the resident's pain was well controlled during her shifts. On 9/29/2021 at 2:37 PM an interview was conducted with Nurse #1. He stated he provided care for Resident #53 on 8/30/2021 and the pregabalin was not on the medication cart. He stated he personally called the pharmacy about the pregabalin and the pharmacist stated the hard script was not sent to the pharmacy. The facility's physician would need to write a script and send it to them before the order could be filled by the pharmacy. He stated he called and left a message for the facility's physician. He did not recall hearing back from pharmacy or the physician and the resident did not get the three scheduled doses of pregabalin on 8/30/2021. He stated he felt the resident's pain was well controlled during his shifts. A phone interview was conducted with the pharmacist on 9/30/2021 at 3:15pm. She stated the hard script for Resident #53's pregabalin was received in the pharmacy on 8/30/221 at 8:30 PM. She did note the hard script was dated 8/27/2021	F 755	how to properly obtain controlled medication prescribed for pain. All nursing staff education will be completed by 10/25/2021 and will not return to work without this re-education. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents prescribed for controlled pain medication(s) have an adequate supply. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	

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F 755	Continued From page 60 and faxed from the facility, but not faxed to the pharmacy until 8/30/2021. She further stated the script was filled and the medication was in the facility the morning of 8/31/2021. On 9/29/2021 at 3:26 PM an interview was conducted with the unit manager who entered the physician's orders when the resident was admitted on 8/27/2021 around 3:30 PM. She stated she did order the medication from pharmacy on 8/27/2021. She did not receive a communication from pharmacy on 8/27/2021 regarding a hard script for the medication but she was aware some medications required a hard script signed by the physician and pregabalin was one of them. She stated if there was a hard script for pregabalin, she did not see it when she put the orders in on 8/27/2021. She stated she did not call the physician and request a hard script for the pregabalin on 8/27/2021. Attempts to contact the facility's physician were not successful. An interview was conducted with the Director of Nursing (DON) and the Administrator on 9/30/2021 at 12:39 PM. The DON stated she had only been employed with the facility for a month and the Administrator stated he was not certain what the current process was for ordering medications that required a hard script. Both stated they needed to look into the process to see how it could be prevented in the future. Both stated they expect medications to be available for administration.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		10/26/21

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F 756	Continued From page 61 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 62 Based on observations, staff, Physician #1 and consultant Pharmacist interviews and record review, the consultant Pharmacist failed to identify the need for target behaviors for the use of psychotropic medications. This was for 4 (Resident #59, Resident #31, Resident #63, Resident #58) of 5 residents reviewed for unnecessary medications. The findings included: 1.Resident #59 was admitted 9/4/20 with cumulative diagnoses of seizures, anxiety, insomnia, bilateral knee contractures and dementia with behavioral disturbance. Review of Resident #59's September 2021 Physician orders included an order dated 8/18/21 for Haldol (antipsychotic) 1 milligram twice daily for yelling and screaming. Review of Resident #59's annual Minimum Data Set (MDS) dated 9/13/21 indicated severe cognitive impairment and she exhibited both verbal and physical behaviors. She was coded for an antipsychotic taken 7 of the 7 days during the MDS look back assessment. The psychotropic Care Area Assessment read as follows: "Resident takes psychotropic medications daily per MD orders for improvement of health status and will receive medications as ordered with no complications thru next review." Resident #59's revised care plan dated 8/18/21 read she used an antipsychotic medication related to yelling and screaming. Interventions included monitoring and recording the occurrence of the target behaviors. Review of Resident #59's September 2021medication administration record (MAR) did	F 756	F-756 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the nursing staff on the need for target behaviors for the use of psychotropic medications. For affected resident(s): Resident #59, #31, #63, and #58 all had target behaviors added to the medication administration record by the Director of Nursing on 10/21/2021. For other residents with the potential to be affected:	

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F 756	Continued From page 63 not include any place for the nurses to document any behaviors nor did the MAR indicated any target behaviors. Review of a Consultant Pharmacist note dated 9/22/21 read as follows: "Pharmacy Review Note: MRR completed. Medical record reviewed including orders, available lab and progress notes. No recommendations at this time." Review of Resident #59's nursing notes since 9/1/21 to 9/27/21 did not include any notes regarding the resident exhibiting any behaviors. An observation on 9/27/21 at 10:12 AM, Resident #59 was sleeping on her left side in her bed. In another observation and interview, on 9/28/21 at 8:50 AM, Resident #59 was sitting up in bed being assisted with her breakfast. She was calm and cooperative. Nurse #3 stated she normally worked third shift so was not as familiar with Resident #59's behaviors but she was aware that she often yelled. In a wound care observation on 9/28/21 at 10:10 AM, Resident #59 was cooperative but was observed saying unintelligible speech and holding her doll. The Treatment Nurse and Nursing Assistant (NA) #3 stated Resident #59 was known to yell out and bang her doll against the wall. In an interview on 9/30/21 at 9:00 AM, Nurse #1 stated Resident #59 could be combative but due to her small stature, she was unable to do any harm. He stated Resident #59 often yelled out, screamed and sang throughout the day. At that	F 756	An audit (title: f-756) was completed on 10/21/2021 by the Director of Nursing to ensure that all residents on psychotropic medications had target behaviors added to the medication administration record. Audit revealed that additional residents were affected. As a result, the necessary target behaviors were added to the medication administration record. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 10/13/2021 the DON, Staff Development Coordinator, and the Unit Manager initiated re-education to the nursing staff regarding the process on how to properly document target behaviors for residents on psychotropic medications. All nursing staff education will be completed by 10/25/2021 and will not return to work without this re-education. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents prescribed psychotropic medications have target behaviors to justify usage. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be	

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F 756	Continued From page 64 time, Resident #59 began yelling in her room. Nurse #1 stated it was time for her morning medications and he was going to administer her medications at this time. Nurse #1 stated there was a placed on the MAR to document yes or no for behaviors. When asked to check the MAR for a place to document behaviors related to Haldol, he confirmed there was no place to document any behaviors but assumed the behaviors were what was written on the Physician order. In an interview on 9/29/21 at 1:17 PM, the Director of Nursing (DON) stated the nurses documented behaviors in the nursing notes. She stated the target behaviors were yelling and screaming and she was unsure how the behaviors were dropped off her MAR. In an interview on 9/29/21 at 2:34 PM, Physician #1 stated target behaviors should have been identified during the monthly pharmacy medication review. In an interview on 9/29/21 at 4:43 PM, the consultant Pharmacist stated not all psychotropic medications require behavior monitoring. He stated during his monthly medication review, he reviewed Physician #1 and psychiatric notes for any behaviors. He stated if he saw monitoring by the Physician and psychiatric provider, they would have had to have obtained their information from the staff. In an interview on 9/30/21 at 1:47 PM, the Administrator and DON stated it was their expectation that the consultant Pharmacist identify the need for target behaviors monitoring when using an antipsychotic. 2) Resident #31 was originally admitted to the	F 756	addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	

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F 756	Continued From page 65	F 756		

facility on 2/3/20 with a recent readmission date of 7/28/21. His diagnoses included dementia with Lewy Bodies, seizure disorder, and depression.

The quarterly Minimum Data Set (MDS) assessment dated 8/1/21 indicated Resident #31 had severe cognitive impairment. He displayed wandering behavior 1 to 3 days and received 7 days of an antipsychotic medication, during the 7 day assessment look back period.

Resident #31's September 2021 physician orders included an order for Seroquel (an antipsychotic) 25 milligrams (mg) by mouth twice a day for anxiety and aggression related to dementia with Lewy Bodies. The date of the original order was 7/28/21.

Review of the Consultant Pharmacist medication review notes for Resident #31 from August 2021 and September 2021 did not reflect the need for monitoring targeted behaviors.

A review of Resident #31's nursing progress notes from 7/28/21 to 9/29/21 was completed and did not include documentation of any behaviors.

Resident #31's Medication Administration Records (MAR's) from 7/28/21 to 9/29/21 indicated he received Seroquel as ordered and exhibited no behaviors. The MAR did not list any targeted behaviors for staff to monitor.

On 9/27/21 at 11:45 AM, Resident #31 was observed sitting up in his wheelchair in the common area watching TV. He smiled when spoken to and appeared to be in good spirits.

Nurse #2 was interviewed on 9/29/21 at 11:42 AM

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and stated there was not a specific behavior monitored for Resident #31, however if he was observed with any behaviors they would be documented in the nursing progress notes. Did she say if the resident ever had behaviors?

On 9/29/21 at 4:43 PM, an interview occurred with the Consultant Pharmacist, who started working with the facility September 2021 and had completed the most recent medication review for Resident #31 on 9/21/21. He explained he referred to the nursing progress notes, physician and psychiatric progress notes to monitor for specific behaviors related to antipsychotic medications. He added monitoring was accomplished with staff documentation when behaviors were present, and he would not have recommended target behaviors to be monitored on a daily basis.

The Director of Nursing was interviewed on 9/30/21 at 12:39 PM and stated it was her expectation for the Pharmacy Consultant to identify any irregularities regarding Resident #31 to include the need for targeted behaviors for the use of Seroquel.

3) Resident #63 was admitted to the facility on 9/12/19 with diagnoses that included vascular dementia with behavioral disturbance, insomnia, seizure disorder and depressive disorder.

An annual Minimum Data Set (MDS) assessment dated 9/17/21 indicated Resident #63 was cognitively intact and had no behaviors. He received 7 days of an antipsychotic medication, during the 7 day look back period.

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Resident #63's September 2021 physician orders included an order for Seroquel (an antipsychotic) 75 milligrams (mg) by mouth at bedtime for agitation related to vascular dementia with behavioral disturbance. The date of the original order was 5/14/21.

Review of the Consultant Pharmacist medication review notes for Resident #63 from June 2021 until September 2021, did not reflect the need for monitoring targeted behaviors.

A review of Resident #63's nursing progress notes from 5/14/21 to 9/28/21 was completed and revealed behavioral symptoms during August 2021 and September 2021 of racial slurs towards staff members, calling out for assistance instead of using call light, making threatening statements towards staff and the facility, and repetitive requests for assistance.

Resident #63's Medication Administration Records (MAR's) from 5/14/21 to 9/28/21 indicated he received Seroquel as ordered and exhibited no behaviors. The MAR did not list any targeted behaviors for staff to monitor.

On 9/28/21 at 10:12 AM, an interview and observation of Resident #63 occurred. He was observed sitting up in bed watching TV. He was pleasant and stated he preferred to spend most of his time in bed watching TV and resting.

Nurse #1 was interviewed on 9/29/21 at 11:45 AM and stated behaviors were monitored on the MAR with documentation in the nursing progress notes. When asked what behaviors were displayed by Resident #63, stated "mostly agitation" and was unable to provide specific behaviors.

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On 9/29/21 at 4:43 PM, an interview occurred with the Consultant Pharmacist, who started working with the facility September 2021 and had completed the most recent medication review for Resident #63 on 9/22/21. He explained he referred to the nursing, physician and psychiatric progress notes to monitor for specific behaviors related to antipsychotic medications. He added monitoring was accomplished with staff documentation when behaviors were present, and he would not have recommended target behaviors to be monitored on a daily basis.

The Director of Nursing was interviewed on 9/30/21 at 12:39 PM and stated it was her expectation for the Pharmacy Consultant to identify any irregularities regarding Resident #63 to include the need for targeted behaviors for the use of Seroquel.

4. Resident #53 was admitted to the facility on 5/7/2021 with most recent readmission on 8/27/2021. Her admitting diagnoses included osteomyelitis (bone infection) of the vertebrae in the lower lumbar region, and major depressive disorder.

Resident #53's admission Minimum Data Set (MDS) dated 9/7/2021 indicated she was severely cognitively impaired with behaviors positive for disorganized thinking. Resident #53 required extensive assistance with activities of daily living (ADL) and received antipsychotic medications 7 out of 7 days, antidepressants 7 out of 7 days, and hypnotics 7 out of 7 days during the assessment period.

A review of Resident #53's care plan, last

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updated on 8/30/2021, revealed the following focus area:

" Resident uses psychotropic medications related to disease process, major depressive disorder and is on antipsychotic and antidepressant medications. Interventions included; administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift and consult with pharmacy, physician, to consider dosage reduction when clinically appropriate at least quarterly.

" Resident has a behavior of yelling out for attention related to care or sometimes noted to call and want nothing. Interventions included, monitor for side effects and effectiveness.

Resident #53's August 2021 and September 2021 Medication Administration Record (MAR) revealed an order for Seroquel 150 milligrams (mg) at bedtime for major depressive disorder with a start date of 8/27/2021. The MARs did not list target behaviors or any area to document if the behaviors were present.

On 9/29/21 at 4:31pm and interview was conducted with NA #7. She stated she did work with Resident #53 and was familiar with her. When asked about behaviors being monitored related to antipsychotic use, she stated she was not sure but she thought it might be that the resident crawled out of bed sometimes. She was not sure where to find Resident #53's targeted behaviors.

On 9/29/2021 at 4:32pm an interview was conducted with NA #8. She stated she worked with an agency but she was assigned to Resident #53 on 9/29/2021 and somewhat familiar with her. She stated she did not know what the resident's target behaviors were and she did not

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know where to find a list of target behaviors for Resident #53.

On 9/29/21 at 4:33pm an interview was conducted with Nurse #6. She stated she was assigned to Resident #53 on 9/29/2021. When asked about target behaviors being monitored related to the use of Seroquel, she stated she was new to the facility and she did not know Resident #53's target behaviors or where to find them. She further stated she has observed the resident talking to people who are not in the room.

Progress notes from 8/27/2021 through 9/29/2021 we reviewed for behavioral symptoms and revealed;
" On 9/20/2021 Nurse #4 documented the resident was yelling out and when asked what she needed, resident stated nothing.
" Resident #53 was reviewed during an Interdisciplinary Team Meeting on 9/24/2021. The target behavior discussed was documented as yelling out.

On 9/29/2021 at 4:43pm an interview occurred with the Consultant Pharmacist who started working with the facility September 2021. He completed Resident #53's most recent medication review on 9/22/2021. He explained he referred to the nursing progress notes, physician notes, and psychiatric progress notes to monitor for specific behaviors related to antipsychotic medications. He further stated monitoring was accomplished with staff documentation when behaviors were present, and he would not have recommended target behaviors be monitored on a daily basis.

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F 756	Continued From page 71 The director of nursing was interviewed on 9/30/2021 at 12:39pm and stated it was her expectation for staff to identify the targeted behavioral symptoms associated with the use of Seroquel.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		10/26/21

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F 758	Continued From page 72 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Physician #1 interviews and record review, the facility failed to identify the need for target behaviors and monitor those behaviors for the use of psychotropic medications. This was for 4 (Resident #59, Resident #31, Resident #63, and Resident #53) of 5 residents reviewed for unnecessary medications. The findings included: 1.Resident #59 was admitted 9/4/20 with cumulative diagnoses of seizures, anxiety, insomnia, bilateral knee contractures and dementia with behavioral disturbance. Review of Resident #59's September 2021 Physician orders included an order dated 8/18/21 for Haldol (antipsychotic) 1 milligram twice daily for yelling and screaming. Review of Resident #59's annual Minimum Data	F 758	F-758 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify	

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F 758	Continued From page 73 Set (MDS) dated 9/13/21 indicated severe cognitive impairment and she exhibited both verbal and physical behaviors. She was coded for an antipsychotic taken 7 of the 7 days during the MDS look back period. The psychotropic Care Area Assessment read as follows: "Resident takes psychotropic medications daily per MD orders for improvement of health status and will receive medications as ordered with no complications thru next review." Resident #59's revised care plan dated 8/18/21 read she used an antipsychotic medication related to yelling and screaming. Interventions included monitoring and recording the occurrence of the target behaviors. Review of Resident #59's September 2021 medication administration record (MAR) did not include any place for the nurses to document any behaviors nor did the MAR indicated any target behaviors. Review of Resident #59's nursing notes since 9/1/21 to 9/27/21 did not include any notes regarding the resident exhibiting any behaviors. An observation on 9/27/21 at 10:12 AM, Resident #59 was sleeping on her left side in her bed. In another observation and interview, on 9/28/21 at 8:50 AM, Resident #59 was sitting up in bed being assisted with her breakfast. She was calm and cooperative. Nurse #3 stated she normally worked third shift so was not as familiar with Resident #59's behaviors but she was aware that she often yelled.	F 758	the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the nursing staff on identifying the need for target behaviors and monitor those behaviors for the use of psychotropic medications. For affected resident(s): Resident #59, #31, #63, and #58 all had target behaviors added to the medication administration record by the Director of Nursing on 10/21/2021 for optimal monitoring. For other residents with the potential to be affected: An audit (titled: f-758) was completed on 10/21/2021 by the Director of Nursing to ensure that all residents on psychotropic medications had target behaviors added to the medication administration record for optimal monitoring. Audit revealed that additional residents were affected. As a result, the necessary target behaviors were added to the medication administration record for optimal monitoring. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 10/13/2021 the DON, Staff Development Coordinator, and Unit	

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F 758	Continued From page 74 In a wound care observation on 9/28/21 at 10:10 AM, Resident #59 was cooperative but was observed saying unintelligible speech and holding her doll. The Treatment Nurse and Nursing Assistant (NA) #3 stated Resident #59 was known to yell out and bang her doll against the wall. In an interview on 9/30/21 at 9:00 AM, Nurse #1 stated Resident #59 could be combative but due to her small stature, she was unable to do any harm. He stated Resident #59 often yelled out, screamed and sang throughout the day. At that time, Resident #59 began yelling in her room. Nurse #1 stated it was time for her morning medications and he was going to administer her medications at this time. Nurse #1 stated there was a placed on the MAR to document yes or no for behaviors. When asked to check the MAR for a place to document behaviors related to Haldol, he confirmed there was no place to document any behaviors but assumed the behaviors were what was written on the Physician order. In an interview on 9/29/21 at 1:17 PM, the Director of Nursing (DON) stated the nurses documented behaviors in the nursing notes. She stated the target behaviors were yelling and screaming and she was unsure how the behaviors were dropped off her MAR. In an interview on 9/29/21 at 2:34 PM, Physician #1 stated target behaviors should have been identified during the facility's monthly medication recommendations review. In an interview on 9/30/21 at 1:47 PM, the	F 758	Manager initiated re-education to the nursing staff regarding the process on how to properly document target behaviors and monitor for residents on psychotropic medications. All nursing staff education will be completed by 10/25/2021 and will not return to work without this re-education. Facility plan to monitor its performance to make sure that solutions are sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents prescribed psychotropic medications have noted target behaviors to justify usage and monitored appropriately. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee 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 substantial compliance. The facility alleges compliance on 10/26/2021	

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Administrator and DON stated it was their expectation that the facility identify the need for target behavior monitoring when using an antipsychotic.

2) Resident #31 was originally admitted to the facility on 2/3/20 with a recent readmission date of 7/28/21. His diagnoses included dementia with Lewy Bodies, seizure disorder, and depression.

A psychiatry progress note dated 7/29/21 indicated Resident #31 was assessed as calm and alert. Staff reported no concerns.

The quarterly Minimum Data Set (MDS) assessment dated 8/1/21 indicated Resident #31 had severe cognitive impairment. He displayed wandering behavior 1 to 3 days and received 7 days of an antipsychotic medication, during the 7 day look back period.

A review of Resident #31's care plan, last reviewed on 8/5/21, revealed the following focus areas:
- Resident uses psychotropic medications (Seroquel) related to dementia with Lewy Bodies. The interventions included to monitor/record occurrences of targeted behavior symptoms (pacing, wandering, disrobing inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol.
- Resident is at risk for behaviors related to diagnosis of Lewy Body Dementia with behavioral disturbances. History of declining medications, ADL care and other aspects of care prior to

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admission. Also, history of ramming wheelchair into staff's legs and ankles during periods of agitation, comments regarding suicide and refuses to wear facemask. The interventions included to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.

Resident #31's September 2021 physician orders included an order for Seroquel (an antipsychotic) 25 milligrams (mg) by mouth twice a day for anxiety and aggression related to dementia with Lewy Bodies. The date of the original order was 7/28/21.

Review of the Consultant Pharmacist medication review notes for Resident #31 from August 2021 and September 2021 did not reflect the need for monitoring targeted behaviors.

A review of Resident #31's nursing progress notes from 7/28/21 to 9/29/21 was completed and did not include documentation of any behaviors.

Resident #31's Medication Administration Records (MAR's) from 7/28/21 to 9/29/21 indicated he received Seroquel as ordered and exhibited no behaviors. The MAR did not list any targeted behaviors for staff to monitor.

On 9/27/21 at 11:45 AM, Resident #31 was observed sitting up in his wheelchair in the common area watching TV. He smiled when spoken to and appeared to be in good spirits.

An interview was held with Nurse Aide (NA) #1 on 9/29/21 at 11:38 AM, who was familiar with

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Resident #31. She stated he currently was without behaviors other than confusion and was accepting of care assistance.

Nurse #2 was interviewed on 9/29/21 at 11:42 AM and stated there was not a specific behavior monitored for Resident #31, however if he was observed with any behaviors they would be documented in the nursing progress notes. Nurse #2 stated in the past Resident #31 would become easily agitated and attempt to stand up on his own as well as being belligerent to staff, but he has not had any negative behaviors for a while.

An interview was completed with Physician #1 on 9/29/21 at 2:33 PM, who stated nursing staff would report if Resident #31 was displaying behaviors or side effects to a medication. Physician #1 added Resident #31's mood and behavior was stable on the current dose of Seroquel. Physician #1 stated he would expect target behaviors to be monitored for Resident #31's antipsychotic medication use and was unaware this was not occurring.

The Unit Manager (UM) was interviewed on 9/29/21 at 3:15 PM and confirmed target behaviors were not monitored on the MAR just whether or not behaviors were present at the time of medication administration by marking yes or no on the MAR.

On 9/29/21 at 4:43 PM, an interview occurred with the Consultant Pharmacist, who started working with the facility September 2021 and had completed the most recent medication review for Resident #31 on 9/21/21. He explained he referred to the nursing progress notes, physician

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and psychiatric progress notes to monitor for specific behaviors related to antipsychotic medications. He added monitoring was accomplished with staff documentation when behaviors were present, and he would not have recommended target behaviors to be monitored on a daily basis.

The Director of Nursing was interviewed on 9/30/21 at 12:39 PM and stated it was her expectation for the staff to identify Resident #31's monitoring need for targeted behavioral symptoms for the use of Seroquel.

3) Resident #63 was admitted to the facility on 9/12/19 with diagnoses that included vascular dementia with behavioral disturbance, insomnia, seizure disorder and depressive disorder.

A psychiatric progress note dated 9/14/21 revealed Resident #63 was talkative and at his baseline. No changes were noted.

An annual Minimum Data Set (MDS) assessment dated 9/17/21 indicated Resident #63 was cognitively intact and had no behaviors. He received 7 days of an antipsychotic medication, during the 7 day look back period.

A review of Resident #63's care plan, last reviewed on 9/20/21, revealed the following focus areas:
- Resident uses an antipsychotic medication. The interventions included to administer antipsychotic medication as ordered by the physician. Monitor for side effects and effectiveness every shift.
- Resident has a behavior problem of being verbally inappropriate to staff, will yell out

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randomly, and uses racial slurs towards staff during periods of agitation. The interventions included to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Document behavior and potential cause.

Resident #63's September 2021 physician orders included an order for Seroquel (an antipsychotic) 75 milligrams (mg) by mouth at bedtime for agitation related to vascular dementia with behavioral disturbance. The date of the original order was 5/14/21.

Review of the Consultant Pharmacist medication review notes for Resident #63 from June 2021 until September 2021, did not reflect the need for monitoring targeted behaviors.

A review of Resident #63's nursing progress notes from 5/14/21 to 9/28/21 was completed and revealed behavioral symptoms during August 2021 and September 2021 of racial slurs towards staff members, calling out for assistance instead of using call light, making threatening statements towards staff members and facility, and repetitive requests for assistance.

Resident #63's Medication Administration Records (MAR's) from 5/14/21 to 9/28/21 indicated he received Seroquel as ordered and exhibited no behaviors. The MAR did not list any targeted behaviors for staff to monitor.

On 9/28/21 at 10:12 AM, an interview and observation of Resident #63 occurred. He was observed sitting up in bed watching TV. He was pleasant and stated he preferred to spend most

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of his time in bed watching TV and resting.

Nurse #1 was interviewed on 9/29/21 at 11:45 AM and stated there was not a specific behavior monitored for Resident #63, however if he was observed with any behaviors they would be documented in the nursing progress notes. When asked what behaviors were displayed by Resident #63, Nurse #1 stated "mostly agitation" and was unable to provide specific behaviors.

An interview was completed with Physician #1 on 9/29/21 at 2:33 PM, who stated nursing staff would report if Resident #63 was displaying behaviors or side effects to a medication. Physician #1 stated he would expect target behaviors to be monitored for Resident #63's antipsychotic medication use and was unaware this was not occurring.

The Unit Manager (UM) was interviewed on 9/29/21 at 3:15 PM and confirmed target behaviors were not monitored on the MAR just whether or not behaviors were present at the time of medication administration by marking yes or no.

On 9/29/21 at 4:43 PM, an interview occurred with the Consultant Pharmacist, who started working with the facility September 2021 and had completed the most recent medication review for Resident #63 on 9/22/21. He explained he referred to the nursing, physician, and psychiatric progress notes to monitor for specific behaviors related to antipsychotic medications. He added monitoring was accomplished with staff documentation when behaviors were present, and he would not have recommended target behaviors to be monitored on a daily basis.

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ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

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The Director of Nursing was interviewed on 9/30/21 at 12:39 PM and stated it was her expectation for the staff to identify Resident #63's monitoring for targeted behavioral symptoms for the use of Seroquel.
4. Resident #53 was admitted to the facility on 5/7/2021 with most recent readmission on 8/27/2021. Her admitting diagnoses included osteomyelitis (bone infection) of the vertebrae in the lower lumbar region, and major depressive disorder.

Resident #53's admission Minimum Data Set (MDS) dated 9/7/2021 indicated she was severely cognitively impaired with behaviors positive for disorganized thinking. Resident #53 required extensive assistance with activities of daily living (ADL) and received antipsychotic medications 7 out of 7 days, antidepressants 7 out of 7 days, and hypnotics 7 out of 7 days during the assessment period.

A review of Resident #53's care plan, last updated on 8/30/2021, revealed the following focus area:
" Resident uses psychotropic medications related to disease process, major depressive disorder and is on antipsychotic and antidepressant medications. Interventions included; administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift and consult with pharmacy, physician, to consider dosage reduction when clinically appropriate at least quarterly.
" Resident has a behavior of yelling out for attention related to care or sometimes noted to call and want nothing. Interventions included,

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monitor for side effects and effectiveness.

Resident #53's August 2021 and September 2021 Medication Administration Record (MAR) revealed an order for Seroquel 150 milligrams (mg) at bedtime for major depressive disorder with a start date of 8/27/2021. The MARs did not list target behaviors or any area to document if the behaviors were present.

On 9/29/21 at 4:31pm and interview was conducted with NA #7. She stated she did work with Resident #53 and was familiar with her. When asked about behaviors being monitored related to antipsychotic use, she stated she was not sure but she thought it might be that the resident crawled out of bed sometimes. She was not sure where to find Resident #53's targeted behaviors.

On 9/29/2021 at 4:32pm an interview was conducted with NA #8. She stated she worked with an agency but she was assigned to Resident #53 on 9/29/2021 and somewhat familiar with her. She stated she did not know what the resident's target behaviors were and she did not know where to find a list of target behaviors for Resident #53.

On 9/29/21 at 4:33pm an interview was conducted with Nurse #6. She stated she was assigned to Resident #53 on 9/29/2021. When asked about target behaviors being monitored related to the use of Seroquel, she stated she was new to the facility and she did not know Resident #53's target behaviors or where to find them. She further stated she has observed the resident talking to people who are not in the

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F 758	Continued From page 83 room. On 9/29/2021 at 4:43pm an interview occurred with the Consultant Pharmacist who started working with the facility September 2021. He completed Resident #53's most recent medication review on 9/22/2021. He explained he referred to the nursing progress notes, physician notes, and psychiatric progress notes to monitor for specific behaviors related to antipsychotic medications. He further stated monitoring was accomplished with staff documentation when behaviors were present, and he would not have recommended target behaviors be monitored on a daily basis. The director of nursing was interviewed on 9/30/2021 at 12:39pm and stated it was her expectation for staff to identify the targeted behavioral symptoms associated with the use of Seroquel.	F 758		
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, facility staff, Speech Therapist (ST), Registered Dietitian (RD) and Medical Director (MD) interviews and record	F 808	F-808 This plan of correction constitutes a	10/26/21

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F 808	Continued From page 84 review, the facility failed to clarify oral dietary recommendations and obtain dietary Physician orders for a resident with a feeding tube. This was for 1 (Resident #32) of 1 residents reviewed for tube feeding. The findings included: Resident #32 was admitted on 12/21/18 with a diagnosis of a Cerebral Vascular Accident and a feeding tube. An ST Evaluation and Plan of Treatment dated 12/10/20 read Resident #32 was referred to ST services due to mild oral dysphagia as evidenced by prolonged mastication. His diet at the time of the evaluation was regular texture with thin liquids. Resident received additional nutritional support via his feeding tube. The ST Discharge Summary dated 1/25/21 read his long-term goal was met and the recommendation was unchanged. Resident #32 was to receive a regular diet with thin liquids. An RD progress note dated 2/5/21 read Resident #32 had a significant weight change of 7.5% weight loss in 90 days. The note read there was an order for a mechanical soft diet and the ST clarified that Resident #32 was ordered a regular diet. The mechanical soft diet order was discontinued. An RD progress note dated 2/26/21 read Resident #32's food trays were discontinued and his tube feeding was increased to continuous with a frozen nutritional cup by mouth three times daily. This was due to 10% weight loss in 180 days. The RD recommended a pleasure tray if cleared by ST.	F 808	written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the nursing staff regarding clarification of oral dietary recommendations and to obtain dietary physician orders for a resident with a feeding tube. For affected resident(s): Resident #32 had oral dietary orders clarified by the speech therapist on 9/28/2021. For other residents with the potential to be affected: An audit (title: f-808) was completed for all residents by the Director of Nursing on	

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An RD progress note dated 4/28/21 read Resident #32 had a significant weight gain of 7.5% in 90 days. The note read his continuous tube feedings were discontinued and now to be administered every 4 hours. He was still receiving the frozen nutritional cup.

An RD progress note dated 5/17/21 read Resident #32 was again prescribed continuous tube feeding with a frozen nutritional cup three times daily. The note read to continue the plan of care and the RD would continue to monitor.

RD notes dated 6/14/21 and 7/30/21 read there were no changes in Resident #32's dietary orders. He was to continue to receive a frozen nutritional cup three times daily along with his continuous tube feeding.

Resident #32's quarterly Minimum Data Set (MDS) dated 8/4/21 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for total assistance with all his activities of daily living. Review of section K (Swallowing/Nutritional Status) indicated he was not coded for the nutritional approach of his feeding tube and not coded for any nutrition taken by mouth.

An RD progress note dated 8/12/21 read there was no change in Resident #32's continuous tube feeding or his frozen nutritional cup, but the new recommendation was for Resident #32 to receive a pleasure tray.

Resident #32's September 2021 Physician orders included an order dated 8/11/21 for a mechanical soft texture diet with thin liquids and an order for a frozen nutritional cup three times daily dated 9/30/2021. No other residents are receiving tube feeding at this time. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

Facility plan to prevent re-occurrence:

To protect residents from similar occurrences, on 10/13/2021 the DON, Staff Development Coordinator, and Unit Manager initiated re-education to the nursing staff along with Dietary Manager regarding the process on how to properly obtain clarification of an oral dietary recommendations and to obtain corresponding dietary physician orders for a resident with a feeding tube. All nursing staff education will be completed by 10/25/2021 and will not return to work without this re-education.

Facility plan to monitor its performance to make sure that solutions are sustained:

A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents on a feeding tube have the needed clarification of oral dietary recommendations and to obtain corresponding dietary physician orders for a resident with a feeding tube. This monitoring process will take place weekly for 4 weeks then monthly for 4 months.

Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will

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F 808	Continued From page 86 2/17/21. Resident #32's September 2021 Physician orders also included an order dated 9/2/21 for tube feeding continuously for nutritional support. An RD progress note dated 9/3/21 read Resident #32 may receive a pleasure tray and a frozen nutritional cup by mouth. There were no new recommendations related to his tube feeding. Resident #32's tube feeding care plan last revised on 9/9/21 read he required a feeding tube related to dysphagia and was to receive pleasure feedings as tolerated. In an observation on 9/27/21 at 11:39 AM, Resident #32 was lying in bed with the head of his bed elevated to approximately 45 degrees. His tube feeding was running continuously as ordered. In an interview on 9/28/21 at 11:00 AM, the Director of Nursing (DON) stated Resident #32 only ate a nutritional supplement by mouth and that he was not NPO (nothing by mouth). The DON reviewed the September 2021 Physician orders and noted the order dated 8/11/21 for a mechanical soft diet with thin liquids. She stated Resident #32 was not receiving a mechanical soft diet. She was unable explain why Resident #32 was not getting his diet as ordered. In an interview on 9/29/21 at 9:00 AM, the Dietary Manager (DM) stated he received a dietary communication form yesterday (9/28/21) for Resident #32 to receive a mechanical soft diet and thin liquids. He stated he recalled at one point, Resident #32 was NPO and changed to a pleasure tray but up until 9/28/21, he was only	F 808	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 substantial compliance. The facility alleges compliance on 10/26/2021	

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given the frozen nutritional cups three times daily. He stated he had not received any additional dietary communication forms except one dated 2/17/21 for the frozen nutritional supplement.

In an interview on 9/29/21 at 10:32 AM, the MD stated Resident #32 should be NPO due to his severe dysphagia. A copy of the dietary communication form dated 9/28/21 for mechanical soft diet with thin liquids was reviewed by the MD. He stated he had never saw that form and it was not signed by him.

In an interview on 9/29/21 at 12:15 PM, the ST stated she stated she was not aware that Resident #32 was not getting his dietary trays. She stated she was asked to evaluate Resident #32 yesterday (9/28/21) and completed a bedside swallow study. Based on the swallow study, Resident #32 displayed no overt signs or symptoms of aspiration/penetration. (Aspiration is when food or liquid goes into the trachea and goes below the vocal cords while penetration is when food or liquid goes into the trachea but stays above the vocal cords). The ST stated she recommended a mechanical soft diet with thin liquids and tapering of his tube feedings. She stated the DON and RD were working together to develop a tube feeding tapering schedule. The ST stated she watched Resident #32 eat his breakfast this morning and he consumed 25% without any problems.

In a telephone interview on 9/29/21 at 2:52 PM, the RD stated she received a call from the facility yesterday (9/28/21) for clarification about Resident #32 diet orders. She stated she thought Resident #32 was receiving only a pleasure tray and the frozen nutritional supplement by mouth.

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The RD stated she was unaware of the order dated 8/11/21 for a mechanical soft diet. The RD stated she visited the facility twice monthly and after each visit, she emailed her recommendations to the Unit Managers (UMs) and the DON to obtain any needed Physician orders. The RD stated she only learned yesterday that Resident #32 was only receiving a frozen supplement by mouth.

In an interview on 9/29/21 at 4:11 PM, the Staff Development Coordinator (SDC) stated she and other UM who recently resigned discovered there was a problem with Resident #32's diet orders. She stated they received clarification orders on 8/11/21 that he should be receiving a mechanical soft diet with thin liquids. The SDC stated it was possible that she nor the resigned UM forgot to complete a dietary communication form to give to the dietary department.

In an interview on 9/30/21 at 1:47 PM, the Administrator and DON stated it was their expectation that Resident #32's oral dietary orders were clarified and accurate and Resident #32 receive his diet as ordered.