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	345000	A. BUILDING _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	401 LAMBERT ROAD BISCOE, NC 27209

(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 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency	E 004		11/12/21

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

Electronically Signed | 11/09/2021

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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The findings included: Review of the EP plan read it was last updated on 6/8/21. The plan did not include any names of signatures of who updated the plan on 6/8/21. On further review of the EP plan, it was noted that the resident list was last updated on 9/13/18, administration and nursing phone number last updated on 6/2/20 and the list of aide phone numbers were last revised on 7/31/20. An interview was conducted with the Administrator on 10/21/21 at 11:15 AM. The Administrator stated she forgot about updating the plan and was unable to explain why the title page read updated on 6/8/21. She stated she was responsible for ensuring the EP plan was updated and current.	E 004	The Emergency Preparedness Plan has been updated with the QAPI committee signatures during an Ad Hoc QAPI meeting on 11/8/2021 convened by the Administrator. The resident list has been updated on 11/8/2021 by the Director of Nursing. The staff phone number list has been updated by the Human Resources Director on 11/8/2021. Ongoing, the EPP will be reviewed for needed updates during each monthly QA committee meeting. The minutes will reflect this update. Any needed changes will be documented in the book with the signatures of those present at the meeting.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/18/21 through 10/21/21. Event ID# EMUJ11 1 of 1 complaint allegation was substantiated but did not result in a deficiency.	F 000		
F 563	Right to Receive/Deny Visitors	F 563		11/12/21

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F 563 SS=F	Continued From page 2 CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews, the facility failed to follow the Centers for Medicare and Medicaid (CMS) visitation guidelines when they imposed a restricted visitation schedule for 1 of 2 residents reviewed for visitation (Resident # 73). This	F 563	Residents have been notified that visitation is open for all visitors with no limitations to time of day/night or length of visitation. It was communicated by the Activities Director verbally and in writing on 10/28/2021.	

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F 563	Continued From page 3 facility practice had the potential to impact all residents residing in the facility. Findings included: The facility's undated Visitation Guidance was reviewed and read in part: " Compassionate care visits are always permitted " Outdoor visitation is preferred over indoor " Consideration should be given to how the total number of visitors in the facility may affect the ability to maintain infection prevention protocols (size of building and physical space). Resident #73 was admitted to the facility on 4/13/2016 with most recent reentry 6/8/2019. Her diagnoses include non-traumatic brain dysfunction and dementia. Resident #73's annual Minimum Data Set (MDS) dated 9/28/2021 indicated the resident was severely cognitively impaired, had unclear speech, rarely understood and rarely understood others. She required extensive assistance with all Activities of Daily Living (ADL), toileting, and personal hygiene. On 10/18/2021 at 2:10 PM an interview was conducted with Resident #73's family. The family member stated that she lived 2 miles away from the facility and wanted to visit Resident #73 more often, but she could not since the facility had restricted visitation. She further stated the facility told her she could only visit on certain days. The facility scheduled visitation per resident hall and a scheduled was provided to family members. On 10/19/2021 at 4:14 PM an interview was	F 563	Responsible parties were notified that visitation is open for all visitors with no limitations through Regroup(robo-call) to all Responsible party's emails, text messages, and voice mail or call to all telephone numbers on file by the Administrator on 10/22/2021. Signs are posted at the front door with this change in visitation. Current staff have been educated that visitation is open to all visitor regardless of time of day/night or length of visitation with the requirement that the visitor pass the screening process and wear a mask during the entire visit while in the building. Education was reinforced to all staff through re education verbally and in writing by the Administrator and Director of Nursing on 11/11/2021. The Administrator will question visitors randomly when they are in the building to ensure that they are aware of the updated visitation guidelines. The Administrator or designee will question residents randomly to ensure that they understand the updated visitation guidelines. This will be documented with 5 visitors a week and 2 alert and oriented residents a week for 8 weeks. The result of this monitoring will be reported by the Administrator to the QA Committee for review and recommendations for the duration of the	

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F 563	Continued From page 4 conducted with the facility's Administrator. When asked if visitation was restricted, she stated visitation is scheduled by hall due to staffing shortages. Visitation was allowed on one resident hall per day, a schedule was provided to residents' family and friends. When asked if she was aware of the most recent CMS guidelines regarding visitation, she stated they are continuing limited visitation to one hall a day due to staffing shortages.	F 563	monitoring period.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		11/12/21

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F 580	Continued From page 5 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff and Responsible Party (RP) interviews and record review, the facility failed to immediately inform the resident's RP of a resident fall with injuries. This failure was for 1 (Resident #175) of 5 residents reviewed for notification of changes in condition. The findings included: Resident #175 was admitted on 7/27/21 with cumulative diagnoses of Cerebral Vascular Accident, dementia and a history of falls. Resident #175's admission Minimum Data Set (MDS) dated 8/2/21 indicated moderate cognitive impairment and she exhibited no behaviors. She	F 580	A notification of the fall for Resident #175 was conducted when resident was sent to the emergency room on the day of the fall. An audit was conducted of resident falls in the last 30 days to validate that notification was completed in a timely manner of no more than an hour. Any reporting that is documented as out of this parameter for notification will be reviewed with the resident/resident representative. This will be completed by the Director of Nursing by 11/11/21. Licensed nurses will be reeducated to	

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F 580	Continued From page 6 was coded for extensive assistance of two staff for bed mobility and transfers. She was also coded for falls prior to admission to the facility. Review of a fall incident dated 8/20/21 and completed by Nurse #3 indicated Resident #175 fell at 12:30 AM. The report read a noise was heard from the hall and discovered Resident #175 was laying on the floor. Swelling and bruising was noted to her left wrist and she complained of left hip pain and an x-rays were ordered. There was not any no documented evidence of Resident #175's RP notification Review of a nursing note dated 8/20/21 at 6:13 AM indicated the facility were still awaiting the results of the x-rays. There was no documented evidence of Resident #175's RP notification Review of a nursing note dated 8/20/21 at 7:03 AM, read the nurse was informed in morning report that Resident #175 fell during third shift and resident was complaining of left hip and left wrist pain. The facility was still awaiting the x-ray results. The note read Resident #175's left leg was rotated inward and her left wrist was swollen and bruised. She sent Resident #175 to the emergency room for an evaluation. Her RP was notified at this time. A telephone interview was conducted on 10/18/21 at 2:17 PM with Resident #175's RP He stated he was not made aware of the fall until the facility sent her to the hospital for an evaluation. The RP stated he expected the facility to notify him for all incidents as soon as possible and have never told anyone at the facility otherwise. An interview was conducted on 10/19/21 at 12:10	F 580	notify the resident representative of the resident's fall as soon as possible after the resident has been assessed and made comfortable, but no later than 1 hour after a fall. The exception is where the resident or representative has requested not to have notification. This education will be completed by 11/11/21 by the Director of Nursing or designee. Any licensed staff that is not working and cannot be reached within the reeducation time frame, will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation and prior to taking an assignment. Falls will be reviewed in the next meeting of the Interdisciplinary Team following the fall. During this review, notification within a 1 hour time frame will be validated in the documentation in the medical record. Any variance from this time frame will be noted and follow up with the nurse and the resident representative to ensure notification was completed timely. This will be documented for each Interdisciplinary Team meeting reviewing a fall for the first time 5 days a week for 4 weeks, and then weekly for 8 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee	

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F 580	Continued From page 7 PM with Nurse #1. She stated upon coming in on 8/20/21 for first shift, Nurse #3 reported Resident #175 sustained a fall on third shift and still awaiting the results of the x-rays. Nurse #1 stated on assessment of Resident #175, her left wrist there was noted swelling and discoloration and she also complained of left hip pain. She notified the Physician and orders were given to send her to the hospital for an evaluation. She stated she notified her RP at the time she was being sent out to the hospital. In a telephone interview on 10/20/21 at 2:25 PM, Nurse #3 stated she noted Resident #175's left wrist was swollen but on assessment, she did not see evidence of a possible hip fracture. Nurse #3 stated Resident #175 initially complained of wrist, hip and ankle pain to her left side but during her neurological checks during the night, and x-rays were ordered. Nurse #3 stated she was waiting for the x-ray results to be available prior to calling her RP. She stated thought she notified Resident #175's RP at 6:30 AM. An interview was conducted on 10/21/21 at 12:15 PM with the DON and Administrator. The Administrator stated she expected the nurses to notify a resident's RP at the time of an incident with injuries. The DON stated some families request not to be called and it would be noted in their medical record. The DON confirmed no documented evidence that Resident #175's RP did not wish to be notified at the time of an incident.	F 580	11/12/2021	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		11/12/21

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F 641	Continued From page 8 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of medications (Resident #8), falls (Resident #8) and discharge disposition (Resident #77) for 3 of 22 sampled residents reviewed (Residents #8 & #77). Findings included: 1a. Resident #8 was originally admitted to the facility on 10/4/19 with multiple diagnoses including psychosis. The quarterly MDS assessment dated 10/12/21 indicated that Resident #8 had severe cognitive impairment and she had received an antipsychotic medication for 7 days during the assessment period. The assessment further indicated that a gradual dose reduction (GDR) for the antipsychotic medication was not attempted. Resident #8 had doctor's orders dated 6/17/21 for Seroquel (an antipsychotic drug) 25 milligrams (mgs) 1 tablet by mouth at bedtime and on 6/18/21 for Seroquel 25 mgs - ½ tablet by mouth in the afternoon (2:00 PM). On 9/3/21, there was an order to discontinue the Seroquel 25 mgs - ½ tablet in the afternoon. MDS Nurse #1 was interviewed on 10/20/21 at 11:45 AM. The MDS Nurse indicated that she reads the psychiatric notes when she completes the section for the antipsychotic medications. The notes indicated that GDR was not indicated, and she thought that there was no GDR	F 641	Resident #77 has had a modification of the discharge assessment completed and transmitted on 11/12/2021. The MDS for Resident # 8 had not been transmitted and was corrected prior to submission to clarify that the a gradual reduction had occurred and that there was a fall with pain, so coded as a fall with injury and transmitted on 11/12/2021. Residents at risk for these issues are those that have had a gradual dose reduction, a fall with pain, or a discharge from the community. Those residents will be have their Minimum Data Set (MDS) Assessments reviewed for accuracy by the Administrator or designee. Any inaccurate coding identified will result in a modification being completed and transmitted. The nurses completing the MDS assessments were reeducated concerning the expectation that gradual dose reductions, pain from falls, and discharge documentation will be coded correctly by the Regional Reimbursement Consultant by 11/11/2021. A reconciliation note can be documented if the documentation fails accurately capture the activity. The MDS will print 5 completed/accepted comprehensive assessments a month. These will be given to the Administrator to	

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F 641	Continued From page 9 attempted. When the order dated 9/3/21 to discontinue the afternoon dose of Seroquel was brought to her attention, she replied that she missed that order. The MDS Nurse reported that she would correct the quarterly assessment dated 10/12/21 to reflect that GDR was attempted. The Director of Nursing (DON) was interviewed on 10/21/21 at 12:16 PM. The DON stated that she expected the MDS assessments to be coded accurately. 1b. Resident #8 was originally admitted to the facility on 10/4/19 with multiple diagnoses including psychosis. The quarterly MDS assessment dated 10/12/21 indicated that Resident #8 had severe cognitive impairment and she had 1 fall with no injury since admission or prior assessment. Review of the progress notes and the incident reports revealed that Resident #8 had a fall on 9/25/21 at 8:50 PM. Resident #8 complained of pain to her right shoulder, the doctor was notified, and x-ray was ordered with no fracture noted. MDS Nurse #1 was interviewed on 10/20/21 at 11:45 AM. The MDS Nurse verified that Resident #8 had a fall on 9/25/21 and she complained of right shoulder pain. The MDS Nurse explained that she normally did not consider pain as an injury in coding the section for falls. The Director of Nursing (DON) was interviewed on 10/21/21 at 12:16 PM. The DON stated that she expected the MDS assessments to be coded accurately. 2) Resident #77 was admitted to the facility on	F 641	review for accuracy of psychotropic medication gradual dose reduction, pain with falls, or discharge locations of coded. This process will be documented for 3 months. The Administrator will report the results of the monitoring to the monthly QA committee for review and recommendations for the time frame of the monitoring period.	

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F 641	Continued From page 10 6/22/21 with diagnoses that included non-pressure chronic ulcer of the left foot, diabetes type 2 and hypertension. He was discharged home on 8/5/21. The Admission Minimum Data Set (MDS) assessment dated 6/28/21 indicated Resident #77 was cognitively intact, expected to be discharged to the community and active discharge planning was occurring. Resident #77's active care plan, last reviewed on 7/7/21, indicated he planned to return to the community setting. A nursing progress note dated 8/5/21 indicated Resident #77 was discharged home in a private vehicle with his spouse. Review of the Discharge MDS assessment dated 8/5/21, revealed Resident #77 was coded as discharged to the acute care hospital. On 10/20/21 at 3:00 PM, an interview was completed with MDS Nurse #1 who confirmed the resident was marked as discharged to the hospital instead of the home setting in error.	F 641		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to trim and	F 677	Resident #19, #20, #29 have had their nails cleaned and trimmed.	11/12/21

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F 677	Continued From page 11 clean dependent residents' nails (Residents #19, #20 and #29) and failed to ensure a resident was free from unwanted facial hair (Resident #59). This was for 4 of 5 residents reviewed for Activities of Daily Living (ADL's). The findings included: 1) Resident #19 was originally admitted to the facility on 9/17/18 with diagnoses that included dementia, muscle weakness, history of a stroke, and type 2 diabetes. A quarterly Minimum Data Set (MDS) assessment dated 7/27/21 indicated Resident #19 had moderately impaired cognition. She required extensive assistance from staff for dressing, personal hygiene and was dependent for bathing. A review of the active care plan, last reviewed on 8/1/21, revealed a focus area for Resident #19 having a self-care deficit related to a history of a stroke. The interventions included to assist with ADL's, dressing, grooming, toileting, feeding and oral care as needed. A review of the nursing progress notes from 1/1/21 to 10/21/21 revealed no refusals of nail care or personal care assistance documented. An observation was made of Resident #19 on 10/19/21 at 8:47 AM while she was lying in bed. She was observed to have long fingernails to both hands with a brown substance under fingernails to both hands. On Resident #19's bedside table was a small can of snuff and a plastic spoon she used to place it in her mouth.	F 677	Resident #59 has been shaved. To identify other residents that have the potential to be affected, an audit of residents' nails was completed 10/25/21 to identify dirty or long nails. Cleaning and clipping has been completed. An audit of observation of residents for facial hair has been completed on 10/25/21 to identify anyone with unwanted facial hair. Those residents identified have had their faces shaved. This was performed by the licensed nurses assigned on 10/25/21. To prevent this from recurring, the Director of Nursing or designee will reeducate the CNA/licensed nursing staff concerning the expectation that residents' finger nails and facial hair be addressed with each care opportunity. Any refusal for nail care or shaving will be documented and the care plan will be updated with that specific area of care that is refused. This education will be completed by the Director of Nursing or designee by 11/11/21. Any licensed staff that cannot be reached	

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F 677	Continued From page 12 An interview occurred with Nurse #2 on 10/19/21 at 10:20 AM and explained nurses or aides could provide nail care when the need arose. Nurse Aides (NAs) were responsible for doing nail care with personal care tasks, baths and as needed. They were unable to cut diabetic fingernails but were able to file and clean under all resident nails. In an observation on 10/19/21 at 3:35 PM, Resident #19 was lying in bed and was noted with long fingernails and a brown substance under her nails to both hands. NA #3 was interviewed on 10/19/21 at 3:45 PM regarding nail care. She explained NAs could only clean under the fingernails of diabetic residents, there was no set schedule only to provide nail care when it was needed but had not seen the need to provide nail care when providing personal care to Resident #19. An observation was made of Resident #19 on 10/20/21 at 10:27 AM while she was lying in bed. She was observed to have long fingernails with a brown substance under them to both hands. The Director of Nursing (DON) was interviewed on 10/20/21 at 12:00 PM and stated nail care could be completed by NA's or nurses during personal care, bathing tasks, skin assessments or med pass when a need was identified. There was no set schedule for nail care to be performed on a regular basis. An observation was made of Resident #19 with the DON and verified her fingernails were long with a brown substance under nails to both hands. She was unable to explain why nail care had not been rendered to Resident #19 and would look into it. The DON	F 677	within the initial reeducation time frame will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation. To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor the finger nails and facial hair of each resident to ensure proper care has been given. This monitoring will be documented 5 days a week for 4 weeks and then weekly for 8 weeks. Any resident identified as having an ongoing issue will be care planned for individual interventions to address the root cause of the ongoing issue. . The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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acknowledged Resident #19 used snuff and stated regular nail care should occur.

An interview occurred with NA #4 on 10/21/21 at 10:37 AM. She explained she was assigned to Resident #19 on 10/20/21 and had not noticed the brown substance under her fingernails until it was brought to her attention on the same day. The NA went on to explain Resident #19 did not refuse nail care when it was completed yesterday afternoon. NA #4 further stated staff were to clean nails when the need was there during personal care or showers/bed baths and if a resident was diabetic they would alert the nurse to cut nails when needed.

Another interview occurred with the DON on 10/21/21 at 3:05 PM and stated she expected nail care to be provided at least twice a week with scheduled bathing, and NAs should retrieve a nurse for any diabetic nail trimming that was needed. She was unable to explain why nail care had not occurred with Resident #19 as there was no documentation to show this had or had not been completed or attempted.

2) Resident #20 was admitted to the facility on 7/30/21 with diagnoses that included muscle weakness, chronic obstructive pulmonary disease (COPD), and pneumonia.

The admission Minimum Data Set (MDS) assessment dated 8/5/21 indicated Resident #20 had moderately impaired cognition and required extensive assistance from staff for dressing, personal hygiene, and bathing.

A review of the active care plan, last reviewed on

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8/10/21, revealed a focus area for Resident #20 having a self-care deficit. The interventions included to assist with ADL's, dressing, grooming, toileting, feeding and oral care as needed.

A review of the nursing progress notes from 8/5/21 to 10/21/21 revealed no refusals of nail care or personal care assistance documented for Resident #20.

An observation was made of Resident #20 on 10/19/21 at 9:17 AM while he was sitting in a wheelchair at his bedside. He was observed to have short fingernails to both hands with a very dark brown substance under nails to both hands. On Resident #20's bedside table was a pack of chewing tobacco. Resident #20 stated he could not recall anyone cleaning under his fingernails on a regular basis.

An interview occurred with Nurse #2 on 10/19/21 at 10:20 AM, who explained nurses or aides could provide nail care when the need arose. Nurse Aides (NAs) were responsible for doing nail care with personal care tasks, baths and as needed. They were unable to cut diabetic fingernails but were able to file and clean under all resident nails.

In an observation on 10/19/21 at 3:21 PM, Resident #20 was lying in bed, watching TV, and was noted with short fingernails and a dark brown substance under the nails to both hands.

NA #3 was interviewed on 10/19/21 at 3:45 PM regarding nail care. She explained there was no set schedule only to provide nail care when it was needed.

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The Director of Nursing (DON) was interviewed on 10/20/21 at 12:15 PM and stated nail care could be completed by NA's or nurses during personal care, bathing tasks, skin assessments or med pass when a need was identified. There was no set schedule for nail care to be performed on a regular basis. An observation was made of Resident #20 with the DON, who verified his nails had a dark brown substance under them to both hands. She was unable to explain why nail care had not been rendered to Resident #20 but would look into it. The DON acknowledged Resident #20 used chewing tobacco and stated regular nail care should occur.

Another interview occurred with the DON on 10/21/21 at 3:05 PM and stated she expected nail care to be provided at least twice a week with scheduled bathing. She was unable to explain why nail care had not occurred with Resident #20 as there was no documentation to show this had or had not been completed or attempted.

3) Resident #29 was originally admitted to the facility on 11/20/15 with diagnoses that included dementia, rheumatoid arthritis, and a history of a stroke.

A quarterly Minimum Data Set (MDS) assessment dated 8/14/21 indicated Resident #29 was cognitively intact and required extensive assistance from staff for dressing, personal hygiene and was dependent for bathing.

A review of Resident #29's active care plan, last reviewed on 8/19/21, revealed the following focus areas:
- Needs assistance with ADL's due to decreased

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mobility and history of a stroke with right sided weakness. The interventions included to assist with bathing and hygiene and provide assistance with ADL's and oral care as needed.
- A focus area that was initiated on 3/19/17, of being at risk for altered behavior's and/or mood related to dementia, depression, and anxiety where Resident #29 declined trimming and filing of nails.

A review of the nursing progress notes from 1/1/21 to 10/21/21 revealed no refusals of nail care or personal care assistance documented.

An observation was made of Resident #29 on 10/19/21 at 10:00 AM while she was lying in bed. She was observed to have long fingernails to both hands with a dark brown substance under nails to both hands. Resident #29 stated her nails were longer than she liked, and it had been a while since anyone had trimmed or cleaned under them.

An interview occurred with Nurse #2 on 10/19/21 at 10:20 AM and explained nurses or aides could provide nail care when the need arose. Nurse Aides (NAs) were responsible for doing nail care with personal care tasks, baths and as needed. They were unable to cut diabetic fingernails but were able to file and clean under all resident nails.

In an observation on 10/19/21 at 3:40 PM, Resident #29 was sitting in the hallway in her wheelchair. Her fingernails were noted to be long with a dark blackish/brown substance under them. The left thumb nail was partially coming off with a large, scabbed area formed to the nail bed. She denied any pain to the area and again stated

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her nails were a little longer than she liked and added she would not decline a staff member caring for them.

NA #3 was interviewed on 10/19/21 at 3:45 PM regarding nail care. She explained NAs could only clean under the fingernails of diabetic residents, there was no set schedule only to provide nail care when it was needed but had not seen the need to provide nail care when providing personal care assistance to Resident #29.

An observation was made of Resident #29 on 10/20/21 at 10:29 AM while she was lying in bed. She was observed to have long fingernails with a blackish/dark brown substance under them as well as the left thumb nail lifted partially from the nail bed. There was no change in appearance of her fingernails from prior observations.

The Director of Nursing (DON) was interviewed on 10/20/21 at 12:00 PM and stated nail care could be completed by NA's or nurses during personal care, bathing tasks, skin assessments or med pass when a need was identified. There was no set schedule for nail care to be performed on a regular basis. An observation was made of Resident #29 with the DON, who verified her nails were long with a black/dark brown substance under nails to both hands as well as the left thumb nail partially off the nail bed. She was unable to explain why nail care had not been rendered to Resident #29 but would look into it.

An interview occurred with NA #4 on 10/21/21 at 10:37 AM. She explained she was assigned to Resident #29 on 10/20/21 and had not noticed the blackish/dark brown substance under her fingernails until it was brought to her attention on

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the same day. The NA went on to explain Resident #29 did not refuse nail care when it was completed yesterday afternoon. NA #4 stated staff were to clean nails when the need was there during personal care or showers/bed baths and if a resident was diabetic they would alert the nurse to cut nails when needed, as well as any abnormalities found to the nails.

Another interview occurred with the DON on 10/21/21 at 3:05 PM and stated she expected nail care to be provided at least twice a week with scheduled bathing, retrieving a nurse for any diabetic nail trimming that was needed or if any abnormalities to the nail was present. She was unable to explain why nail care had not occurred with Resident #29 as there was no documentation to show this had or had not been completed or attempted.

4. Resident #59 was admitted on 4/3/21 with a Cerebral Vascular Accident with hemiplegia.

The quarterly Minimum Data Set dated 9/27/21 indicated he was conatively intact and exhibited rejection of care behaviors. He was coded for extensive assistance with personal hygiene.

Resident #59 was care planned for a self-care deficit on 4/3/21. Interventions included staff assistance with grooming. He was also care planned for rejection of care on 7/6/21 but the care plan did not mention noncompliance with personal grooming.

In an interview and observation on 10/18/21 at 11:26 AM, Resident #59 appeared disheveled and presented with facial hair. Resident #59 stated he preferred to be clean shaven but nobody at the facility had assisted him with

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F 677	Continued From page 19 shaving in "a long time." Resident #59 stated he required assistance with his grooming due to his left sided weakness. In an observation on 10/19/21 at 12:50 PM, Resident #59 was observed at the nurses station talking on the phone. Facial hair was observed. In an interview on 10/19/21 at 11:30 AM, Nursing Assistant (NA) #1 stated was familiar with Resident #59 and he shaved himself and only required set up. In an interview on 10/19/21 at 12:10 PM, Nurse #1 stated Resident #59 was capable of shaving himself if he wanted to. She stated he would go down to the shower room and shave where there was better lighting and mirror.	F 677		
F 689 SS=G	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 observations, staff, Physician and Responsible Party (RP) interviews and record review , the facility failed to prevent falls as evidenced by not ensuring call bell was within reach (Resident #175) and not ensuring a resident's wheelchair was safe for use (Resident #66). The facility also failed to analyze and	F 689	For Resident # 175, x-ray orders were obtained and resident was sent to the emergency room. Upon readmission to the facility, resident #175 has had no further falls since her fall on 8/20/21. For Resident #66, the wheelchair was replaced by Rehabilitation department.	11/12/21

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F 689	Continued From page 20 identify the root cause of the falls and failed to implement effective interventions to prevent further falls (Residents #175). Resident ##175 sustained a left wrist fracture and Resident #66 sustained a right ankle sprain from the falls. This was evident for 2 of 5 sampled residents reviewed for accidents. The finding included: 1. Resident #175 was admitted on 7/27/21 with cumulative diagnoses of Cerebral Vascular Accident, dementia and a history of falls. Review of Resident #175's hospital Discharge Summary 7/27/21 indicated she was admitted to the hospital due to multiple falls at home due to gait instability. Review of Resident #175's cumulative fall care plan initiated on 7/27/21 included the following interventions on admission: encourage resident to call for assistance, encourage the use of nonskid footwear, encourage resident to keep the bed in the low position, implement preventative fall interventions/devices, maintain her call light in reach and educate resident on how to use the call light. Additional interventions implemented on admission included maintaining needed items within reach, therapy evaluation and educate Resident #175 and her family regarding the fall interventions/devices and safety devices. Resident #175's admission Minimum Data Set (MDS) dated 8/2/21 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for extensive assistance of two staff for bed mobility and transfers, frequently incontinent of bladder and always incontinent of bowel. She was also coded for falls prior to admission to the facility.	F 689	Resident #66 has not had a fall related to equipment issues since the fall on 9/18/21. To identify other residents that have the potential to be affected, the Director of Nursing or designee will review each resident's care plan to identify individualized fall interventions and ensure that they are triggered to the Kardex. The Director of Nursing or designee will observe each resident to ensure that the care planned interventions are in place and functioning appropriately. Any issue identified will be corrected at the time of identification. The Director of Rehabilitation or designee will review falls from the last 30 days to ensure the root cause was identified. The Director of Nursing or designee will reeducate the nursing staff and the Interdisciplinary Team to utilized the care plan/Kardex information and ensure that all fall prevention interventions are in place. Re education provided for all staff to ensure call bells are in reach of resident. Anyone assigned to wheelchair cleaning will be trained by the Maintenance Department employees to identify when the wheelchair is not functioning properly. The nursing staff will be reeducated to replace any wheelchair with another if the wheelchair is a hazard to the residents safety. Also, that they must notify the maintenance department using a work order sheet if equipment is not functioning	

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F 689	Continued From page 21 Review of a Fall Risk Evaluation dated 8/3/21 indicated a fall risk score of 24 (high risk). Review of a fall incident dated 8/6/21 indicated Resident #175 was found on the floor in front of her wheelchair at 4:50 PM. One side of her wheelchair brakes were unlocked. She stated "I was trying to go to bed". There were no injuries. The report read she was wearing nonskid footwear and last toileted at 2:45 PM. The new interventions was Dycem (nonskid pad) under her wheelchair cushion to prevent sliding. Review of a fall incident dated 8/20/21 indicated Resident #175 fell at 12:30 AM. The report read a noise was heard from the hall and discovered Resident #175 was laying on the floor. Swelling and bruising was noted to her left wrist and she complained of left hip pain and x-rays were ordered by the Physician. She was incontinent of stool at the time of the fall. The report indicated Resident #175's call light was in the nightstand drawer. Resident #175 stated "I was trying to reach my call light but it was in the drawer. I had to get up." The report also indicated the facility implemented a fall mat on the floor at the bedside for the new intervention. Review of a nursing note written by Nurse #3 dated 8/20/21 at 6:13 AM indicated the facility were still awaiting the results of the x-rays In a telephone interview on 10/20/21 at 2:25 PM, Nurse #3 stated NA #2 notified her that Resident #175 was lying on the floor beside her bed. She stated she went into the room to assess her for injuries. She stated she was not moved until she did her assessment. She noted her left wrist was	F 689	appropriately. This education will be completed by 11/11/21 by the Director of Nursing or designee/Maintenance Director/ Administrator. Administrator will reeducate the Interdisciplinary Team concerning the expectation that the root cause of the fall is clarified when a fall occurs using the 5 Whys method. Any staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation. Agency and newly hired staff will have this education during their orientation. To monitor and maintain ongoing compliance, the Director of Nursing or designee will review new falls to identify if all care planned interventions were in place and equipment was working appropriately at the time of a fall. Any issues during the fall will be investigated to determine if any staff were aware of the interventions not being in place or the equipment malfunction prior to the fall by the Director of Nursing or designee The root cause of the fall will be validated during the Interdisciplinary team meeting by the Rehabilitation Director or designee. This will be documented with each initial Interdisciplinary Team review of a fall for 5 days a week for 4 weeks, and then weekly for 8 weeks. Call bells audits will be completed for 7 days for 2 weeks, 5 days	

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swollen but on assessment, she did not see evidence of a possible hip fracture. Nurse #3 stated Resident #175 initially complained of wrist, hip and ankle pain to her left side. She was given Tylenol at the time for pain. Nurse #3 stated during her neurological checks during the night, Resident #175 did not complain of worsening pain. She stated when she went into the room to assess her, she did not notice that Resident #175's call light was in her nightstand drawer. Nurse #3 stated no member of management asked her about the fall. Resident #175 was capable of using the call light but sometimes she forgot.

Review of a nursing note Nurse #1 dated 8/20/21 at 7:03 AM, read the nurse was informed in morning report that Resident #175 fell during third shift and resident was now complaining of left hip and left wrist pain. The facility was still awaiting the x-ray results. The note read Resident #175's left leg was rotated inward and her left wrist was swollen and bruised. She sent Resident #175 to the emergency room for an evaluation. Her RP was notified at this time.

An interview was conducted on 10/19/21 at 12:10 PM with Nurse #1. She stated upon coming in on 8/20/21 for first shift, Nurse #3 reported Resident #175 sustained a fall on third shift and still awaiting the results of the x-rays. Nurse #1 stated on assessment of Resident #175, her left wrist there was noted swelling and discoloration and she also complained of left hip pain. She notified the Physician and orders were given to send her to the hospital for an evaluation.

An interview was conducted on 10/20/21 at 3:15 PM with NA #2 who was assigned Resident #175

per week for 3 weeks and then weekly for 8 weeks.

The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.

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on 8/20/21 second shift. NA #2 stated she placed Resident #175's call light inside her nightstand table drawer on second shift on 8/20/21. She stated she did this because Resident #175 was restless on second shift and her call light and bed control would not stay on the bed. She further stated she thought Resident #175 could reach her call light and she left her drawer partially open so she could see where her call light was. She stated when the other aide came in at 11:00 PM, she turned Resident #175 over to NA #6. She stated early on third shift, NA #6 left the facility to go pick up dinner and she was watching her residents until she returned. She stated it was during this time that NA #6 left to get her dinner. NA #6 returned in time to assist with the transfer of Resident #175 back to bed after she was evaluated by Nurse #3. NA #2 stated she was aware that she was not supposed to put a resident's call light in the nightstand drawer and stated no member of management asked her about what happened on that night. NA #2 stated prior to her fall with fractures, she was ambulatory and was known to wander about in her room and she did not always remember to use her call light.

In an interview on 10/20/21 at 1:10 PM, Nursing Assistant (NA) #1 stated when Resident #175 was admitted, she recalled that the family had stressed and communicated the need for close observation because of her multiple falls at home. She stated prior to her fall, she was good about using her call light but would forget on occasion. NA #1 stated the family had stressed to the staff the need for close observation.

In an interview on 10/21/21 at 10:25 AM, NA #4 stated she assisted Resident #175 and she would use her call light if it was with visible reach or put

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in her hand. NA #4 stated prior to the fall on 8/20/21, Resident #175 was ambulatory with the use of a walker and able to transfer unassisted.

An interview was conducted on 10/21/21 at 10:45 AM with the Director of Nursing (DON) and the Nurse Consultant. The DON stated all resident falls were discussed daily in their morning meetings and the Interdisciplinary Team (IDT) met once a week to discuss the falls. The DON stated the IDT did discuss and investigate Resident #175's fall on 8/20/21 but they forgot to write a note.

Review of Resident #175's nursing notes did not reveal documented evidence that the Interdisciplinary Team (IDT) reviewed and addressed the circumstance of the fall that occurred on 8/20/21.

In an observation on 10/18/21 at 11:00 AM, Resident #175 was sitting up in bed. She was pleasantly confused and unable to recall the fall on 8/20/21. Her bed was in the low position with a floor mat at her bedside and her call light was wrapped around the grab bar on her bed. There was no cast observed to her left wrist.

A telephone interview was conducted on 10/18/21 at 2:17 PM with Resident #175's RP. He stated she had a history of falls at home and the family decided that Resident #175 needed a higher level of care prior to admission to the facility. He stated the facility was made aware of her history of falls at home and thought more interventions would have been put in place prior to her fall on 8/20/21. The RP stated the fall on 8/20/21 resulted in a fracture of her left wrist and left hip but he was not made aware of any of the circumstances

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regarding the fall and only notified when she was sent to the hospital for an evaluation.

An interview was conducted on 10/20/21 at 2:20 PM with the Physician. She stated she was not aware that Resident #175 fell while reaching for her call light. She stated she expected resident's call lights to always be in reach and visible. The Physician stated the fall and injuries could have possibly been prevented.

Review of the facility staffing assignments indicated NA #6 was assigned Resident #175 on 8/20/21. Multiple telephone attempts were completed to reach NA #6 were unsuccessful and the voice mailbox was full.

An interview was conducted on 10/21/21 at 10:45 AM with the Director of Nursing (DON) and the Nurse Consultant. The DON stated she did not discuss with NA #2 the fact that Resident #175's was located in her nightstand drawer. She further confirmed the facility had no evidence of re-education or in-servicing regarding call light accessibility. The DON stated she did speak to Nurse #3 regarding her assessment and action at the time of the fall on 8/20/21. They have the floor nurse doing post fall huddle form, incident statement by NA #2 and a communication form the MD. That was the extend of the documentation about the fall.

An interview was conducted on 10/21/21 at 12:15 PM with the DON and Administrator. The Administrator stated she expected Resident #175's call light to remain in her reach and visible. She further stated the fall that occurred on 8/20/21 that resulted in her injuries should have been thoroughly investigated, staff re-educated

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and staff in-serviced regarding call light accessibility.

2. Resident #66 was admitted on 12/15/20 with cumulative diagnoses of Atrial Fibrillation, osteoporosis and dementia.

Resident #66's quarterly Minimum Data Set (MDS) dated 10/2/21 indicated severe cognitive impairment and she exhibited no behaviors. She was coded for limited assistance of one staff member with bed mobility and transfer, incontinent of bladder and bowel and she was coded for 2 or more falls without injury.

Review of a fall incident report dated 9/18/21 at 9:30 PM read Resident #66 was found on the floor in the sitting position in front of her wheelchair. She stated she was sitting in her chair and trying to lock her wheelchair brakes. She stated she moved forward and slid out of her wheelchair. The report read Resident #66 was not wearing nonskid socks, a new wheelchair cushion was recommended along with assessment of the anti-rollback brakes (devices used to ensure a wheelchair user who forgot to lock the manual hand brakes would remain safe). The report read the wheelchair cushion possibly contributed to the fall. Resident #66 had no injuries.

Review of and Interdisciplinary Team (IDT) meeting progress note dated 9/22/21 at 11:48 AM read Resident #66's wheelchair cushion was reviewed and changed to reduce risk. The note read Resident #66 was out of the bed daily as desired, often moved personal items in her room and did not use her call light or request staff assistance.

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Review of a fall incident report dated 9/27/21 at 5:20 AM read staff heard a loud noise and went to Resident #66's room. Resident #66 was on the floor blocking the entrance. The room was accessed using her roommates bathroom door. Resident #66 stated she was standing in front of her closet and she went to sit down in her wheelchair and the wheels were not locked when she slid to the floor. Resident #66's anti-rollback brakes were assessed by therapy.

An x-ray was ordered on 9/27/21 due to right ankle pain and swelling. The x-ray indicated no fractures.

A nursing note dated 9/28/21 at 4:48 PM read she was sent to an orthopedic on 9/29/21 where Resident #66 was diagnosed with a right ankle sprain and an ankle brace was implemented.

Review of and Interdisciplinary Team (IDT) meeting progress note dated 9/29/21 at 1:59 PM read Resident #66 had a fall on 9/27/21 and her anti-rollback wheelchair brakes were not working properly.

Observation on 10/18/21 at 10:40 AM, Resident #66's door to her room was closed. Inside the room, Resident #66 was self-propelling herself in her wheelchair. She stated she was re-organizing things in her room.

An observation and interview was conducted on 10/19/21 at 11:30 AM with Resident #66. She was sitting in her wheelchair coloring a picture on top of 2 plastic storage bins. Her call light was observed wrapped around the left side grab bar on her bed and not within her reach. Resident

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#66 stated if she needed help, she could get to her call light using her wheelchair. When asked if she could reach her call light if she fell somewhere in her room too far away from her bed and call light, she stated she would just yell for help. She recalled both falls and stated the falls were related to her wheelchair not working right but she stated the wheelchair had been repaired.

In an interview on 10/20/21 at 12:10 PM, Nurse #1 stated Resident #66 insisted on keeping her door closed. She stated Resident #66 has had multiple falls, medication adjustments and being treated for a urinary tract infection (UTI). Nurse #1 stated she was not aware of a problem with her wheelchair cushion but she was aware that it had been replaced. Nurse #1 stated she was not aware that the fall on 9/27/21 was related to her wheelchair brakes. She stated the maintenance department was responsible for repairs to a resident wheelchair.

In an interview on 10/20/21 at 10:25 AM, the Rehabilitator Manager (RM) stated it was the responsibility of the maintenance department to ensure all wheelchairs were in good repair and functional. She stated the therapy department did not routinely assess resident equipment unless the resident was on caseload or something was noticed during a therapy screen. The RM stated she was part of the Interdisciplinary Team (IDT) that met weekly and daily for a morning meeting where all resident falls were discussed. She stated the fall related to Resident #66's wheelchair cushion was replaced after her 9/18/21 fall by the therapy department. The RM stated if therapy had discovered the issue with her brakes, a work order would have been

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completed and given to the Maintenance Director (MD).

An interview was conducted on 10/20/21 at 11:15 AM with the MD and Maintenance Assistant (MA). The MD stated he was also over the Housekeeping Department and he had only been working at the facility for a few weeks. The MA stated when problems with wheelchairs were identified by staff or if the Housekeeping Department noted a concern during wheelchair cleaning, a work order was completed and then given to the Maintenance Department. The MA provided documented evidence of work orders for Resident #66's wheelchair cushion and anti-rollback brakes that were both dated 9/27/21. He stated he did not have a work order dated 9/18/21 regarding Resident #66's wheelchair cushion. The MD stated there was no routine assessment or maintenance conducted of the resident wheelchairs.

In an interview on 10/20/21 at 1:10 PM, Nursing Assistant (NA) #1 stated if Resident #66's wheelchair cushion or anti-rollback brakes weren't working, there should have been a work order completed as soon as the wheelchair concerns were identified and not after Resident #66 sustained 2 falls related to the function of her wheelchair.

In an interview on 10/20/21 at 1:25 PM, Nurse #5 stated Resident #66 exhibited poor safety awareness and insisted on keeping her door closed. She stated Resident #66 often used her call light but she was not aware that Resident #66's wheelchair cushion and her wheelchair brakes were not working properly and contributed to her recent falls. Nurse #5 stated when a staff

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member identified the need for a repair of resident equipment, they completed a work order and placed it in the maintenance folder and the MD comes around to the nurses station and picks them up daily.

Review of the facility staff assignment sheets indicated that Resident #66's assigned NA #7 on 9/18/21 and on 9/27/21. Multiple telephone attempts were completed to reach NA #7 were unsuccessful and the voice mailbox was full.

A telephone interview was conducted on 10/20/21 at 1:00 PM with Nurse #4. She was assigned Resident #66 on 9/18/21 and 9/27/21 at the time of her falls. She stated the wheelchair cushion had ties where it could be secured to a wheelchair. She stated she told the therapy department that Resident #66's wheelchair cushion was missing a securement tie on one side of her cushion. Nurse #4 stated therapy replaced her wheelchair cushion after the fall. Nurse #4 stated Resident #66's fall on 9/27/21 was related to her anti-rollback brakes not working on the wheelchair and resulted in Resident #66's fall with an ankle sprain. Nurse #4 stated she notified therapy and notified the maintenance department about repairing Resident #66's wheelchair brakes after the fall. She stated she completed a work order for both occurrences and left them in the folder for maintenance to address. Nurse #4 stated Resident #66's fall on 9/18/21 and 9/27/21 were contributed to her wheelchair because in both instance, the wheelchair contributed to the falls and could have been avoided.

An interview was conducted on 10/20/21 at 2:20 PM with the Physician. She stated both falls could

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possibly been related to Resident #66's wheelchair and she thought that resident equipment was assessed periodically to ensure good working condition.

In an interview on 10/21/ at 10:25 AM, NA #4 stated if she noted something wrong with a resident wheelchair, they would tell the nurse and complete a work order. She stated the Housekeeping Department washed the resident wheelchairs weekly and maintenance did all repairs.

An interview was conducted on 10/21/21 at 10:45 AM with the Director of Nursing (DON) and the Nurse Consultant. The DON stated she was aware that Resident #66's two falls in September 2021 were related to her wheelchair and she expected that whoever noticed the problems with Resident #66's wheelchair cushion or brakes should have completed a work order when the issues were discovered. The Nurse Consultant stated the facility relied heavily on the staff but there was no expectation that the facility routinely assess resident wheelchairs.

In an interview on 10/21/21 at 11:43 AM, Housekeeper #1 stated the wheelchairs were washed according to a schedule by the housekeeping department. She stated she was not aware that a work order was to be completed if something was broken on a wheelchair and not sure if she would be able to identify concerns related to a wheelchair.

In an interview on 10/21/21 at 11:45 AM, the MD stated Resident #66's wheelchair was identified to be malfunctioning at the time of the fall on 9/18/21 and 9/27/21, a work order was

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F 689	Continued From page 32 completed, given to maintenance, repaired and then returned to Resident #66.	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide ongoing communication documentation with the dialysis center regarding care and treatment for 3 of 3 sampled residents reviewed for dialysis (Residents # 16, #74 & #13). Findings included: 1. Resident #16 was originally admitted to the facility on 5/3/17 and was readmitted on 7/22/21 with multiple diagnoses including end stage renal disease (ESRD). The significant change in status Minimum Data Set (MDS) assessment dated 7/26/21 indicated that Resident #16's cognition was intact, and he was receiving dialysis treatment while at the facility. Resident #16 was care planned dated 7/22/21 to receive hemodialysis related to ESRD. The approaches included to obtain vital signs and weight per protocol and to encourage resident to go to scheduled dialysis appointments. Resident #16 had a doctor's order dated 7/22/21	F 698	The community obtained updated information from the dialysis centers for Resident #13, 16, and 74 by 10/25/21. To identify other residents that have the potential to be affected, an audit of current residents receiving dialysis has been completed to ensure that they have the order for the assigned assessment. This audit will be completed by the Director of Nursing or designee. This will be completed by 10/25/21 To prevent this from recurring, licensed staff will be reeducated concerning the expectation that the Saber Dialysis Communication tool assessment	11/12/21

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F 698	Continued From page 33 to receive hemodialysis 3 times a week on Tuesday, Thursday, and Saturday. On 10/13/21, there was a doctor's order to change the dialysis schedule to Monday, Wednesday, and Friday and to weigh the resident before and after dialysis and to send results to the dialysis center. Resident #16 was observed in bed on 10/19/21 at 12:15 PM. He had a dialysis port on his right upper chest wall and the dressing was noted to be dry and intact. Review of Resident #16's electronic medical records, there were no records of communication with the dialysis center. Nurse #2, assigned to Resident #16, was interviewed on 10/20/21 at 9:50 AM. Nurse #2 stated that the facility uses a dialysis communication tool to communicate with the dialysis center. The form contained the resident's pre dialysis vital signs and weight. She reported that she was not utilizing the communication tool at this time and she just calls the dialysis center when needed and the dialysis center also calls the facility when needed. Nurse #2 was unable to remember the last time she utilized the communication tool. The Nurse added that Resident #16 was weighed before and after dialysis and the weights were recorded on the Medication Administration Records (MARs) but she could not find documentation that these weights were sent to the dialysis center. The Dialysis Nurse was interviewed on 10/20/21 at 10:25 AM. The Dialysis Nurse indicated that the facility used to have a communication book. They sent the book with the resident during dialysis. She reported that she had not seen the	F 698	be completed and printed to send with the resident prior to the resident going to dialysis and being collected when the resident returns. The Dialysis Center will be educated to complete the document and send back with the resident. This information will be reviewed by the nurse and then scanned into the chart of the resident. This education will be completed by 11/11/21 by the Director of Nursing or designee. Any licensed staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation. To monitor and maintain ongoing compliance, the Director of Nursing or designee will review the assessments for residents who received dialysis the day prior during the next Interdisciplinary Team meeting. Any missing documentation will be noted, the nurse and the dialysis center will be contacted for the missing information, and the information will be entered into the resident's medical record when received. The monitoring will be documented 5 days a week for 4 weeks and then weekly for 8 weeks. The Director of Nursing will report the	

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communication book for a while, and she calls the facility when there were issues during the dialysis. She remembered having problems with their weighing scale and requested for the facility to weigh the resident before and after dialysis.

Nurse #7, assigned to Resident #16, was interviewed on 10/21/21 at 10:10 AM. She stated that the facility has a communication tool used to communicate with the dialysis center. The nurse was supposed to fill out the tool with the resident's pre dialysis vital signs and weight and to send the form with the resident to dialysis center. The dialysis center has to return the form back to the facility with pre and post dialysis weights. Nurse #7 reported that she had not been utilizing the form consistently during dialysis days. She could not remember the last time she sent the tool with a dialysis resident to the dialysis center.

The Director of Nursing (DON) was interviewed on 10/21/21 at 12:16 PM. The DON stated that the facility uses a communication tool to communicate with the dialysis center. She expected nursing to complete the dialysis communication tool and to send it with the dialysis residents to the dialysis center. She explained that she reviewed the resident's records and found only 3 communication tools (8/10/21, 8/14/21 & 8/17/21) sent to the dialysis center. She stated that she would in-service the staff on the importance of using the dialysis communication tool.

2. Resident #74 was admitted to the facility on 4/9/20 with multiple diagnoses including end stage renal disease (ESRD). The significant

results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.

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change in status Minimum Data Set (MDS) assessment dated 9/29/21 indicated that Resident #74's cognition was intact, and she was receiving dialysis while at the facility.

Resident #74 was care planned dated 9/29/21 to receive hemodialysis 3 times weekly. The approaches included to maintain communication with dialysis staff and physician per routine.

Review of Resident #74's electronic medical records, there were no records of communication with the dialysis center.

Nurse #2 was interviewed on 10/20/21 at 9:50 AM. Nurse #2 stated that the facility uses a dialysis communication tool to communicate with the dialysis center. The form contained the resident's pre dialysis vital signs and weight. She reported that she was not utilizing the communication tool at this time and she just calls the dialysis center when needed and the dialysis center also calls the facility when needed. Nurse #2 was unable to remember the last time she utilized the communication tool.

The Dialysis Nurse was interviewed on 10/20/21 at 10:25 AM. The Dialysis Nurse indicated that the facility used to have a communication book. They sent the book with the resident during dialysis. She reported that she had not seen the communication book for a while, and she calls the facility when there were issues during the dialysis.

Nurse #7 was interviewed on 10/21/21 at 10:10 AM. She stated that the facility has a communication tool used to communicate with the dialysis center. The nurse was supposed to

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fill out the tool with the resident's pre dialysis vital signs and weight, and to send the form with the resident to dialysis center. The dialysis center has to return the form back to the facility with pre and post dialysis weights. Nurse #7 reported that she had not been utilizing the form consistently during dialysis days. She could not remember the last time she sent the tool with a dialysis resident to the dialysis center.

The Director of Nursing (DON) was interviewed on 10/21/21 at 12:16 PM. The DON stated that the facility uses a communication tool to communicate with the dialysis center. She expected nursing to complete the dialysis communication tool and to send it with the dialysis residents to the dialysis center. She explained that she reviewed the resident's records and could not find any communication tool for the resident. She stated that she would in-service the staff on the importance of using the dialysis communication tool.

3. Resident # 13 was admitted to the facility on 6/21/21 with multiple diagnoses including end stage renal disease (ESRD). The quarterly Minimum Data Set (MDS) assessment dated 10/5/21 indicated that Resident #13's cognition was intact, and he was receiving dialysis while at the facility.

Resident #13 was care planned dated 10/5/21 to receive hemodialysis 3 times weekly. The approaches included to monitor dialysis shunt and to administer medications prior to dialysis.

Review of Resident #13's electronic medical records, there were no records of communication

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F 698	Continued From page 37	F 698		

with the dialysis center.

Nurse #2 was interviewed on 10/20/21 at 9:50 AM. Nurse #2 stated that the facility uses a dialysis communication tool to communicate with the dialysis center. The form contained the resident's pre dialysis vital signs and weight. She reported that she was not utilizing the communication tool at this time and she just calls the dialysis center when needed and the dialysis center also calls the facility when needed. Nurse #2 was unable to remember the last time she utilized the communication tool.

The Dialysis Nurse was interviewed on 10/20/21 at 10:25 AM. The Dialysis Nurse indicated that the facility used to have a communication book. They sent the book with the resident during dialysis. She reported that she had not seen the communication book for a while, and she calls the facility when there were issues during the dialysis.

Nurse #7 was interviewed on 10/21/21 at 10:10 AM. She stated that the facility has a communication tool used to communicate with the dialysis center. The nurse was supposed to fill out the tool with the resident's pre dialysis vital signs and weight, and to send the form with the resident to dialysis center. The dialysis center has to return the form back to the facility with pre and post dialysis weights. Nurse #7 reported that she had not been utilizing the form consistently during dialysis days. She could not remember the last time she sent the tool with a dialysis resident to the dialysis center.

The Director of Nursing (DON) was interviewed on 10/21/21 at 12:16 PM. The DON stated that

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F 698	Continued From page 38 the facility uses a communication tool to communicate with the dialysis center. She expected nursing to complete the dialysis communication tool and to send it with the dialysis residents to the dialysis center. She explained that she reviewed the resident's records and could not find any communication tool for the resident. She stated that she would in-service the staff on the importance of using the dialysis communication tool.	F 698		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours per day, 7 days a week for 5 out of 30 days reviewed. The findings included: A review of Daily Staff Posting Forms and the Staff Assignment Sheets from 9/17/2021 to	F 727	No resident specified Current residents are at risk with non-compliance with this regulation.	11/12/21

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F 727	Continued From page 39 10/18/2021 revealed the facility had not had the required Registered Nurse (RN) coverage (at least 8 consecutive hours per days, 7 days a week) on 10/8/2021, 10/9/2021, 10/10/2021, 10/14/2021 or 10/15/2021. On these days the facility's census was between 68 and 71 and no RN coverage hours were documented on the Daily Staff Posting Form or the Staff Assignment Sheets. On 10/20/2021 at 3:30PM an interview was conducted with the Director of Nursing (DON) who also fills the role of scheduler. She stated they had some staffing challenges and had been using some staffing agency nurses. She further stated she believed the facility had RN coverage for 8 consecutive hours 7 days a week. When asked about the Daily Staff Posting Forms indicating there was no RN coverage, she stated she made a mistake. At 4:00 PM on 10/20/2021 the Administrator stated the dates where posting sheets have no RN coverage hours, RN coverage was provided by the Minimum Data Set (MDS) nurses as follows: on 10/8/2021, 10/14/2021, and 10/15/2021 MDS #2 worked as unit manager. On 10/9/2021 and 10/10/2021 MDS nurse #1 worked as unit manager. When asked if they were working in the capacity of MDS nurse or if they were working in the role of resident care, the Administrator stated they were working as unit managers on those days. She also stated they did not have time cards due to being salaried employees. On 10/20/2021 at 4:08 PM an interview was conducted with both MDS nurse #1 and MDS nurse #2. MDS nurse #1 stated she had not	F 727	To prevent this from recurring, current registered nurses have been educated that 8 consecutive hours must be spent in the building each day. The registered nurse is responsible to be available to the staff for any guidance necessary. The registered nurses will call the Director of Nursing with any issue that requires further consultation. This education was provided by the Administrator on 11/9/21. Agency registered nurses and newly hired registered nurses will have this education during their orientation. To monitor and maintain ongoing compliance, the Director of Nursing will review the schedule to ensure there is a registered nurse scheduled for 8 consecutive hours each day. The Administrator will review the hours documented as worked by registered nurses each day to validate that there were 8 consecutive hours. This will be documented daily for 7 days, 5 days a week for 3 weeks, and then weekly for 8 weeks. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 727	Continued From page 40 worked as a unit manager or a staff nurse during the month of October 2021. MDS nurse #2 stated she had worked as a unit nurse on the floor a few months ago but did not work as a unit manager or staff nurse during the month of October 2021.	F 727		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §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.	F 756		11/12/21

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F 756	Continued From page 41 §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: Based on record review, Pharmacy Consultant and staff interview, the Pharmacy Consultant failed to identify and to address the need to monitor the side effects and the behavior of a resident on antianxiety medication and the need to try non pharmacological interventions prior to administering as needed (PRN) antianxiety medication for 1 of 6 sampled residents reviewed for unnecessary medications (Resident #8). Findings included: Resident #8 was originally admitted to the facility on 10/4/19 and was readmitted on 6/17/21 with multiple diagnoses including anxiety. The quarterly Minimum Data Set (MDS) assessment dated 10/12/21 indicated that Resident #8 has severe cognitive impairment, and she has received an antianxiety medication for 5 days during the assessment period. The assessment further indicated that the resident has displayed behaviors of delusions, rejection of care and wandering. Resident #8 was care planned dated 10/12/21 for the use of PRN anti-anxiety medication. The care plan problem was at risk for adverse effects related to the use of psychoactive medication. The goals were for the resident to be free from adverse effects and the behavior will be managed	F 756	Resident #8 has had orders for the documentation of side effects, behaviors, and the documentation of the non-pharmacological interventions prior to administration added to their Medication Administration Record as soon as it was identified as missing on 10/20/21 To identify other residents that have the potential to be affected, an audit of current residents who are receiving prn psychotropic medication will be completed to validate that there is documentation for the side effects, the behaviors, and the non-pharmacological interventions. Any missing documentation will be addressed by correction moving forward. This audit will be completed by the Director of Nursing or designee by 11/11/21. To prevent this from recurring, the pharmacist has been reeducated to review any prn psychotropic medications	

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F 756	Continued From page 42 on the lowest therapeutic dose. The approaches included to monitor medication side effects and for effectiveness and pharmacy review per routine. Resident #8 has doctor's order for Ativan (an anti-anxiety drug) 0.5 milligrams (mgs) 1 tablet by mouth every 6 hours PRN for 14 days for anxiety on 6/17/21, and was renewed on 6/25/21, 7/11/21, 7/25/ 21, 8/16/21 and 10/15/21. There was also an order for Ativan 0.5 mgs by mouth every 4 hours PRN for 14 days for anxiety on 8/30/21, and was renewed on 9/15/21, and 9/30/21. The Medication Administration Records (MARs) for June, July, August, September, and October 2021 were reviewed. The MARs revealed that Resident #8 had received Ativan thirteen times in June 2021, twenty times in July 2021, sixteen times in August 2021, twelve times in September 2021 and twelve times in October 2021 for anxiety/agitation. Review of the MARs and the progress notes from June through October 2021 revealed no monitoring of resident's behavior and side effects of the medication and there was no documentation of non-pharmacological interventions tried prior to administering the PRN Ativan. Review of Resident #8's monthly drug regimen review (DRR) notes from June through October 2021 were conducted. The DRR notes dated 6/30/21, 7/30/21, 8/31/21, 9/22/21 and 10/15/21 revealed that the Pharmacy Consultant did not address the need to monitor the side effects and the behavior of Resident #8 who was on PRN	F 756	for side effects, behaviors, or non pharmacological interventions being documented. This education will be completed by 11/11/21 by the Director of Nursing or designee. To monitor and maintain ongoing compliance, the Director of Nursing or designee will review the monthly drug regimen review report and compare to the psychotropic medications ordered prn for current residents. This will be documented each month for the next 3 months. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 756	Continued From page 43 Ativan and the need to try non-pharmacological interventions prior to administering a PRN Ativan. The Pharmacy Consultant was interviewed on 10/20/21 at 11:03 AM. She reported that she was conducting the DRR remotely. The Pharmacy Consultant stated that she conducted the DRR for Resident #8 on 8/31/21 and 10/15/21. She indicated that she expected nursing to monitor the side effects and behavior of residents on psychotropic medications and to try non-pharmacological interventions prior to administering the PRN Ativan. The Consultant commented that nursing had documented the resident's behaviors on the MARs when the PRN Ativan was administered. She also indicated that she reviewed the nursing progress notes and the MARs and did not see any documentation that non-pharmacological interventions had been tried prior to administering the PRN Ativan. She also stated that she reviewed the monthly DRR notes of the other Pharmacy Consultants and did not see any recommendations to address the need to monitor drug side effects and resident's behavior and for the need to try non-pharmacological interventions prior to administering the PRN Ativan. She verified that the Pharmacists missed to report these irregularities to the Director of Nursing (DON). The Director of Nursing (DON) was interviewed on 10/21/21 at 12:16 PM. The DON stated that she expected the Pharmacy Consultant to identify and to address drug irregularities to the DON or the Attending Physician if any.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		11/12/21

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F 758	Continued From page 44 §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 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	F 758		

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F 758	Continued From page 45 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 record review, observation and staff interview, the facility failed to monitor the side effects and the behavior of a resident on as needed (PRN) anti-anxiety medication and failed to try non-pharmacological interventions prior to administering a PRN anti-anxiety medication for 1 of 6 sampled residents reviewed for unnecessary medications (Resident #8). Findings included: 1a. Resident #8 was originally admitted to the facility on 10/4/19 and was readmitted on 6/17/21 with multiple diagnoses including dementia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 10/12/21 indicated that Resident #8 has severe cognitive impairment, and she has received an antianxiety medication for 5 days during the assessment period. The assessment further indicated that the resident has displayed behaviors of delusions, rejection of care and wandering. Resident #8 was care planned dated 10/12/21 for the use of PRN anti-anxiety medication. The care plan problem was at risk for adverse effects related to use o psychoactive medication. The goals were for the resident to be free from adverse effects and the behavior will be managed	F 758	Resident #8 has had orders for the documentation of side effects, behaviors, and the documentation of the non-pharmacological interventions prior to administration added to their Medication Administration Record as soon as it was identified as missing on 10/20/21. To identify other residents that have the potential to be affected, an audit of current residents who are receiving prn psychotropic medication will be completed to validate that there is documentation for the side effects, the behaviors, and the non-pharmacological interventions. Any missing documentation will be addressed by correction moving forward. This audit will be completed by the Director of Nursing or designee by 11/11/21 To prevent this from recurring, the licensed nurses have been reeducated concerning the expectation that prn	

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F 758	Continued From page 46 on the lowest therapeutic dose. The approaches included to monitor medication side effects, monitor medication for effectiveness, report to physician any negative outcome associated with the use of psychotropic drug and to report changes in behavior or mood state. Resident #8 has doctor's order for Ativan (an anti-anxiety drug) 0.5 milligrams (mgs) 1 tablet by mouth every 6 hours PRN for 14 days for anxiety on 6/17/21, and was renewed on 6/25/21, 7/11/21, 7/25/ 21, 8/16/21 and 10/15/21. There was also an order for Ativan 0.5 mgs by mouth every 4 hours PRN for 14 days for anxiety on 8/30/21, and was renewed on 9/15/21, and 9/30/21. The Medication Administration Records (MARs) for June, July, August, September, and October 2021 were reviewed. The MARs revealed that Resident #8 had received Ativan thirteen times in June 2021, twenty times in July 2021, sixteen times in August 2021, twelve times in September 2021 and twelve times in October 2021 for anxiety/agitation. Resident #8 was observed on 10/19/21 at 12:30 PM and 3:15 PM. She was in wheelchair and was observed rolling up and down the hallway. There was no anxiety or agitation noted. Review of the MARs and the progress notes from June through October 2021 revealed no monitoring of resident's behavior and side effects of the medication. Nurse #2 was interviewed on 10/20/21 at 9:15 AM. She stated that the side effects and behaviors of residents on psychotropic	F 758	psychotropic medications must have documentation of side effects, behavior, and non pharmacological interventions attempts when it is given. This education will be completed by 11/11/21 by the Director of Nursing or designee. To monitor and maintain ongoing compliance, the Director of Nursing or designee will review prn psychotropic medications given to ensure that there is documentation of side effects, behavior, and non-pharmacological interventions attempted. Any incomplete documentation will result in the nurse being called to complete the documentation. This monitoring will be documented 5 days a week for 4 weeks and then weekly for 8 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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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
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medication were monitored every shift and documented on the MARs. The Nurse has verified that Resident #8 was on PRN Ativan and her behavior and the side effects should have been documented on the MARS. She checked the MARs and stated that whoever wrote the order for the PRN Ativan missed to enter the side effects and behavior monitoring on the MARs. Nurse #2 reported that the resident's behaviors were mostly wandering and anxiety looking and calling for her mother, grandmother, and children.

The attending physician of Resident #8 was interviewed on 10/20/21 at 2:30 PM. She stated that she expected nursing to monitor and to document the side effects and behaviors of residents on PRN psychotropic medication. She was aware that Resident #8 had been on PRN Ativan for a while, and she would reassess the resident for the continued need of the PRN Ativan.

The Director of Nursing (DON) was interviewed on 10/21/21 at 12:16 PM. The DON stated that she expected nursing to monitor and to document side effects and behaviors of residents on psychotropic medications.

1b. Resident #8 was originally admitted to the facility on 10/4/19 and was readmitted on 6/17/21 with multiple diagnoses including dementia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 10/12/21 indicated that Resident #8 has severe cognitive impairment, and she has received an antianxiety medication for 5 days during the assessment period. The assessment further indicated that the resident has displayed behaviors of delusions, rejection of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING _____ B. WING _____	C 10/21/2021

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care and wandering.

Resident #8 was care planned dated 10/12/21 for the use of PRN anti-anxiety medication. The care plan problem was at risk for adverse effects related to use o psychoactive medication. The goals were for the resident to be free from adverse effects and the behavior will be managed on the lowest therapeutic dose. The approaches included to monitor medication side effects, monitor medication for effectiveness, report to physician any negative outcome associated with the use of psychotropic drug and to report changes in behavior or mood state.

Resident #8 has doctor's order for Ativan (an anti-anxiety drug) 0.5 milligrams (mgs) 1 tablet by mouth every 6 hours PRN for 14 days for anxiety on 6/17/21, and was renewed on 6/25/21, 7/11/21, 7/25/ 21, 8/16/21 and 10/15/21. There was also an order for Ativan 0.5 mgs by mouth every 4 hours PRN for 14 days for anxiety on 8/30/21, and was renewed on 9/15/21, and 9/30/21.

The Medication Administration Records (MARs) for June, July, August, September, and October 2021 were reviewed. The MARs revealed that Resident #8 had received Ativan thirteen times in June 2021, twenty times in July 2021, sixteen times in August 2021, twelve times in September 2021 and twelve times in October 2021 for anxiety/agitation.

Review of the MARs and progress notes revealed that there were no non-pharmacological interventions tried prior to administering the PRN Ativan.

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Nurse #2 was interviewed on 10/20/21 at 9:15 AM. She stated that nursing should try non-pharmacological interventions prior to administering a PRN psychotropic medication and to document the interventions on the MARs or progress notes. Nurse #2 reviewed the MARs and the progress notes of Resident #8 and stated that she could not find any documentation that non-pharmacological interventions have been tried prior to the administration of PRN Ativan. She reported that redirection did not work for Resident #8.

The attending physician of Resident #8 was interviewed on 10/20/21 at 2:30 PM. She stated that she expected nursing to try non-pharmacological interventions prior to administering PRN psychotropic medication.

The Director of Nursing (DON) was interviewed on 10/21/21 at 12:16 PM. The DON stated that she expected nursing to try non-pharmacological interventions prior to administering PRN Ativan for Resident #8 and to document the interventions on the MARs or progress notes.