STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 11/29/21 to 12/2/21. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# DAZ011.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		12/30/21

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

Electronically Signed | 12/20/2021

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F 550	Continued From page 1 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations record review and staff interviews, the facility failed to maintain the dignity of a dependent resident as evidenced by two staff members use of the term "feeder" to describe a resident who needed assistance with eating for 1 of 4 residents (Resident #14) reviewed for dignity. The findings included: Resident #14 admitted to the facility on 9/9/16 with diagnoses that included, in part, vascular dementia and blindness. A quarterly Minimum Data Set assessment dated 10/1/21 revealed Resident #14 had severe cognitive impairment and was dependent on staff for eating. On 11/29/21 at 12:35 PM, during an observation of meal delivery, NA #1 was standing at the meal cart outside Resident #14's room and was heard referring to Resident #14 as a "feeder." NA #2 was also standing outside Resident #14's room at the meal cart and was heard referring to Resident #14 as a "feeder." During an interview with NA #1 on 12/2/21 at 10:40 AM, she stated she and NA #2 were not	F 550	Resident #14 was assessed by the Social Worker on 12/8/21 and the resident was determined to be free from any negative outcome. A quality review was completed of each resident□s feeding status by the Director of Nursing, RN Educator and Unit Manager on 12/6/21. It is noted that 8 of residents have the potential to be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing and/or the RN Nurse Educator provided education to staff in all departments re: providing a dignified existence for the residents. Staff should address residents with the name or pronoun of the resident□s choice, avoiding the use of labels for residents such as feeders or walkers, completed by 12/23/21.	

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F 550	Continued From page 2 aware they were not supposed to use the term "feeder" for residents that needed assistance with meals. On 12/2/21 at 10:50 AM, an interview was conducted with the Staff Development Coordinator. She stated she did not do any education with staff on resident dignity and referring to dependent residents as "feeders." She stated when she was doing rounds and heard staff using the term "feeder" she would correct it right then and she stated other management staff did the same. On 12/2/21 at 3:15 PM, the Administrator was interviewed. She stated it was inappropriate for staff to refer to dependent residents as "feeders."	F 550	To ensure the resident's dignity, monitors were put into place to monitor the provision of meal trays to 8 random residents 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 8 weeks. These monitors will be completed by the RN Educator or Social Work staff. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess the ability of two residents to self-administer medications that were left at bedside for 2 of 2 residents reviewed for medications left at the bedside. (Resident #46 and Resident #47). The findings were: 1. Resident #46 was admitted to the facility on 4/16/18 with a diagnosis of chronic pain.	F 554	Director of Nursing educated responsible nurse regarding medication administration. Resident's #'46 & 47 were made aware that medications cannot be left at bedside on 11/29/21. A quality review was completed by the RN Nurse Educator and the Unit Manager of all resident rooms on 12/3/21 and no further issues related to medications at the bedside were identified.	12/30/21

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F 554	Continued From page 3 A quarterly Minimum Data Set (MDS) assessment dated 10/22/21 revealed Resident #46 had moderate cognitive impairment. A comprehensive medical record review revealed no order, care plan or assessment to indicate Resident #46 was assessed for medication self-administration. On 11/29/21 at 10:05 AM, two orange-colored tablets were observed in a one-ounce plastic medication cup on Resident #46's bedside table. Resident #46 was not in the room. On 11/29/21 at 10:10 AM, an interview was conducted with Nurse #2. She stated she did not know what the medication was on Resident #46's bedside table. She stated Resident #46 did not receive medication on day shift and she had not entered his room. She stated she did not observe the medication left on the bedside. She added medications are not supposed to be left on residents' bedside tables. On 12/2/21 at 2:30 PM, the Director of Nursing was interviewed. She stated medications were not to be left at bedside for residents who had not been assessed for self-administration of medications. 2. Resident #47 was admitted to the facility on 10/20/20 with diagnoses of, in part, repeated falls and chronic obstructive pulmonary disease. A quarterly MDS assessment dated 10/22/21 revealed Resident #47 had intact cognition. A review of the physician orders revealed nystatin powder apply to groin topically two times a day for	F 554	An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the Department Managers on monitoring for medications at the bedside when completing mock survey environmental rounds on 12/7/21. The Director of Nursing and/or the RN Nurse Educator provided education licensed nurses regarding medication administration including not leaving medications at bedside, completed on 11/29/21. Monitors were put into place to monitor that medications were not left at bedside on 8 random residents 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 8 weeks. These monitors will be completed by the RN Educator/Unit Manager/Director of Nursing or a Department Manager. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	

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F 554	Continued From page 4 redness on 11/2/21. On 11/29/21 at 10:18 AM, a one-ounce clear plastic medication cup that contained an off-white powdered substance was observed on Resident #47's bedside table. Resident #47 was lying in his bed with his eyes closed. On 11/29/21 at 10:19 AM, an interview was conducted with Nurse #3 who stated the substance in the medicine cup looked like nystatin powder, but she did not leave it in Resident #47's room, that it may have been the night shift nurse. She added she did not see it in Resident #47's room during the morning medication pass and it should not have been left in the room. A comprehensive medical record review revealed no order, care plan or assessment to indicate Resident #47 was assessed for medication self-administration. On 12/2/21 at 2:30 PM, the Director of Nursing was interviewed. She stated medications were not to be left at bedside for residents who had not been assessed for self-administration of medications.	F 554		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		12/30/21

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F 584	Continued From page 5 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain clean rooms and clean floors and bedside tables for 2 of 12 rooms (121 and 122), failed to maintain a bathroom floor in good repair for 1 of 12 rooms (Room 121), and	F 584	Rooms 109, 121 & 122 were cleaned thoroughly on 12/6/21. Rooms 109, 121 & 122 and the bathroom of 122 had their walls and floor tiling repaired by 12/24/21.	

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F 584	Continued From page 6 failed to maintain walls in good repair for 3 of 12 rooms (121B, 122A and 109B). The findings were: 1. On 11/29/21 at 10:10 AM, an observation was made of the floor in Room 121. The floor was visibly soiled with dirt and dried debris, crumbs and other debris were observed on the side of the bed against the wall and there was non-skid tape under the bed that were that was loosening and torn up. The bedside table bases were also observed to have stained substances on them. Overbed lights in the room had dust build up. In room 122, old non-skid tape was coming loose from the floor in several areas. The floor in room 122 was also visibly soiled with dried substances and visible debris. Overbed lights were dusty over both beds in Room 122. Observations made on 11/29/21 at 3:20 PM, 11/30/21 at 8:59 AM and 12/1/21 at 11:56 AM revealed none of the areas were corrected. The floor remained dirty with visible crumbs and debris and the torn up nonskid strips were still visible under the bed. The bedside table bases remained stained with dried substances on them, and dust remained on the overbed lights. On 12/2/21 at 11:50 AM, Housekeeper #1 was interviewed. He stated when he arrives in the morning, he empties the trash, cleans the bathroom, and sweeps and mops the floor. When he is getting ready to leave for the day, he checks the trash in the resident's rooms again and makes sure the rooms have toilet paper. He added he did not clean the bedside tables or dust the overbed lights. On 12/2/21 at 11:59 AM, the Corporate	F 584	A quality review was completed of each resident to identify other areas needing cleaning, wall repair and tile replacement. This was completed on 12/7/21 by the Executive Director, the Housekeeping Supervisor, the Regional Housekeeping Supervisor, the Maintenance Assistant and the Maintenance Director. It was identified that there were 41 out of 52 resident rooms/bathrooms identified as needing a deep clean, non-skid strips removed, walls patched/painted, dust build up needing removed from the top of the lights, over bed tables needing cleaned and/or tiles replaced. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. On 12/13/21 the Maintenance Director, the Housekeeping Supervisor, the Regional Housekeeping Supervisor, the Divisional Housekeeping Supervisor for North Carolina and the Executive Director met to make a plan as to correcting and maintaining issues identified in the quality review. The Regional Director of Housekeeping and Laundry Service educated the Housekeeping Supervisor on proper cleaning of resident rooms and bathrooms with competencies on 12/13/21. The Executive Director educated the Maintenance Director and the Maintenance Assistant on timely	

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F 584	Continued From page 7 Housekeeping Director was interviewed. He stated the housekeepers were supposed to sweep, mop, and dust every day and wipe down the bedside tables. He stated the housekeeper should have swept and mopped the floor daily and added he would take care of it right away. He stated the rooms and floors were due to be deep cleaned and they usually deep clean 2 rooms a week, but every time they get ready to start cleaning floors, someone gets COVID and they have to wait 10 days after to start cleaning again. He could not recall the last time deep cleaning of rooms was completed. On 12/2/21 at 3:15 PM, a tour was conducted with the Administrator of Rooms 121 and 122. The Administrator stated the floors needed to be cleaned and the nonskid tape on the floors needed to be removed. She stated the bedside tables got cleaned but were stained and they needed to be replaced. 2. On 11/29/21 at 11:10 AM, an observation was made of the bathroom between rooms 121 and 122. There was a baseball sized hole in the floor between the sink and the toilet with chipped, cracked tile exposed. One of the four residents utilized the bathroom between the two rooms. On 12/2/21 at 12:15 PM, the Maintenance Director was interviewed. He stated there is a log at the nurse's station that staff can write things down in that need to be repaired. He added he doesn't do routine audits to check for repairs, but they are now working on the most damaged rooms. The Maintenance Director and his assistant conducted an audit on 12/2/21 of all rooms in the facility that required repairs.	F 584	replace/repair of floor tile and walls on 12/13/21. On 12/13/21 the Executive Director educated the Department Managers, the Director of Nursing and the RN Educator regarding the importance of identifying and recording issues with cleanliness, holes in walls and broken floor tiles when completing their room rounds (mock survey rounds) daily Monday-Friday. The Director of Nursing and/or RN Educator educated the nursing staff regarding the importance of utilizing the housekeeping and maintenance books on the units to identify issues with cleanliness, holes in walls and broken floor tiles. Additionally the nursing staff was educated to use care when moving beds, wheel chairs, furniture in order to prevent holes in the walls and floor tiles. The education further included the need for nursing staff to clean up spills from beds, floors, walls when an accident occurs. This education concluded on 12/24/21. Monitors were put into place to monitor the cleanliness of resident rooms/bathrooms as well as the timely replacement/repair of resident's rooms and bathrooms. This monitor will be completed on 8 resident rooms 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 8 weeks. These monitors will be completed by the Executive Director or RN Educator.	

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F 584	Continued From page 8 On 12/2/21 at 3:15 PM, a tour was conducted with the Administrator of Rooms 121 and 122. The Administrator stated the department heads rounded and reported concerns to maintenance and the corporate nurse had also identified areas of concern and maintenance had begun to work on those areas. 3a. On 11/29/21 at 11:10 AM, an observation of Room 121 revealed a large section of the corner wall by the closet of Room 121 was removed, exposing sheetrock. The baseboard was peeling from the wall and the paint was chipped in several areas beside the bed in Room 121. On 12/2/21 at 12:15 PM, the Maintenance Director was interviewed. He stated there is a log at the nurse's station that staff can write things down in that need to be repaired. He added he doesn't do routine audits to check for repair and there is not a formal audit tool that is used, but they are now working on the most damaged rooms. The Maintenance Director and his assistant conducted an audit on 12/2/21 of all rooms in the facility that required repairs. On 12/2/21 at 3:15 PM, a tour was conducted with the Administrator of Rooms 121 and 122. The Administrator stated the department heads rounded and reported concerns to maintenance and the corporate nurse had also identified areas of concern and maintenance had begun to work on those areas. 3b. On 11/29/21 at 11:15 AM, Room 122 was observed to have peeling baseboard from the wall and paint was chipped from several streaked areas beside the bed.	F 584	The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	

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F 584	Continued From page 9	F 584		

On 12/2/21 at 12:15 PM, the Maintenance Director was interviewed. He stated there is a log at the nurse's station that staff can write things down in that need to be repaired. He added he doesn't do routine audits to check for repairs, but they are now working on the most damaged rooms. The Maintenance Director and his assistant conducted an audit on 12/2/21 of all rooms in the facility that required repairs.

On 12/2/21 at 3:15 PM, a tour was conducted with the Administrator of Rooms 121 and 122. The Administrator stated the department heads rounded and reported concerns to maintenance and the corporate nurse had also identified areas of concern and maintenance had begun to work on those areas.

3c. Observations of room 109B on 11/30/21 at 1:57 PM and 12/1/21 at 9:47 AM revealed a hole at the base of the wall behind the resident's bed.

During an interview with the Maintenance Director on 12/2/21 at 10:06 AM he explained there were work order binders located at both nurses' stations where staff entered in areas of concern that the maintenance department needed to repair. The Maintenance Director said he checked the binders twice a day, completed repairs, then checked off in the binders that the repairs were done. He added there was not a formal audit tool he used to routinely identify areas of resident rooms that needed repairs but made repairs as he happened to see issues. Room 109B was observed with the Maintenance Director on 12/2/21 at 10:10 AM during which he verified a 2-3 inch hole in the wall behind the

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F 584	Continued From page 10 resident's bed. He said the hole was from the bed bumping against the wall and stated he was unaware of the damage to the wall. An interview was completed with the Administrator on 12/2/21 at 1:08 PM. She stated department managers completed rounds on resident rooms, identified environmental issues and reported back to the Maintenance Director. She thought the departmental staff needed to be more consistent and thorough when they made rounds so that concerns could be identified and addressed. The Administrator added the corporate nurse had identified environmental issues which included holes in walls and scuff marks on walls. She further stated the Maintenance Director had been working on patching walls and replacing bathroom doors as part of the issues that were identified by the corporate nurse.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		12/30/21

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paragraph (c)(5) of this section.

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12	F 623		

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

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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F 623	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to notify the Ombudsman and provide the resident representative a written notification for the reason for transfer to the hospital for 2 of 2 residents (Resident #34 and Resident #228) reviewed for hospitalization. Findings included: 1. Resident #34 was admitted to the facility on 7/21/20 with diagnoses that included, in part, diabetes and chronic obstructive pulmonary disease. The comprehensive minimum data set assessment dated 11/11/21 revealed Resident #34 was minimally cognitively intact. A nurse's note in the medical record reported Resident #34 was transferred to the hospital on 11/6/21 due to low oxygen levels and bleeding. The note indicated Resident #34's representative was present at the facility during the transfer to the hospital. The resident was re-admitted to the facility on 11/11/21. No written notice of transfer was documented to have been provided to the resident representative. An interview was completed with the Admissions Coordinator on 12/2/21 at 10:57 AM during which she stated that she was unaware of any paper transfer/discharge notice that needed to be completed when a resident was transferred to the hospital. During an interview with the Director of Nursing on 12/2/21 at 11:02 AM she revealed the nurses typically sent a clinical transfer form with the	F 623	Resident #228 readmitted to the facility on 11/17/2021 and #34 readmitted to the facility on 11/11/2021. The Director of Nursing and/or the RN Educator did a quality review of the last 30 days of discharges to identify notification to resident, responsible party and ombudsman on 12/7/21. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the RN Admissions Coordinator and the Social Work staff of the need to follow up with the family on the first business day after a resident's discharge in addition to mailing out a copy of the Notice of Transfer/Discharge to both the family and the Ombudsman. Director of Nursing and/or the RN Educator educated the Charge Nurses to complete a Notice of Transfer/Discharge form at the time the resident is transferred, place a copy with records going with the resident and a copy to the medical records. A monitor was put into place to monitor all discharges for 12 weeks. This monitor will be completed daily Monday-Friday and will be completed by the RN Educator and/or Executive Director. The results of the monitoring will be	

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resident when they were discharged to the hospital and that was all. She, nor the nursing staff, had never completed a written notice of transfer/discharge when a resident went to the hospital and added she was unsure who was responsible to have the notice sent to the resident and/or resident representative.

On 12/2/21 at 11:35 AM an interview with the Administrator revealed that she was unaware of the regulation requiring the facility to complete a transfer/discharge notice, which included notifying the Ombudsman, when a resident was transferred to the hospital.

2. Resident #228 was admitted to the facility on 10/1/21 with diagnoses that included, in part, Parkinson's disease and chronic obstructive pulmonary disease.

The comprehensive minimum data set assessment dated 11/13/21 revealed Resident #228 was minimally cognitively intact.

A nurse's note in the medical record reported Resident #228 was transferred to the hospital on 11/5/21 due to low oxygen levels and sudden left sided chest pain. The note indicated Resident #228's representative was contacted by phone and was aware of the transfer to the hospital. No written notice of transfer was documented to have been provided to the resident representative.

An interview was completed with the Admissions Coordinator on 12/2/21 at 10:57 AM during which she stated that she was unaware of any paper transfer/discharge notice that needed to be completed when a resident was transferred to the hospital.

brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.

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F 623	Continued From page 15 During an interview with the Director of Nursing on 12/2/21 at 11:02 AM she revealed the nurses typically sent a clinical transfer form with the resident when they were discharged to the hospital and that was all. She, nor the nursing staff, had never completed a written notice of transfer/discharge when a resident went to the hospital and added she was unsure who was responsible to have the notice sent to the resident and/or resident representative. On 12/2/21 at 11:35 AM an interview with the Administrator revealed that she was unaware of the regulation requiring the facility to complete a transfer/discharge notice, which included notifying the Ombudsman, when a resident was transferred to the hospital.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code urinary incontinence, failed to accurately code a prognosis of less than six months and failed to accurately code the Pre-Admission Screening and Resident Review (PASRR) on the comprehensive Minimum Data Set (MDS) assessment for 3 of 24 residents (Resident #18, Resident #10 and Resident #33) reviewed for MDS accuracy. The findings included:	F 641	The MDS Coordinator corrected the assessments for accuracy as follows: #10 on 11/29/21, #18 on 12/13/21, # 33 on 12/1/21. A quality review for accuracy was completed of each resident's prior assessment regarding coding of the Pre-Admission Screening and Resident Review (PASRR), Urinary Incontinence and Prognosis of an anticipated 6 months or less to live by 12/24/21. All	12/30/21

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F 641	Continued From page 16 1. Resident #18 was admitted to the facility on 10/9/14 with diagnoses of Alzheimer's disease and behavioral disturbances. An annual Minimum Data Set (MDS) assessment dated 10/3/21 indicated that Resident #18 had severe cognitive impairment, required limited assistance with dressing and toileting and was always continent of bladder. An observation of incontinent care provided by Nurse #1 to Resident #18 on 12/1/21 at 2:15 PM revealed no concerns. On 12/1/21 at 2:30 PM an interview was conducted with the Nurse #1. She stated she was very familiar with Resident #18 and worked with her often. She stated she could walk unassisted and would frequently take herself to the toilet throughout the day but she had at least one wet brief daily. During an interview with the MDS Nurse on 12/2/21 at 9:42 AM, he stated he was responsible for making sure the MDS was coded correctly. He also stated that he relied on the documentation from the nurse aides to help him code correctly. After reviewing the nurse aide documentation, he noted there had been gaps in the reporting. The Director of Nursing was interviewed on 12/2/21 at 10:26 AM. She shared that Resident #18 did have episodes where the staff would need to perform incontinence care and that it should have been marked accordingly on the MDS.	F 641	assessments were corrected by 12/29/21. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. On 12/13/21 the Executive Director educated the MDS Coordinator on the MDS process from the CMS's RAI Version 3.0 Manual in regards to Rationale, Steps for Assessment & Coding Instructions for the following MDS items: A1500; Preadmission Screening and Resident Review (PASRR) Item H0300: Urinary Continence J1400: Prognosis The education included reviewing supportive documentation personally, reviewing MD orders/notes, and nurse's notes, interviewing staff across shifts during the look back period and interviewing the resident/resident representative as able. Additionally, since the conclusion of the survey, the MDS Coordinator attended an intensive course on the MDS process and became Resident Assessment Coordinator Certified (RAC-CT) on 12/10/21. Monitors were put into place to monitor the correct coding of MDS Assessments completed regarding the Pre-Admission Screening and Resident Review (PASRR), Urinary Incontinence and Prognosis as follows: All MDS assessments will be monitored for 4 weeks, then 3 assessments per week for	

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F 641	Continued From page 17 2. Resident #10 was admitted to the facility on 6/30/18. Diagnosis included, in part, unspecified severe protein calorie malnutrition. The medical record revealed Resident #10 was admitted to Hospice services on 9/11/21. The comprehensive MDS assessment dated 9/11/21 indicated the resident received Hospice services. Further review of the MDS assessment revealed a prognosis of less than six months was not checked. The Hospice agency's plan of care dated 9/11/21 was reviewed and indicated a prognosis of a life expectancy of six months or less. During an interview with the MDS Coordinator on 11/30/21 at 3:47 PM, he explained he routinely checked Hospice care on the MDS when he completed the assessment for a resident who was admitted to Hospice services. The MDS Coordinator added he had not checked a prognosis of less than six months because he was not aware the section also needed to be checked when he completed the assessment for a Hospice resident. The MDS Coordinator reviewed the Resident Assessment Instrument manual and stated he should have checked "yes" to the statement the resident had a prognosis of less than six months.	F 641	4 weeks then 2 assessments a week for 8 weeks by the Director of Nursing, the RN Admissions Coordinator and/or the Executive Director. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	

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On 12/2/21 at 1:03 PM an interview was completed with the Administrator. She was unsure why the MDS Coordinator did not correctly code the prognosis section of the MDS assessment. She thought the MDS Coordinator might need extra help since he was "working so fast."

3. Resident #33 was admitted to the facility on 5/6/20. Diagnoses included, in part, major depressive disorder and schizophrenia.

The medical record specified Resident #33 had a level two PASRR determination that was effective 8/6/20.

The comprehensive MDS assessment dated 5/15/21 did not indicate Resident #33 had a level two PASRR determination.

During an interview with the MDS Coordinator on 12/1/21 at 3:31 PM, he shared there had not been a conversation with the interdisciplinary team about how level two PASRR determinations were communicated to the MDS office. He explained he routinely looked at the residents' "profile section" in the electronic health record (EHR) for PASRR information. Upon review of Resident #33's information, the MDS Coordinator said he should have coded the MDS assessment to reflect a level two PASRR determination.

On 12/2/21 at 1:03 PM an interview was completed with the Administrator. She stated the MDS Coordinator should have personally reviewed Resident #33's PASRR determination and not relied on the information in the profile section of the EHR.

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F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		12/30/21

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F 655	Continued From page 20 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to initiate a baseline care plan within 48 hours for 2 of 4 new admissions reviewed for baseline care plans (Resident #225 and Resident #228). The findings included: 1. Resident #225 was admitted to the facility on 11/24/21 with diagnoses which included: chronic obstructive pulmonary disease and bilateral lower leg cellulitis. A review of Resident #225's Electronic Medical Record (EMR) conducted on 12/1/21 showed that her scanned baseline care plan was completed on 11/27/21. An interview was conducted with the Minimum Data Set (MDS) Coordinator on 12/1/21 at 10:30 AM who stated that baseline care plans are completed by the admissions nurse, scanned into the chart, and then given to him to hold for 21 days or until the comprehensive care plan is completed. An interview was conducted with the Admissions Nurse on 12/1/21 at 10:45 AM who stated she just didn't get that baseline care plan done within the 48 hour time frame due to being off for the holiday. She stated she did not work on 11/26 or 11/27 so she did not fully complete it until either	F 655	Resident's #225 & 228 had their baseline care plans completed and reviewed with the residents on 12/2/21. A quality review of residents admitted in the last 30 days was conducted by the Director of Nursing and the RN Educator on 12/10/21. This quality review was to determine if the baseline care plans for these admitted residents were developed and reviewed with the resident within 48 hours. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the Director of Nursing, RN Educator and Unit Manager on the expectations of nursing management ensuring that the policy & procedures were adhered to regarding the completion of the baseline care plans on 12/7/21. On 12/9/21 the Director of Nursing and/or the RN Nurse Educator provided education to the nursing staff regarding developing and reviewing baseline care plans with the resident and/or responsible party within 48 hours to include instructions necessary to properly care for	

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F 655	Continued From page 21 Monday or Tuesday of this week. She was unsure of the exact date of completion. She also stated that if a new admission enters over the weekend, she will complete their baseline care plan on Monday when she comes in as she is the only one who completes them in the facility. An interview was conducted with the Director of Nursing on 12/2/21 at 10:25 AM who stated she was aware of the 48 hour time frame for baseline care plan completion and was assuming that the nurses on the weekend and/or holidays were completing the care plans in the admission nurse's absence. An interview was conducted on 12/2/21 at 10:30 AM with the facility Administrator. The Administrator said the MDS nurse and the admission nurse needed to develop a baseline care plan in a timely manner. 2. Resident #228 was admitted to the facility on 10/1/21 with diagnoses which included: chronic obstructive pulmonary disease and Parkinson's disease. A review of Resident #228's Electronic Medical Record (EMR) conducted on 12/1/21 showed that his chart did not contain a copy of his baseline care plan. An interview was conducted with the Minimum Data Set (MDS) Coordinator on 12/1/21 at 10:30 AM who stated that baseline care plans are completed by the admissions nurse, scanned into the chart, and then given to him to hold for 21 days or until the comprehensive care plan is completed. He was unable to find the paper copy.	F 655	a resident including, but not limited to-(A) Initial goals based on admission orders. (B) Physician orders.(C) Dietary orders. (D) Therapy services.(E) Social services. (F) PASARR recommendation, if applicable. The facility must provide the resident and their representative with a summary of the baseline care plan that include but is not limited to:(i) The initial goals of the resident.(ii) A summary of the resident's medications and dietary instructions.(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.(iv) Any updated information based on the details of the comprehensive care plan, as necessary. Monitors were put into place to monitor the development and implementation of baseline care plans within 48 hours with provision of that care plan to the resident and their responsible party. This monitor will be completed for all new admissions for 8 weeks then 2 baseline care plans per week for 4 weeks. These monitors will be completed by the RN Educator, Unit Manager and/or the Director of Nursing. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	

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F 655	Continued From page 22 An interview was conducted with the Admissions Nurse on 12/1/21 at 10:45 AM who stated she does not recall completing a baseline care plan for Resident #228. She stated she is the only one who completes baseline care plans. An interview was conducted with the Director of Nursing on 12/2/21 at 10:25 AM who stated she was aware of the 48 hour time frame for baseline care plan completion and was assuming that the nurses on the weekend and/or holidays were completing the care plans in the admission nurse's absence. An interview was conducted on 12/2/21 at 10:30 AM with the facility Administrator. The Administrator said the MDS nurse and the admission nurse needed to develop a baseline care plan in a timely manner.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		12/30/21

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F 656	Continued From page 23 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 3 (Resident #44) residents reviewed for Activities, 1 of 5 (Resident #66) residents reviewed for unnecessary medications and 1 of 1 (Resident #75) residents reviewed for discharge to the community. The findings included: 1. Resident #44 was admitted on 7/7/2021 with	F 656	Resident #75 has discharged from the facility. The comprehensive care plan for resident's #'s 44 was completed on 12/1/21. Resident #'s 66 activities care plan was revised on 12/7/2 by the Activity Director and the Executive Director. These care plans were reviewed with the interdisciplinary team on 12/8/21. A quality review of the development of comprehensive care plans was completed by the MDS Coordinator of new	

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F 656	Continued From page 24 diagnoses that included a pressure ulcer of the sacral region. A review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 7/15/2021, revealed Resident #44 was cognitively intact. The activity preferences section indicated the Resident found it very important to have his favorite activities and fresh air and somewhat important to have access to current news, religious services, music, and pets. He required total assistance of two staff members for transfers and extensive assistance of one staff member for dressing. The Care area assessment did not trigger for activities. A review of the care plan for Resident #44, dated 10/17/2021, was conducted on 11/29/2021 and an activity focused area was not included. On 11/30/2021 at 11:35 a.m. an observation was conducted of Resident #44 lying in a dark room, in bed. He was looking towards the wall, awake, doing nothing. An interview was conducted on 11/30/2021 at 11:35 AM with Resident #44 and he stated the activities on the activities calendar do not interest him. He added he likes to mix music, play cards, sit outside, watch sports with a small group of men, and enjoys music and sports magazines. An interview was conducted on 12/1/2021 at 11:31 AM with the Administrator and the Activities Director. The Administrator reviewed the admission MDS assessment for Resident #44. She stated the assessment revealed music, pets, news, and religious services were somewhat important and his favorite activities and	F 656	admissions in the last 30 days. A quality review was completed by the Social Worker of current residents as related to their discharge care plans on 12/7/21. A quality review of activities care plans of current residents was completed on 12/7/21. Based on the results of the quality reviews, the care plans were initiated/updated accordingly by 12/27/21. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. On 12/7/21, the Executive Director provided education to the MDS Coordinator, the Social Worker, the Social Work Assistant, the Activities Director and the Activities Assistant regarding timely completion of a comprehensive, person centered care plans (within 7 days of the completion of the CAA's), including that comprehensive care plans are to include a discharge planning care plan and an activities care plan for each resident. Quality monitors were put into place to monitor timely completion, comprehensiveness of care plans to include a discharge plan & activities care plan for each resident for all admissions over the next 8 weeks, then 2 comprehensive care plans for 4 weeks. These monitors will be completed by the Executive Director, the Director of Nursing and/or RN Educator.	

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F 656	Continued From page 25 outdoor/fresh air were very important. Resident #44's care plan for activities had not been completed nor was it Resident centered. On 12/02/2021 at 2:09 PM an interview was conducted with the MDS coordinator and he stated an activity focused area was not in place on the care plan from 7/15/2021 through 11/30/2021. He stated he added the Resident refused activities to the care plan after 11/30/2021 because the Resident does not want to go to group activities scheduled on the calendar. He stated he did not interview the Resident for preferred activities to list on a care plan. 2. Resident #66 was admitted to the facility on 10/20/2021 with diagnoses that included metabolic encephalopathy, multiple fractures, dysphagia, generalized anxiety and major depressive disorder. A review of the comprehensive Minimum Data Set (MDS) assessment dated 10/23/2021 revealed Resident #66 had cognitive impairment, required extensive assistance of one staff member with activities of daily living and had functional impairments on one side of his upper and lower extremities. A review of the care plan section of the electronic medical record for Resident #66 revealed a comprehensive care plan had not been created. An interview was conducted on 12/1/2021 at 4:56 PM with the MDS coordinator and he revealed Resident #66 was originally admitted on 10/20/2021 with a comprehensive MDS assessment completed on 10/23/2021 with the	F 656	The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	

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discharge return anticipated combined in the same assessment. He stated a new entry, a report completed to show what date a resident returned to the facility, was completed on 10/30/2021 and a new five-day admission assessment was completed on 11/6/2021. The comprehensive care plan was due on 11/12/2021 and was missed, possibly because of the discharge and reentry of the Resident, per the MDS coordinator. He stated, at the time of the interview it was 19 days late and there was not a care plan in place for the Resident.

An interview was conducted on 12/1/2021 at 5:37 PM with the Director of Nursing (DON) and she reviewed the electronic care plan and then revealed was unable to locate a comprehensive resident centered care plan for Resident #66. She stated she expected a care plan to be completed for a resident per guidelines and it was her expectation it be completed as soon as possible. She revealed the MDS coordinator was responsible for completing the care plan.

3. Resident #75 was admitted to the facility on 5/10/21 with diagnoses that included, in part, Parkinson's disease and diabetes mellitus type 2. Resident #75 discharged home on 9/28/21.

The comprehensive care plan dated 5/17/21 was reviewed for Resident #75 and did not include information that addressed discharge planning.

The admission Minimum Data Set (MDS) assessment dated 9/28/21 revealed Resident #25 had minimally impaired cognition.

On 12/2/21 at 12:50 PM an interview with the Social Worker revealed that she did not add

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F 656	Continued From page 27 anything about discharge care plans to the resident's care plans in the facility. She stated they completed a form entitled, "Journey home", that would address their wants, needs, and when they planned on discharging from the facility. She stated that form was scanned into their chart under the miscellaneous tab and it was not attached to the comprehensive care plan. On 12/2/21 at 1:00 PM an interview was completed with the Director of Nursing (DON). She stated she had not completed a care plan for Resident #75 that addressed discharge planning and had never added discharge care plans to the comprehensive care plans for residents in the facility.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to provide an on-going activity program 1) as scheduled for 1 of 3 residents (Resident #50) and 2) that met the individual interest and needs to enhance the quality of life for 1 of 3 residents	F 679	Resident's #50 and #44 were interviewed and their care plans were updated according to their interests on 12/7/21. A quality review was completed with all current residents being interviewed to	12/30/21

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F 679	Continued From page 28 (Resident #44) reviewed for activities. Findings included: 1. Resident #50 was admitted 4/2/2019 with diagnoses that included heart failure, anxiety disorder and depression. The comprehensive Minimum Data Set (MDS) dated 1/29/2021 revealed Resident #50 was cognitively intact. A depression screening assessment tool indicated mild symptoms of depression present at the time of the assessment. The activity preference assessment indicated the Resident found it somewhat important to participate in group activities. The quarterly MDS dated 10/14/2021 revealed Resident #50 had a depression screening assessment tool that indicated moderate symptoms of depression with an increase in the score by 6 points since the comprehensive assessment. Resident #50's care plan, dated 10/18/2021, revealed focused areas identified that included: A. At risk for an alteration in psychosocial well being related to fear of COVID 19, restriction on visitation and social isolation due to COVID 19. The interventions included encourage participation in group activities and social events within the facility. B. Resident #50 does like to attend our bingo games, our social parties, and our game activities. The interventions included resident will express satisfaction with the type of activities and level of activity involvement when asked through	F 679	determine their likes and dislikes in relation to activity interests by the Activities Director and the Activity Assistant. The results of the quality review were used to develop person centered activity care plans by 12/27/21. A new activity assistant was put into place on 12/16/21. The Executive Director educated/re-educated the Activities Director and Activity Assistant on the Community Life policies and procedures on 12/16/21. Using the results of the quality review, the ongoing Activities Calendar was adjusted to reflect interests on 12/18/21. Quality Monitors were put into place to ensure activities were taking place per calendar and that the residents were being offered residents of their interest. These monitors will be completed 3 days per week for 8 weeks to include 6 residents, then 2 times a week for 4 weeks. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	

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the review date. Modify daily schedule, treatment plan as needed to accommodate the community life participation as requested by the resident.

C. Resident #50 has a mood affective disorder and anxiety. Interventions included assist the resident in developing a program of activities that are meaningful and of interest.

On 11/30/2021 Resident #50 was observed lying in bed, sleeping at 10:45 AM.

An interview was conducted with Resident #50 on 11/30/2021 at 10:54 AM. She revealed activities had been available prior to the COVID pandemic. If activities were available, she would attend. She added she is bored to death. She had been eating, sleeping, and watching TV. She stated BINGO was on the calendar but had been cancelled for a long time and the country store, another activity listed daily on the calendar, was just a snack cart pushed around and not an activity in her opinion. She stated nails and tales was on the calendar at 2:30 pm but it would not take place either. She revealed she understood cancelling the activities at first, but this had gone on too long and it was driving her crazy and making her sad to not have something to do.

A review of the Activities calendar for November 2021 revealed for the date of November 30, 2021 an activity was scheduled at 2:30 called Nails and Tales. It was scheduled to take place in the Hen house, beauty shop. A cool craft activity was scheduled to take place on 12/1/2021 at 10:30 AM.

On 11/30/2021 at 2:32 PM an observation was conducted of the hen house, beauty shop, and a

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complete walk through of the facility was completed. No nail painting activity was observed in the facility.

On 12/1/2021 at 10:35 AM an observation of the main dining room was conducted, and two staff members were observed utilizing the space for work/office space. One staff member stated he was on a conference call. No cool craft activity was taking place.

On 12/1/2021 at 10:39 AM an observation was conducted of the short and long hall with no craft activities occurring with any residents. Resident #50 was observed in the bed asleep.

On 12/1/2021 at 11:06 AM an interview was conducted with the Activities Director and the Administrator. The Administrator revealed an activities assistant had went out a few weeks prior to having a baby prematurely. She stated prior to this, the activities assistant was conducting one-on-one activities in the rooms. She added that coloring pages of puppy dogs and cats had been bulk copied and provided for weekend activities. The radio for music had been broken and no longer available for the snack cart therefore the snack cart activity was just a snack cart with no other activity included. She added that group activities had been stopped due to the facility being in COVID 19 outbreak status. She stated this had been for longer than six weeks. She denied any residents currently being positive with COVID 19 and stated it had been greater than 14 days since there had been a positive resident with COVID 19. When the Administrator was asked what current guidelines she had utilized for stopping group activities she consulted her corporate consultant and referred to the

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Centers for Medicare and Medicaid Services (CMS) Memorandum Summary, "Center for Clinical Standards and Quality/Survey & Certification Group Ref: QSO-20-39-NH revised 11/12/2021," subject Nursing Home visitation; headline communal activities, dining, and resident outings. The Administrator then stated, this read that while adhering to core principles of COVID 19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. She stated, according to these guidelines, she interpreted this to mean group activities should be occurring with safety measures in place.

2. Resident #44 was admitted on 7/7/2021 with diagnoses that included diabetes mellitus and a pressure ulcer of the sacral region.

A review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 7/15/2021, revealed Resident #44 was cognitively intact. The activity preferences section indicated the Resident found it very important to have his favorite activities and fresh air and somewhat important to have access to current news, religious services, music, and pets. He required total assistance of two staff members for transfers and extensive assistance of one staff member for dressing.

A review of the care plan for Resident #44, dated 10/17/2021, was conducted on 11/29/2021 and an activity focused area was not included.

On 11/30/2021 at 11:35 an observation was conducted of Resident #44 lying in a dark room,

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in bed. He was looking towards the wall, awake, doing nothing.

An interview was conducted on 11/30/2021 at 11:35 AM with Resident #44 and he revealed the activities on the activities calendar do not interest him. He has no need for Nails and tales. Doing things with people that much older than him do not interest him. A card game, like Rook, would be fun occasionally but it would have to be on a day that he does not have therapy and wound care. He denied being asked what he likes specifically. He stated they asked if he liked pets or music but did not ask what he specifically likes (type of music, if he needed something to play the music on, pet therapy or if he had a pet) or if they could do anything for him. He revealed he did not feel a facility for seniors could do much for a man that was middle aged. He added he likes to mix music, play cards, sit outside, watch sports with a small group of men, and enjoys music and sports magazines.

An interview was conducted on 12/1/2021 at 11:31 AM with the Administrator and she reviewed the admission MDS assessment for Resident #44. She stated the assessment revealed music, pets, news, and religious services were somewhat important and his favorite activities and outdoor/fresh air were very important. She stated these activities, except for the resident taking himself outside, were not being completed. She added that coloring pages and cross word puzzles as well as nails and tales had been the activities presented to Resident #44 and his care plan for activities had not been completed nor was it Resident centered. She denied being aware if any staff member had asked the Resident for specific options that he

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F 679	Continued From page 33 preferred. She stated in the future, music could be included for the Resident, per his preference and other options would be discussed with the Resident.	F 679		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		12/30/21

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F 732	Continued From page 34 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of the daily nursing staff postings, the facility failed to include the census on the daily nursing staff posting for 7 of 30 days. Findings included: On 11/29/21 at 10:39 AM an observation was made of the facility's daily nurse staffing which was posted on the bulletin board in the front hallway across from the nurse's desk. There was no census number listed on the nurse staffing sheet. The daily nursing staff postings were reviewed for November 1-30, 2021. The postings did not include the facility census on the following dates: 11/18/21, 11/19/21, 11/20/21, 11/21/21, 11/22/21, 11/23/21 and 11/29/21. During an interview with the Director of Nursing (DON) on 12/2/21 at 12:02 PM she said she completed the daily nursing staff postings. She explained the information on the postings included the facility name and date, the hours for the nurses and nurse aides and the daily census. The DON said she had not worked 11/18/21-11/20/21. Typically when she was off or during the weekend she completed the staff posting in advance and if the census changed another staff member revised the information on the form. She added if she was not in the	F 732	The staffing sheet was corrected to reflect the correct census & hours on 12/2/21 by the Director of Nursing. A quality review was completed of the last 30 days of staffing sheets to determine extent of deficient practice on 12/7/21 by the Director of Nursing. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the Director of Nursing & RN Educator regarding the accuracy and completeness of the staffing sheets on 12/9/21. The RN Educator, the Staffing Coordinator and the nurses were educated as to how to complete and update the staffing sheet with ongoing census and staffing changes by 12/23/21. Monitors were put into place to monitor the accuracy and completeness of the nursing staffing sheets. The monitors will be completed daily, 5 times a week for 8 weeks, then 2 times weekly for 4 weeks. These monitors will be completed by the Director of Nursing, the RN Educator or the Unit Manager.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 35 building, the Administrator helped with the nursing staff posting. She did not know why the census had not been added to the posting for the seven days in November 2021 and expressed the census should have been included in the posting.	F 732	The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to obtain mental health services for a resident exhibiting symptoms of depression for 1 of 2 residents (Resident #174) reviewed for mood and behavior. The findings were: Resident #174 was admitted to the facility on 11/5/21 with diagnoses of anxiety and depression. The hospital discharge summary dated 11/5/21 revealed Resident #174 was admitted to the hospital for depression and suicidal thoughts and received electroconvulsive therapy while hospitalized.	F 740	Resident #14 was assessed by the Social Worker on 12/3/21 and determined to be free from any negative outcome. The resident was seen by psychiatric services on 12/6/21. A quality review was completed by the Social Work department to identify any residents with signs and symptoms of depression through interviews with staff across all shifts and interviewing the residents. Referrals to psych services will be made as needed with the results of the quality review. A quality review of all hospital discharge summaries was completed of the last 30 days of admissions to ensure that all	12/30/21

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	345089	A. BUILDING _____ B. WING _____	12/02/2021

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F 740	Continued From page 36 An admission Minimum Data Set assessment dated 11/12/21 revealed Resident #174 had impaired cognition. Resident #174 was assessed as feeling down, depressed, or hopeless and had little interest in doing things for 7-11 days of the assessments look-back period. Resident #174 had thoughts of being better off dead or of hurting self for 1 day of the look back period. Review of the Medication Administration Record for November 2021 revealed Resident #174 received Lexapro (an antidepressant) 15 milligrams daily and Abilify (an antipsychotic) 7.5 milligrams daily. Resident #174's medical record included an order dated 11/12/21 - Mental Health is to see next week. A review of the medical record revealed no evidence Resident #174 had a mental health evaluation. On 11/29/21 at 2:47 PM, Resident #174 was interviewed. The resident was observed lying in bed with a flat affect and stated her mood was consistently depressed. Resident #174 was unsure if anyone had talked to her about it or if she received medications to treat depression. On 12/1/21 at 10:10 AM, a follow up interview was conducted with Resident #174 who was observed lying in bed with only a shirt on. The resident stated she was hot, didn't know if she would get out of bed today and didn't know what she wanted to do. Affect was flat and she endorsed depression. On 12/1/21 at 10:50 AM, an interview was	F 740	residents with symptoms of depression, suicidal ideations and treatment for psychiatric symptoms in the hospital are identified. Referrals to psych services will be made as needed with the results of the quality review. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the Social Worker, the Social Work Assistant, the Director of Nursing and the RN Educator re: ~if a staff member/friend/family notes/reports, ~or if a resident expresses feeling down, depressed or hopeless with little interest in doing things, the nurse, the physician, psychiatric services, the family and Social Worker/Social Work Assistant and need to be made aware. It will be communicated to the Social Work Department in person during business hours and through the 24 hour report off hours. The Director of Nursing and/or RN Educator educated the nurses and CNA's re: ~ if a staff member/friend/family notes/reports, ~or if a resident expresses feeling down, depressed or hopeless with little interest in doing things, the nurse, the physician, psychiatric services, the family and Social	

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F 740	Continued From page 37 conducted with the Social Worker (SW) who stated when a resident is admitted and it is determined mental health services are needed, she gets consent, a physician's order then calls the nurse practitioner to review resident information. The mental health nurse practitioner sees residents each Monday. The SW stated she didn't know why the order didn't get put in on admission but, there was a change in mental health providers and Resident #174 got missed and never got evaluated. On 12/2/21 at 3:15 PM, the Administrator was interviewed. She stated the SW informed her Resident #174 did not receive a mental health evaluation. She added there was a change in their mental health provider and she got missed.	F 740	Worker/Social Work Assistant and need to be made aware. It will be communicated to the Social Work Department in person during business hours and through the 24 hour report off hours. The Regional Director of Clinical Services educated the Director of Nursing, the RN Educator and the Unit Managers re: a thorough review of the discharge summary upon admission to identify any residents with symptoms of depression, suicidal ideations and treatment for psychiatric symptoms in the hospital and are monitored for those symptoms, that the Social Work department is made aware and a referral is made to psychiatric services. A meeting was held with Regional Vice President of Operations, the Regional Director of Clinical Services and the Administrator regarding the current psychiatric services. As a result of the meeting, the Medical Director was made aware of concerns with psychiatric services. The facility is in the process of obtaining new psychiatric services which will begin the first week of February. The current services will continue until such time. A quality monitor was implemented to ensure that staff were aware of what to do with expressions or exacerbated/ongoing symptoms of depression. The monitor will also include ensuring that new residents on psychiatric medications or residents	

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F 740	Continued From page 38	F 740	with exacerbated/ongoing depression are seen timely and as needed by psychiatric services. The quality monitor also included monitoring 8 random residents on psychoactive medications to monitor for expressions of depression or exacerbated/ongoing symptoms of depression. This monitor will be completed 5 days a week for 5 weeks, then 3 days a week for 4 weeks then weekly for 4 weeks. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	
F 756 SS=D	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	F 756		12/30/21

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F 756	Continued From page 39 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the Pharmacy consultant failed to identify and address an as needed (PRN) psychotropic medication that was prescribed for greater than 14 days with no documented rationale (Resident #66) for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #66 was admitted to the facility on 10/20/2021 with diagnoses that included metabolic encephalopathy, chronic obstructive pulmonary disease, multiple fractures, anxiety, and major depressive disorder. A review of Resident #66's comprehensive Minimum Data Set (MDS) dated 10/23/2021, revealed Resident #66 had cognitive impairment	F 756	Upon review of the consultant reports sent via e-mail to the facility on 12/1/21, it was determined that the pharmacist had completed a consult report requesting resident #66 not having a stop date on the anxiolytic and the facility failed to act on it. A quality review was completed by the Director of Nursing of all current physician orders to ensure that all PRN anxiolytics had a stop date. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the Director of Clinical Services, the RN	

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F 756	Continued From page 40 and received antianxiety medication 3 days during the 3-day lookback period. A review of a Nurse Practitioner progress note written on 11/2/2021 read, Clonazepam 1 mg tab with a start date of 10/21/2021 and a stop date of 11/20/2021 for anxiety. A medication order was received on 11/9/2021 at 6:28 p.m., for Resident #66, Clonazepam 0.5 mg tab every 12 hours PRN, start on 11/9/2021 and end date indefinite. The order was entered by Nurse #4 and ordered by the physician. The order was active on 12/1/2021. A review of the Pharmacy Consultant electronic progress notes, dated 11/30/2021, read Pharmacy Medication Regimen Review (MRR): This resident's medical record including electronic documentation was reviewed on this date: [X] See report for any noted irregularities and/or recommendations. The Administrator provided a copy of each MRR for the date of 11/30/2021. A complete review was conducted and a recommendation for Resident #66 was not made on 11/30/2021. An interview was conducted on 12/1/2021 at 5:37 p.m. with the Director of Nursing (DON) and she revealed it was the expectation of the facility that a resident was not on a PRN psychotropic longer than 14 days. She reviewed the order for Resident #66, Clonazepam 0.5 mg tab every 12 hours PRN and stated this had been longer than 14 days and should have been discontinued on day 14 or less. She reviewed the MMR recommendations for 11/30/2021 and stated she did not see a pharmacy consultant	F 756	Educator and the Nurse Manager on the facility policy and procedure for Monthly Drug Regimen Review especially as related to unnecessary medications on 12/10/21. A quality monitoring tool was implemented to monitor completion of pharmacy recommendations in a timely manner to be completed monthly by the Executive Director for 3 months. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	

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F 756	Continued From page 41 recommendation for this medication, and this was a medication that she expected the pharmacy consultant to review and recommend a stop date to the physician. She stated she was going to contact the practitioner and pharmacy consultant immediately for an action. An interview was conducted on 12/2/2021 at 11:22 a.m. with the DON and she revealed she had been in contact with the NP and the PRN medication had been discontinued. She stated it was her expectation and the NPs that a PRN antianxiety medication does not go beyond 14 days without the necessary rationale from the physician.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		12/30/21

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F 758	Continued From page 42 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §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 and staff interviews the facility failed to obtain documentation for the rationale and duration to extend an as needed (PRN) order for a psychotropic medication beyond 14 days for 1 of 5 residents (Resident #66) reviewed for unnecessary medications. The findings included: Resident #66 was admitted to the facility on 10/20/2021 with diagnoses that included	F 758	The PRN medication for resident #66 was addressed through physician orders on 12.6.21. A quality review was completed by the Director of Nursing of all PRN anxiolytic for current residents on 12/21/21 & no other issues of concern were noted. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and	

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F 758	Continued From page 43 metabolic encephalopathy, chronic obstructive pulmonary disease, multiple fractures, anxiety, and major depressive disorder. A review of Resident #66's comprehensive Minimum Data Set (MDS) dated 10/23/2021, revealed Resident #66 had cognitive impairment and received antianxiety medication 3 days during the 3-day lookback period. A review of a Nurse Practitioner's progress note written on 11/2/2021 read, Clonazepam 1 mg tab with a start date of 10/21/2021 and a stop date of 11/20/2021 for anxiety. A medication order was received on 11/9/2021 at 6:28 p.m., for Resident #66, Clonazepam 0.5 mg tab every 12 hours PRN, start on 11/9/2021 and end date indefinite. The order was entered by Nurse #4 and ordered by the physician. The order was active on 12/1/2021. An interview was conducted on 12/1/2021 at 5:37 p.m. with the Director of Nursing (DON) and she revealed it was the expectation of the facility that a resident was not on a PRN psychotropic longer than 14 days. She reviewed the order for Resident #66, Clonazepam 0.5 mg tab every 12 hours PRN and stated this had been longer than 14 days and should have been discontinued on day 14 or less. She stated she was going to contact the practitioner immediately for an action. An interview was conducted on 12/2/2021 at 11:22 a.m. with the DON and she revealed she had been in contact with the NP and the PRN medication had been discontinued. She stated it was her expectation and the NPs that a PRN antianxiety medication does not go beyond 14	F 758	approve a plan of correction for the deficient practice. The Director of Nursing educated the Nurse Practitioner who wrote the PRN anxiolytic order without a stop date on the importance of including a stop date within 14 days. The Executive Director educated the Director of Nursing, the RN Educator and the Unit Manager on 12/13/21 on the importance of reviewing all new orders every Monday through Friday to identify any other anxiolytic orders that may not have a stop date. The Director of Nursing and/or the RN Nurse Educator provided education to the licensed nurses to reviewing all orders when noting the orders off to ensure that any PRN anxiolytic medications had a 14 day stop date. Monitors were put into place review all orders daily Monday – Friday for 12 weeks to be completed by the Executive Director, the Director of Nursing or the RN Educator to ensure that all anxiolytics have a stop date within 14 days. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	

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F 758	Continued From page 44 days without the necessary rationale from the physician.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications from one of one medication room reviewed for medication storage. The findings included:	F 761	The expired medication was removed from the back-up narcotic circulation on 12-2-21. A quality review of all narcotics in the facility was conducted on 12-3-21 by the	12/30/21

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F 761	Continued From page 45 Observations of the medication room for the front and north halls were conducted on 12/2/2021 at 11:41a.m. with Nurse #1 present. The observation revealed a locked narcotic box inside the refrigerator that contained 18 prefilled syringes for Lorazepam (sedative) 1 mg (milligram) topical gel. The expiration date for all 18 syringes was 10/14/2020. An interview was conducted with the Director of Nursing (DON) on 12/2/2021 at 11:57 a.m. and she reviewed the 18 Lorazepam syringes, stated they were expired on 10/14/2020 and removed the syringes immediately to be returned to pharmacy to be destroyed. She stated she was not sure how this medication was missed during medication room checks for expired medications and will review this with the administrative team for possible solutions. She added it was her expectation that expired medications were not stored on the hall or in the medication storage room.	F 761	Director of Nursing and the RN Educator to identify any other issues. An ADHOC Quality Assurance Performance Improvement Committee was held on 12/3/21 to formulate and approve a plan of correction for the deficient practice. Education regarding timely identification and removal of medications prior to the expiration date was provided to the licensed nursing staff by the Director of Nursing on 12/13/21. Monitors were put into place to be completed by the Unit Managers and/or RN Educator to check for expired medication in all medication storage areas of the facility 2 times weekly for 4 weeks, then weekly for 8 weeks. The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months.	