STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

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F 000	INITIAL COMMENTS A recertification with complaint survery was conducted from 11/14/2021 to 11/18/2021. 1 of 1 allegation was unsubstantiated. The facility was found in compliance with CFR 483.73 Emergency Preparedness. Event ID #N49311.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all 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	F 550		12/16/21

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

Electronically Signed | 12/03/2021

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to treat a resident in a dignified manner when the facility staff failed to retrieve a call bell and bed remote that was out of resident reach. The facility staff also discussed the contents of a resident's medical record. This was for 1 (Resident #42) of 1 reviewed for dignity The findings included: Resident #42 was admitted on 10/15/21 with cumulative diagnoses of a Traumatic Brain Injury (TBI), depression and anxiety. The admission Minimum Data Set (MDS) assessment dated 10/26/21 indicated Resident #42 was cognitively intact and exhibited no behaviors. In an initial interview with Resident #42 on 11/14/21 at 3:02 PM, she stated she had no care concerns with the facility and went on to list a few employees she was especially fond of. A second interview was attempted on 11/15/21 at 2:00 PM but the Activities Director (AD) was in the room visiting with Resident #42.	F 550	Preparation and submission of this plan of correction by Wadesboro Health and Rehabilitation does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. F550 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. The Administrator conducted a one-on-one interview with the resident concerning her grievance on 11/16/21. 1b. The Administrator completed a grievance form and submitted to the Grievance Officer on 11/16/21. 1c. The Administrator reeducated the Activities Director on the Resident Grievances and Concerns Policy on 11/17/21.	

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F 550	Continued From page 2 An interview was conducted on 11/16/21 at 2:45 PM with Resident #42. She stated yesterday when the AD was in her room and she discussed concerns about the nurses and aides discussing something in her medical record that was not accurate. Resident #42 also stated she told the AD yesterday about an incident that occurred one day last week. She stated one day last week around 4:00 PM, she laid her bed down to stretch her back out causing her call bed and bed remote to fall onto the floor out of her reach. She stated she did not yell because she knew Nurse #1 would be in to give her medications. Resident #42 stated when Nurse #1 came in to give her the medications, she ask Nurse #1 to give her bed remote and call bell to her so she could raise her bed. She stated Nurse #1 tried to bend down to pick up her call bell and bed remote but Nurse #1 stated she could not bend that far and she would tell someone to come in and get them for her. Resident #42 stated she waited for about 30 minutes then she was able to reach her cell phone and she called the facility and spoke with Nursing Assistant (NA) #1 who immediately came to her room and got her call bell and bed remote for her. An interview was conducted on 11/16/21 at 2:50 PM with the AD. She stated Resident #42 told her about the staff talking about something in her medical record and about an incident that occurred last week involving Nurse #1. She stated Resident #42 was a new resident and she felt she was just having a difficult time adjusting to the facility. An interview was conducted on 11/16/21 at 4:03 PM with Nursing Assistant (NA) #1. She recalled one day last week, the DON answered the phone	F 550	2. Address how corrective action will be accomplished for those resident's having potential to be affected by the same deficient practice: 2a. On 11/17/21 the Administrator delegated staff to interview all alert & oriented residents concerning Resident Rights using an Abuse Allegation Audit Tool. 2b. The Nurse #1 was immediately suspended on 11/16/21, pending investigation. 2c. Nurse #1 was terminated on 11/22/21 after completion of the investigation. 3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur. 3a. The DON implemented reeducation of all staff on the Abuse, Neglect, and Exploitation Policy to be completed by 12/10/21. 3b. The DON implemented reeducation of all staff on the Saber HIPAA Policy to be completed by 12/10/21. 4. Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained: 4a. The Administrator or Designee will assign designated staff to complete an Abuse Allegation Audit Tool on all alert and oriented residents weekly x 12 weeks, then monthly x 12 months. Results of the audit will be brought to QAPI by the Administrator or DON and will be reviewed monthly for 3 months by the QAPI Committee. If any discrepancies	

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F 550	Continued From page 3 and asked her to go check to see what Resident #42 needed help with. She stated when she entered the room, Resident #42 was upset and told her what happened with Nurse #1. NA #1 explained that it was not intentional and that she probably forgot to tell someone you needed someone to get your call bell and bed remote. NA #1 stated Resident #42 mentioned that staff were discussing something that was untrue found in her medical record. She stated she told Resident #42 to not worry about what people say. Multiple phone call attempts and messages left for Nurse #1 to return phone call. An interview was conducted on 11/17/21 at 2:40 PM with the Administrator. She stated she expected the facility staff to not discuss the contents of Resident #42' medical record and ensure her call bell and bed remote reminded within her reach.	F 550	are noted, further action will be implemented by the Administrator.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		12/16/21

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F 561	Continued From page 4 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to honor residents' choices related to showers. This was for 6 of 6 residents reviewed for choices (Residents #18, #19, #22, #25, #49 and #42). The findings included: 1) Resident #18 was originally admitted to the facility on 12/19/19 with diagnoses that included end stage renal disease (ESRD) on hemodialysis, chronic pain, and diabetes. The annual Minimum Data Set (MDS) assessment dated 10/1/21 indicated Resident #18 was cognitively intact and was coded as it being very important to choose between a tub bath, shower, bed bath or sponge bath for his daily preferences. Resident #18 was dependent on staff for personal hygiene, bathing, and transfers with limited range of motion to all four extremities.	F 561	F561 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. The Unit Manager interviewed residents #18,19,22,25,49 and 42 regarding their shower choice on 11/15/21. The shower schedule was updated to reflect their choice. 1b. The DON or designee interviewed the above mentioned residents to see if they had been offered a shower on 11/30/21, all had been offered a shower. 2. Address how corrective action will be accomplished for those resident's having potential to be affected by the same deficient practice: 2a. The Unit Manager interviewed all alert and oriented Residents concerning their shower choice and the DON updated the shower schedule on 11/15/21.	

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F 561	Continued From page 5 Resident #18's active care plan, last reviewed on 10/12/21, revealed a focus area for self-care deficit related to bilateral upper and lower extremity amputations. The interventions included physical assistance by a staff member when taking a bath or shower. A review of Resident #18's nursing progress note from 9/1/2020 through 11/17/21 did not reveal any refusals for showers or bathing assistance. A review of Resident #18's Nursing Assistant (NA) bathing/shower documentation from 1/1/21 through 11/15/21, indicated he had not received a shower at any time, only bed baths were documented as given. An interview was completed with Resident #18 on 11/14/21 at 2:25 PM, who stated he would like to receive his showers as scheduled weekly, but it had been "months" since he had received a shower. Resident #18 explained staff didn't offer a shower but provided a bed bath daily and when asked about a shower he was told the shower room on his hall was not working. On 11/16/21 at 11:23 AM, an undated form titled "Shower Schedule" was provided by the Assistant Director of Nursing (ADON). The form listed resident room number and name, a column for request of a shower with either yes or no documented and 2 other columns named "Days of the week" and "Shift to receive shower". The ADON explained alert and oriented residents were asked if they would like to receive a shower and yes or no was documented. She was unsure who completed the list or the last time it was updated. Resident #18 was listed as yes to request of a shower provided on Tuesday during	F 561	2b. On 11/17/21 the DON contacted all family members of residents who cannot make their own decisions and the shower schedule was updated. 3. Address what measure will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. The DON reeducated all CNAs on offering the residents a shower by 12/15/21. Any employee not completing the education will not be allowed to work until education completed. 3b. The DON reeducated the CNAs on documenting showers given or refused in the Point of Care system on 12/15/21. Any employee not completing the education will not be allowed to work until education completed. 4. Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained: DON or designee will complete 5 resident interviews weekly regarding showers x 12 weeks then monthly for 12 months. Results of the audit will be brought to QAPI by the Administrator and/or DON will be reviewed monthly for 12 months by the QAPI Committee. If any discrepancies are noted, further action will be implemented by the Administrator.	

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the 3:00 PM to 11:00 PM (2nd) shift.

The Director of Nursing (DON) was interviewed on 11/16/21 at 11:45 AM and explained the undated shower schedule provided was recently updated in the last week. She reviewed the shower schedule and NA flow records confirming Resident #18 was scheduled for a shower on Tuesday's 2nd shift and he had only received bed baths in the past 11 months. She further stated she would have expected the NAs to provide the shower as scheduled and if Resident #18 had refused it should have been documented, reported to the nurse and then an alternate means of bathing should have been provided.

On 11/16/21 at 3:45 PM, an interview occurred with NA #2 who worked on the 2nd shift, was familiar with Resident #18 and was assigned to him on scheduled shower day of 10/19/21. She reviewed the shower schedule and confirmed Resident #18 was listed as a scheduled shower on 2nd shift Tuesdays. After reviewing the NA flow record for October 2021, she was unable to state why Resident #18 had not received a shower as scheduled on 10/19/21 only that he had received a bed bath during the 7:00 AM to 3:00 PM (1st) shift.

During an interview with NA #3 on 11/16/21 at 3:47 PM, she indicated she worked on the 2nd shift and was familiar with Resident #18. NA #3 reviewed the shower schedule and verified he was scheduled for showers on Tuesday 2nd shift. She was unable to state why Resident #18 had not received a shower as scheduled for the days she was assigned to him (9/7/21, 10/26/21 or 11/9/21).

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The Administrator was interviewed on 11/17/21 at 8:30 AM and explained showers stopped during the COVID-19 outbreak in 2020 and bed baths were provided to all residents, however she would have expected all residents to be provided showers on a regular basis and provided to the opportunity to refuse at this time.

2) Resident #19 was originally admitted to the facility on 4/26/19 with diagnoses that included muscle weakness, osteoarthritis, and diabetes.

The annual Minimum Data Set (MDS) assessment dated 7/1/21 indicated Resident #19 had moderate impairment to his cognition and was coded as it being very important to choose between a tub bath, shower, bed bath or sponge bath for his daily preferences.

A quarterly MDS assessment on 10/1/21 indicated Resident #19 had moderate impairment to his cognition and displayed no behaviors. He required extensive assistance with transfers, personal hygiene, and bathing.

Resident #19's nursing progress notes were reviewed from 7/26/19 through 11/17/21 and indicated he was alert and oriented with periods of confusion. Documentation did not reveal any refusals for showers or bathing assistance.

A review of Resident #19's Nursing Assistant (NA) bathing/shower documentation from 1/1/21 through 11/16/21, indicated he had not received a shower at any time, only bed baths were documented as given.

An interview was completed with Resident #19 on

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11/16/21 at 2:25 PM, who stated he was asked yesterday and today if he wanted to take a shower and told the staff member "yes". He explained he was told his name would be put on the list for a shower but wasn't told how often or when he would get one. Resident #19 went on to say he used to get a shower at least weekly, but it had been "some time" since he had received one. Bed baths were provided every morning, no one offered him a shower and he would like to get shower at least once or twice a week.

On 11/16/21 at 11:23 AM, an undated form titled "Shower Schedule" was provided by the Assistant Director of Nursing (ADON). The form listed resident room number and name, a column for request of a shower with either yes or no documented and 2 other columns named "Days of the week" and "Shift to receive shower". The ADON explained alert and oriented residents were asked if they would like to receive a shower and yes or no was documented. She was unsure who completed the list or the last time it was updated. Resident #19 was listed as no to request of a shower with no day or shift to offer one listed.

The Director of Nursing (DON) was interviewed on 11/16/21 at 11:45 AM and explained the undated shower schedule provided was recently updated in the last week. She reviewed the shower schedule and NA flow records confirming Resident #19 had only received bed baths in the past 11 months. She stated he was listed as "no" to request of a shower and stated the list was updated periodically with a staff member going to the alert and oriented residents and asking if they wanted to be put on the list for showers. The DON acknowledged all residents should be

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scheduled for a shower at least weekly and had the right to refuse if they didn't want one that day.

On 11/16/21 at 3:45 PM, an interview occurred with NAs #2 and #3, who worked 3:00 PM to 11:00 PM (2nd) shift and was familiar with Resident #19. They denied offering Resident #19 a shower on their shift and stated he received a bed bath on the 7:00 AM to 3:00 PM (1st) shift.

The Administrator was interviewed on 11/17/21 at 8:30 AM and explained showers stopped during the COVID-19 outbreak in 2020 and bed baths were provided to all residents. She stated she would have expected all residents to be provided showers on a regular basis and provided the opportunity to refuse, at this time.

On 11/17/21 at 11:00 AM, NA #5, who was familiar with Resident #19, was interviewed. She verified she worked 1st shift and denied offering him a shower, providing only a bed bath because he was listed as "no" on the shower schedule. NA #5 further stated Resident #19 used to go to the shower room prior to COVID-19 but was unsure why this had not resumed.

3) Resident #22 was originally admitted to the facility on 9/3/13 with diagnoses that included low back pain, muscle weakness and muscle spasms.

The annual Minimum Data Set (MDS) assessment dated 6/4/21 indicated Resident #22 was cognitively intact and was coded as it being very important to choose between a tub bath, shower, bed bath or sponge bath for his daily preferences.

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Resident #22's active care plan, last reviewed on 7/15/21, included a focus area for self-care deficit. The interventions included to assist with personal care, assist with bath and showers and required 1 staff member when taking a bath/shower.

A quarterly MDS assessment on 10/12/21 indicated Resident #22 was cognitively intact and displayed no behaviors. He required assistance with personal hygiene and bathing.

A review of Resident #22's nursing progress notes from 1/1/2020 through 11/17/21 indicated he was alert and oriented and had not refused shower or bathing assistance.

A review of Resident #22's Nursing Assistant (NA) bathing/shower documentation from 1/1/21 through 11/16/21, indicated he had received only bed baths except for a tub bath on 1/5/21.

An interview was completed with Resident #22 on 11/16/21 at 2:25 PM, who stated he was asked yesterday and today if he wanted to take a shower and told the staff member "yes". He explained he was told his name would be put on the list for a shower but wasn't told how often or when he would get one. Resident #22 went on to say it had been "a long time" since he had been in the shower and had not been offered one when his bed baths were provided. Resident #22 further stated he needed assistance with setup and supervision for his bathing and would like to receive a shower at least once or twice a week.

On 11/16/21 at 11:23 AM, an undated form titled "Shower Schedule" was provided by the Assistant

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Director of Nursing (ADON). The form listed resident room number and name, a column for request of a shower with either yes or no documented and 2 other columns named "Days of the week" and "Shift to receive shower". The ADON explained alert and oriented residents were asked if they would like to receive a shower and yes or no was documented. She was unsure who completed the list or the last time it was updated. Resident #22 was listed as "no" to request of a shower with no day or shift to offer one listed.

The Director of Nursing (DON) was interviewed on 11/16/21 at 11:45 AM and explained the undated shower schedule provided was recently updated in the last week. She reviewed the shower schedule and NA flow records confirming Resident #22 had only received bed baths in the past 11 months with the exception of a tub bath on 1/5/21. She stated he was listed as "no" to request of a shower and stated the list was updated periodically with a staff member going to the alert and oriented residents and asking if they wanted to be put on the list for showers. The DON acknowledged all residents should be scheduled for a shower at least weekly and had the right to refuse if they didn't want one that day.

On 11/16/21 at 3:45 PM, an interview occurred with NAs #2 and #3, who worked 3:00 PM to 11:00 PM (2nd) shift and was familiar with Resident #22. They denied offering him a shower on their shift and stated he received a bed bath on the 7:00 AM to 3:00 PM (1st) shift.

The Administrator was interviewed on 11/17/21 at 8:30 AM and explained showers stopped during the COVID-19 outbreak in 2020 and bed baths

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were provided to all residents. She stated she would have expected by now all residents to be provided showers on a regular basis and provided the opportunity to refuse.

On 11/17/21 at 11:00 AM, NA #5, who was familiar with Resident #22 was interviewed. She verified she worked 1st shift and denied offering him a shower, providing only a bed bath because he was listed as "no" on the shower schedule. NA #5 further stated Resident #22 used to go to the shower room prior to COVID-19 but was unsure why this had not resumed.

4) Resident #25 was originally admitted to the facility on 5/20/16 with diagnoses that included diabetes, and muscle weakness.

The annual Minimum Data Set (MDS) assessment dated 7/9/21 indicated Resident #25 was cognitively intact and displayed no behaviors. He was coded as it being very important to choose between a tub bath, shower, bed bath or sponge bath for his daily preferences.

A quarterly MDS assessment on 10/8/21 indicated Resident #25 was cognitively intact and displayed no behaviors. He required set up and supervision assistance with transfers, personal hygiene, and bathing.

Resident #25's nursing progress notes were reviewed from 1/1/2020 through 11/17/21 and indicated he was alert and oriented with no refusals for showers or bathing assistance.

A review of Resident #25's Nursing Assistant (NA) bathing/shower documentation from 1/1/21

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through 11/16/21, indicated he had not received a shower at any time, only bed baths were documented as given on the 7:00 AM to 3:00 PM (1st) shift.

An interview was completed with Resident #25 on 11/16/21 at 2:25 PM, who stated he was asked yesterday and today if he wanted to take a shower and told the staff member "yes". He explained he was told his name would be put on the list for a shower but wasn't told how often or when he would get one. Resident #25 went on to say it had been "a long time" since he had received a shower and would like to be offered one at least once or twice a week.

On 11/16/21 at 11:23 AM, an undated form titled "Shower Schedule" was provided by the Assistant Director of Nursing (ADON). The form listed resident room number and name, a column for request of a shower with either yes or no documented and 2 other columns named "Days of the week" and "Shift to receive shower". The ADON explained alert and oriented residents were asked if they would like to receive a shower and yes or no was documented. She was unsure who completed the list or the last time it was updated. Resident #25 was listed as "no" to request of a shower with no day or shift to offer one listed.

The Director of Nursing (DON) was interviewed on 11/16/21 at 11:45 AM and explained the undated shower schedule provided was recently updated in the last week. She reviewed the shower schedule and NA flow records confirming Resident #25 had only received bed baths in the past 11 months. She stated he was listed as "no" to request of a shower and stated the list was

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updated periodically with a staff member going to the alert and oriented residents and asking if they wanted to be put on the list for showers. The DON acknowledged all residents should be scheduled for a shower at least weekly and had the right to refuse if they didn't want one that day.

On 11/16/21 at 3:31 PM, an interview occurred with NA #6, who worked 3:00 PM to 11:00 PM (2nd) shift and was familiar with Resident #25. She denied offering Resident #25 a shower on her shift and stated he received a bed bath on 1st shift. NA #6 stated the shower schedule listed residents as yes or no to wanting showers and if they were listed as "no" then a bed bath was provided during the day shift.

The Administrator was interviewed on 11/17/21 at 8:30 AM and explained showers stopped during the COVID-19 outbreak in 2020 and bed baths were provided to all residents. She stated she would have expected by now all residents to be provided showers on a regular basis and provided the opportunity to refuse.

On 11/17/21 at 11:00 AM, NA #1, who was familiar with Resident #25, was interviewed. She verified she worked 2nd shift and denied offering him a shower adding, if a resident had "no" by their name on the shower schedule a bed bath was only provided to them during the day.

5) Resident #49 was originally admitted to the facility on 7/23/19 with diagnoses that included muscle weakness, and chronic obstructive pulmonary disease (COPD).

The annual Minimum Data Set (MDS)

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assessment dated 10/22/21 indicated Resident #49 was cognitively intact and coded as it being somewhat important to choose between a tub bath, shower, bed bath or sponge bath for his daily preferences.

A quarterly MDS assessment on 11/1/21 indicated Resident #49 was cognitively intact and displayed no behaviors. He required extensive assistance with bathing.

Resident #49's nursing progress notes were reviewed from 1/1/2020 through 11/17/21 and indicated he was alert and oriented and had no refusals for showers or bathing assistance.

A review of Resident #49's Nursing Assistant (NA) bathing/shower documentation from 1/1/21 through 11/16/21, indicated he had not received a shower at any time, only bed baths were documented as given.

An interview was completed with Resident #49 on 11/14/21 at 2:25 PM, who stated he had not received a shower in over a year and would like one at least once or twice a week. He explained a bed bath was provided every morning, but no one offered him a shower.

On 11/16/21 at 11:23 AM, an undated form titled "Shower Schedule" was provided by the Assistant Director of Nursing (ADON). The form listed resident room number and name, a column for request of a shower with either yes or no documented and 2 other columns named "Days of the week" and "Shift to receive shower". The ADON explained alert and oriented residents were asked if they would like to receive a shower and yes or no was documented. She was unsure

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who completed the list or the last time it was updated. Resident #49 was listed as no to request of a shower with no day or shift to offer one listed.

The Director of Nursing (DON) was interviewed on 11/16/21 at 11:45 AM and explained the undated shower schedule provided was recently updated in the last week. She reviewed the shower schedule and NA flow records confirming Resident #49 had only received bed baths in the past 11 months. She stated he was listed as "no" to request of a shower and stated the list was updated periodically with a staff member going to the alert and oriented residents and asking if they wanted to be put on the list for showers. The DON acknowledged all residents should be scheduled for a shower at least weekly and had the right to refuse if they didn't want one that day.

On 11/16/21 at 3:45 PM an interview occurred with NAs #2 and #3, who worked 3:00 PM to 11:00 PM (2nd) shift and were familiar with Resident #49. They denied offering him a shower on their shift and stated he received a bed bath on the day shift.

The Administrator was interviewed on 11/17/21 at 8:30 AM and explained showers stopped during the COVID-19 outbreak in 2020 and bed baths were provided to all residents. She stated she would have expected by now all residents to be provided showers on a regular basis and provided the opportunity to refuse.

On 11/17/21 at 11:00 AM, NA #5, who was familiar with Resident #49, was interviewed. She verified she worked 1st shift and denied offering him a shower, providing only a bed bath because

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he was listed as "no" on the shower schedule.

6.Resident #42 was admitted on 10/15/21 with cumulative diagnoses of a Traumatic Brain Injury (TBI), depression and anxiety.

The admission Minimum Data Set (MDS) assessment dated 10/26/21 indicated Resident #42 was cognitively intact and exhibited no behaviors. She was coded for extensive staff assistance with her personal hygiene and bathing. Section F of the MDS titled : Preferences for Customary Routine and Activities indicated choosing between a tub bath, shower, bed bath or sponge bath was very important to her.

Resident #42's care plan dated 10/18/21 indicated she had a self-care deficit and staff were to assist her with all her activities of daily living (ADLs).

Review of the Activities Initial Evaluation completed 10/25/21, indicated the form did not have a question about bathing preferences.

Review of Resident #42's ADL aide documentation indicated Resident #42 received a bed bath everyday from 10/15/21 to present.

In an initial interview with Resident #42 on 11/14/21 at 3:02 PM, she stated she had no care concerns with the facility and went on to list a few employees she was especially fond of.

An interview was conducted on 11/16/21 at 2:45 PM with Resident #42. When asked about her bathing preference, she responded by saying "I didn't know I could have a shower. I remember

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when I was admitted, I saw a shower room but nobody ever asked me about getting a shower. " Resident #42 stated she thought she could only have bed baths. She stated she went to the beautician once a week to have her hair washed. An interview was conducted on 11/16/21 at 2:50 PM with the AD. She stated she completed section F of Resident #42 the initial activities evaluation on 10/25/21. She stated she did not realize that the evaluation did not include preferences for ADLs.

On 11/16/21 at 11:23 AM, the Assistant Director of Nursing (ADON) provided a undated Shower Schedule that read Resident #42 was documented for "no" for showers. She stated the asked when staff asked if she wanted to shower, she stated "no." She stated the residents are asked on admission their preference. The ADON stated she was unsure when the undated shower schedule was last updated.

An interview was conducted with the Director of Nursing (DON) on 11/16/21 at 11:45 AM. She stated the shower schedule had recently updated in the past 2 months and the nursing supervisor went around Sunday (11/14/21) and asked all the residents asking if they wanted to receive a shower or not. This would be the list that was provided showing the majority of residents listed as "no" for showers. The DON stated the shower schedule was updated "probably monthly." The DON stated the residents had the right to be offered a shower at least weekly.

An interview was conducted on 11/16/21 at 4:03 PM with Nursing Assistant (NA) #1. She stated the aides go by the shower schedule and Resident #42 was documented as a "no." NA #1

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F 561	Continued From page 19 stated the only way Resident #42 would be showered was if she asked for a shower. She stated she was unsure who made the shower schedule or how often it was updated. NA #1 stated if Resident #42 always a bed bath daily and had not mentioned wanting a shower to her knowledge. An interview was conducted on 11/16/21 at 3:45 PM with NA #2 and NA #3. Both confirmed there was a list of residents that indicated whether they wanted showers or not. Anyone who was listed a "no" for showers was given daily bed baths. In an interview on 11/17/21 at 8:30 AM with the Administrator. She stated the showers were stopped during the COVID-19 outbreak in 2020 when the residents were not allowed to be co-mingling in the hallways and efforts were focused on keeping the residents in their rooms. The Administrator stated the residents were provided bed baths during that time. She stated Resident #42 should receive showers according to her preferences.	F 561		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		12/16/21

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F 584	Continued From page 20 (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 a homelike environment by ensuring 1 of 2 shower rooms was in good working condition for 14 consecutive months (East Hall). The findings included: On 11/14/21 between 2:25 PM and 3:00 PM, alert	F 584	F584 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. The Administrator has emailed the correct department at our Corporate office for an update on the project getting started on 11/15/21.	

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F 584	Continued From page 21 and oriented resident interviews, who resided on the East Hall (Rooms 1-18), revealed the shower room on that hall was not in good working condition. The residents stated the shower room on their hallway had been closed for over a year as the water was not draining properly in there. An observation of the East hall shower room on 11/14/21 at 3:30 PM, revealed the door was closed with a handwritten sign on the door that read "Shower out of order". Upon entering the room, there were 2 shower stalls with either the knobs removed for the water or the hand-held shower removed. Resident care items and equipment was being stored in this room. On 11/17/21 at 8:20 AM, an interview occurred with the Administrator who stated the East hall shower room had been nonoperational since September 2020 due to poor drainage of the water. She reached out to the corporate office, a plumber was sent out and the repair was not able to be completed due to the COVID-19 pandemic. The Administrator stated the last conversation was in June 2021, she had received no dates for the repair and had reached out to the corporate office again on 11/14/21 inquiring about the repair of the shower room. An interview occurred with the Maintenance Director on 11/18/21 at 9:45 AM, who explained staff had reported the showers in the East hall shower room were not draining properly towards the end of August 2020/beginning of September 2020. He placed an auger in the drains and had a return of dirt coming up from the drains. Both the shower stalls in the East hall shower room connect with the same drain. The Maintenance Director reported his findings to the Administrator	F 584	1b. The Administrator received an email from the Corporate Office and the project has been approved and a quote signed on 11/22/21. 1c. The Vendor has been notified of approval and the project will begin on 12/16/21. 2. Address how corrective action will be accomplished for those resident's having potential to be affected by the same deficient practice: 2a. Any resident desiring to have a shower will be showered in the West Hall Shower Room until the project has been completed. 3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. The project has been approved as of 11/22/21 and the vendor has ordered the parts to complete the project. The project is set to begin on 12/16/21. 4. Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained: The Administrator will stay in contact with the Corporate Office to obtain updates on the proposed date of project start of 12/16/21.	

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who then contacted the corporate office for further assistance in repairing the shower.

Another interview was completed with the Administrator on 11/18/21 at 10:00 AM who reviewed her timeline of events regarding the needed repair of the East hall shower room:
- On 9/9/2020 the corporate office was contacted regarding the improper draining of water in the East hall shower room.
- On 9/11/2020 a plumber was dispatched to the facility and reported the drain had collapsed.
- On 10/16/2020 the Administrator contacted the corporate office to inquire about the status of the needed repairs.
- On 3/4/21 the Administrator contacted the corporate office again to inquire about the repair of the shower room.
- The corporate office responded on 3/5/21 that the issue was being revisited with the vendor regarding repairs.
- On 6/10/21 the Administrator contacted the corporate office again to get an update on the repair to the East hall shower room. The issue had been mentioned in the Resident Council Meeting with residents inquiring about the repairs and acknowledging there was a shower room on the West Hall but preferred a shower on their hallway.
- The corporate office responded on 6/11/21 that the issue was being revisited as it originally occurred during the pandemic and access to building was put on hold.
- The corporate office responded on 6/29/21 that the revised quotes had been reviewed and approval would be forthcoming to move forward in next couple of days.

The Administrator stated she was aware the residents on the East hall have voiced a desire to

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F 584	Continued From page 23 have the shower on their hallway working again. She further stated when the shower was deemed nonoperational in September 2020, it was at the start of the COVID-19 pandemic and should have been revisited in January 2021 when the facility had removed the COVID barrier and there were no further COVID positive residents.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:	F 585		12/16/21

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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 585	Continued From page 24 (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and	F 585		

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F 585	Continued From page 25 as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility to implement the facility's grievance policy for a resident concern regarding staff discussing her medical record. This was for 1 (Resident #42) of 1 residents reviewed for grievances. The findings included: 1.Resident #42 was admitted on 10/15/21 with cumulative diagnoses of a Traumatic Brain Injury (TBI), depression and anxiety. The facility grievance policy titled "Resident Grievances and Concerns Policy" dated	F 585	F585 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. Administrator conducted a one-on-one interview with Resident #42 the concerning her Grievance on 11/16/21. 1b. The Administrator completed a grievance form and submitted to the Grievance Officer on 11/16/21. 1c. The Grievance Officer did a resolution of concern with Resident #42 on 11/30/21. 1d. The Administrator reeducated the	

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F 585	Continued From page 26 November 2016 and last revised in August 2018 read in part that residents have the right to voice grievances regarding the behavior of staff. The admission Minimum Data Set (MDS) assessment dated 10/26/21 indicated Resident #42 was cognitively intact and exhibited no behaviors. In an initial interview with Resident #42 on 11/14/21 at 3:02 PM, she stated she had no care concerns with the facility and went on to list a few employees she was especially fond of. A second interview was attempted on 11/15/21 at 2:00 PM but the Activities Director (AD) was in the room visiting with Resident #42. An interview was conducted on 11/16/21 at 2:45 PM with Resident #42. She stated yesterday when the AD was in her room, she discussed concerns about staff discussing her medical record. Resident #42 reported that she heard that the nurses and aides read or heard about something in her medical record that was not accurate. When questioned regarding her discussion with the AD on 11/16/21, she stated the AD did not mention anything about a grievance or concern form. An interview was conducted on 11/16/21 at 2:50 PM with the AD. She stated Resident #42 told her the staff talking about something in her medical record but she did not think about doing a grievance. The AD stated "I probably should have." She stated Resident #42 was a new resident and she felt she was just having a difficult time adjusting to the facility.	F 585	Activities Director on the Resident Grievances and Concerns Policy on 11/17/21. 2. Address how corrective action will be accomplished for those resident's having potential to be affected the same deficient practice: 2a. On 11/30/21 the Administrator delegated staff to interview all inter-viewable residents related to Grievance Resolution this week. All audits were completed by 12/3/21. Out of 33 residents interviewed only one dietary grievance was received. A grievance form was completed on 12/2/21 and resolved on 12/7/21. 3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. The DON or designee will reeducate all staff on the Resident Grievance and Concern Policy by 12/15/21. Any employee not completing the education by 12/15/21 will not be allowed to work. 3b. The Administrator or designee will audit the grievance log and concern forms weekly x 12 weeks then monthly x 12 months. 4. Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained: The Administrator or Designee will assign designated staff to complete a Grievance Resolution Audit Tool on all inter-viewable residents weekly X 12 weeks then monthly x 12 months. The Administrator	

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F 585	Continued From page 27 An interview was conducted on 11/16/21 at 2:55 PM with the Administrator, Director of Nursing (DON) and the Social Worker (SW) who was the facility's grievance officer. The Administrator stated she had heard something about Resident #42's concern but there was no grievance form. The SW stated she would go and speak with Resident #42 but she was not aware of Resident #42's concern. She stated when a family member, resident or a staff member brought her a grievance, she logged it and assigned it to the appropriate department. The SW stated she ensured the grievance was resolved, reviewed by the Administrator, then discussed the outcome with the person who filed the grievance and given a copy of the resolution. She stated she did not have a grievance form for the concern about staff discussing the contents of her medical record. The DON, SW and Administrator stated a grievance form should have been completed when staff became aware of Resident #42's concern. On 11/17/21 at 2:40 PM, the Administrator stated Resident #42 confirmed the concern upon interview with the SW yesterday. She stated it was her expectation the facility staff immediately complete a grievance form for any voiced concerns regarding care or the behavior of the staff. An interview was conducted on 11/17/21 at 3:02 PM with Resident #42. She stated the facility had spoken to her and stated they would follow up after they investigated her concern.	F 585	or designee will bring the Grievance Log and Concern form audit to QAPI. Results of these audits will be brought to QAPI by the Administrator or DON and will be reviewed monthly for 12 months by the QAPI Committee. If any discrepancies are noted, further action will be implemented by the Administrator.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		12/16/21

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F 609	Continued From page 28 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to report an injury of unknown origin (UKO) to the state agency for 1 (Resident #2) of 3 residents reviewed for abuse. The findings included: Resident #2 was admitted on 1/9/20 with a diagnosis of Alzheimer's Disease.	F 609	F609 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. The DON or designee completed a weekly skin care evaluation on Resident #2 on 11/22/21. No skin impairments were identified during the body audit.	

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F 609	Continued From page 29 Her quarterly Minimum Data Set (MDS) dated 8/14/21 indicated Resident #2 had severe cognitive impairment and exhibited no behaviors. A nursing note dated 4/7/21 at 4:19 PM read Resident #2 was noted to have swelling and bruising to her left fifth finger with a large blood blister noted on the outside of her finger. She exhibited pain when touched. Review of a Nurse Practitioner (NP) note dated 4/7/21 read Resident #2 was evaluated due to a large bruise to her left fifth finger. The note read Resident #2 could have struck her hand and finger against the wall. An x-ray was order of Resident #2's left hand and an antibiotic was ordered for cellulitis (inflammation). Review of a NP note dated 4/9/21 read the results of the left hand x-ray dated 4/8/21 indicated no acute fractures to left fifth finger but there was evidence of an old, healed fracture to the same finger. The note read Resident #2 was able to move all fingers without any difficulty. There were no new orders. Review of a undated document titled Resident #2-"injury to left pinky finger 4/7/21": read that interviews were conducted with her assigned nurse and assigned aide on 4/7/21 at the time the injury was discovered. It was concluded that her bed placement was likely the cause of her injury. There was no evidence that staff who worked with Resident #2 on the previous shifts were interviewed and there was no evidence that the facility reported the injury of UKO on 4/7/21 or to present.	F 609	2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: 2a. A weekly skin evaluation will be completed on all non inter-viewable residents by 12/2/21 by the DON or designee. 3. Address what measures will be put into place, or system changes to ensure that the deficient practice will not occur: 3a. The Administrator reeducated the DON on the expectations that an injury of unknown origin will be reported to the State Agency on 11/24/21. 4. Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained. The Administrator or designee will monitor all incident reports weekly to determine if they require a report to the state agency. This will be completed weekly and results will be taken to the QAPI meeting x 3 months.	

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F 609	Continued From page 30 An interview was conducted with the Director of Nursing on 11/17/21 at 2:40 PM. She stated she did not complete a report to submit to state because she and NP thought Resident #2's injury was self-inflicted. The DON stated Resident #2 may have hit her hand since she is restless and wiggles all the time but stated she should have completed a 2-hour report and submitted to the state agency at the time the injury was discovered. The DON also stated a thorough investigation should have been completed.	F 609		
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 record reviews, observations, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of smoking (Resident #18) and disposition (Resident #59). This was for 2 of 25 residents reviewed. The findings included: 1) Resident #18 was originally admitted to the facility on 12/19/19 with diagnoses that included diabetes and chronic pain. On 9/29/21 a smoking assessment was completed for Resident #18 and he was assessed as being able to smoke independently or with set up. The annual MDS dated 10/1/21, indicated	F 641	F641 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. Resident #18 Minimum Data Set (MDS) in the area of smoking corrected by the MDS Coordinator on 11/18/2021. Resident #59 Minimum Data Set (MDS) in the area of disposition was corrected by the MDS Coordinator on 11/16/2021. MDS for Resident #59 and #18 was resubmitted on 11/18/2021. 2. Address how correction action will be accomplished for those resident's having potential to be affected by the same deficient practice: 2a. An audit was completed by the	12/16/21

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F 641	Continued From page 31 Resident #18 did not use tobacco during the assessment period. Resident #18's active care plan, last reviewed on 10/12/21 included a focus area that he was a smoker. A monthly nursing note dated 10/18/21 indicated Resident #18 went outside to smoke. On 11/14/21 at 3:30 PM, Resident #18 was observed smoking in the outside smoking area. An interview occurred with MDS Nurse #1 on 11/18/21 at 9:30 AM. She verified Resident #18 used tobacco based on the smoking assessment, care plan and her observations. MDS Nurse #1 added the annual MDS dated 10/1/21, should have been coded for tobacco use and was an error that it was not. 2. Resident #59 was admitted to the facility on 8/3/2021 with diagnoses that included cerebral vascular accident (stroke). His admission Minimum Data Set (MDS) dated 8/10/2021 indicated the resident had no cognitive impairment, could understand, and could be understood. Resident #59 required extensive assistance with activities of daily living (ADL). Resident #59 had a discharge MDS dated 9/16/2021 which indicated the resident was discharged to acute hospital setting. The resident's baseline care plan dated 8/3/2021 indicated the resident had a focus for self-care deficit with plan to return to the community.	F 641	Administrator and/or DON on 12/01/21 on all MDS assessments for the residents discharge disposition, 8 discharged in the last 30 days and no corrections were identified. The Administrator and/or DON completed an audit on all smokers on MDS Assessment on 12/1/21, the 8 identified smokers were coded correctly. 3.Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. Education to the MDS Nurses was conducted by the Administrator on 11/30/21 on accuracy of coding residents appropriately to reflect the resident's status to include coding MDS for the areas of disposition and smoking. 3b. Audits will be conducted by the DON or designee on MDS Assessments on disposition and smoking weekly x 12 weeks then monthly x 12 months. 4. Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained: Administrator and/or DON will review MDS calendar for full assessments and review discharges for the previous week and complete an audit weekly x 12 weeks, then monthly x 12 months. Results of the audit will be brought to QAPI by the Administrator and/or DON and will be reviewed monthly for 3 months by the QAPI Committee. If any discrepancies are noted further action will be implemented by the Administrator.	

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F 641	Continued From page 32 Resident #59's medical record revealed a discharge summary with recapitulation of stay dated 9/16/2021 which revealed the resident discharged to an assisted living facility. On 11/17/2021 and interview was conducted with MDS nurse #1. She stated the resident was discharged to assisted living facility and the discharge MDS was coded as discharged to acute hospital in error.	F 641		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		12/16/21

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F 657	Continued From page 33 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to revise a resident care plan in the area of contractures and refusals of therapy and splinting. This was for 1 (Resident #21) of 2 residents reviewed for range of motion. The findings included: Resident #21 was originally admitted on 5/19/20 with cumulative diagnoses of a subarachnoid Hemorrhage and contractures. The quarterly Minimum Data Set (MDS) dated 10/8/21 indicated Resident #21 was cognitively intact, she exhibited no behaviors and coded for impairment of one side upper and lower extremities. Review of Occupational Therapy (OT) discharge summary dated 2/24/21 read Resident #21 declined the splinting program and the splint to left upper extremity. Review of Resident #21's Physician orders for November 20201 did not include any orders for splints. Review of Resident #21's comprehensive care plan did not include a care plan for her contractures and her refusal or therapy and splinting. In an observation on11/15/21 at 3:10 PM, Resident #21 was lying in bed with an obvious contracture of her left hand. She stated she had a	F 657	F657 Care Plan 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. On 11/17/21 the DON initiated a Therapy Referral on resident #21. The DON has interviewed the resident and she has refused to wear her splint. 1b. The CNAs continued to do active and passive ROM as addressed in the Care Plan. 1c. The TASK of a resident wearing a splint has been removed from 11/17/21. 1d. The Occupational Therapist is working with the resident on tolerating a resting left hand splint. This will be continued for 3-5 times a week for 8 weeks. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: 2a. All current residents in the facility receiving a splint will have a Care Plan Review for completeness by the DON on 12/6/21. Out of the 10 reviewed 2 Care Plans had to be revised. 2b. Resident #21 had a Care Plan revision on 12/8/2021 related to Occupational Therapy as ordered and range of motion. 3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur:	

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F 657	Continued From page 34 hand splint but she refused to wear it. She stated it was painful to wear and the therapist asked her periodically if she would agree to be evaluated and treated for her left hand contracture. An interview was completed on 11/16/21 at 9:00 AM with Nurse #2. She stated Resident #21 wore a hand splint in the past but she complained about it being painful so she refused to wear it. She stated she understood that therapy discontinued it. She stated the aides performed active and passive ROM during care. An interview was completed on 11/16/21 at 2:25 PM with Nursing Assistant (NA) #8. She stated Resident #21 wore a hand splint in past but she thought they were discontinued it because Resident #21 refused to wear the hand splint because she said they hurt when she wore them. NA #8 stated ROM was completed during her daily care. Review of the therapy screens dated 7/27/21, 8/2/21, 9/22/21 and 9/27/21 read Resident #21 refused to allow therapy to complete an assessment of her left hand. An interview was conducted on 11/17/21 at 2:40 PM, the Director of Nursing (DON) stated Resident #21's contractures and for her refusal of therapy and splinting should be care planned. An interview was completed on 11/17/21 at 3:30 PM with MDS Nurse #2. She stated Resident #21's contractures, her refusal of therapy and splinting. MDS Nurse #2 stated it was an oversite and she had been doing MDS's for about two months.	F 657	3a. The Administrator educated both MDS Coordinators on 12/1/21 on developing a comprehensive person-centered and individualized care plan in the area of splinting/refusal of therapy/ROM. 3b. The DON or designee will follow the weekly care plan schedule and conduct a audit weekly x 12 weeks then monthly x 12 months in the areas of individualized care plan, splint, ROM, refusal of therapy. 4.Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained: DON/or designee will follow the weekly care plan schedule and conduct an audit weekly x 12 weeks in the areas of individualized care plan,splinting, ROM and refusal of therapy. Results of the audit will be brought to QAPI and reviewed monthly for 3 months by the QAPI Committee. If discrepancies are identified, further action will be implemented by the Administrator.	

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F 756	Continued From page 35	F 756		
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 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	F 756		12/16/21

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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 Pharmacy Consultant and staff interviews, the Pharmacy Consultant failed to address the use of an as needed (PRN) psychotropic medication without a stop date for 1 of 6 residents reviewed for unnecessary medications (Resident #18).

The findings included:

Resident #18 was originally admitted to the facility on 12/19/19 with a recent readmission date of 6/15/21. Diagnoses included diabetes with underlying neuropathy, end stage renal disease (ESRD) on hemodialysis and peripheral vascular disease (PVD).

Resident #18 had a physician's order dated 6/15/21 for Valium (an antianxiety medication) 2 milligrams (mg) 1 tablet by mouth every 12 hours as needed (prn) for arm pain.

The annual Minimum Data Set (MDS) assessment dated 10/1/21 indicated Resident #18 was cognitively intact and had received 2 days of an antianxiety medication during the assessment period.

A review of the Medication Administration Records (MARs) revealed Resident #18 had received Valium 9 times in July 2021, 14 times in August 2021, 5 times in September 2021, 6 times in October 2021 and 5 times in November 2021.

Review of the Pharmacy Consultant's monthly drug regimen review (DRR) was conducted. The

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1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
1a. The Unit Manager contact the Family Nurse Practitioner on 11/17/21 and received a stop date for Resident #18 as needed psychotropic medication.

2. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice:
2a. Pharmacy Consultant conducted a 100% audit of all residents in the building for as needed psychotropic medications without a stop date on 11/21/21. On 11/29/21 the Pharmacy Consultant Identified 5 Residents from her audit that did not have a stop date for the as needed medication. The stop dates needed were brought to the Family Nurse Practitioner on 11/29/21 and were immediately corrected.

3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur:
3a. The Omnicare Clinical Manager, reeducated the Pharmacy Consultant on 12/1/21 to ensure as needed psychotropic medications have a time limit.
3b. The Pharmacy Consultant will review

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F 756	Continued From page 37 DRR notes indicated Resident #18's drug regimen was reviewed on 7/28/21, 8/23/21, 9/27/21 and 10/26/21. The DRR notes did not address the use of the PRN Valium without a stop date to the physician or Director of Nursing (DON). On 11/18/21 at 10:10 AM, a phone interview was conducted with the Pharmacy Consultant. The Pharmacy Consultant reviewed her records and stated she was aware Resident #18 was taking Valium PRN but felt it was needed due to the treatment of muscle spasms rather than anxiety. She could not comment as to why she did not address or identify the use of the PRN Valium without a stop date to the physician. The DON was interviewed on 11/18/21 at 10:30 AM and stated she expected the Pharmacy Consultant to address use of PRN psychotropic medications without a stop date with either herself or the physician.	F 756	any residents needing a stop date for their as needed psychotropic medication monthly. The Pharmacy Consultant will provide the Director of Nursing a Consultation Report to the Physician for follow up monthly x 12 months. 4. Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained: 4a. The Pharmacy Consultant will review all residents monthly and submit a Consultation Report to the Physician for any resident needing a stop date for the medication. 4b. The Director of Nursing or designee will be responsible for monthly Consultation Reports being submitted to the Physician for a response.The Director of Nursing or designee will bring monthly Consultation Report to QAPI monthly x 12 months. If any discrepancies are noted, further action will be implemented by the Administrator.	
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	F 758		12/16/21

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F 758	Continued From page 38 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 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 interviews with staff, Pharmacy Consultant, and the Medical Director,	F 758	F758 1. Address how corrective action will be	

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F 758	Continued From page 39 the facility failed to ensure an as needed (PRN) psychotropic medication was time limited in duration for 1 of 6 residents reviewed for unnecessary medications (Resident #18). The findings included: Resident #18 was originally admitted to the facility on 12/19/19 with a recent readmission date of 6/15/21. Diagnoses included diabetes with underlying neuropathy, end stage renal disease (ESRD) on hemodialysis and peripheral vascular disease (PVD). Resident #18 had a physician's order dated 6/15/21 for Valium (an antianxiety medication) 2 milligrams (mg) 1 tablet by mouth every 12 hours as needed (PRN) for arm pain. The order for the Valium PRN was entered into the Electronic Medical Record (EMR) by the unit manager and had no stop date. The annual Minimum Data Set (MDS) assessment dated 10/1/21 indicated Resident #18 was cognitively intact and had received 2 days of an antianxiety medication during the assessment period. A review of the Medication Administration Records (MARs) revealed Resident #18 had received Valium 9 times in July 2021, 14 times in August 2021, 5 times in September 2021, 6 times in October 2021 and 5 times in November 2021. A review of the pharmacy medication reviews revealed they were completed monthly with the last review dated 10/26/21. The Unit Manager was interviewed on 11/17/21 at	F 758	accomplished for those residents found to have been affected by the deficient practice: 1a. The Unit Manager contact the Family Nurse Practitioner on 11/17/21 and received a stop date for the as needed psychotropic medication. 2.Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: 2a. The Pharmacy Consultant conducted a 100% audit of all residents in the building for as needed psychotropic medications without a stop date on 11/21/21. On 11/29/21 the Pharmacy Consultant identified 5 Residents from her audit that did not have a stop date for their as needed medication. The stop dates needed were brought to the Family Nurse Practitioner on 11/29/21 and were immediately corrected. 3. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur: 3a. The Unit Manager was reeducated on 11/24/21 by the Director of Nursing on the need for a stop date on the as needed Psychotropic Medications. The Director of Nursing reeducated the Medical Director, on 12/1/21 on the need for a stop date on the as needed Psychotropic Medications. The Director of Nursing reeducated the Family Nurse Practitioner on 11/29/21 on the need for a stop date on as needed psychotropic medications.	

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F 758	Continued From page 40 12:25 PM and confirmed there was no stop date for the Valium that was ordered PRN. He was aware of the need for a stop date to provide reassessment for the continued need of the medication and stated it was oversight. A phone interview occurred with the Medical Director on 11/17/21 at 3:32 PM, who stated he was aware of the regulation that required all PRN psychotropic medications to be time limited in duration. He indicated it was error if a stop date was not included in a physician's order for the PRN psychotropic medication. On 11/18/21 at 10:10 AM, a phone interview was conducted with the Pharmacy Consultant and stated per the regulation PRN psychotropic medications should be time limited in duration to allow for reassessment of the continued need for the medication.	F 758	4. Indicate how the facility plans to monitor its performance to make sure the solution(2) are sustained: 4a. The Pharmacy Consultant will review any residents needing a stop for their pas needed psychotropic medication monthly. The Pharmacy Consultation will provide the Director of Nursing a Consultation Report to the Physician for follow up monthly. 4b. The Director of Nursing or designee will be responsible for monthly Consultation Reports being submitted to the Physician for response. The Director of Nursing or designee will bring to QAPI monthly. 4c. The Director of Nursing or designee will audit all Residents with a as needed psychotropic medication for stop dates Monthly x 12 months. The Director of Nursing or designee will bring to QAPI Committee and if any discrepancies are noted, further action will be implemented by the Administrator.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and interviews with the consulting pharmacist and nurse practitioner the facility failed to ensure residents were free of significant medication errors for 1 of 1 (Resident #23) reviewed for medication errors.	F 760	F760 Medication Error 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. The Director of Nursing reviewed the	12/16/21

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F 760	Continued From page 41 The findings included: A. Resident #23 was admitted to the facility 10/30/2020 with diagnoses that included vascular dementia and epilepsy with complex partial seizures. The resident's annual Minimum Data Set (MDS) dated 10/7/2021 indicated the resident had moderate cognitive impairment but could understand others and be understood by others. She required extensive assistance with activities of daily living. Resident #23's active orders for March 2021 included an order for the anticonvulsant Lacosamide 50 milligram (mg) tablets, give 3 tablets by mouth 3 times daily. The start date on the order was 10/30/2020. A medication error report dated 3/16/2021 indicated Resident #23 received 450mg of lacosamide by nurse # 3 during the 8:00 PM medication pass on 3/16/2021. A phone interview was conducted with Nurse #3 on 11/18/2021 at 6:41 AM. She stated the pharmacy had been sending the lacosamide in cards of 50mg tablets and the resident got 3 tablets or a total of 150mg three times daily. On 3/16/2021 the resident had a new card of lacosmide tablets and she gave three tablets before she realized the tablets were not 50mg tablets but 150mg tablets. She further stated she reported the medication error to the nurse practitioner. An interview was conducted with the unit manager on 11/17/2021 at 12:14 PM. When	F 760	order summary report from the electronic medical record for Resident #23 medication for any potential discrepancies on 12/3/21 none identified. 1b. The Family Nurse Practitioner will review the order summary report from the electronic medical record for Resident #23 medication for any potential discrepancies by 12/6/21. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: 2a. The Administrator or designee will review any/all medication administration incident reports for the past three months on 12/3/21 and none were identified. 3. Address what measure will be put into place, or systemic changes to ensure that the deficient practice will not occur. 3a. The Director of Nursing or designee will review all new admission orders for a medication reconciliation during the next morning meeting. 3b. All nurses will be reeducated on Rights of Medication Administration by the Director of Nursing or designee by 12/7/21. Any nurse not reeducated by 12/7/21 will not be allowed to work until educated by the Director of Nursing. 4. Indicate how the facility plans to monitor its performance to make sure the solution(s) are sustained: 4a. The Director of Nursing or designee will complete a New Admission Reconciliation Audit weekly x 12 weeks	

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F 760	Continued From page 42 asked if he was aware of the medication error that occurred on 3/16/2021 involving Resident #23, he stated he was made aware. On 11/18/21 at 10:06 AM a phone interview was conducted with the facility's nurse practitioner. She stated she did not recall being notified of a medication error with lacosamide in March of 2021. However, she was familiar with Resident #23 and stated she had a history of breakthrough seizures so the additional anticonvulsant would have been more beneficial than harmful. She stated she did not recall the incident so she could not say if she ordered increased observations or notified the pharmacist of the medication error. 11/18/2021 11:00am an interview was conducted with the pharmacist. He confirmed the resident was getting cards of 50mg lacosamide tablets up until 3/16/2021 when the pharmacy sent a card of 150mg tablets. He stated he was not made aware of a medication error involving Resident #23's lacosamide in March of 2021. When asked what he would have recommended if he had been notified. He stated he would have recommended the provider be made aware and he would have looked up the toxic dose of lacosamide to determine if poison control needed to be notified. On 11/18/2021 at 10:37 AM an attempt was made to contact the facility's medical director. A return call was not received. An interview was conducted with the Director of Nursing (DON) on 11/18/2021 at 11:10 AM she stated the facility does not routinely notify pharmacy of medication errors. She further stated it was her expectation nurses complete the five rights of medication administration which include	F 760	and monthly x 12 months.Audit will be brought to QAPI by the Director of Nursing or designee and will be reviewed monthly x 12 months by the QAPI committee. If any discrepancies are noted, further action will be implemented by the Administrator. 4b. The Administrator will review Incident Reports for any medication errors weekly x 12 weeks and monthly x 12 months. Audits will be brought to QAPI by the Administrator or Director of Nursing and will be reviewed monthly x 12 months by the QAPI Committee. If any discrepancies are noted, further action will be implemented by the Administrator.	

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checking the dosage of the medication being administered.

B. A review of Resident #23's hospital discharge summary dated 6/29/2021 indicated the resident was hospitalized on 6/20/2021 for sepsis secondary to pyelonephritis (kidney infection). The resident returned to the facility on 6/29/2021 with a left nephrostomy tube, peripheral inserted central venous catheter (PICC), and indwelling foley catheter with instructions to continue intravenous (IV) antibiotics. The discharge summary also revealed the resident was on the antibiotic meropenem, 500mg IV every 6 hours, with recommendations by infectious disease to continue the antibiotic until 7/4/2021.

Resident #23's Medication Administration Record (MAR) for June 2021 revealed the resident did not get IV antibiotics on 6/29/2021 or 6/30/2021. The MAR for July 2021 revealed the resident missed the first two doses of the IV antibiotic on 7/1/2021 and received the noon and 6:00 PM doses. The resident's MAR indicated the resident missed a total of 7 doses of the IV antibiotic Meropenem.

The resident's active orders for July 2021 revealed an order for Meropenem 500mg in 50 milliliters (ml) IV every 6 hours until 7/6/2021. The start date of the order was 7/1/2021.

A record review revealed Resident #23 returned from the hospital on 6/29/2021 around 5:00 PM and her orders were entered by the unit manager.

An interview was conducted with the unit manager on 11/17/2021 at 12:14 PM. He stated

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he did enter Resident #23's orders when she returned from the hospital. He stated the order for meropenem was not on the same page as Resident #23's other medications, it was on a separate page and he missed it. When asked if he read the discharge summary in whole, he stated he thought he did but he must have missed the recommendations by infectious disease to continue IV antibiotics until 7/4/2021. He further stated he would have expected the omission to have been caught sooner but the nurses did not question why the resident had a PICC line and did not have orders for IV medications until 7/1/2021. The unit manager stated when the omission was identified, the facility contacted the medical director who instructed them to contact the infectious disease physician. The infectious disease physician gave the facility an order to restart the Meropenem and give the remaining doses starting 7/1/2021 and ending 7/6/2021. The resident did get all ordered doses of the antibiotic. The unit manager stated the resident was monitored for fever and signs and symptoms of infection after the missed doses of antibiotics. He stated the resident did not experience any harm from the missed doses of the IV antibiotic.

On 11/18/2021 at 10:37 AM an attempt was made to contact the facility's medical director. A return call was not received.

An interview was conducted with the Director of Nursing (DON) on 11/18/2021 at 11:10 AM she stated it was her expectation that all orders get entered when a resident returns from the hospital. However, they did reach out to the infectious disease physician and the resident did receive all doses of the IV antibiotic and did not experience

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F 760	Continued From page 45 any harm from the missed doses.	F 760		