STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

(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 from 12/12/2021 through 12/16/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #WMBM11	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 12/12/2021 through 12/16/2021. Event ID# WMBM11. 12 of the 38 allegations were substantiated resulting in deficiencies.	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.	F 550		1/12/22

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

Electronically Signed | 01/07/2022

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to treat residents in a dignified manner as evident by staff standing while providing assistance with eating (Resident #31, #85) and entering a resident's room without knocking on the door (Resident #89) for 3 of 8 residents reviewed for dignity. Findings included: 1. Resident #31 was admitted to the facility on 10/29/2018 with diagnoses that included Alzheimer's disease. The current Minimum Data Set (MDS) dated 10/2/2021 indicated Resident #31 was severely cognitively impaired. Per MDS she required one-person physical assistance with meals. A current plan of care last reviewed on 10/2/2021 addressed activities of daily living (ADL). The	F 550	River Trace Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. River Trace Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, River Trace Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	

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F 550	Continued From page 2 interventions included staff to provide set up assistance only with the head of the bed elevated and a specialized cup for beverage assistance. An observation on 12/12/2021 at 12:42 pm revealed Nurse Aide (NA) #3 standing beside Resident #31's bed assisting her to eat her lunch. There was one resident reclining chair observed in the room. During an interview with NA #3 on 12/12/2021 at 12:47 pm she stated she did not know that she needed to be seated when assisting a resident with a meal. She then stated the room did not have a chair in it for her to sit in. On 12/12/2021 at 1:07 pm during an interview with Nurse #2 she stated she was aware the NAs needed to be seated while assisting with meals. She stated she did not see NA #3 standing while assisting Resident #31 with her meal or she would have reminded her to get a chair. The Director of Nursing stated on 12/14/2021 at 10:30 am NA #3 should have been seated while assisting Resident #31 with her meal. She further stated the NAs have been educated on not standing over a resident while assisting with a meal. 2. Resident #89 was admitted to the facility on 6/8/21. Resident #89's care plan dated 9/20/21 revealed he was care planned for to require assistance with activities of daily living. The interventions included to provide total assistance with feeding, feed resident slowly, and encourage the resident to assist with feeding.	F 550	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights On 12/12/21, Nurse Aide #3 (NA) was verbally educated by Director of Nursing on dignity and respect with emphasis sitting at resident eye level and not standing when providing feeding assistance to a resident. On 12/13/21, the Facility Consultant educated the Wound Care Nurse on dignity and respect with emphasis sitting at resident eye level and not standing when providing feeding assistance to a resident. On 12/12/21, the Director of Nursing verbally educated Nursing Assistant #1 in regards to dignity and respect with emphasis on knocking on resident door before entering resident□s room and/or asking for permission to enter residents□ room. On 1/3/22, the Minimum Data Set Nurse (MDS) completed an audit of all residents requiring feeding assistance to include resident #31 and #89. This audit is to ensure all residents were treated with dignity and respect during meals with emphasis on staff sitting at resident eye level when providing feeding assistance and not standing. The MDS nurse will address all concerns identified during the	

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F 550	Continued From page 3 Resident #89's minimum data set assessment dated 11/16/21 revealed he was assessed as severely cognitively impaired. He had no behaviors and required extensive assistance with eating. During observation on 12/13/21 at 8:09 AM the Wound Care Nurse was observed standing over Resident #89 while assisting with his meal. During an interview on 12/13/21 at 8:10 AM the Wound Care Nurse stated she would always stand while assisting Resident #89 with his meal. During an interview on 12/14/21 at 9:16 AM the Director of Nursing stated staff should not stand while assisting residents with meals as it was a dignity concern. 3. Resident #85 was admitted to the facility on 8/13/20. Resident #85's minimum data set assessment dated 11/15/21 revealed she was assessed as moderately cognitively impaired and had no behaviors. Resident #85's care plan dated 11/29/21 revealed she was care planned for progressive decline in intellectual functioning making her at risk for unmet needs and/or compromised dignity. The interventions included to ensure staff introduce themselves and are wearing name tags at initiation of each interaction with resident. During observation on 12/12/21 at 11:17 AM Nurse Aide #1 was observed to enter Resident #85's room without knocking. She was observed to wash her hands, speak to the resident, and	F 550	audit to include education of staff. On 1/3/22, the Social Worker completed resident questionnaires with all alert and oriented residents in regards to staff knocking on doors. The Social Worker, Staff Facilitator and/or Nurse Supervisor will address all concerns identified during the audit. On 1/6/22 the Director of Nursing initiated an in-service with all nurses to include wound care nurse, nursing assistants (NA), dietary staff, housekeeping staff, therapy staff, maintenance staff, activity staff, Social Worker, Accounts Payable, Accounts Receivable, Medical Records Director, Admission Director and receptionist in regards to Resident Rights. Emphasis is on treating resident with dignity and respect by sitting at resident eye level when providing feeding assistance and by knocking on resident door before entering resident□s room and/or asking for permission to enter residents□ room. In-service will be completed by 1/12/22. After 1/12/22, any nurse, nursing assistants (NA), dietary staff, housekeeping staff, therapy staff, maintenance staff, activity staff, Social Worker, Accounts Payable, Accounts Receivable, Medical Records Director, Admission Director and receptionist who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses, nursing assistants (NA), dietary staff, housekeeping staff, therapy staff, maintenance staff, activity staff, Social Worker, Accounts Payable,	

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F 550	Continued From page 4 leave. During an interview on 12/12/21 at 2:36 PM Resident #85 stated if her door was opened or closed, she wished staff would knock before entering but staff walked in without knocking all the time, so she had to just get used to it. During an interview on 12/12/21 at 2:41 PM Nurse Aide #1 stated because the resident's door was open, she did not knock when she entered the room, but she would have knocked if the door had been closed. She concluded she should knock or announce her presence when entering any resident's room. During an interview on 12/14/21 at 9:16 AM the Director of Nursing stated staff should announce their presence before entering a resident room every time. She stated the door to their room was like their front door and staff should knock or announce themselves every time prior to entering a resident room to promote dignity.	F 550	Accounts Receivable, Medical Records Director, Admission Director and receptionist will be in-serviced by the Staff Facilitator during orientation in regards to Resident Rights. The Nurse Supervisor and/or Staff Facilitator will complete 15 resident care observations to include all shifts, resident #31, #85 and #89 weekly x 4 weeks then monthly x 1 month utilizing the Resident Rights Audit Tool. This audit is to ensure staff treat residents with dignity and respect during mealtime by sitting at resident eye level when providing feeding assistance and by knocking on resident door before entering resident□s room and/or asking for permission to enter residents□ room. The Nurse Supervisor and/or Staff Facilitator will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the Resident Rights Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Resident Rights Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Resident Rights Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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F 565	Continued From page 5	F 565		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 565		1/12/22

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F 565	Continued From page 6 Based on interviews with Resident Council members and facility staff and review of the Resident Council minutes the facility failed to communicate the facility's efforts to resolve the group concerns verbalized during Resident Council meeting for 2 of 6 months when grievances were conveyed. The findings included: A review of the Resident Council minutes from 6/15/21 through 11/16/21 revealed no information documented in the Old Business section. The Old Business section of the form was blank for each of the monthly meetings. 1. On 6/15/21 the New Business section of the minutes included 200 and 300 hall showers were not being offered, linens were still short, and no linens were available on the 300 hall. Attached to the minutes was a Resident Council Grievance Follow-up form. The identified problem was listed as 200/300 halls shower are not being offered. The responsible department was listed as nursing. The response was "Nurses are to sign off and document when showers are given." The form was signed by the Administrator and dated 6/23/21. The next Resident Council meeting documented was on 7/20/21. The minutes to this meeting were reviewed. The minutes did document the previous minutes were approved as read. The next section of the minutes labeled Old Business was blank. The minutes were signed by the Social Worker. On 12/13/21 at 2:40 PM the Social Worker (SW) stated the concerns from the Resident Council	F 565	F565 Resident/Family Group and Response On 1/3/22, the Accounts Receivable completed an audit of all resident council meeting minutes for the past 60 days. This audit is to identify any resident concerns voiced during a resident council meeting to ensure concerns were addressed, the resident council provided a written response per facility protocol and response reviewed during the next council meeting with documentation in the Old Business section of council meeting minutes. The Social Worker and/or Activity Director will address all concerns identified during the audit to include completion of a written grievance with a written follow up provided to the resident council president to be presented at the next resident council meeting. On 12/21/21, the Social Workers held a resident council meeting with alert and oriented residents to review grievance resolution follow up for all grievances voiced for the past 60 days and to review rights of residents in a nursing home setting. Any alert and oriented resident who did not attend the meeting will be in-serviced 1:1 by the Social Worker and/or Activity Director. Review was completed on 1/6/22. On 12/15/21, the Regional Vice President completed an in-service with the Administrator, Director of Nursing, and the Social Worker in regards to Resident Grievance Policy. Emphasis is on	

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F 565	Continued From page 7 meetings were documented on the minutes of the meeting and a concern form was then completed by the SW for each concern. The concern form was then given to the appropriate department head who addressed the concern and documented the results on the concern follow-up form. The concern follow-up form was returned to the SW. The SW stated she then presented the concern follow-up form to the Administrator for her signature and the follow-up form was attached to the minutes of the meeting in which the grievance was voiced. She then stated she was not sure if the resolution of the grievance were talked about in the next meeting or not. She stated there was no documentation on the following months Resident Council meeting form to indicate if the resolution was discussed. During a meeting with the residents who regularly attend the Resident Council on 12/13/21 at 3:10 PM, 8 residents who regularly attend the Resident Council meetings stated the resolution of the concerns was not discussed in the Resident Council meetings. On 12/14/21 at 2:45 PM the Activity Director stated she remembered the residents had expressed concerns about linens, but it was not discussed at the following meeting. She said she did not know what happens related to grievances from the Resident Council group. On 12/15/21 at 2:30 PM the Administrator stated she was not aware the grievance resolutions were not being discussed in the following Resident Council meeting. She said the regional vice president of operations provided education to the Administrator and the SW.	F 565	completing grievance investigation for all grievances voiced during resident council and that the Social Worker and/or Activities review grievance resolution during the next resident council meeting with documentation in the Old Business section of the council meeting minutes. The Social Worker and/or Activity Director will provide a written grievance summary to resident council following completion of grievance investigation. It is the Administrator□s responsibility to ensure the grievance process is completed per facility protocol. All newly hired Administrator, Director of Nursing, and/or Social Worker will be in-serviced during orientation in regards to the Resident Grievance Policy. The Accounts Receivable will review all resident council meeting minutes monthly x 2 months utilizing the Resident Council Audit Tool. This audit is to ensure all grievances voiced during resident council are investigated per facility protocol and that the Social Worker and/or Activity Director provide a written grievance summary with review of grievance resolution during the next resident council meeting with documentation in the Old Business section of the council meeting minutes. The Accounts Receivable, Social Worker and/or Activity Director will address all concerns identified during the audit. The Administrator will review and initial the resident council meeting minutes and the Resident Council Audit Tool monthly x 2 months to ensure all concerns were addressed.	

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F 565	Continued From page 8 2. A review of the minutes for the 8/17/21 Resident Council meeting revealed new business was "Laundry is not getting clothes back to residents and Residents are still reporting laundry shortages." The minutes were signed by the SW. Attached to the minutes was a Resident Council Grievance Follow-up. The follow-up restated the problem. The form identified the responsible party was housekeeping. This section of the form was dated 8/19/21. The department response to the grievance read; "Housekeeping supervisor in-serviced employees on procedures. SW encouraged residents to make sure names are in clothes, families to make sure clothes are labeled when brought into facility and Administrator/housekeeping supervisor have ordered additional linens. The Resident Council Grievance Follow-up form was signed by the Administrator 8/19/21. A review of the 9/21/21 Resident council minutes revealed the previous Resident Council minutes were approved as read. The no old business section had no documentation. On 12/13/21 at 2:40 PM the Social Worker stated the concerns from the Resident Council meetings were documented on the minutes of the meeting and a concern form was then completed by the SW for each concern. The concern form was then given to the appropriate department head who addressed the concern and documented the results on the concern form. The concern form was returned to the SW. The SW stated she then presented the concern follow-up form to the Administrator for her signature and the follow-up form was attached to the minutes of the meeting in which the grievance was voiced. She then stated she was not sure if the resolution of the	F 565	The Administrator will forward the results of the Resident Council Audit Tool to the Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Resident Council Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 565	Continued From page 9 grievance were talked about in the next meeting or not. She stated there was no documentation on the following months Resident Council form to indicate if the resolution was discussed. During a meeting with the residents who regularly attend the Resident Council on 12/13/21 at 3:10 PM, 6 residents who attend the Resident Council meeting on 8/17/21 were present. They stated the resolution of the concerns was not discussed in the Resident Council meetings. On 12/15/21 at 2:30 PM the Administrator stated she was not aware the grievance resolutions were not being discussed in the following Resident Council meeting. She said the regional vice president of operations provided education to the Administrator and the SW.	F 565		
F 572 SS=E	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and	F 572		1/12/22

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F 572	Continued From page 10 obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interviews with the Resident Council members and facility staff, and review of the Resident Council minutes the facility failed to provide ongoing communication of the rights of the residents in a nursing home setting to the residents. This occurred for 8 of 8 residents who regularly attend the Resident Council meetings (Residents #10, 23, 33, 47, 65, 71, 81, & 90). The findings included: A review of the Resident Council meeting minutes from 1/19/21 through 11/16/21 revealed the resident rights reviewed section did not contain any information about resident's rights. During a group meeting on 12/13/21 at 3:10 PM with Residents #10, 23, 33, 47, 65, 71, 81, & 90 they stated they regularly attend the Resident Council meeting. The Residents stated residents' rights were not discussed in their council meetings. They stated they did not know where the results of the state inspections were located and they did not know who the ombudsman was, what an ombudsman was or how to contact the ombudsman. During an interview with the Social Worker (SW) on 12/13/21 at 3:25 PM she stated she had not discussed residents' rights since the facility resumed having in person group Resident Council meetings. She added they were not discussed when the facility was conducting the	F 572	F572 Notice of Rights and Rules On 1/3/22, the Accounts Receivable completed an audit of all resident council meeting minutes for the past 60 days. This audit is to ensure the facility provided ongoing communication of the rights of a resident in a nursing home setting and that the Social Worker and/or Activity Director documented the review on the resident council meeting minutes each month. The Administrator will address all concerns identified during the audit. On 12/21/21, the Social Worker held a resident council meeting with alert and oriented residents to review rights of residents in a nursing home setting, name and contact information for the Ombudsman and location of state inspection survey results. Any alert and oriented resident who did not attend the meeting will be in-serviced 1:1 by the Social Worker and/or Activity Director. Review was completed on 1/6/2022. On 12/15/21, the Regional Vice President completed an in-service with the Administrator, Director of Nursing, and the Social Worker in regard to Resident Council. Emphasis is on completing resident council meeting minutes to include complete and accurate	

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F 572	Continued From page 11 Resident Council meeting one on one with those residents who frequently attended the meetings. The SW added she could not remember the last time resident rights were reviewed. She said if it was not in the minutes it was not done. On 12/15/21 at 2:30 PM the Administrator stated she was not aware residents' rights were not being discussed in the Resident Council meeting. She said the regional vice president of operations provided education to the Administrator and the SW.	F 572	documentation of items reviewed (new and old business), review of resident rights, review of location of state inspection results for resident review, name and contact information for Ombudsman, completion of grievance form for all concerns identified during meeting, notification of the Administrator and/or DON of all concerns voiced and review of grievance resolution from previous meeting minutes. All newly hired Administrator, Director of Nursing, and/or Social Worker will be in-serviced during orientation in regard to the Resident Council. The Accounts Receivable will review all resident council meeting minutes monthly x 2 months utilizing the Resident Council Audit Tool. This audit is to ensure the Social Worker and/or Activity Director completed written resident council meeting minutes for each meeting held. Minutes should include complete and accurate documentation of items reviewed (new and old business), review of resident rights, completion of grievance form for all concerns identified during meeting, notification of the Administrator and/or DON of all concerns voiced and review of grievance resolution from previous meeting minutes. The Accounts Receivable, Social Worker and/or Activity Director will address all concerns identified during the audit. The Administrator will review and initial the resident council meeting minutes and the Resident Council Audit Tool monthly x 2 months to ensure all concerns were	

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F 572	Continued From page 12	F 572	addressed. The Administrator will forward the results of the Resident Council Audit Tool to the Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Resident Council Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective	F 574		1/12/22

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F 574	Continued From page 13	F 574		

services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)

(iii) Information regarding Medicare and Medicaid eligibility and coverage;

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;

(v) Contact information for the Medicaid Fraud Control Unit; and

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation,

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F 574	Continued From page 14 misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interviews with the Resident Council members and facility staff, and review of the Resident Council minutes the facility failed to provide information and contact information about the local ombudsman program that was easily readable. This occurred for 8 of 8 residents who regularly attend the Resident Council meetings (Residents # 10, 23, 33, 47, 65, 71, 81, & 90). The findings included: A review of the Resident Council meeting minutes from 1/19/21 through 11/16/21 revealed the resident rights reviewed section did not contain any information about residents' rights including information on the contact information for the local ombudsman. During a group meeting on 12/13/21 at 3:10 PM with Residents # 10, 23, 33, 47, 65, 71, 81, & 90 they stated they regularly attend the Resident Council meeting. The Residents stated residents' rights were not discussed in their council meetings. They stated they did not know who the ombudsman was, what an ombudsman was or how to contact the ombudsman. During a tour of the facility on 12/13/21 at 3:40PM after the Resident Council meeting the contact information for the ombudsman was observed to be written on the bottom of the poster located on the bulletin board on the wall near the nursing station. The information was located at eye level	F 574	F574 Required Notices and Contact Information On 1/4/22, the Social Worker placed a bright colored sign in large font on the bulletin board located near the nursing station with the name and contact information for the Ombudsman. Signage was posted at both seating and standing eye level for easy access to all residents. The Social Worker also provided each resident a written copy of the name and contact information of for the Ombudsman. On 1/4/22, the Admission Director added the name and contact information for the Ombudsman to each admission packet. On 12/21/21, the Social Worker held a resident council meeting with alert and oriented residents to review rights of residents in a nursing home setting, reviewed the role of the Ombudsman and provided residents with Ombudsman name and contact information. Any alert and oriented resident who did not attend the meeting will be in-serviced 1:1 by the Social Worker and/or Activity Director. Review was completed on 1/6/2022. 12/15/21, the Regional Vice President completed an in-service with the	

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F 574	Continued From page 15 for someone who was standing. The information was written in black ink with letters approximately ¼ inch tall. On 12/13/21 at 3:50 PM Resident #33 was observed sitting in her wheelchair next to the bulletin board attempting to see the ombudsman's name and contact information. Resident #33 stated she could not read the information because she could not see it from her location. She said she would need a magnifying glass to see what was written there. On 12/15/21 at 2:30 PM the Administrator stated she was not aware residents could not locate the contact information for the ombudsman or that the residents seated in a wheelchair could not see it clearly enough to be able to read the contact information.	F 574	Administrator, Director of Nursing, and the Social Worker in regards to Resident Council. Emphasis on completing resident council meeting minutes to include complete and accurate documentation of items reviewed (new and old business), review of resident rights, review of location of state inspection results for resident review, and name/contact information for the Ombudsman. All newly hired Administrator, Director of Nursing, and/or Social Worker will be in-serviced during orientation in regards to the Resident Council. The Account Receivable will review all resident council meeting minutes monthly x 2 months utilizing the Resident Council Audit Tool. This audit is to ensure the Social Worker and/or Activity Director completed written resident council meeting minutes for each meeting held. Minutes should include complete and accurate documentation of items reviewed (new and old business), review of resident rights, review of name/contact information of Ombudsman, location of state inspection results, completion of grievance form for all concerns identified during meeting, notification of the Administrator and/or DON of all concerns voiced and review of grievance resolution from previous meeting minutes. The Accounts Receivable, Social Worker or Activities Director will address all concerns identified during the audit. The Administrator will review and initial the resident council meeting minutes and the Resident Council Audit Tool monthly x 2	

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F 574	Continued From page 16	F 574	months to ensure all concerns were addressed. The Administrator will forward the results of the Resident Council Audit Tool to the Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Resident Council Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		1/12/22

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F 578	Continued From page 17 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to change the code status from Do Not Resuscitate (DNR) when a resident expressed his desire to be a Full Code. This was for 1 of 32 residents (Resident #310) reviewed for Advance Directives. This placed Resident #310 at risk of not receiving Cardio-Pulmonary Resuscitation (CPR) in the event of cardiac and/or respiratory arrest. Findings included: Resident #310 was admitted to the facility on 12/08/2021 with a diagnosis of hemiplegia (paralysis of one side of the body). A review of the current care plan for Resident #310 revealed a focus area initiated on 12/09/2021 of Advance Directives. The goal was	F 578	F578 Request/Refuse/Discontinue Treatment/Formite Advance Directive On 12/14/21, the Director of Nursing clarified the code status/advance directive wishes of resident #310 and notified the physician of resident desire to be a Full Code status. A new order was obtained to change resident #310 from a Do not Resuscitate to a Full Code status. The DON updated resident advance directive to Full Code in the electronic record. On 1/5/22, the Social Worker and Admission Director initiated an audit of all resident/resident representative resident #310 in regard to Code Status. This audit was to verify the desired code status per resident preference. The Social Worker,	

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F 578	Continued From page 18 end of life planning directives. Advance Directives will be honored per established documentation through next review. An intervention was DNR. A physician's order for Resident #310 dated 12/09/2021 revealed DNR. A review of a progress note dated 12/09/2021 at 4:58 PM revealed Resident #310 was alert, oriented and able to make his own decisions. It further revealed Advanced Directive information was explained to Resident #310 and he understood. Resident #310 expressed his desire to be a Full Code. On 12/14/2021 at 8:47 AM an interview with Nurse #3 indicated she was assigned to Resident #310 that day. She went on to say Resident #310 had a code status of DNR. She stated this meant if he were to experience cardiac and/or respiratory arrest while she was caring for him, she would not provide him with CPR. On 12/14/2021 at 8:52 AM an interview with Resident #310 indicated he recalled having a conversation about his code status when he was admitted to the facility. He stated he told them if his heart were to stop or he were to stop breathing he wanted them to try to revive him. On 12/14/2021 at 9:04 AM a telephone interview with the Admissions Director indicated she had a conversation with Resident #310 about Advanced Directives on 12/09/2021. She stated Resident #310 was alert and oriented and able to make his own decisions. She went on to say Resident #310 expressed to her he wanted to be a Full Code. The Admissions Director further indicated she asked Nurse #4 to witness Resident #310's	F 578	Admission Director and/or Director of Nursing will address all concerns identified during the interviews to include notification of the physician for changes in preference for code status and updating resident electronic record. Audit will be completed by 1/12/22. 1/6/22, the Director of Nursing initiated an in-service with all nurses, Social Worker and Admissions Director in regard to Code Status/Advance Directive. Emphasis is on notification of the nurse when a resident/resident representative verbalizes a desire to change code status/advance directive, nurses□ responsibility of notifying the physician immediately for any resident who desires a change in code status/advance directive, obtaining new order when indicated and updating resident electronic record. In-service will be completed by 1/12/22. All newly hired Social Worker, Admission Director and nurses in regard to Code Status/Advance Directive. The Social Worker and/or Admission Director will interview 5 alert and oriented residents to include resident #310 and 5 resident representatives for residents who are unable to report in regard to Code Status weekly x 4 weeks then monthly x 1 month utilizing the Advance Directive Audit Tool. This audit is to clarify resident code status and to ensure the physician order and electronic record accurately reflects the resident and/or resident representative desired code status/advanced directive. The Nurse	

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F 578	Continued From page 19 decision on 12/09/2021. She stated it would be nursing's responsibility to get a physician's order. She further indicated she communicated Resident #310's wishes to the Director of Nursing (DON). On 12/14/2021 at 11:15 AM a telephone interview with Nurse #4 indicated she witnessed Resident #310's request to be a Full Code with the Admissions Director on 12/09/2021. She stated it was her understanding the Admissions Director was responsible for getting Resident #310's code status order changed. She further indicated she had not gotten an order for this from Resident #310's physician. On 12/14/2021 at 11:35 AM an interview with the DON indicated when Resident #310 was admitted to the facility his code status was DNR. She stated she did not recall anyone notifying her that Resident #310 expressed a desire to be a Full Code. She went on to say Nurse #4 should have gotten an order from Resident #310's physician immediately if that was the case. On 12/16/2021 at 11:05 AM an interview with the Administrator indicated Resident #310's code status change from DNR to Full Code should have been taken care of immediately when Resident #310 expressed his desires.	F 578	Supervisor and/or assigned hall nurse will address all concerns identified during the audit to include notification of the physician with changes in desired code status and updating the electronic record to accurately to reflect code status. The DON will review and initial the Advance Directive Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the results of the Advance Directive Audit Tool to the Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Advance Directive Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		1/12/22

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the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

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F 623	Continued From page 21 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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	345215	A. BUILDING _____ B. WING _____	C 12/16/2021

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F 623	Continued From page 22 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff and responsible party interviews and record review the facility failed to provide a notice of discharge to a resident representative for 1 of 1 closed record reviewed for hospitalization. (Resident #110) Findings included: Resident #110's minimum data set assessment dated 8/11/21 revealed she was assessed as severely cognitively impaired. A nursing note dated 9/11/21 revealed Resident #110 had sustained a fall and was transferred to the hospital for evaluation. A notice of discharge to the hospital on 9/11/21 was provided to the responsible party. Review of Resident #110's chart revealed the resident did not return to the facility. There was no notice of discharge provided to the responsible party indicated Resident #110's needs could not be met in the facility. During an interview on 12/13/21 at 8:06 AM Resident #110's representative stated the hospital informed her they would arrange transport back	F 623	F623 Notice Requirements before Transfer/Discharge Resident #110 no longer resides in the facility On 1/4/22, the Administrator completed an audit of resident transfer/discharges for the past 30 days. This audit to ensure residents/resident representative and the Ombudsman received written notification indicating the reason for transfer/discharge from the facility, date of transfer/discharge, location to which resident is transferred/discharged and that the notification was provided at least 30 days prior to transfer/discharge unless transfer/discharge is due to urgent medical or safety need. There were no additional concerns identified. On 1/6/22, the Director of Nursing initiated an in-service with all nurses, Social Workers, Admission Coordinator, and Administrator in regards to Notice of Transfer/Discharge. Emphasis is on providing a written Notice of	

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F 623	Continued From page 23 to the facility, however the hospital then called her back and told her the facility would not take Resident #110 back because they could not meet her mother's needs. She did not understand this as her mother's care status had not changed during the hospitalization and she did not receive a discharge notice from the facility. During an interview on 12/13/21 at 2:24 PM AM the Administrator stated she did not complete a notice of discharge and provide it to Resident #110's responsible party when the facility informed the hospital Resident #110's needs could not be met in the facility.	F 623	Transfer/Discharge to the resident/resident representative and Ombudsman that indicates reason for transfer, date of transfer and location to which the resident is transferred to at least 30 days prior to transfer unless immediate transfer is required due to urgent medical or safety needs. In-service will be completed by 1/12/22. After 1/12/22, any nurse, Social Workers, Admission Coordinator, and Administrator who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses, social worker, admission coordinator, DON and/or Administrator will be in-serviced by the Staff Facilitator during orientation in regards to Notice of Transfer/Discharge. The Medical Records Director will complete an audit of all newly transferred/discharged residents utilizing the Notice of Transfer/Discharge Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure the resident/resident representative and Ombudsman received a written Notice of Transfer/Discharge that indicates reason for transfer, date of transfer and location to which the resident is transferred to at least 30 days prior to transfer unless immediate transfer is required due to urgent medical or safety needs. The Nurse Supervisor, and/or DON will address all concerns identified during the audit to include education of staff and mailing of Notice of Transfer/Discharge as indicated. The Administrator will review	

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F 623	Continued From page 24	F 623	the Notice of Transfer/Discharge Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed. addressed. The Administrator will forward the Notice of Transfer/Discharge Audit Tool to the Executive QAPI Committee monthly x 2 month. The Executive QAPI Committee will review the Notice of Transfer/Discharge Audit Tool monthly x 2 month to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident	F 626		1/12/22

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F 626	Continued From page 25 who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on staff and responsible party interviews and record review the facility failed to allow a resident to return from the hospital to the first available room for 1 of 1 closed record reviewed for hospitalization. (Resident #110) Findings included: Resident #110 was admitted to the facility on 8/5/21. Resident #110 ' s minimum data set assessment dated 8/11/21 revealed she was assessed as severely cognitively impaired. She required extensive assistance with bed mobility and was totally dependent on staff for transfers, dressing, toilet use, and personal hygiene. She required supervision with eating. She had an indwelling catheter and was frequently incontinent of bowel. Her active diagnoses included displaced intertrochanteric fracture of left femur, anemia,	F 626	F626 Permitting Residents to Return to Facility Resident #110 no longer resides in the facility On 1/6/22, the Medical Records Director completed an audit of all discharges from the facility for the past 30 days. This audit is to identify any resident denied readmission and to ensure facility provided the resident and/or resident representative a written Notice of Transfer/Discharger per facility guidelines. There were no additional concerns identified. On 1/5/22, the Director of Nursing initiated an in-service with Social Workers, Admission Coordinator and Administrator in regards to Notice of	

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F 626	Continued From page 26 atrial fibrillation and other dysrhythmias, hypertension, arthritis, Alzheimer ' s disease, dementia, anxiety disorder, and depression. A note dated 9/9/21 revealed Resident #110's responsible party was in facility that morning at Resident #110's bedside. The Responsible Party requested staff not leave Resident #110's walker within reach and suggest staff lock the restroom door to keep the resident from trying to get up. The Responsible Party was educated that this would increase the risk of falls. A nursing note dated 9/11/21 revealed Resident #110 had sustained a fall and was transferred to the hospital for evaluation. Review of a note dated 9/17/21 revealed the responsible party called the Administrator and indicated her mother would not be readmitted to the facility unless the responsible party said so. The responsible party had several buildings they were speaking with and would make their decision that day. The Administrator acknowledged this and indicated the facility was there for her if she needed them. Review of Resident #110's chart revealed the resident did not return to the facility. During an interview on 12/13/21 at 8:06 AM the Resident #110's representative stated in September her mother went to the hospital following a fall and she told the hospital she did not wish her mother to return to the facility. She stated she attempted to find placement at other facilities but later in September when her mother was ready to discharge from the hospital, she had not found other placement and told the hospital to	F 626	Transfer/Discharge. Emphasis is on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave if previous room available or immediately upon the first availability of a bed in a semiprivate room or the facility must provide a written Notice of Transfer/Discharge to the resident/resident representative. Notification should include reason, date and location to which resident will be discharged. In-service will be completed by 1/12/22. After 1/12/22, any Social Workers, Admission Coordinator and Administrator who has not received the in-service will receive in-service upon next scheduled shift. All newly hired social worker, admission coordinator and/or Administrator will be in-serviced by the Staff Facilitator during orientation in regards to Notice of Transfer/Discharge The Medical Records will complete an audit of all newly transferred/discharged residents utilizing the Notice of Transfer/Discharge Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure residents are permitted to return to the facility after they are hospitalized or placed on therapeutic leave if previous room available or immediately upon the first availability of a bed in a semiprivate room or the facility must provide a written Notice of Transfer/Discharge to the resident/resident representative. The Medical Records and/or Social Worker will address all concerns identified during the audit. The Administrator will review the	

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F 626	Continued From page 27 send her mother back to the facility. The hospital informed her they would arrange transport, however the hospital then called her back and told her the facility would not take Resident #110 back because they could not meet her mother ' s needs. She did not understand this as her mother ' s care status had not changed during the hospitalization. During an interview on 12/13/21 at 9:03 AM the Social Worker stated to her knowledge resident representative chose another facility while Resident #110 was at the hospital. She further stated she was not aware of the facility refusing to take Resident #110 back and the Administrator was talking with the family member and the admission ' s coordinator at the hospital and ultimately, she did not return. The Social Worker did not have any other information about Resident #110's discharge and option to return and it was taken care of by the Administrator. During an interview on 12/13/21 at 9:07 AM the Administrator stated she remembered Resident #110. She further stated the family member wanted the facility to place Resident #110's walker out of her reach and lock the bathroom door for Resident #110 as she felt this was why her mother would fall in the facility. The resident had to be discharged to the hospital in September 2021. She further stated the family member was inconsistent with if she wanted the resident to come back to the facility or not from the hospital. On 9/17/21 the hospital communicated to the facility that the family member did not want the resident to return to the facility and was seeking placement elsewhere. On 9/20/21 the family member changed her mind, and the hospital was planning to arrange transport back to their facility	F 626	Notice of Transfer/Discharge Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The Administrator will forward the Notice of Transfer/Discharge Audit Tool to the Executive QAPI Committee monthly x 2 month. The Executive QAPI Committee will review the Notice of Transfer/Discharge Audit Tool monthly x 2 month to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 626	Continued From page 28 because the family member could not find placement elsewhere. The Administrator told the Admissions Coordinator to tell the hospital discharge planner they could not meet the needs of the resident because of the family member's request to keep Resident #110's walker out of her reach and keep the bathroom door locked. She stated it was the family member ' s request to keep her mother secluded which caused the facility to be unable to meet the resident's needs. She concluded the facility could have met the care needs of the resident had the family been realistic. During an interview on 12/14/21 at 9:08 AM the Admission Director stated she remembered Resident #110. She stated she could not remember everything about the discharge and not returning to the facility because there were many discussions with the family, the hospital, and the administrator. She concluded all she could remember was the family did not want the bed hold, and when she chose to come back, they had given her bed to someone else but could not remember the conclusion of why Resident #110 did not admit to the first available bed and went to a different facility.	F 626		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 637		1/12/22

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F 637	Continued From page 29 implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change Minimum Data Set (MDS) assessment after election of the hospice benefit for 2 of 3 residents (Resident #102 and Resident #29) reviewed for hospice. Findings included: 1. Resident #102 was admitted to the facility on 12/06/2011 with a diagnoses of spinal stenosis (narrowing of the spinal canal). A review of Resident #102's Notice of Hospice Election/Admission form revealed the date of her hospice admission was 07/12/2021. A review of the facility's payor source for Resident #102 revealed hospice Medicaid was active as of 07/12/2021. A review of Resident #102's MDS assessments revealed no significant change MDS assessment had been completed. On 12/16/2021 at 10:30 AM an interview with the MDS Coordinator indicated Resident #102 was admitted to hospice on 07/12/2021. She stated this change in payor source to hospice Medicaid on 07/12/2021 should have triggered her to complete a significant change MDS assessment for Resident #102 within 14 days of her	F 637	F637 Comprehensive Assessment after Significant Change On 12/16/21, the Minimum Data Set Nurse (MDS) completed a significant change correction for resident # 102 and #29 for hospice services. On 12/16/2021, MDS Consultant completed an audit of all residents with significant change related to election of hospice benefits in the past 30 days to include resident #102 and #29. This audit was to ensure a comprehensive assessment was completed within 14 days of a significant change related to the election of hospice benefits. The MDS Consultant addressed all concerns identified during the audit to include assessment of resident for significant change. 12/16/2021, the MDS Consultant in-serviced the MDS nurses and Director of Nursing in regards to MDS Assessment following Significant Change. Emphasis is on completing assessment within 14 days for significant change related to election of hospice benefits. All newly hired MDS nurses will be in-serviced during orientation in regards to Assessment following Significant Change.	

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F 637	Continued From page 30 admission to hospice. She stated she did not know why this MDS assessment had not been completed. She stated she must have missed it. On 12/16/2021 at 11:08 AM an interview with the Administrator indicated a significant change MDS assessment should have been completed for Resident #102 within 14 days of her admission to hospice. 2. Resident #29 was admitted to the facility on 11/23/2016 with a diagnoses of dementia. A review of Resident #29's Notice of Hospice Election/Admission form revealed the date of her hospice admission was 11/09/2021. A review of the facility's payor source for Resident #29 revealed hospice Medicaid was active as of 11/09/2021. A review of Resident #29's MDS assessments revealed no significant change MDS assessment had been completed. On 12/16/2021 at 10:48 AM an interview with the MDS Coordinator indicated Resident #29 was admitted to hospice on 11/09/2021. She stated the change in her payor source to hospice Medicaid on 11/09/2021 should have triggered her to complete a significant change MDS assessment for Resident #29 within 14 days of her admission to hospice. She stated she did not know why this MDS assessment had not been completed. She stated she must have missed it. On 12/16/2021 at 11:08 AM an interview with the Administrator indicated a significant change MDS assessment should have been completed for	F 637	10% of residents with significant change related to election of hospice benefits to include resident #102 and #29 will be reviewed by the IDT team to include Director of Nursing, Staff Facilitator and MDS nurse weekly x 4 weeks then monthly x 1 month utilizing the Change of Condition Audit Tool. This audit is ensure a MDS Comprehensive Assessment was completed within 14 days of a significant change related to election of hospice benefits. The MDS nurse will address all areas of concern identified during the audit to include assessment of the resident and re-education of staff. The Director of Nursing (DON) will review and initial the Change of Condition Audit Tool weekly x 4 weeks then monthly x 1 month to ensure completion and that all areas of concerns were addressed. DON will forward the results of the Change of Condition Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Change of Condition Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 637	Continued From page 31 Resident #29 within 14 days of her admission to hospice.	F 637		
F 641 SS=B	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 the Preadmission Screening and Resident Review (PASARR) on a Minimum Data Set (MDS) assessment for 1 of 4 resident reviewed for PASARR. (Resident #85) Findings included: Resident #85 was admitted to the facility on 8/13/20. Her active diagnoses included schizophrenia, heart failure, anemia, and anxiety disorder. Resident #85's PASARR level II determination notification dated 8/26/20 revealed she was assessed to be level II PASARR. Resident #85's MDS assessment dated 8/20/21 revealed she was assessed to not have a level II PASARR. During an interview on 12/15/21 at 8:23 AM the MDS Coordinator stated Resident #85 was a level II PASARR and it should have been captured on the 8/20/21 MDS and it was coded incorrectly. She concluded she was going to complete a modification of the 8/20/21 MDS.	F 641	F641 Accuracy of Assessments On 12/15/2021 the Minimum Data Set Nurse (MDS) made a modification to the MDS assessment for resident #85 to correctly identify resident as a level II PASARR. On 12/15/21, the Minimum Data Set Consultant (MDS) completed an audit of the most recent admission, annual or significant change MDS assessment section A for residents with a level II PASARR. The audit was to ensure that the MDS assessment completed was coded accurately for level II PASARR during the assessment. The MDS Consultant and MDS Coordinator addressed all concerns identified during the audit to include completing a modification to the assessment when indicated. On 12/15/21, the MDS Consultant completed an in-service with the with the Administrator, MDS Coordinator, MDS Nurse, Social Worker and Director of Nursing in regard to MDS Assessments	1/12/22

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F 641	Continued From page 32 During an interview on 12/15/21 at 8:29 AM the Administrator stated MDS assessments should accurately capture PASARR status.	F 641	and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator and/or MDS nurse will be in-serviced by the Director of Nursing during orientation in regard to MDS Assessments and Coding. The Director of Nursing will complete an audit of 10% of all resident□s most recent MDS admission, annual and/or significant change assessments section A weekly x 4 weeks then monthly x 1 month utilizing the PASARR Audit Tool. This audit is to ensure all MDS assessments completed are coded accurately for residents with a level II PASARR. The Director of Nursing will address all concerns identified during the audit. The Administrator will review and initial the PASARR Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of PASARR Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 1 months. The Executive QAPI Committee will meet monthly x 1 months and review the PASARR Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		1/12/22

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F 644	Continued From page 33 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to request a Level II Preadmission Screening and Resident Review (PASARR) determination for residents with active diagnosis of serious mental illness for 2 of 4 residents (Resident #1, #4) reviewed for PASARR. Findings included: 1. A review of Resident #1's current PASARR dated 5/16/2017 revealed she was assessed as Level I. There were no further referrals for Resident #1. Resident #1 was initially admitted to the facility on 5/23/2017 and readmitted on 4/22/2021 with diagnoses that included schizoaffective disorder. A review of Resident #1's record revealed she	F 644	F644 Coordination of PASARR and Assessments On 12/21/2021 the Admission Coordinator submitted for review a PASARR for resident #1 and #4. On 1/6/22, the Medical Records and Admission Director initiated an audit of diagnosis for all residents with a Level I PASRR. This audit is to identify any resident with a newly added Level II PASARR qualifying diagnosis to ensure resident assessed for need to re-submit PASARR for evaluation. The Social Worker and/or Admission Director will address all concerns identified during the audit to include submission of Level II	

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F 644	Continued From page 34 was diagnosed with schizoaffective disorder on 12/5/2019. The most recent comprehensive Minimum Data Set (MDS) dated 4/9/2021 indicated Resident #1 did not have a PASARR level II determination, had severe cognitive impairment, had no behaviors, received antipsychotic medications daily and had an active diagnosis of schizophrenia. A care plan initiated on 3/11/2021 and last reviewed on 11/9/2021 revealed no plan of care to address Resident #1's diagnosis of schizoaffective disorder. During an interview with the Admission Coordinator (AC) on 12/14/2021 at 10:30 am, she stated she was responsible for updating Resident #1's PASARR. She stated since she did not attend the daily meetings, she had no way to know when a resident received a new mental health diagnosis. The AC then stated she had not requested a Level II PASSAR for Resident #1. An observation on 12/15/2021 at 11:00 am revealed Resident #1 was sitting in a chair in her room with oxygen running via nasal cannula. No behaviors were observed. The Administrator stated on 12/16/2021 at 10:00 am during an interview the AC should have sent in the paperwork for the PASARR re-evaluation when Resident #1 received the new schizoaffective disorder diagnosis. 2. Resident #4 was originally admitted to the facility on 2/16/2016 and readmitted to the facility on 8/21/2021 with active diagnoses that included paranoid schizophrenia and vascular dementia	F 644	PASARR evaluation/re-evaluation. Audit will be completed by 1/12/22. On 1/7/2022, Administrator completed an in-service on Level II PASARRs with the Admission Director, Social Worker, Minimum Data Set Nurse (MDS), Director of Nursing with emphasis on referral for evaluation/re-evaluation of PASARR following changes in mental health status or newly Level II qualifying diagnosis. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing will be in-serviced during orientation on PASARRs in regard to referral for re-evaluation following changes in mental health status. The IDT to include the Director of Nursing, MDS nurse, Staff Facilitator, Social Worker and Administrator, will review all newly written physician orders 5 times a week x 4 weeks utilizing the PASRR Audit Tool. This audit is to ensure any newly written PASARR qualifying diagnosis and/or change in mental status is reviewed to determine the need for re-submission of PASARR information. The Admission Director and/or Social Worker will address all concerns identified during the audit to include completing a new PASARR review. The Director of Nursing (DON) will review and initial the PASARR Audit Tool weekly for 4 weeks to ensure all areas of concern were addressed. The Director of Nursing will forward the results of the PASARR Audit Tool to the	

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F 644	Continued From page 35 with behavior disturbances. A review of Resident #4's current Preadmission Screening and Record Review (PASARR) dated 9/7/2016 revealed he was to retain the existing PASSRR Level I. A care plan initiated on 3/6/2017 and last reviewed 11/25/2021 addressed the use of psychotropic drugs related to chronic anxiety or agitation, dementia with behavior disturbance, depression, and paranoid schizophrenia. The interventions included a psychiatric consult as indicated. A review of Resident #4's record revealed he was diagnosed with paranoid schizophrenia on 3/6/2019. The most recent comprehensive Minimum Data Set (MDS) dated 4/9/2021 indicated Resident #4 did not have a PASARR level II determination, had severe cognitive impairment, no behaviors and active diagnoses including schizophrenia. An observation on 12/16/2021 at 10:40 am revealed Resident #4 was in the bed with his eyes closed. No behaviors were observed. During an interview with the Admission Coordinator (AC) on 12/14/2021 at 10:30 am, she stated she was responsible for keeping Resident #4's PASSRR updated. She then stated since she did not attend the daily meetings, she had no way to know when a resident received a new mental health diagnosis. The AC further stated she had not requested a Level II PASSAR for Resident #4 . The Administrator stated on 12/16/2021 at 10:00	F 644	Executive QAPI Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the PASARR Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 644	Continued From page 36 am the AC should have sent in the paperwork for the PASARR re-evaluation when Resident #4 received the new paranoid schizophrenia diagnosis.	F 644		
F 657 SS=E	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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and Physician's Assistant interviews,	F 657	F657 Care Plan Timing and Revision	1/12/22

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F 657	Continued From page 37 the facility failed to review and/or revise the care plan to reflect the individual care needs for 4 of 26 residents reviewed for care plans (Resident #40, #265, #95, and #4). Findings included: 1. Resident #40 was admitted to the facility on 3/01/21 with diagnoses which included cerebrovascular accident. Resident #40's quarterly Minimum Data Set (MDS) dated 10/12/21 revealed she had moderately impaired cognition and was coded as not to have a swallowing disorder or altered nutrition during the 7-day lookback period. Review of Resident #40's care plan last revised 7/29/21 revealed an activities of daily living focus which included an intervention which read in part of eating via feeding tube and to check position of tube prior to feedings. Provide feeds and flush as per MD orders. Observed for signs and symptoms of respiratory distress during/following feeding. Change tubing per facility protocol. Review of Physician's orders revealed Resident #40's tube feedings were discontinued on 3/24/21. Further review revealed Resident #40 was placed on a regular diet on 3/24/21. An interview on 12/15/21 at 9:25 AM with the MDS Coordinator confirmed the tube feeding was still on the care plan and should have been removed. She stated it was a simple mistake and just got overlooked. An interview on 12/14/21 at 3:44 PM with the Physician's Assistant (PA) confirmed that	F 657	Resident #265 no longer resides in facility. On 12/13/2021, the Minimum Data Set Nurse (MDS Nurse) updated the care plan for resident #4 to reflect accurately renal status. (removal of Dialysis) On 12/14/2021, the Minimum Data Set Nurse updated the care plan for resident #95 to reflect accurately for interventions related to smoking (smoking apron). On 1/7/2022 the Minimum Data Set Nurse Consultant updated the care plan for resident #40 to reflect accurately for residents activity of daily living (ADL) in regards to nutrition. On 1/7/2022, the Minimum Data Set Nurse Consultant completed an audit of care plans for all residents to include resident #40 for activities of daily living related to nutritional support. This audit was to ensure residents are care planned accurately for route of nutritional support. No additional concerns identified during audit. On 1/7/2022, the Facility Nurse Consultant initiated an audit of care plans for all residents with skin/wound concerns. This audit is to ensure all residents with skin/wound concerns are care planned accurately for type and location of skin/wound concerns. The Director of Nursing will address all concerns identified during the audit. Audit will be completed by 1/12/2022.	

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F 657	Continued From page 38 Resident #40 was on a regular diet and her feeding tube had been removed in May. An interview on 12/16/21 at 8:38 AM with the Administrator revealed she expected Resident #40's care plan to be accurate. 2. Resident #265 was admitted to the facility on 12/02/21 with diagnoses which included cerebrovascular accident. Resident #265's Admission Minimum Data Set (MDS) dated 12/08/21 revealed she had severe cognitive impairment. Review of Resident #265's care plan last revised on 12/06/21 revealed no focus or intervention related to skin tears. Review of Physician's orders dated 12/06/21 revealed an order which read in part to cleanse broken skin areas to bilateral upper arms with normal saline, pat dry, and apply tegaderm (a transparent dressing) every 5 days and as needed for wound healing. An interview on 12/15/21 at 9:25 AM with the MDS Coordinator confirmed that Resident #265 had skin tears to her upper arms, and it should have been added to the care plan. She stated it was a simple mistake and just got overlooked. An interview on 12/16/21 at 8:38 AM with the Administrator revealed she expected Resident #265's care plan to be accurate. 3. Resident #95 was admitted to the facility on 08/11/2017 with a diagnoses of dementia. A review of the quarterly Minimum Data Set	F 657	On 1/6/2022, the Administrator completed an audit of care plans and smoking assessments for all residents to include resident #95 identified as a smoker or desires to smoke. This audit was to ensure that residents are care planned accurately for interventions for safe smoking to include but not limited to use of smoke apron. No additional concerns identified. On 1/5/2022, the Administrator completed an audit of care plans for all residents with a diagnosis of renal disease to include resident #4. This audit was to ensure that residents are care planned accurately related to dialysis. There were no additional concerns identified. On 1/6/2022, the Director of Nursing initiated an in-service with all nurses in regard to Care Plans. Emphasis is on ensuring care plan is updated timely and accurately with all aspects of resident care to include but not limited to ADLs, skin/wound concerns, interventions for smoking and medical diagnosis/treatment. In-service will be completed by 1/12/2022. All newly hired nurses will be in-serviced during orientation in regard to Care Plans. The Director of Nursing will review care plans for 10% of residents weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure care plans updated timely and accurately with all aspects of resident care to include but not limited to ADLs, skin/wound concerns, interventions for	

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F 657	Continued From page 39 (MDS) assessment for Resident #95 dated 11/17/2021 revealed she was moderately cognitively impaired. It further revealed she was independent with transfers and locomotion. She used a walker for mobility. The current care plan for Resident #95 revealed a focus area initiated on 07/19/2018 of problematic way resident acts characterized by inappropriate smoking or use of tobacco products related to: non-compliance with smoking policy, smoking in bathroom, and hiding smoking materials. The goal last revised on 09/13/2021 was for Resident #95 to smoke safely in designated areas with supervision through next the next review. An intervention was to provide Resident #95 with a smoking apron. On 12/14/2021 at 1:58 PM an observation of Resident #95 revealed she was smoking a cigarette in the facility designated smoking area. She was being supervised by NA #4. Resident #95 was not observed to be wearing a smoking apron. An interview with NA #4 at that time indicated Resident #95 did not use a smoking apron. NA #4 stated Resident #95 was able to use the ashtray that was provided in the smoking area and did not drop ashes or lit smoking materials on herself when she was smoking. On 12/14/2021 at 2:14 PM an interview with the director of nursing (DON) indicated the decision for the use of a smoking apron by residents who smoked was based on their smoking evaluation. She stated Resident #95 last had a smoking evaluation completed on 11/18/2021. The DON went on to say the results of this smoking evaluation revealed Resident #95 did not require the use of a smoking apron while she was	F 657	smoking and medical diagnosis/treatment. The assigned nurse, Nurse Supervisor, wound care nurse and MDS nurse will address all concerns identified during the audit to include updating care plans and/or re-training of staff. The Director of Nursing will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns identified. The Director of Nursing will forward the results of the Care Plan Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 657	Continued From page 40	F 657		

smoking. She stated the intervention should have been removed from Resident #95's care plan.

On 12/14/2021 at 2:35 PM an interview with the MDS coordinator indicated although Resident #95 required supervision when she was smoking, she did not require the use of a smoking apron. She stated this intervention should have been removed from her care plan.

On 12/16/2021 at 11:07 AM an interview with the administrator indicated resident's care plans should be an accurate reflection of the care they required.

4. Resident #4 was originally admitted to the facility on 2/16/2016 and readmitted to the facility on 8/21/2021 with active diagnoses that included chronic kidney disease and diabetes mellitus.

The current Minimum Data Set (MDS) dated 11/2/2021 indicated he was severely cognitively impaired. The active diagnoses included renal insufficiency, renal failure, or end stage renal disease. Dialysis while a resident was not marked on the MDS.

An active plan of care dated 5/12/2019 and last reviewed on 11/2/2021 included a plan that addressed cardiac or respiratory disease process related to chronic kidney failure, hypertension, atrial fibrillation, and end stage renal disease on dialysis.

A review of Resident #4's record revealed no physician order for dialysis and no progress notes pertaining to post dialysis assessments.

During an interview with the MDS Coordinator on 12/13/2021 at 3:30 pm she stated she was

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F 657	Continued From page 41 familiar with Resident #4 and he was never on dialysis. She then confirmed the plan of care had Resident #4 as a dialysis resident. She further stated it was an error, but she should have caught it and removed it when the plan of care was reviewed. The Director of Nursing stated on 12/14/2021 at 10:30 am Resident #4's plan of care should have been accurate to reflect the resident's medical status and needs. On 12/16/2021 at 10:00 am the Administrator stated during an interview Resident #4's plan of care should have been reviewed with each MDS assessment. She then stated since Resident #4 was not a dialysis resident, it should not have been on the plan of care.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to transcribe a physician ' s verbal order to administer supplemental oxygen at 4 liters per minute continuously for 1 of 1 resident (Resident #107) reviewed for oxygen therapy. Findings included: Resident #107 was admitted to the facility on 9/29/2021 with diagnoses that included	F 658	F658 Services Provided Meet Professional Standards Resident #107 no longer resides in the facility On 1/5/22, the Director of Nursing initiated an audit of verbal physician orders for oxygen for the past 30 days for current residents. This audit is to ensure all	1/12/22

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F 658	Continued From page 42 hypertension and diabetes mellitus. A review of the nursing note dated 12/12/2021 at 4:13 am written by Nurse #5 revealed Resident #107 was coughing frequently with a wet sounding cough, and crackles (sharp snapping noise) was heard through the stethoscope. His oxygen level ranged between 70 and 80 percent (normal ranges 94 - 100 percent) on 2L of oxygen. The note indicated the Physician was called at 3:35 am to report Resident #107 ' s low oxygen level and Nurse #5 received physician orders to increase the oxygen to 4 L and to obtain a chest x-ray. A review of a nursing note dated 12/12/2021 at 8:56 am written by Nurse #3 indicated Resident #107 ' s oxygen saturation level was 90 percent at 4 L per minute. An observation on 12/12/2021 at 3:10 pm revealed Resident #107 was resting in bed with his eyes closed. An oxygen concentrator was in his room and he was receiving oxygen via nasal cannula at 4.5 L per minute. Further review of the record revealed no orders for oxygen via nasal cannula at 4 L per minute. An interview with Nurse #5 on 12/12/2021 at 3:15 pm revealed the physician had given a verbal order for 4 L of oxygen on the 11-7 shift. Nurse #5 confirmed there was no physician order on the record for oxygen at 4 L per minute. She further stated she had received the physician order and did not transcribe the order on during her shift. She then stated there should have been an order on Resident 107 ' s record for the oxygen.	F 658	oxygen orders were transcribed timely and accurately to the MAR. The Nurse Supervisor, assigned hall nurse and or Staff Facilitator will address all concerns identified during the audit. Audit will be completed by 1/12/22. On 1/6/22, the Director of Nursing initiated an in-service with all nurses to include nurse #3 in regard to Transcribing/Following Physician Orders. Emphasis is on ensuring the nurse transcribes oxygen orders timely and accurately to the MAR. In-service will be completed by 1/12/22. All newly hired nurses will be in-serviced during orientation in regard to Transcribing/Following Physician Orders. The IDT team to include Director of Nursing, MDS nurse and Staff Facilitator will review all newly written and/or verbal physician orders five times a week x 4 weeks then monthly x 1 month utilizing Physician Orders Audit Tool. This audit is to ensure the nurse transcribes all new orders timely and accurately to the MAR. The MDS nurse, Staff Facilitator and/or assigned nurse will address all concerns identified during the audit. The DON will review and initial the Physician Orders Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Physician Orders Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QA Committee	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 43 During an interview with Nurse #3 on 12/15/2021 at 11:00 am she stated the physician had given a verbal order for Resident #107 to have oxygen at 4 L on 12/12/2021 at 3:35 am and she should have made sure an order was in the record before she left the building. During an interview with the Director of Nursing (DON) on 12/15/2021 at 2:00 pm the DON stated she was aware Resident #107 ' s oxygen saturation level decreased on 12/12/2021 and he was started on oxygen. She then stated his oxygen was increased to 4L to get his oxygen level to 90 percent. She further stated she was informed the resident had congestive heart failure. She stated she did not know an order had not been written when the oxygen was increased to 4 L per minute. The DON stated Nurse #5 should have transcribed the physician orders during her work hours. On 12/16/2021 at 10:00 am the Administrator stated Nurse #5 should have written the verbal physician order as it was told to her and followed the physician ' s order for oxygen via nasal cannula at 4 L per minutes.	F 658	will meet monthly x 2 months and review the Physician Orders Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F 661		1/12/22

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F 661	Continued From page 44 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a recapitulation of stay for 1 of 1 resident reviewed for a planned discharge from the facility to another facility (Resident #267). This practice had the potential to affect other residents. Findings included: Resident #267 was admitted to the facility on 11/02/20 and discharged to another facility on 8/19/21. A review of the discharge Minimum Data Set dated 8/19/21 revealed Resident #267 was coded as moderately impaired cognition. Review of the electronic health record and paper	F 661	F661 Discharge Summary Resident #267 no longer resides in the facility. On 1/4/22, the Administrator initiated an audit of all discharges for the past 30 days. This audit is to ensure a recapitulation of resident stay was completed to include but not limited to diagnoses, course of illness/treatment/therapy, pertinent lab/radiology, consultation results, medications and post discharge plan of care. The Director of Nursing, assigned hall nurse and Nurse Supervisor will address all concerns identified during the audit to include completion of	

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F 661	Continued From page 45 chart revealed no physician discharge summary and no recapitulation of Resident #267's stay in the facility. An interview on 12/16/21 at 10:51 AM with the Social Worker revealed she was unaware of the requirement for a recapitulation summary. She stated she looked at the electronic health record to ensure a discharge summary was completed but did not look at it to see if it was complete or had the required elements for a recapitulation summary. An interview on 12/15/21 at 7:57 AM with the Administrator revealed the Social Worker was supposed to ensure the recapitulation summary was completed and she did not know why it had not been done for Resident #267.	F 661	recapitulation when indicated. Audit will be completed by 1/12/22. On 1/7/22, the Administrator initiated an in-service with all nurses, social worker, Therapy Director, Dietary Manager and Physician in regards to Discharge Summary with emphasis on completing a recapitulation of resident stay. In-service will be completed by 1/12/22. After 1/12/22, any nurse, Social Workers, Therapy Director, Dietary Manager and Physician who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses, social worker, Therapy Director, Dietary Manager and physician will be in-serviced during orientation in regards to Discharge Summary. The IDT team to include Director of Nursing, Social Worker, Dietary Manager and MDS nurse will review 10% of all discharges weekly x4 weeks then monthly x 1 month utilizing the Discharge Summary Audit Tool. This audit is to ensure a recapitulation of stay is completed to include but not limited to diagnoses, course of illness/treatment/therapy, pertinent lab/radiology, consultation results, medications and post discharge plan of care. The Director of Nursing, Nurse Supervisor, and Social Worker will address all concerns identified during the audit. The Administrator will review and initial the Discharge Summary Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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F 661	Continued From page 46	F 661	The Administrator will forward the results of the Discharge Summary Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Discharge Summary Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff, residents, and representative interviews, and record review the facility failed to provide incontinent care for 2 of 7 residents (Resident #11, #29) who were dependent on facility staff for activities of daily living. Findings included: 1. Resident #11 was admitted to the facility on 8/26/2019 and readmitted on 4/12/2021 with multiple diagnoses that included congestive heart failure, depression, and unspecified retention of urine. The Minimum Data Set (MDS) dated 9/10/2021 indicated Resident #11 was moderately cognitively impaired with no behaviors or rejection of care. Per MDS she required one person total assistance for toilet use and toilet hygiene.	F 677	F677 ADL Care Provided for Dependent Residents On 12/12/21, the nurse provided incontinent care to resident #11 to include changing of linen and use of a single incontinent brief. On 1/5/22, the Director of Nursing assessed resident #29 for urine incontinence. Resident was dry, brief not soiled and was noted in a single incontinent brief. On 1/5/21, the Nurse Supervisor initiated an audit of all incontinent residents to include resident #11 and #29. This audit was to ensure residents were provided	1/12/22

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F 677	Continued From page 47 Resident #11's MDS revealed she was always incontinent of bowel and bladder. Her active medications included taking a diuretic (water pill) for 7 days during the look back assessment period. A care plan last reviewed on 9/23/2021 addressed activities of daily living (ADL) and personal care. The interventions included toileting with one to two person total assistance. An observation and interview on 12/12/2021 at 10:00 am with Resident #11 revealed she was resting in bed with her eyes open. She stated that her adult brief was soaked. She then stated she have not been assisted with incontinence care since 2:00 am that morning. She held up the right side of her gown and stated her gown was wet with urine. She said Nurse Aide (NA) #3 had responded to her call light this morning and stated she would be in to assist her as soon as she could. During another observation and interview on 12/12/2021 at 10:45 am revealed Resident #11 was still resting in the bed in the same position. She stated NA #3 have not been back in her room to assist her with toileting. On 12/12/2021 at 11:00 am during an interview with Nurse #2 she stated NA #3 was from an agency and have not reached Resident #11's room yet to give the morning care. She stated NA #3 was working her way down to the resident's room. She then stated she would go to assist Resident #11 with incontinent care. An observation of Resident #11's incontinent care with Nurse #3 on 12/12/2021 at 11:05 pm	F 677	incontinent care timely and residents were dressed in a single incontinent brief only. Nurse Supervisor addressed all concerns identified during audit. On 1/6/22, the Director of Nursing initiated an in-service with all nurses and nursing assistants in regards to Resident Rights. Emphasis is on providing incontinent care timely and treating resident with dignity and respect by not dressing with multiple incontinent briefs. In-service will be completed by 1/12/22. After 1/12/22, any nurse nursing assistant who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation in regards to Resident Rights. The Nurse Supervisor and/or Staff Facilitator will complete 15 resident care observations to include all shifts, resident #11 and #29 weekly x 4 weeks then monthly x 1 month utilizing the Resident Rights Audit Tool. This audit is to ensure staff provided incontinent care timely and that staff treat residents with dignity and respect by not dressing with multiple incontinent briefs. The Nurse Supervisor and/or Staff Facility will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will initial the Resident Rights Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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F 677	Continued From page 48 revealed Nurse #2 assisted with providing incontinent care and changing the bed linen. Resident #11 had on double adult briefs (one brown and one blue). Nurse #2 stated the bottom brief (brown) was soaked with urine, and the gown was wet on the right side. When she removed the folded sheet that was under the resident, she pointed out two large dried yellowish stains that was on the fitted sheet. An interview with NA #3 on 12/12/2021 at 11:45 am revealed she was assigned to Resident #11 and had not reached her room to assist with the morning care. Nurse #5 stated on 12/14/2021 at 8:30 am she worked on 11-7 shift on 12/11/2021. She then stated she remembered NA #5 made 2 toileting round during the night shift. A review of the daily assignment worksheet for nursing for 12/11/2021 (11-7 shift) revealed NA #5 was assigned to Resident #11. A review of the NA activities of daily living flowsheet for 12/11/2021 (11-7 shift) revealed there was no documentation for toileting. On 12/14/2021 at 10:30 am during an interview the Director of Nursing (DON) she stated NA #3 and NA #5 should have checked on Resident #11 more frequently for incontinence episodes and provided care as needed. On 12/16/2021 at 9:00 am during a telephone interview NA #5, she denied working with Resident #11 on 12/11/2021 during the 11-7 shift. Further attempts to reach NA #5 via telephone	F 677	The DON will forward the results of the Resident Rights Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Resident Rights Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring	

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F 677	Continued From page 49	F 677		

were unsuccessful.

During an interview with the Administrator on 12/16/2021 at 10:00 am she stated NA #3 and NA #5 should have provided incontinent care every 2 to 3 hours and as needed.

2. Resident #29 was admitted to the facility on 11/23/2016 with a diagnoses of dementia.

A review of the annual Minimum Data Set (MDS) assessment for Resident #29 dated 10/01/2021 revealed she was severely cognitively impaired. It further revealed she required the extensive assistance of one person for bed mobility and the total assistance of one person for personal hygiene and toileting. Resident #29 was always incontinent of bowel and bladder. She had no pressure ulcers or moisture associated skin damage.

A review of the current care plan for Resident #29 revealed a focus area initiated 12/01/2016 of at risk for skin breakdown related to immobility and incontinence. The goal was for Resident #29 to not develop any pressure ulcer through the next review. Interventions included incontinence care after each incontinent episode and report to nurse any red or open areas.

A review of a Facility Grievance Form for Resident #29 dated 10/25/2021 revealed Resident #29's family member reported "Day shift had double diapered" Resident #29 on 10/24/2021.

On 12/15/2021 at 8:49 AM an interview with

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F 677	Continued From page 50	F 677		

nurse aide (NA) #5 indicated she was assigned to care for Resident #29 on day shift (7AM-3PM) 10/24/2021. She stated she provided incontinence care to Resident #29 three times that day, in the morning, after breakfast, and after lunch in the afternoon. NA #5 went on to say she had not "double diapered" (placed 2 incontinence briefs on at once) Resident #29.

On 12/15/2021 at 9:18 AM a telephone interview with NA #6 indicated she was assigned to care for Resident #29 on 10/24/2021 on the 3PM-11PM shift. She stated when she first checked Resident #29 for incontinence on 10/24/2021 at 4:00 PM, she noticed Resident #29's pad was wet but her incontinence brief did not appear to be. She went on to say she opened Resident #29's incontinence brief and noticed Resident #29 had another incontinence brief on underneath which was saturated with urine. NA #6 stated Resident #29 did not have any redness or skin breakdown at that time. She further indicated when she came in to work on 10/25/2021, the Director of Nursing (DON) asked her about the incident and she reported to the DON what she knew. NA #6 went on to say she had not worked at the facility since then.

On 12/15/2021 at 12:59 PM an interview with the DON indicated she received a report from Resident #29's family member on 10/25/2021 that a facility staff member had "double diapered" Resident #29 on 10/24/2021. She stated her investigation of the incident determined NA #5 had not been responsible. She went on to say on 10/25/2021 NA #6 had been very reluctant to speak with her about the incident, so the staffing agency was asked not to send her to the facility again. The DON stated an in service was

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F 677	Continued From page 51 conducted with nursing staff on 11/05/2021 related to providing incontinence care to residents according to their needs and not "double briefing". She went on to say "double briefing" was not an acceptable practice and placed residents at risk for skin breakdown. On 12/15/2021 at 2:59 PM a telephone interview with Resident #29's family member indicated when she visited Resident #29 on 10/24/2021 she was told by NA #6 that when she first provided incontinence care to Resident #29 on the 3PM-11PM shift, she noticed someone had "double diapered" her. On 12/16/2021 at 11:10 AM an interview with the Administrator indicated the practice of "double briefing" residents was unacceptable and should never happen. She stated it placed residents at risk for skin breakdown due to an excessive amount of moisture.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure weekly skin assessments were completed to monitor non-pressure wounds	F 684	F684 Quality of Care Resident #265 no longer resides in the	1/12/22

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F 684	Continued From page 52 for 2 of 5 residents reviewed for wound care (Resident #14 and #265). Findings included: 1. Resident #14 admitted to the facility on 9/14/21 with diagnoses which included non-Alzheimer's dementia, anxiety disorder, and depression. Resident #14's admission Minimum Data Set dated 9/21/21 revealed he had severe cognitive impairment and was coded to have no skin conditions. Review of Resident #14's care plan last revised on 9/24/21 revealed a focus on potential or actual skin integrity with a focus on skin care and treatment as ordered or per facility protocol. Review of Resident #14's Physician's orders revealed an order dated 10/25/21 which read in part to cleanse the skin tear on top of the right hand with normal saline, pat dry, apply an absorbent calcium alginate gauze dressing to wounds every 3 days and as needed. This order was discontinued on 11/18/21. Further review of the medical record revealed there were no weekly skin assessments to monitor the condition of the skin tear. An interview on 12/14/21 at 1:58 PM with the Treatment Nurse revealed she was responsible for wound documentation. She stated she did not do weekly skin assessments for skin tears and had not completed a progress note for Resident #14's right hand skin tear to reflect the condition of the skin tear.	F 684	facility. On 12/14/21, the wound care nurse completed an assessment of resident #14 wound and updated the electronic record. The resident representative and physician were notified of skin concerns. On 1/3/22, the Director of Nursing initiated skin checks on all residents to include resident # 14. This audit is to identify any resident with skin/wound concerns to include skin tears and to ensure resident assessed per facility protocol. The wound care nurse and hall nurse will address all concerns identified during the audit to include assessment of the resident, initiation of treatment and notification of the physician/resident representative with documentation in the electronic record. Audit will be completed by 1/12/22. On 1/7/22, the facility consultant completed an in-service with the wound care nurse and Director of Nursing in regards to the Wound Process and Tips for Treatment Nurse. Emphasis is on identifying new skin concerns, initiating treatment per wound protocol or physician order and assessments of skin/wound concerns per facility protocol with notification of the physician/resident representative. The Director Nursing and/or Minimum Data Set Nurse (MDS) will review 10% residents with non-pressure skin conditions to include resident #14 weekly x 4 weeks then monthly x 1 month utilizing	

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F 684	Continued From page 53 An interview on 12/16/21 at 8:38 AM with the Director of Nursing revealed she expected skin assessments to be completed and she did not know why this had not been done for Resident #14. An interview on 12/14/21 at 3:16 PM with the Administrator and Corporate Nurse Consultant revealed that Resident #14's skin assessment documentation should have been completed. 2. Resident #265 was admitted to the facility on 12/02/21 with diagnoses which included cerebrovascular accident. Resident #265's Admission Minimum Data Set (MDS) dated 12/08/21 revealed she had severe cognitive impairment and she was coded to have skin tears. Review of Physician's orders dated 12/06/21 revealed an order which read in part to cleanse broken skin areas to bilateral upper arms with normal saline, pat dry, and apply tegaderm (a transparent dressing) every 5 days and as needed for wound healing. Further review of the medical record revealed there were no weekly skin assessments to monitor the condition of the skin tear. An interview on 12/14/21 at 1:58 PM with the Treatment Nurse revealed she was responsible for wound documentation. She stated she did not do weekly skin assessments for skin tears and had not completed a progress note for Resident #265's bilateral upper arm skin tears. An interview on 12/16/21 at 8:38 AM with the	F 684	the Flowsheet of Non-Ulcer Audit Tool. This audit is to ensure residents with skin/wound concerns are assessed weekly and as needed per facility protocol. The Director of Nursing, Nurse Supervisor and wound care nurse will address all concerns identified during the audit to include assessment of the resident. The Administrator will review and initial all Flowsheet of Non-Ulcer Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Flowsheet of Non-Ulcer Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Flowsheet of Non-Ulcer Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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F 684	Continued From page 54 Director of Nursing revealed she expected skin assessments to be completed and she did not know why this had not been done for Resident #265. An interview on 12/14/21 at 3:16 PM with the Administrator and Corporate Nurse Consultant revealed that Resident #265's skin assessment documentation should have been completed.	F 684		
F 732 SS=B	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	F 732		1/12/22

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	345215	A. BUILDING _____ B. WING _____	C 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 55 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post accurate daily nurse staffing information for 2 of the 5 days reviewed. Findings included: The daily nurse staffing information posted was observed on 12/12/21 at 10:30 AM. The posting revealed a resident census of 124 residents. The actual skilled nursing facility census was 115. The daily nurse staffing information posted was observed on 12/13/21 at 8:53 AM. The posting revealed a resident census of 124 residents. The actual skilled nursing facility census was 114. An interview on 12/13/21 at 9:00 AM with the Director of Nursing (DON) and the Corporate Nurse Consultant revealed the DON was not aware that the facility rest home beds were not supposed to be included in the resident census on the daily posted staffing. An interview with the Administrator on 12/16/21 at 8:38 AM revealed she expected the posted staffing to be accurate and she did not know why	F 732	F732 Posted Nurse Staffing Information On 12/13/21, The Director of Nursing immediately updated and posted the Daily Nursing Staff Sheet with complete staffing information and corrected resident census. On 1/5/22, the Accounts Receivable completed an audit of the Daily Staffing Sheets for the past 30 days. This audit was to ensure all sheets were completed accurately for resident census. The Accounts Receivable addressed all concerns identified during the audit. On 12/13/21, The Facility Consultant in-serviced the Director of Nursing on requirements for posted nursing staffing to include accurate hours worked for nursing staff and accurate resident census for skilled Medicare/Medicaid certified beds. On 12/13/21 the Administrator initiated an in-service with all nurses, scheduler, and receptionist in regards to Posting Nursing	

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F 732	Continued From page 56 the rest home beds were included in the resident census.	F 732	Staff Information with emphasis on ensuring daily nursing staffing is posted at the beginning of the shift and post accurately reflects current staff hours worked and resident census for Medicare/Medicaid certified beds. In-service will be completed by 1/12/22. After 1/12/22, any nurse, scheduler and receptionist who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses, scheduler and receptionists will be in-serviced during orientation in regards to Posting Nursing Staff Information. The Accounts receivable will review staff posting logs with staffing assignment sheets five times a week x 4 weeks then monthly x 1 month utilizing the Daily Staffing Audit Tool. This audit is to ensure nursing staffing hours are posted at the beginning of the shift and that staff posting accurately reflects current staff hours worked and resident census for Medicare/Medicaid certified beds. The Accounts Receivable will address all concerns identified during the audit to include updating postings with accurate information as indicated and re-education of staff. The Administrator will review the staff posting weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Daily Staffing Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet	

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F 732	Continued From page 57	F 732	monthly x 2 months and review the Daily Staffing Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain physician ordered psychiatry consultations for 2 of 3 residents reviewed for unnecessary medications (Residents #14 and #4). Findings included: 1. Resident #14 was admitted to the facility on 9/14/21 with diagnoses which included non-Alzheimer's dementia, anxiety disorder, and depression. Resident #14's admission Minimum Data Set dated 9/21/21 revealed he had severe cognitive impairment and was coded to have received	F 742	F742 Treatment/Services Mental/Psychosocial Concerns On 1/5/22, resident #14 evaluated by Psych Services per physician recommendation. On 1/5/22, resident #4 evaluated by Psych Services per physician recommendations. On 1/5/22, the Director of Nursing initiated an audit of all physician orders for consults for Psych Services for the past 60 days. This audit is to ensure consult referrals were completed per physician orders and/or the physician notified when	1/12/22

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F 742	Continued From page 58 antipsychotic and antidepressant medications 7 out of 7 days during the lookback period. He was also coded to have received antianxiety medication 1 out of 7 days during the lookback period. Review of Resident #14's Physician's orders revealed an order dated 10/26/21 for an in-house Psychiatry consult for agitation and behaviors. Review of Resident #14's electronic medical records revealed no Psychiatry consult. An interview on 12/13/21 at 2:20 PM with the Unit Manager revealed he was responsible for completing Physician consult referrals, but he did not know how to look in the electronic medical record to see if Resident #14 had been referred to Psychiatry. An interview on 12/14/21 at 10:30 AM with the Corporate Nurse Consultant revealed the Psychiatry consult for Resident #14 had not been completed and should have been. She stated she did not know why it had not been done but thought it had just been missed. She stated the Psychiatrist comes to the facility monthly and the resident should have been seen in November. An interview on 12/15/21 at 7:57 AM with the Administrator revealed she expected Physician orders to be followed in a timely manner and she did not know why Resident #14 had not been referred and seen by the in-house Psychiatrist. 2. Resident #4 was originally admitted to the facility on 2/16/2016 and readmitted to the facility on 8/21/2021 with active diagnoses that included paranoid schizophrenia and vascular dementia with behavior disturbances.	F 742	order cannot be completed for further instructions. The Director of Nursing, Nurse Supervisor and assigned hall nurse will address all concerns identified during the audit to include scheduling consult and/or notification of the physician when a consult could not be completed as ordered. Audit will be completed by 1/12/22. On 1/5/22, the Director of Nursing initiated an in-service with all nurses in regards to Following Physician Orders. Emphasis is on ensuring consult referrals and/or the physician is notified when orders cannot be completed for further recommendations. In-service will be completed by 1/12/22. After 1/12/22, any nurse who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses will be in-serviced during orientation in regards to Following Physician's Orders. The IDT team to include the Director of Nursing, Nurse Supervisor, Staff Facilitator and Wound Care Nurse will audit all physician orders for consults weekly x 4 weeks then monthly x 1 month utilizing the Physician's Orders Audit Tool. This audit is to ensure consult referrals completed and/or the physician notified when orders cannot be completed. The Director of Nursing, Nurse Supervisor, Staff Facilitator and Wound Care Nurse will address all concerns identified during the audit to include scheduling consult per physician or notification of the physician when order cannot be completed for	

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F 742	Continued From page 59 A review of a physician order dated 9/20/2021 revealed a referral for psychiatric consult for intrusive thoughts. The current Minimum Data Set (MDS) dated 11/25/2021 indicated Resident #4 was severely cognitively impaired. Per MDS he had verbal behavioral s symptoms directed toward others 1 to 3 days during the assessment period. The MDS revealed Resident #4 took an antidepressant 7 days during the assessment look back period. The active diagnoses included schizophrenia. A care plan initiated on 3/6/2017 and last reviewed 11/25/2021 addressed the use of psychotropic drugs related to chronic anxiety or agitation, dementia with behavior disturbance, depression, and paranoid schizophrenia. The interventions included a psychiatric consult as indicated. A review of Resident #4's record revealed no psychiatric evaluation or progress note. During an interview with the Unit Manager on 12/14/2021 at 2:00 pm he stated he was responsible for making the referrals. He then stated he was not employed at the time of the order. He further stated from his record review the referral had not been completed. On 12/14/2021 at 10:30 am during an interview the Director of Nursing (DON) stated the Unit Manager was responsible for making sure the referrals were completed. She then stated Resident #4's psychiatric referral should have been followed and arrangements made for the	F 742	further recommendations. The DON will review and initial the Physician's Orders Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Physician's Orders Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Physician's Orders Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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F 742	Continued From page 60 evaluation. During an interview with the Nurse Practitioner on 12/14/2021 at 3:58 pm she stated she preferred the Psychiatrist to follow any psychiatric medication. She then stated she would have wanted Resident #4 to see the psychiatrist within 30 to 60 days. The Administrator stated during an interview on 12/16/2021 at 10:00 am Resident #4's psychiatric referral should have been followed and arranged as ordered.	F 742		
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	F 761		1/12/22

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F 761	Continued From page 61 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 secure an unattended medication cart (100 hall) for 1 of 3 medication carts and failed to lock a treatment cart (at the nursing station between the 300 and 400 hall) for 1 of 1 treatment cart reviewed for medication storage. Findings included: 1. An observation on 12/12/2021 at 12:18 pm revealed an unattended medication cart (100 hall) at the beginning of the 100 was unlocked. Nurse #3 was assigned to the 300-hall medication cart. She was observed sitting at the nursing station on the computer with her back towards the medication cart. At 12:20 pm a Nurse Aide (NA) was observed to walk pass the medication cart twice. At 12:23 pm a resident was observed as he propelled his wheelchair past the open medication cart to enter the 100 hall. During an interview with Nurse #3 on 12/12/2021 at 12:25 pm she stated she had left the medication cart to go restock the over the counter medications and to check a resident's blood sugar level. She then stated she must had forgotten to lock the medication cart. She further stated it was important for the cart to be locked to prevent anyone from getting medications out of the cart. On 12/14/2021 at 10:30 am during an interview with the Director of Nursing she stated Nurse #3 should have locked the medication cart before	F 761	F761 Label/Store Drugs and Biologicals On 12/12/21, the assigned hall nurse immediately secured medication cart for the 100 hall On 12/13/21, the wound care nurse immediately secured treatment cart. On 1/6/22, the Admission Director and Human Resource Director completed an audit of all medication and treatment carts. This audit is to ensure all medication and treatment carts were locked when not in direct supervision of the nurse or medication aide. No additional concerns identified. On 1/5/22, the Staff Facilitator initiated an in-service with all nurses to include nurse #3 and medication aides in regards to Medications Storage with emphasis on securing medication cart/treatment cart when not directly supervised by assigned nurse or medication aide. In-service will be completed by 1/12/22. After 1/12/22, any nurse and medication aides who has not received the in-service will receive in-service upon next scheduled shift. All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation in regards to Medications Storage.	

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F 761	Continued From page 62 she walked away from the medication cart. During an interview with the Administrator on 12/16/2021 at 10:00 am she stated Nurse #3's medication cart should have been locked when it was not within her line of vision. 2. During observation on 12/13/21 at 1:40 PM the treatment cart was observed unlocked and unattended at the nursing station. At 1:43 PM a nurse aide walked by the treatment cart. A resident was in a chair at the nursing station on the opposite side of the nursing station. At 1:44 PM the Wound Care Nurse returned to the treatment cart and locked the treatment cart. During observation on 12/13/21 at 1:44 PM the Treatment Cart was observed to contain dynagel moisturizing wound hydrogel, zinc oxide ointment, triple antibiotic ointment, medihoney gel, silver alginate gel, Vaseline, skin prep, antifungal powder with miconazole nitrate 2%, wound cleanser, alcohol cleaner, Iodine, and antiseptic skin cleanser. During an interview on 12/13/21 at 1:44 PM the Wound Care Nurse stated the treatment cart should be locked when unattended and she should have locked the cart prior to leaving it unattended. During an interview on 12/13/21 at 2:22 PM the Director of Nursing stated treatment carts were to be locked when unattended.	F 761	The Minimum Data Set Nurse (MDS) and/or Nurse Supervisor will audit all medication and treatment carts 3 x a week x 2 weeks then weekly x 2 weeks then monthly x 1 month utilizing the Medication/Treatment Cart Audit Tool. This audit is to ensure all medication and treatment carts were locked when not in direct supervision of the nurse or medication aide. The MDS nurse and/or Nurse Supervisor will address all concerns identified during the audit to include locking medication and/or treatment cart when not in direct supervision of the nurse and/or medication aide and re-education of staff. The DON will review and initial the Medication/Treatment Cart Audit Tool for completion and to ensure all areas of concerns were addressed weekly X 4 weeks then monthly X 1 month. The Director of Nursing will forward the results of the Medication/Treatment Cart Audit Tool to the Executive QAPI Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Medication/Treatment Cart Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		1/12/22

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F 880	Continued From page 63	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 64 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review, the facility failed to have staff wear personal protective equipment (PPE) per Centers for Disease Control and Prevention (CDC) guidelines for counties with substantial or high transmission for 5 of 5 halls observed and failed to have staff wear PPE while in an enhanced barrier precaution room for 1 of 2 residents reviewed for transmission based precautions. (Resident #265) Findings included:	F 880	F880 Infection Prevention & Control On 12/12/21, the Wound Care Nurse, immediately verbally educated all staff currently working in regards to Guidelines for use of PPE to include use of eye protection. Eye protection was provided for all staff. On 12/13/21, the Therapy Director educated Speech Therapist in regards to following required PPE use for the type of isolation required for quarantine/isolation	

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F 880	Continued From page 65 The CDC COVID-19 community transmission rate for Beaufort County dated 12/12/21 revealed the county the facility was in was documented as high. The Centers for Disease Control and Prevention (CDC) guideline entitled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" dated 9/10/21 contained the following statements: Implement Universal Use of Personal Protective Equipment for HCP [Health Care Providers] If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: · Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. During observation on 12/12/21 at 11:49 AM Nurse Aide #1 was observed in a resident's room providing care with no eye protection. At 11:50 AM the nurse aide entered another resident's room and provided care to a resident. During an interview on 12/12/21 at 2:05 PM Nurse Aide #1 stated she was not aware of any requirement to wear eye protection during patient care encounters at the facility. During observation on 12/12/21 at 11:56 AM Housekeeper #1 was observed in a resident's room, with the resident present, cleaning the	F 880	rooms. On 1/5/22, the Nurse Supervisor completed an audit of all staff currently working to ensure staff don/doff PPE per facility guidelines. There were no additional concerns identified. On 1/5/22, the housekeeping staff proactively completed cleaning of all high touch areas. On 1/5/22, the Infection Preventionist and Nurse Supervisor initiated 100% audit of all staff to include speech therapist, nurses, housekeeping staff and nursing assistants on PPE Knowledge Demonstration on Donning/Doffing PPE to include use of eye protection requirements based on county transmission rate. This observation is to ensure all staff to include speech therapist, nurses, housekeeping staff and nursing assistants successfully demonstrate knowledge of the use of personal protective equipment (PPE) while providing care and services in a resident’s room and/or on the quarantine unit. The Nurse Supervisor and/or Infection Preventionist will immediately retrained staff for all concerns identified during the audit. The observations will be completed by 1/12/22. After 1/12/22, any staff who has not completed return demonstrations were complete demonstration on next scheduled work shift. On 1/5/22, the Facility Consultant	

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	345215	A. BUILDING _____ B. WING _____	C 12/16/2021

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F 880	Continued From page 66 room with no eye protection. She was observed to move the resident's bed, clean the bedside table, floor, and then return the bed to its previous position. During an interview on 12/12/21 02:03 PM Housekeeper #1 stated she wore whatever PPE she was told and was not aware to use eye protection with resident encounters. During an interview on 12/12/21 12:00 PM Resident #30 stated staff had not worn eye protection when providing him care for several months. During observation on 12/12/21 at 12:04 PM Nurse #1 entered Resident #30's room with no eye protection and gave medications to the resident. During an interview on 12/12/21 at 12:13 PM Nurse #1 stated staff used to be required to wear eye protection, but it had not been required for patient care for about two months. During observation on 12/12/21 at 12:27 PM Nurse Aide #2 was observed with no eye protection to provide meal trays to residents on the 200 hall. At 1:53 PM the nurse aide was observed to enter Resident #30's room to provide him activities of daily living care without eye protection. During an interview on 12/12/21 at 2:54 PM Nurse Aide #2 stated she had not been wearing eye protection during care for a while and staff had not been told to wear eye protection during care. She stated this had changed this afternoon and now staff were being told they needed eye	F 880	completed an in-service with the Director of Nursing/ Infection Preventionist in regards to (1) role of Infection Preventionist, (2) monitoring infection control, (3) monitoring county transmission rate for changes in recommendations related to PPE use and (4) educating staff on infection control policies/procedures and new guidance on Covid 19 based on CDC recommendations. On 1/5/22, the Infection Preventionist initiated an in-service with all nurses, nursing assistants, therapy staff, dietary staff, housekeeping staff, Accounts Receivable, Administrator, Accounts Payable, medical records, receptionist, screener, social worker and maintenance staff in regards to facility Guidelines for PPE Use. Emphasis is on appropriate donning/doffing PPE to include but not limited to gowns/eye protection and use of PPE when enter resident rooms and/or quarantine rooms based on CDC guidelines. In-service will be completed by 1/12/22. All newly hired staff will be in-serviced during orientation in regards to facility Guidelines for PPE Use for Covid 19. The Nurse Supervisor, Staff Facilitator, Social Worker, Accounts Receivable, and Admission Director will complete 10 Staff Observation Audit-PPE Use weekly x 4 weeks then monthly x 1 month to ensure staff don/doff PPE per facility guidelines. The Staff Facilitator will address all concerns identified during the audit to	

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F 880	Continued From page 67 protection, but she had left it in a different room. During an interview on 12/13/21 at 10:07 AM the Director of Nursing stated she oversaw infection control at the facility. She indicated from what she understood, when the county transmission rate was red, the facility staff were to wear eye protection during resident care. She further stated staff should have been wearing eye protection during patient care because the county had been in the red the past week and this week. She further stated because they had not had a positive case in the facility, she believed that was why staff did not realize they were to be wearing eye protection. She concluded she had not implemented eye protection and educated staff to wear eye protection at the facility for several months because she had not known the county transmission rate had gone into the red. 2. Resident #265 was admitted to the facility on 12/02/21. Observation of Resident #265 revealed she was in a room in the quarantine with an enhanced droplet isolation sign on her door. Review of the enhanced droplet isolation sign posted on Resident #265's door with a revised date of 1/15/21 read in part that before entering the room to follow the instructions which included universal masking, perform hand hygiene, wear eye protection, and wear gown and gloves. Review of Resident #265's electronic medical health immunization record revealed she was not vaccinated for COVID. Observation on 12/13/21 at 9:50 AM revealed a Speech Therapist (ST) carrying a cup of fluid and	F 880	include re-training of staff. The DON will review and initial the Staff Observation Audit-PPE Use weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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F 880	Continued From page 68	F 880		

a small electronic tablet enter the room wearing a face mask and eye protection, place the items on the bedside table and exit the room. The ST was observed to walk approximately 10 feet down the hall to a hand sanitizer where she sanitized her hands. She then walked back toward Resident #265's room, stopped and picked the quarantine sign off of the floor and placed it back on the stand. She then stepped around the quarantine sign and walked into Resident #265's room wearing a face mask and eye protection.

An interview on 12/13/21 at 2:31 PM with the ST revealed she was preoccupied and had not paid attention to the posted isolation signage for Resident #265. She stated she had been trained on wearing personal protective equipment (ppe) and should have put it on prior to entering the resident room.

An interview on 12/13/21 at 2:37 PM with the Rehabilitation Director revealed her staff had been trained on wearing ppe and she expected them to follow the infection control guidelines.

An interview on 12/14/21 at 3:16 PM with the Administrator revealed she expected all staff to follow infection control guidelines.