STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 1/24/22 through 1/27/22. The exit date was changed to 2/3/22 to obtain additional information. The facility was found out of compliance with the requirement CFR 483.73, Emergency Preparedness at E0004 and E0037. See Event ID #29SQ11.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004		3/3/22

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

Electronically Signed | 02/19/2022

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E 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the Emergency Preparedness (EP) Plan was reviewed and updated at least annually. Findings included: The facility's EP Plan was reviewed. The Plan did not have dates/signatures to indicate that it was reviewed and updated at least annually. The EP Plan information listed the previous Administrator, Director of Nursing and Maintenance Coordinator. Interview with the Administrator was conducted on 1/27/22 at 11:45 AM. She stated that she just started as Administrator of the facility 2 months ago. She reported that she just started reviewing the EP book but had not started the updates. She commented that she didn't know why the previous Administrators had not updated the EP book.	E 004	Bethany Woods 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 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. Bethany Woods 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, Bethany Woods Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure	

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E 004	Continued From page 2	E 004	and/or any other administrative or legal proceedings. During annual survey the facility's EP Plan was reviewed. The Plan did not have dates/signatures to indicate that it was reviewed and updated at least annually. The EP Plan information listed the previous Administrator, Director of Nursing and Maintenance Coordinator. The Emergency Preparedness Program and Plans have been reviewed and revised on 02-10-2022. Administrator, Medical Director, Director of Nursing and Maintenance Coordinator have signed revised Emergency Preparedness Program and Plans. Systemic changes implemented to ensure practice will not recur: The Emergency Preparedness Program and Plans will be reviewed and updated annually in February. Monitoring corrective actions and performance: Beginning February, the Administrator will have Emergency Preparedness Program and Plans on QAPI agenda each meeting for revision as needed.	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1),	E 037		3/3/22

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E 037	Continued From page 3 §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its	E 037		

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E 037	Continued From page 4	E 037		

emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at

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E 037	Continued From page 5	E 037		

least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented

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E 037	Continued From page 6	E 037		

and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent

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E 037	Continued From page 7 with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide and maintain documentation of annual staff training on the Emergency Preparedness (EP) Plan. Findings included: A review of the facility's EP Plan revealed no documentation of the annual staff training. Interview with the Administrator was conducted on 1/27/22 at 11:45 AM. She stated that she just started as Administrator of the facility 2 months ago and she expected the facility to provide the EP training to all staff at least annually. She indicated if training was provided, the Staff Development Coordinator (SDC) should have the documentation of the training. The SDC was interviewed on 1/27/22 at 12:30 PM. The SDC reported that the staff were not trained on the complete facility's EP Plan. She reported that the staff were given a quiz with 7 questions regarding tornado, power outage and inclement weather in Aril 2021.	E 037	E 037 Emergency Preparedness (EP) Plan Based on record review and staff interviews, the facility failed to provide and maintain documentation of annual staff training on the Emergency Preparedness (EP) Plan. All staff and residents have the potential to be affected: Emergency Preparedness (EP) Plan was reviewed by the Administrator, and revisions made to the plan on 02-10-2022. Systemic changes to ensure practice will not recur: On 01-31-2022, the Assistant Regional Vice President of Charlotte Region educated Administrator and Director of Nursing on importance of Emergency Preparedness (EP) Plan. The facility's EP and manual must be reviewed and approved by Administrator, Director of Nursing and Medical Director at least annually. Additionally, the plan must be revised, reviewed and approved	

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E 037	Continued From page 8	E 037	any time the facility identifies any changes or new threats. On 02-16-2022 Emergency Preparedness (EP) Plan education began for all staff by Administrator, Staff Development Coordinator and Maintenance Director. Staff will not be allowed to work until education on EP has been conducted. Monitoring corrective actions and performance: The Director of Nursing or Administrator will monitor employee files to ensure education is provided to all staff on the Emergency Preparedness yearly. The results of the monitoring will be taken to the Quality Assurance Performance Improvement (QAPI) Committee meeting for review, trending, and recommendations to maintain regulatory compliance. Beginning February 25, 2022, the Administrator will review revised Emergency Preparedness (EP) Plan monthly. During monthly at the Quality Assurance Performance Improvement (QAPI) Committee meetings the Administrator will address EP plan and needs for revisions for additional monitoring/updates to maintain regulatory compliance.	
F 000	INITIAL COMMENTS An unannounced recertification, complaint and	F 000		

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F 000	Continued From page 9 facility reported incident (FRI) survey was conducted from 1/24/22 to 1/27/22. The exit date was changed to 2/3/22 to obtain additional information. The FRI was substantiated resulting a citation at F609. Twenty eight of the 38 complaint allegations were substantiated resulting in citations at F550, F561, F584, F677, F684, F686 and F689. See Event # 29SQ11.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		3/3/22

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F 550	Continued From page 10 §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, resident and staff interviews and record review, the facility failed to promote a dignified dining experience by serving 9 of 9 observed meals on disposable plates and utensils on 7 of 7 halls that included Resident #36 and Resident #24. The facility also failed to provide dignity by allowing a resident to eat in a room with a strong urine odor for 1 (Resident #25) of 1 resident reviewed for dignity. The findings included: 1. During the initial kitchen tour on 1/24/22 at 12:10 PM, the kitchen staff were serving meals on disposable plates and using disposable utensils. The Dietary Manager (DM) stated the rationale for using disposable plates and utensils was because of COVID. Observations conducted on all 7 halls revealed all the residents except for the tube feeding residents were served meals on disposable plates and utensils for lunch and dinner on 1/24/22, breakfast, lunch and dinner on 1/25/22, breakfast, lunch and dinner on 1/26/22, breakfast and lunch on 1/27/22.	F 550	F550 483.10 Resident Rights / Exercise of Rights / Regular Dinnerware For identified residents affected: During annual survey of facility observations were noted of facility serving resident meals on disposable dinnerware. During these observations it was also noted a resident was given a meal in his room with a strong odor. Resident #24 continues to reside at the facility. She is being served on regular dinnerware. Resident #36 continues to reside at the facility. She is being served on regular dinnerware. Resident #25 odor in room was corrected upon notification. He is being served on regular dinnerware. He is also receiving a dignified clean, dry, and odor free environment during meals. All residents have the potential to be affected: On 01-29-2022 Department Heads were	

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F 550	Continued From page 11 Review of the facility grievance logs from October 2020 to present did not include any grievances related to dining on disposable plates and utensils. An interview was conducted with the DM on 1/26/22 at 9:20 AM. He stated he had worked at the facility less than a year. He stated he was told it was a standard practice to serve meals on disposable plates and utensils. He stated it was a corporate directive for COVID. An interview was conducted with Cook #1 on 1/26/22 at 11:30 AM. He stated he had worked at the facility for 24 years. He stated on occasion a staff member called out but there was enough staff to wash the dishes but rather serving meals on disposable plates and utensils due to COVID. Dietary Aide #1 stated she thought the reason all meals were served on disposable plates and utensils for only due to COVID. a. Resident #36 was admitted to the facility on 1/19/21. A quarterly Minimum Data Set (MDS) assessment dated 10/25/21, indicated Resident #36 was cognitively intact. On 1/26/22 at 12:16 PM, an interview occurred with Resident #36 who stated all meals had been served on Styrofoam plates with plastic utensils since he had returned to the facility on 1/19/21. He went onto say, he could understand someone with COVID-19 being served on disposable dinnerware but not everyone. Resident #36 added, he would prefer to have normal plates and utensils for his meals. b. Resident #24 was originally admitted to the facility on 7/16/21. The quarterly Minimum Data	F 550	educated by Administrator to serve residents on regular dinnerware unless disposable dinnerware was required. This education included notification of Resident Council President/members of the need to use disposable dinnerware on occasions. On 01-29-2022 Dietary Department was educated to serve residents on regular dinnerware by the facility Administrator. In the event disposable dinnerware is required the Dietary Manager must notify the facility Administrator and Resident Council President. On 01-29-2022 Dietary Department began serving residents on regular dinnerware unless disposable dinnerware was required. On 02-16-2022 an audit of the facility was completed by Dietary Manager to ensure all residents were being served on regular dinnerware unless disposable dinnerware was required. On 02-16-2022 an audit was completed by Dietary Manager to ensure all residents are served meals in a dignified/homelike environment (free of odor, clean, and dry). Systemic changes implemented to ensure practice will not recur: Beginning 02-16-2022 monitoring of residents to be served meals to promote a dignified dining experience will be conducted by Dietary Manager on 5 residents randomly daily x 5 days/week for 2 weeks, then 5 residents randomly 3 x weekly for 2 weeks, then 5 residents randomly weekly for 2 months. The Dietary Manager will ensure substantial compliance of residents to be served	

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F 550	Continued From page 12 Set (MDS) assessment dated 10/14/21 indicated that Resident #24 had moderate cognitive impairment and she was independent with eating. Resident #24 was observed on 1/24/22 at 12:30 PM and on 1/25/22 at 12:32 PM during a lunch meal observation. Her food was served on a styro foam plate with plastic utensils. When interviewed, she stated that she would prefer to use regular plate and regular utensils. She also indicated that she was told by the staff that disposable plates and plastic utensils were used due to the pandemic. She also reported that she had been served disposable plate and plastic utensils since she was admitted to the facility. An interview was conducted on 1/27/22 at 1:34 PM with the Administrator. She stated she had only been at the facility a few months and she was not aware that the residents were eating off of disposable plates and using disposable utensils. The Administrator stated there was no reason for the residents to being eating from disposable items due to the COVID pandemic at this point unless they were COVID positive. 2. Resident #25 was admitted to the facility on 7/28/21 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 10/20/21 indicated that Resident #25 had moderate cognitive impairment and was occasionally incontinent of bowel and bladder. The resident needed extensive assistance with toilet use. Resident #25 was observed on 1/24/22 at 12:10 PM. He was up in wheelchair on the hallway. His room was noted to have a strong urine odor. His	F 550	meals to promote a dignified dining experience, any concerns will be immediately reported to the facility administrator or Director of Nursing for immediate corrective action. Monitoring corrective actions and performance: Beginning February 25, 2022, the Dietary Manager will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 550	Continued From page 13	F 550		

bed sheet and draw sheet were noted to be wet with urine.

On 1/24/22 at 12:15 PM, NA #4 was observed to bring Resident #25 to his room and to serve his lunch tray in front of him. At 12:17 PM, Resident #25 was observed to transfer self from his wheelchair into the side of his bed and started eating his lunch. The resident sat on the call light that was on his bed and the call light had turned on.

On 1/24/22 at 12:17 PM, NA #5 was observed to answer the call light on Resident #25's room. She noticed that Resident #25 was sitting on his call light and asked him to stand up and she removed the call light from the bed. When interviewed after she left the room, NA #5 stated that she noticed the wet bed sheet and draw sheet from the resident's bed and the urine odor in the room. She indicated that she thought she would remove the wet sheets and would change the bed after the resident had finished eating his lunch. When asked if it was okay to let resident eat in a room with urine odor, she responded that she would go ahead and remove the wet sheets from his bed.

On 1/24/22 a 12:30 PM, NA #4 was interviewed. She verified that she served the lunch tray to Resident #25. She stated that she did not notice the urine odor and the wet bed sheet and draw sheet in resident's bed.

On 1/27/22 at 1:35 PM, The Director of Nursing (DON) was interviewed. She stated that residents should not be eating in a room with urine odor. She expected the NA to remove the wet sheets from the room before the tray was served to the

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F 550	Continued From page 14 resident.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interviews, the facility failed to accommodate resident's request to be assisted out of bed (Resident #24), failed to honor	F 561	F561 483.10 Self Determination For identified residents affected:	3/3/22

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F 561	Continued From page 15	F 561		

resident's choice to smoke (Resident #81) and failed to provide showers/shampoo as preferred and scheduled (Residents #100 & #6). This was evident for 4 of 5 sampled residents reviewed for choices.

Findings included:

1. Resident #24 was originally admitted to the facility on 7/16/21 with multiple diagnosis including right above the knee amputation (AKA). On 10/7/21, the resident was readmitted to the facility with diagnosis of left below the knee amputation (BKA). The quarterly Minimum Data Set (MDS) assessment dated 10/14/21 indicated that Resident #24 had moderate cognitive impairment.

Resident #24's care plan dated 10/14/21 was reviewed. The approaches included transfers with one- person mechanical device/total dependence.

On 1/27/22 at 9:55 AM, Resident #24 (residing on 200 hall) was observed in bed. She stated that she had been waiting for NA (Nurse Aide) #1 to get her out of bed. She told the NA right after breakfast and the NA told her that she was coming back at 9:00 AM to get her up and it is almost 1 hour, and she has not come back.

On 1/27/22 at 10:30 AM, Resident #24 was observed in bed with a frowning face. She stated that NA #1 has not come back to get her up and she had been waiting since after breakfast.

On 1/27/22 at 10:35 AM, NA #1 was observed heading to 200 hall from 100 hall. When interviewed, she stated that Resident #24 had

Resident #24 continues to reside at the facility. She was assisted out of bed 1/27/22 before 11 am. Resident #24 continues to be assisted out of bed by staff prior to 11 am as agreed by her and staff. Resident #24 remains in bed if she refuses out of bed.
Resident #81 continues to reside at the facility. It was not the resident #81's choice not to smoke. On 01-27-2022, Nurse Practitioner met with resident #81 regarding his desire to smoke. The resident stated, "Yes", when asked if he wanted to smoke. He was educated on smoking cessation, and he stated that he would try the nicotine patch again. Nicotine Patch was ordered by the Nurse Practitioner. Resident #81 was re-assessed by Nurse Practitioner on 2/1/22 on his co-morbidities, smoking cessation, disease progression, continuous oxygen use, and risk vs benefits of smoking and nicotine patch continues. Resident #81 has not requested to smoke.
Resident #6 was given a shower and haircare on 1/27/22. Resident #6 continues to get a shower and haircare assisted by facility staff on her assigned shower days as she allows. In the event resident #6 refuses her shower and/or haircare facility assist with gives bed baths and haircare as resident #6 allows.
Resident #100 was given a shower and haircare on 1/27/22. Resident #100 continues to get a shower and haircare assisted by facility staff on her assigned shower days as she allows. In the event resident #100 refuses her shower and/or

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F 561	Continued From page 16 requested to be out of bed his morning (not sure of time) and she told the resident that she would be back. She explained that she had 9 residents on the quarantine hall (100 hall) and 3 residents on 200 hall. She started working on the 100 hall and would go to 200 hall when finished. NA #1 added that it would be before 11 AM that she would be able to get Resident #24 up. On 1/27/22 at 1:40 PM, the Director of Nursing (DON) was interviewed. The DON verified that there were 2 NAs assigned to 100 and 200 halls. One of the two NAs had a split hall (100 and 200 hall). The DON stated that she expected residents to be up as requested. The DON reported that she was aware that the facility was short of staff, but the administration was trying to hire more staff. The facility also was utilizing the agency for staffing needs. 2. Resident #81 was admitted to the facility on 6/18/19 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting unspecified side. The annual Minimum Data Set (MDS) assessment dated 12/1/21 indicated that Resident #81 had moderate cognitive impairment. Resident #81 had smoking assessments completed on 1/18/21 and 2/14/21 and he was deemed to be an unsafe smoker and required direct supervision while smoking. Resident #81's nurse's note dated 2/13/21 at 12:22 PM revealed that he was observed to have 2 cigarette burn marks on his right abdomen and 1 burn mark on his right thigh. The Director of Nursing (DON), Nurse Practitioner and the family	F 561	haircare facility assist with gives bed baths and haircare as resident #100 allows. All residents have the potential to be affected: On 02/16/2022 an audit of all residents was completed by nursing to ensure all residents have a scheduled shower and haircare day twice weekly. Results of the audit revealed no changes needed for shower days, only shower times. The schedule revisions were made to accommodate requests. On 02/16/2022 an audit was completed by social services to ensure all residents that would like to smoke were being allowed/assisted with smoking. Only resident #81 needed to be added to the smoking list. The facility is taking measures to accommodate his rights. On 02/16/2022 an audit was completed by social services on all oriented residents to ensure they were assisted out of bed in a timely/acceptable time. The results of the audit identified six (6) residents who exercised self-determination when choosing times. Any resident with specific accommodation was updated on his/her care plan and/or care guide for staff knowledge/reference. Systemic changes implemented to ensure practice will not recur: On 01-28-2022, Director of Nursing was educated by Administrator on accommodating resident request to	

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F 561	Continued From page 17	F 561		

were notified. The writer of this note no longer works at the facility.

The incident report dated 2/13/21 was reviewed. The report indicated that the nurse was administering Resident #81's scheduled insulin in his abdomen when she noticed cigarette burn marks, 2 on his abdomen and 1 on his right thigh. Intervention put in place "called the Administrator and Director of Nursing - set plan of no smoking was put in place". The nurse who completed the report no longer works at the facility.

On 1/26/22 at 9:50 AM, Nurse # 3 was interviewed. Nurse #3 was the weekend Unit Manager assigned to Resident #81. She stated that she was informed that Resident #81 was noted to have 3 cigarette burn marks on 2/13/21. The Administration was notified, and the Administrator had made the decision not to allow the resident to smoke. Nurse #3 further reported that the responsible party (RP) was called and informed of the plan to stop Resident #81 from smoking and the RP had agreed. Nurse #3 reported that the resident was never asked if he was willing to stop smoking.

On 1/27/22 at 1:40 PM, the Administrator was interviewed. She stated that the incident had happened before she was the administrator of the facility. She stated that the staff could assist the resident in holding the cigarette if the resident was unable to hold the cigarette but not to stop him from smoking.

3. Resident #6 was admitted on 10/6/21 with a compression fracture to Thoracic vertebra 9 and 10.

smoke (staff may have to assist resident with smoking), assisting with resident showers on his/her scheduled shower days and personal hygiene encouraging personal hygiene & reporting/documenting resident refusals, and assisting resident out of bed at an acceptable time. This education included updating resident care plans and care guides to reflect any resident specific accommodations.
Beginning on 02-17-2022, R.N.s, L.P.N.s and C.N.A.s were educated by Director of Nursing accommodating all residents regarding requests to smoke (staff may have to assist resident with smoking), assisting with resident showers on his/her scheduled shower days and personal hygiene, and assisting resident out of bed at an acceptable time. This education included encouraging personal hygiene & reporting/documenting resident refusals. This education also included referring to resident care plans and care guides to reflect any resident specific accommodations and asking co-staff for assistance and/or information on residents. No Nursing Staff will be eligible to work until he/she has received this education.
Beginning on 02/17/2022 all R.N.s, L.P.N.s and C.N.A.s educated on BATH AND SKIN ASSESSMENT SCHEDULE by Director of Nursing.
Beginning 02/21/2022 monitoring of resident's showers through BATH AND SKIN ASSESSMENT SCHEDULE will be monitored by assigned charge nurse daily and supervised by Unit Managers. Report to be given to Director of Nursing weekly

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F 561	Continued From page 18 Review of her admission Minimum Data Set (MDS) dated 10/13/21 indicated Resident #6 was moderately cognitively impairment and she exhibited no behaviors. Resident #6 was coded for total assistance for bathing and that choosing between and bath or shower was very important to her. Review of Resident #6's activities of daily living (ADLs) care plan revised on 10/19/21 indicated she required assistance with bathing due to her fracture and weakness. Interventions included staff assisting with bathing. There was no care plan for any ADL refusals. Review of Resident #6's aide documentation regarding bathing and bath type from 10/31/21 to 1/25/22 included one refusal and no documented evidence of any showers. An interview and observation was conducted on 1/26/22 at 1:30 PM with Resident #6. She appeared clean, groomed and absent of odors. Resident #6 stated she received a shower yesterday but prior to that, she wasn't sure when the last time was that she had a shower. She stated about 2 weeks ago, the Activity Director came in on the weekend and took her and some of the other residents to the beauty shop and washed everyone's hair. Resident #6 stated it was very important to her to have regular showers and have her hair washed. She stated her scheduled shower days were Monday and Thursdays on first shift. An interview was conducted on 1/27/22 at 11:35	F 561	to monitor compliance. The Unit Managers will ensure substantial compliance of residents are receiving his/her showers as scheduled, any concerns will be immediately reported to the Administrator and Director of Nursing for immediate corrective action. To ensure residents are accommodated for his/her residents desire to smoke beginning 02/21/2022 Social Services will monitor resident's desire to smoke on: 5 residents daily x 5 days week for 2 weeks (audits by 02-26-22 & audits by 03-05-22) 5 residents 3 x weekly for 2 weeks (audits by 03-19-2022) 5 residents weekly for 2 months (audits by 05-19-2022) Social Services will ensure substantial compliance of residents are accommodated for his/her residents desire to smoke, any concerns will be immediately reported to the Administrator or Director of Nursing for immediate corrective action. Monitoring corrective actions and performance: Beginning February 25, 2022, Social Services will review smoking results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Beginning February 25, 2022, the Director of Nursing will review BATH AND SKIN	

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F 561	Continued From page 19 AM with Nursing Assistant (NA) #12. She stated there was not enough time to give her assigned residents which included Resident #6 their scheduled showers due to staffing. NA #12 stated she was not aware of any ADL refusals by Resident #6 and she was aware that it was every important to Resident #6 to have her showers and her hair washed. An interview was conducted on 1/27/22 at 1:34 with the Director of Nursing (DON). The DON stated the facility was having problems with staffing and utilizing mostly agency staff. She stated honoring Resident #6's preference to receive her scheduled showers was likely due to staffing. She stated it was important for the facility to provide Resident #6's scheduled showers and wash her hair. 4. Resident #100 was admitted to the facility 10/6/2020 with diagnoses that included age related osteoporosis. Her quarterly Minimum Data Set (MDS) dated 12/31/2021 indicated the resident had moderate cognitive impairment, understands others, and could be understood by others. During the assessment period the resident required extensive assistance with all activities of daily living and personal hygiene. The resident was coded as total dependent in bathing with one person assistance. The MDS did not indicate the resident rejected care during the assessment period. Resident #100's comprehensive care plan last updated 1/7/2022 had a focus for care. Interventions included baths and showers and	F 561	ASSESSMENT SCHEDULE results during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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F 561	Continued From page 20	F 561		

indicated resident preferred showers.

On 1/24/2022 at 12:14 PM an interview was conducted with Resident 100. She stated she had made staff aware she would like to have showers and have her hair washed more often. She stated she did not get her hair washed unless she got a shower and she had not had one in a long time. She further stated her shower days were Wednesdays and Saturdays, but she rarely got a shower. Resident #100's hair was observed to be greasy and in need of cleaning.

Bath logs for Resident #100 from 10/26/2021 through 1/11/2022 revealed the resident received 3 showers (11/3/2021, 11/20/2021, and 1/8/2022). All other days were document as bed baths. There was one refusal by resident documented on 12/14/2021.

On 1/26/2022 at 2:31 PM an interview was conducted with Nurse Assistant (NA) #3. She stated she worked with Resident #100 and had never known her to refuse a bath or shower. When asked if she had ever given the resident a shower, she stated she had not. When asked how long she had worked in the facility she stated she was contract staff and had been in the facility for 4 months. She further stated staffing was the reason residents did not get scheduled showers. If there was one NA assigned to a hall, residents who require two-person assistance could not get a shower. Residents who required one person assistance did not always get their showers either. If she is assisting a resident with a shower, and she is the only NA on the hall, there is no one to cover her area while she is assisting in the shower. She further stated all residents got a bed bath daily unless they refused.

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F 565 SS=D	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: Based on record review, and staff interviews, the	F 565	F565 483.10 Resident / Family Group	3/3/22

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F 565	Continued From page 22 facility failed to document reported grievances and resolutions for two Resident Council meetings (9/16/21 and 11/18/21). This was for 2 of 4 resident council meetings reviewed. The findings included: A review of the Resident Council minutes from 9/16/21 listed grievances as: second shift taking breaks together leaving no one on the hall to answer call lights and nurse aides (NAs) rough with care. The minutes further revealed the Administrator was present at the meeting and would address the grievances. A review of the Resident Council minutes from 11/18/21 listed grievances as: 800 hall call lights not being answered in a timely manner, residents don't know who the first or second shift aides are and lift batteries not being charged daily so residents can get in and out of bed. The minutes further revealed the Administrator was present at the meeting. A review of the facility grievance logs from September 2021 to January 2022 did not reveal any grievance forms that had been completed on behalf of the Resident Council meetings for the dates of 9/16/21 or 11/18/21. On 1/26/22 at 2:00 PM, an interview was conducted with the Activities Director (AD) who stated if a grievance was expressed during a Resident Council meeting, she would have completed the Resident Council Grievance Form and provided to the Administrator for proper investigation to occur. She recalled the 9/16/21 meeting, stated the prior Administrator was present who told her she would complete the	F 565	Response For identified residents: During annual survey, survey team noted Resident Council grievances/concerns were not addressed for 9/16/2021 and 11/18/2021. On 02/14/2022 these previous Resident Council grievances/concerns were recreated and documented by the Administrator and Activities Department using the Resident Council Grievance Follow Up Form. On 02/24/2022 these previous Resident Council grievances/concerns were re-addressed with the Resident Council members to ensure these Resident Council grievances/concerns have been resolved and documented on the Resident Council Grievance Follow Up Form. All residents have the potential to be affected: On 02/16/2022, the Administrator audited the previous 6 months (08/2021 – 01/2022) of Resident Council Meeting minutes to ensure Resident Council grievances/concerns have been documented and resolved using the Resident Council Grievance Form. Any noted Resident Council grievances/concerns were re-created, documented, and will be reviewed with Resident Council on 02/24/2022, to ensure an acceptable resolution. The only grievances/concerns were not	

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F 565	Continued From page 23 grievance form and have the concerns investigated. The AD further stated for the 11/18/21 concern she completed the Resident Council Grievance Form and handed to the Administrator for further investigation. She was unaware where the form was but recalled providing a verbal response to the Resident Council that the Administrator had taken care of their concerns. The Administrator was interviewed on 1/27/22 at 9:15 AM. She stated she was unable to locate a Resident Council Grievance Form for 9/16/21 and couldn't comment on the reason as the incident occurred with the previous Administrator. She went onto say she recalled being present at the Resident Council meeting on 11/18/21 as she had just started in the position within that week. The Administrator stated she followed up with staff regarding expectations to prevent the grievance issues from reoccurring but failed to initiate a Resident Council Grievance form as she thought the AD had done one. She added it was an oversight and expected all Resident Council grievances to be documented, logged, investigated, with resolutions documented and communicated back to the Resident Council.	F 565	addressed were for 09/16/21 and 11/18/21. On 02/24/2022, the Administrator will review with Resident Council members the two grievances that were not addressed previously (09/16/2021 and 11/18/2021). The review will include the outcomes: 1) In servicing on care rounds, 2) Charging lift batteries, 3) Introducing self to residents, 4) Hall coverage during breaks, 5) Be kind, gentle & respectful during ADL care. Systemic changes implemented to ensure practice will not recur: Beginning 02/24/2022, the Social Service Department will log grievances in the log notebook. Beginning 02/24/2022, the Social Service Department and the Activities Department will review Resident Council Grievance/Concerns voiced in Resident Council meetings with the Administrator monthly. The Administrator will review Resident grievances/concerns voiced in the Resident Council Meetings with the appropriate department head for a timely, documented, and acceptable resolution. The Administrator will have oversight to ensure grievances are addressed and followed up with Resident Council members. The results of the previous 6 months Resident Council Minutes audit were covered during the Administrator's review with Resident Council on 02/24/2022. The follow up for the 09/16/2021 and 11/18/2021 grievances initially dated 09/16/2021 and 11/18/2021 were covered by the Administrator with	

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F 565	Continued From page 24	F 565	the Resident Council on 02/24/2022. All resident grievances/concerns will be reviewed daily in Morning Meeting/IDT Meeting to immediately address for corrective action. Social Services will maintain Grievances/Concern Log. Monitoring corrective actions and performance: Beginning February 25, 2022, the Administrator will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		3/3/22

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F 584	Continued From page 25 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to maintain a clean environment as evidenced by dirty toilets and strong urine smells in 3 of 7 bathrooms observed on the 500 hall. In addition, the facility failed to provide clean bed linens for 2 of 2 residents (Residents #6 and #59). The findings included: 1) On 1/25/22 at 12:15 PM, observations of the 500 hall revealed the following: - Bathroom in room 501 had a strong urine smell and dark yellow stains on the floor around the toilet.	F 584	F584 483.10 Safe/Clean/Comfortable/Homelike Environment For identified residents affected: During annual survey of based on record review, observations, resident and staff interviews, the facility failed to maintain a clean environment as evidenced by stained toilets and strong urine smells in 3 of 7 bathrooms observed on 500 Hall. In addition, the facility failed to provide clean bed linens of 2 of 2 residents (Resident #6 and #59).	

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F 584	Continued From page 26 - Bathroom between rooms 503 and 505 had a strong urine smell. There were yellowish orange stains on the toilet seat and dark yellow stains noted on the floor around the toilet. - Bathroom between rooms 504 and 506 had a strong urine smell. There were yellowish orange stains on the toilet seat. On 1/26/22 at 11:09 AM, an interview occurred with the Housekeeping Director and stated that if she or her staff observed areas in the bathroom that needed repair or replacing such as the yellowish orange stains to the toilet lids, a work order would be sent to the Maintenance department. She was unable to state if work orders had been completed for the stains to the toilet lids on the 500 hall. Another observation was made on 1/26/22 at 3:07 PM of the 500-hall revealing the following: - Bathroom in room 501 had strong urine smell with dark yellow stains on the floor around the toilet. - Bathroom between rooms 503 and 505 had strong urine smell and dark yellow stains around the base of the toilet. The toilet lid was free of yellowish orange stains. - Bathroom between rooms 504 and 506 had a strong urine smell and dark yellow stains on the floor around the toilet. The toilet lid was free of yellowish orange stains. An interview occurred with the Maintenance Director on 1/27/22 at 8:37 AM. He stated if there was a need for an item to be replaced due to stains in the bathrooms, he would receive a work order. He verified that on 1/26/22 the housekeeping director mentioned several toilet lids needed replacing on the 500 hall which he	F 584	Resident #6 continues to reside at the facility. Her linens were changed and will be changed on bath days and as needed. Resident #59 continues to reside at the facility. Her linens were changed and will be changed on bath days and as needed. Residents on 500 Hall bathrooms as identified were cleaned and disinfected. All residents have the potential to be affected: Maintenance changed all toilet seats that were stained effective 01-28-2022. On 02-01-2022, the Housekeeping Director audited all resident rooms for stained toilets and urine odors, including the 500 Hall and instructed Housekeeper to correct identified areas. There were three toilet seats that were identified as needing to be changed and this was completed. Director of Nursing audited linens for all residents on 02/01/2022 and corrected the problem immediately if identified. Approximately three bed linens needed to be changed and this was completed. R.N., L.P.N., and C.N.A.s will be educated by Director of Nursing on reporting any stained toilets and/or strong urine smells to housekeeping by 03-03-2022. Any R.N., L.P.N., and/or C.N.A.s who has not received education will be educated prior to their next shift. Systemic changes implemented to ensure practice will not recur: Beginning on 02-14-2022 Director of Nursing and Unit Managers were	

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F 584	Continued From page 27 completed. The Maintenance Director further stated several years ago it was decided to add extra caulk around the base of the toilet to prevent urine from seeping into the floor. If a bathroom was observed to have buildup of stains around the toilet he would receive a work order and would replace the toilet seal and caulk. He denied receiving any such work orders recently. On 1/27/22 at 9:38 AM, Housekeeper #1 was observed mopping in a resident's room and bathroom on the 500 hall. She stated she was the normal housekeeping aide assigned to that area and cleaned the residents' rooms, bathrooms, and common areas daily. When cleaning in the bathrooms she wiped down the fixtures, toilet seat, scrubbed the toilet bowl and mopped the floor making sure to get around the base of the toilet. She stated it was difficult to get the strong odor of urine out of the bathrooms. The Administrator was interviewed on 1/27/22 at 1:34 PM and stated she was unaware of the condition of the bathrooms on the 500 hall, but expected the facility to be clean, sanitary, and homelike. If stains were present in the bathrooms that could not be removed by cleaning, she would expect a work order to be sent to the Maintenance Department so it could be addressed. 2. Resident #6 was admitted on 10/6/21. Review of her admission Minimum Data Set (MDS) dated 10/13/21 moderate cognitive impairment and she exhibited no behaviors. Resident #6 was coded for frequent incontinence of bladder and bowel. An interview and observation was conducted on	F 584	educated by Administrator to ensure bed linens changed on bath days and as needed. Beginning on 02-17-2022 the Director of Nursing will educate R.N.s, L.P.N.s and C.N.A.s on ensuring that all resident's bed linens are changed 2 x week and as needed. In addition, nursing staff will be educated on the new BATH AND SKIN ASSESSMENT tool for ensuring baths, linens, etc. are completed as scheduled. No nursing staff will be eligible to work until he/she has received this education. Beginning 02-21-2022 a new BATH AND SKIN ASSESSMENT monitoring tool will begin for all residents to ensure linens are changed as scheduled and as needed. Charge Nurses and Unit Managers will be responsible to audit BATH AND SKIN ASSESSMENT tools as baths are scheduled. Completed weekly BATH AND SKIN ASSESSMENT tools will be submitted to Director of Nursing weekly for review. Effective 02-17-2022, the Housekeeping Director will audit randomly bathrooms to check toilet seats, toilet basis and for urine odors daily x 2 weeks, three times a week x 3 weeks and weekly x 4 weeks. Monitoring corrective actions and performance: Beginning February 25, 2022, the Director of Nursing will review results of collected BATH AND SKIN ASSESSMENT tools (which includes linens, baths, shampoo, and nails) and report results to the Quality Assurance Performance Improvement	

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F 584	Continued From page 28 1/26/22 at 3:20 PM with Resident #6. She stated her bed linens were not changed unless they were wet with urine or stool. She stated her bed linen had not been changed since sometime last week. The bed linens were observed and there was noted to have orange colored stains on them. Resident #6 stated the stains were food stains. Observations of linen closet on 1/26/22 at 4:10 PM for the hall Resident #6 resided were well stocked with clean bed linens. An interview was conducted on 1/27/22 at 11:35 AM with Nursing Assistant (NA) #13. She stated the aides did not have time to change the bed linens more frequently due to the staffing issues. She stated there was no problem with the supplies of clean linens but the only problem was not enough time. An interview was conducted on 1/27/22 at 1:34 PM with the Administrator and Director of Nursing (DON). The DON stated she was not aware that the bed linens were not being changed and stated she expected the bed linens to be changed on shower days and as needed but staffing was an issue and they were operating with mostly agency staff. 3. Resident #59 was admitted on 11/4/21. Her admission Minimum Data Set (MDS) dated 11/11/21 indicated Resident #59 was cognitively intact and she exhibited no behaviors. Resident	F 584	(QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Beginning February 25, 2022, the Housekeeping Director will review results of audit and report results to the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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F 584	Continued From page 29 #59 was coded for frequent incontinence of bladder and bowel. An interview and observation was conducted on 1/26/22 at 3:35 PM with Resident #59. She stated her bed linens were not changed consistently. She was able to recall that her bed linens were changed sometime last weekend because the linens were soiled. She stated she thought the bed linens were only changed when they were visibly soiled. The bed linens were observed and noted to have a tan stain on her top bed linen. She stated it was a peanut butter stain. Observations of linen closet on 1/26/22 at 4:10 PM for the hall Resident #59 resided were well stocked with clean bed linens. An interview was conducted on 1/27/22 at 11:35 AM with Nursing Assistant (NA) #13. She stated the aides did not have time to change the bed linens more frequently due to the staffing issues. She stated there was no problem with the supplies of clean linens but the only problem was not enough time. An interview was conducted on 1/27/22 at 1:34 with the Administrator and Director of Nursing (DON). The DON stated she was not aware that the bed linens were not being changed and stated she expected the bed linens to be changed on shower days and as needed but staffing was an issue and they were operating with mostly agency staff.	F 584		
F 585 SS=D	Grievances	F 585		3/3/22

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F 585	Continued From page 30 CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone	F 585		

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F 585	Continued From page 31	F 585		

number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not

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F 585	Continued From page 32 confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide a written grievance response summary for 3 of 3 residents reviewed for grievances (Residents #32, #36 and #81). The findings included: 1) Resident #32 was admitted to the facility 10/23/21. The admission Minimum Data Set (MDS) assessment dated 10/29/21 indicated Resident #32 had severe cognitive impairment. Review of the facility grievance logs indicated a grievance form was initiated on 12/14/21 by a family member for Resident #32, regarding a missing TV, glasses, and dentures. The grievance form indicated the Social Worker (SW) spoke with the family member on 12/23/21 at 1:00 PM in person related to the resolution of the grievance. The form indicated a written response was not requested nor provided to the family	F 585	F585 483.10 During annual survey, the survey team noted persons submitting grievances/concerns were not receiving written resolution letter. Resident #32 continues to reside at the facility. Resident #32 family member was mailed a resolution letter regarding a grievance/concern dated 02/17/2022 by the Social Worker and Administrator on 02/18/2022. Resident #36 continues to reside at the facility. Resident #36 family member was mailed a resolution letter regarding a grievance/concern dated 01/10/2022 and a second grievance dated 01/24/2022 by the Social Worker and Administrator on 02/18/2022.	

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F 585	Continued From page 33 member, was signed by the Administrator and dated 12/29/21. On 1/25/22 at 2:55 PM, an interview occurred with the Social Worker (SW) who stated she had been employed at the facility for 4 months. She explained normally verbal responses were made to the person filing the grievance and she would document on the form the date, time, who she talked to and what was discussed. The SW stated she was not aware a written response was required for grievances, nor had she been told to provide written responses for grievance resolutions. Several attempts were made to contact family member of Resident #32 on 1/25/22 and 1/26/22. The Administrator was interviewed on 1/27/22 at 9:15 AM and stated she was unaware a written grievance response was required in addition to the verbal responses when a grievance had been resolved. The Administrator stated it was her expectation that the facility adhered to the regulatory guidelines regarding written grievance response summaries. 2) Resident #36 was admitted to the facility on 1/19/21. A quarterly MDS assessment dated 10/25/21 indicated Resident #36 was cognitively intact. Review of the facility grievance logs indicated the following grievance forms had been initiated by Resident #36: - A grievance form was initiated on 1/10/22, regarding a housekeeping employee entering his room without knocking. The grievance form	F 585	Resident #81 continues to reside in the facility. Resident #81 family member was mailed a resolution letter regarding a grievance/concern dated 08/19/2021 by the Social Worker and Administrator on 02/18/2022. Residents that have the potential to be affected. All residents have the potential to be affected. Systemic changes implemented to ensure the deficient practice does not recur: On 02/28/2022, Administrator and Department Heads will be educated by Assistant Regional Vice President on resolution letters are to be mailed, or hand delivered. Grievance/concern resolution letters were signed by complainant for hand delivered grievance/concern resolution letters. On 02/16/2022, an audit of resident grievances/concerns were reviewed for the previous 30 days (01/05/2022) by Social Services. Administrator will address all identified areas of concerns during the audit by mailing or hand delivering resolution letters. Grievance/concern resolution letters were signed by complainant for hand delivered grievance/concern resolution letters.	

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 585	Continued From page 34 indicated the Housekeeping Director spoke with Resident #36 on 1/10/22 in person related to the resolution of the grievance. The form indicated a written response was not requested nor provided, was signed by the Administrator and dated 1/10/22. - A grievance form was initiated on 1/24/22, regarding not being assisted with the breakfast meal. The grievance form indicated the Director of Nursing (DON) spoke with Resident #36 on 1/24/22 in person related to the resolution of the grievance. The form indicated a written response was not requested nor provided, signed by the Administrator, and dated 1/24/22. On 1/25/22 at 2:55 PM, an interview occurred with the SW who stated she had been employed at the facility for 4 months. She explained normally verbal responses were made to the person filing the grievance and she would document on the form the date, time, who she talked to and what was discussed. The SW stated she was not aware a written response was required for grievances, nor had she been told to provide written responses for grievance resolutions. An interview was completed with the Housekeeping Director on 1/26/22 at 11:09 AM who explained on 1/10/22 Resident #36 expressed a grievance regarding one of her employees. She reported it to the Administrator, completed a Grievance form and investigated the concern. The Housekeeping Director added after her investigation was completed, she verbally reported to Resident #36 what the resolution was and returned the form to the Administrator. On 1/26/22 at 12:16 PM, an interview occurred	F 585	Beginning 02/25/2022, Administrator and Social Service Department will ensure that each resident grievance/concern is resolved with an appropriate resolution. The Administrator will ensure the grievance/concern is completed with a mailed/hand delivered resolution letter. A copy of the resolution letter will be maintained in a file by the Social Service Department. Monitor corrective actions and performances: Beginning 02/28/2022, monitoring of Resident grievances/concerns will be conducted by Social Service Department for 6 filed grievances/concerns weekly x1 month then 3 filed grievances/concerns weekly x 2 months to ensure Resident grievances/concerns are completed in its entirety and a resolution letter has been mailed/hand delivered to the complainant. Social Service Department will ensure substantial compliance of Resident grievances/concerns are completed in its entirety and a resolution letter has been mailed/hand delivered to the complainant. Any concerns will be immediately reported to the facility administrator for immediate corrective action. Beginning 02/25/2022, the Social Service Department will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain	

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F 585	Continued From page 35	F 585	regulatory compliance.	

with Resident #36 and verified he had not received any written responses regarding his recent grievances that had been filed.

The Administrator was interviewed on 1/27/22 at 9:15 AM and stated she was unaware a written grievance response was required in addition to the verbal responses when a grievance had been resolved. The Administrator stated it was her expectation that the facility adhered to the regulatory guidelines regarding written grievance response summaries.

3. Resident #81 was admitted to the facility on 6/18/19.

Review of the grievance log was conducted. Resident #81's responsible party (RP) had filed a grievance dated 8/19/21. The grievance concern was for missing personal items.

The grievance concern was investigated, and action was taken. Missing items were searched and were accounted for. The grievance resolution including "investigation findings reported to person voicing concern" were left blank. The form was completed and signed by the previous Administrator with the date of 9/7/21.

The annual Minimum Data Set (MDS) assessment dated 12/1/21 indicated that Resident # 81 had moderate cognitive impairment.

Resident #81's RP was unable to be reached for an interview.

The Social Worker (SW) was interviewed on 1/25/22 at 2:55 PM. The SW stated that she thought she was the grievance officer. She

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F 585	Continued From page 36 reported that the department heads investigated the concerns and then turned into her to be logged in. The SW reported that did not know why the grievance resolution and the response notification for the grievance dated 8/19/21 were left blank. She indicated that normally, a verbal response was made to the person filing the complaint. The SW stated that she was not aware that a written response was required for grievances. The Administrator was interviewed on 1/27/22 at 9:15 AM. The Administrator stated that the facility did not provide written response to the grievance unless requested by the person filing the grievance. She further reported that a verbal response was provided but she was not aware that a written response was required.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		3/3/22

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F 609	Continued From page 37 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to report to the Administrator an incident of resident (Resident #54 towards Resident #41) to resident abuse immediately or as soon as practicable. Resident #54 shoved Resident #41 in the chest with no negative outcome. This was for 1 of 1 incident reviewed for resident-to-resident abuse. The findings included: a) Resident #54 was admitted to the facility on 11/2/21 with diagnoses that included unspecified dementia with behavioral disturbance. The admission Minimum Data Set (MDS) assessment dated 11/9/21 indicated Resident #54 had severe cognitive impairment and was coded for physical and verbal behavioral symptoms directed towards others. b) Resident #41 was admitted to the facility on 2/25/20 with multiple diagnoses that included dementia with Lewy Bodies and anxiety disorder. An annual MDS dated 10/27/21 indicated Resident #41 had severe cognitive impairment and was not coded with any behaviors.	F 609	F609 483.12 Reporting of Alleged Violations For those residents affected: During annual survey, survey team noted the facility failed to report to the Administrator an incident of resident (Resident #54 towards Resident #41) to resident abuse immediately or as soon as practicable. Resident #54 shoved Resident #41 in the chest with no negative outcome. This was for 1 of 1 incident reviewed for resident-to-resident abuse. Initial Allegation Report dated 12/16/21 revealed the incident occurred on 12/15/21 but the facility became aware of the incident on 12/16/21 at 1:30 PM. The allegation details read "During the 24-hour nursing note review, it was noted a resident-to-resident altercation was identified. Resident #54 is currently on one on one. Physician and Resident Representatives were notified". Both residents were on the dementia unit and had severe cognitive impairment.	

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F 609	Continued From page 38 Review of a nursing note dated 12/15/21 at 3:20 PM, read Resident #54 had gotten in front of Resident #41, and punched her in the chest without any word exchange. Resident #54 gave no explanation for his actions. Resident #41 reported pain just after the incident which later subsided. Both residents were separated and assessed with no injuries noted and vital signs stable. The responsible parties for both residents were notified as well as the physician. Both residents were assessed by the facility practitioner on 12/16/21 and the psychological service provider on 12/17/21 where Resident #54's medications were adjusted. A review of the Initial Allegation Report dated 12/16/21 revealed the incident occurred on 12/15/21 but the facility became aware of the incident on 12/16/21 at 1:30 PM. The allegation details read "During the 24-hour nursing note review, it was noted a resident-to-resident altercation was identified. Resident #54 is currently on one on one. Physician and Resident Representatives were notified". The form stated both residents were on the dementia unit and had severe cognitive impairment. Upon assessment of Resident #41 there was no bruising or redness. No concerns were identified with the 5-day Investigation Report. Review of an In-Service Training Report dated 12/16/21 indicated all facility staff received education on the importance of reporting abuse, resident to resident, staff to resident and read as follows: " Protect resident first " Put other resident on 1 on 1	F 609	Upon assessment of Resident #41 there was no bruising or redness. No concerns were identified with the 5-day Investigation Report. Root cause of delay was the lack of effective, accurate communication with Director of Nursing and/or Administrator. An In-Service Training Report dated 12/16/21 indicated all facility staff received education on the importance of reporting abuse, resident to resident, staff to resident and read as follows: " Protect resident first, put other resident on 1 on 1, report immediately to Director of Nursing (DON) and Administrator, family, and physician & State must be notified within 2 hours." Administrator is the abuse coordinator. All residents have the potential to be affected: Beginning 12/16/2022, education on reporting alleged abuse immediately was begun by Staff Development Coordinator. The importance of immediately reporting all alleged violations involving abuse, neglect, exploitation, or mistreatment was reviewed. Any staff that has not worked and received the in-service will completed upon next scheduled shift. The Director of Nursing and Administrator will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, through ongoing education at orientation and annually or as needed.	

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F 609	Continued From page 39 " Report immediately to Director of Nursing (DON) and Administrator, family, and physician. " Administrator is the abuse coordinator. " State must be notified within 2 hours. On 1/26/22 at 8:00 PM, an interview occurred with Nurse #1 who was on duty at the time of the resident-to-resident incident between Residents #54 and #41. Nurse #1 explained when she arrived for her shift at 3:00 PM on 12/15/21, both residents were walking in the hallway with no agitation. She went behind the nursing station to get ready for the evening and heard the Nurse Aide (NA) calling out that Resident #54 had punched Resident #41 in the chest. The residents were separated, and Nurse #1 assessed Resident #41 who was free from any redness or bruising. Neither resident was able to state what occurred. The physician and resident representatives were notified. Nurse #1 stated the DON was still in the building and she notified her that there had been an incident but couldn't recall if she told her any further details. She further stated with the prior administrative staff she had always just notified the DON who then let the Administrator know when there was a resident-to-resident altercation. Nurse #1 stated on 12/16/21 she was counseled by the Administrator and DON who made it clear that both should be notified immediately when any type of abuse occurred. The Administrator and DON were interviewed on 1/27/22 at 9:00 AM and stated they felt the delay in notification to them of the incident was lack of communication. The DON stated on 12/15/21 when the incident occurred, she was leaving the facility when Nurse #1 approached her and said, "we had an incident back there but it's ok now".	F 609	Systemic changes implemented to ensure the practice will not recur: Each morning, 5 x week, there is held an Interdisciplinary Team meeting to review all behaviors will be reviewed for the potential of abuse, neglect, or resident to resident. The Interdisciplinary Team meeting to review any allegations of abuse, allegations of neglect, allegations of exploitation, or allegations of mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately. Starting 02/18/22, the Staff Development Coordinator will re-educate all staff on alleged violations involving abuse, neglect, exploitation, or mistreatment, resident to resident, including injuries of unknown source and misappropriation of resident property, are reported immediately and completed by 03-03-2022. Any staff that has not worked and received the in-service will be completed upon next scheduled shift. Monitoring corrective actions and performance: Social Services will audit staff randomly on their knowledge of alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property and the importance of reporting immediately.	

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F 609	Continued From page 40 She stated Nurse #1 didn't elaborate and she didn't ask further questions. The DON stated the next day she was reviewing the 24-hour nursing report and saw where a resident punched another resident in the dementia unit and immediately reported it to the Administrator. The investigation began, Resident #54 was observed 1:1 for 24 hours, the facility practitioner assessed and examined both residents and the psychological service provider saw both residents. The Administrator explained a conversation took place with Nurse #1 regarding the incident and the importance of reporting abuse to her immediately. The Administrator added that 100% staff education began on 12/16/21 and was completed by 12/21/21 regarding reporting allegations of or witnessed abuse. On 1/27/22 at 10:31 AM, an interview took place with NA #1 who had worked at the facility for 3 months and was present during the incident between Residents #54 and #41. She recalled Resident #41 was bent over pretending to wipe the floor as she normally did and was outside of a room in the hallway. Resident #54 walked up to this room thinking it was his. She stated she was assisting another resident at the nursing station and overheard Resident #54 say something like "move" or "get out of the way". When she heard him say that she began walking down towards him as she recognized Resident #54 was becoming agitated. As she got closer to them, she saw Resident #54 shove Resident #41 with an open hand in the middle of her chest. Resident #41 didn't fall but began crying. NA #1 stated she put herself in the middle of them with her back to Resident #54 and began walking Resident #41 to the nursing station. Both residents were separated and assessed by the nurse. NA #1	F 609	This audit will be completed randomly on five staff members x 2 weeks, then five random staff members weekly x 4 weeks, then five random staff members monthly x 3 months. Beginning February 25, 2022, the Administrator will report on any reportable incidents and Social Service will report on the audit outcome during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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F 609	Continued From page 41 stated she reported the incident to the nurse immediately. On 1/27/22 at 1:34 PM, both the Administrator and DON stated it was their expectation for facility staff to report any witnessed or allegations of abuse immediately to them. The Administrator stated abuse allegations should be reported to the state survey agency within 2 hours of becoming aware of the incident and a full investigation report sent within 5 working days of the incident.	F 609		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in 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.	F 623		3/3/22

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F 623	Continued From page 42	F 623		

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

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

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F 623	Continued From page 43 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview with the responsible party (RP) and staff, the facility failed to notify the RP in writing of the reason for the discharge to the hospital for 2 of 2 sampled residents reviewed for hospitalizations (Residents #1 & #52)).	F 623	F623 Notice Requirements Before Transfer/Discharges For those Residents affected: During annual survey, survey team noted facility failed to notify the RP in writing of	

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F 623	Continued From page 44 Findings included: 1. Resident #1 was admitted to the facility on 10/15/08. Review of the nurse's note dated 9/22/21 at 9:44 AM revealed that the resident was discharged to the hospital after a fall and was readmitted back on 9/22/21. The note dated 1/2/22 at 10:06 AM revealed that the resident was discharged to the hospital and was readmitted back on 1/6/22. Nurse #5 was interviewed on 1/27/22 at 10:30 AM. The Nurse stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge. Nurse Unit Manager #1 was interviewed on 1/27/22 at 11:58 AM. The Unit Manager stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge. Resident #1's RP was unable to be reached for an interview. The Director of Nursing (DON) was interviewed on 1/27/22 at 1:40 PM. The DON stated that she didn't know the regulation to notify the RP in writing the reason for hospitalization. She reported that the nurse notified the RP by calling her/him.	F 623	the reason for the discharge to the hospital for 2 of 2 sampled residents reviewed for hospitalizations (Resident #1 and #52). Resident #1's RP was mailed a written NOTICE OF TRANSFER/DISCHARGE on 02-15-2022 by Social Services and Administrator. Resident #52's RP was mailed a written NOTICE OF TRANSFER/DISCHARGE on 02-15-2022 by Social Services and Administrator. All Residents with the potential to be affected: The Social Services will audit the last 3 months (11-01-21 through 02-18-22) of transfers/discharges for a written NOTICE OF TRANSFER/DISCHARGE given. All identified areas of concerns will be addressed by the Social Worker during the audit by providing a written notification of notice of transfer/discharge to the resident representative. Approximately 37 written notice of transfer/discharges will be mailed to the resident representative by the completion of the audit on 03-03-22. Systemic changes implemented to ensure practice will not recur: The Social Services will audit for written NOTICE OF TRANSFER/DISCHARGE given weekly effective 02/21/2022. Social Services will submit to Administrator weekly the NOTICE OF TRANSFER/DISCHARGE audit every	

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 623	Continued From page 45 2) Resident #52 was admitted to the facility on 11/2/21. The admission Minimum Data Set (MDS) assessment dated 11/9/21 indicated Resident #52 had severe cognitive impairment. Resident #52's medical record revealed she was transferred to the hospital on 1/14/22 and was readmitted back to the facility on 1/18/22. There was no documentation that a written notice of transfer was provided to the resident and/or responsible party (RP). On 1/27/22 at 11:58 AM, an interview occurred with the Unit Manager, who explained when a resident was transferred to the hospital, the nursing staff called the RP to inform them but was not aware a written notification was needed. The Director of Nursing and Administrator were interviewed on 1/27/22 at 2:00 PM and stated when a resident was transferred to the hospital the bed hold policy was sent with them, the RP was notified of the transfer and nursing notes would indicate the reason for the transfer. They both indicated they were unaware written notifications regarding the reason for the hospital transfer was required.	F 623	Monday for the previous week. The BEDHOLD AGREEMENT AND NOTICE OF TRANSFER/DISCHARGE will be submitted to local Ombudsman weekly, every Monday. Weekly audits will be monitored by Administrator to ensure compliance. The Director of Nursing will educate the nurses on completing BEDHOLD AGREEMENT AND NOTICE OF TRANSFER/DISCHARGE and documenting in nursing notes. The in service will be completed by 03-03-22. For any nurses that have not worked and not received the in service will receive the in service prior to the start of next scheduled shift by the Director of Nursing. Social Services will collect BEDHOLD AGREEMENT AND NOTICE OF TRANSFER/DISCHARGE notices given to mail out or hand deliver. The Director of Nursing will complete and update the Unplanned Discharge/Transfers Interdisciplinary Team Meeting (IDT) audit 5 x week during Interdisciplinary Team Meetings. Staff Development Coordinator will audit continue educating new nurses on BEDHOLD AGREEMENT AND NOTICE OF TRANSFER/DISCHARGE. Weekly audits will be monitored by Administrator to ensure compliance. Monitoring corrective actions and performances: Beginning February 25, 2022, the Social Services and Administrator will review results of this monitoring during the	

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F 623	Continued From page 46	F 623	Quality Assurance Performance Improvement (QAPI) Committee meetings monthly to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. The Director of Nursing will review data from the Unplanned Discharge/Transfers IDT Audit Tool in Quality Assurance Performance Improvement (QAPI) Committee meetings monthly x 3 months 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 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of nutrition (Residents #24 & #16), falls (Resident #1), pressure ulcers (Resident #6), dental status (Resident #3) and urinary catheter (Resident #88) for 6 of 26 sampled residents reviewed. Findings included: 1. Resident # 24 was originally admitted to the facility on 7/16/21 and was readmitted on 10/7/21 with multiple diagnoses including left above the knee amputation (AKA). The quarterly MDS assessment dated 10/14/21 indicated that Resident #24 had moderate cognitive impairment	F 641	F 641 483.20 Accuracy of Assessments For identified residents affected: During annual survey of the facility, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of nutrition (Residents #24 & #16), falls (Resident #1), pressure ulcers (Resident #6), dental status (Resident #3), and urinary catheter (Resident #88) for 6 of 26 sampled residents reviewed. MDS Nurse Manager completed: •Resident #24's assessment for weight loss was corrected and resubmitted on 02-02-22.	3/3/22

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F 641	Continued From page 47 and had no weight loss. Review of the Resident #24's weight revealed that she was admitted on 7/16/21 with the weight of 256 pounds (lbs.) and on 10/13/21, she weighed 185 lbs., a 71 lbs. weight loss. MDS Nurses #1 & #2 were interviewed on 1/27/22 at 12:58 PM. They both verified that Resident #24 had a significant weight loss due to amputation and the MDS dated 10/14/21 should have been coded for weight loss but it was not. The Director of Nursing and the Administrator were interviewed on 1/27/22 at 1:36 PM. The Administrator stated she would expect the MDS assessments to be coded accurately. 2. Resident # 1 was admitted to the facility on 10/15/18 with multiple diagnoses including dementia. The annual MDS assessment dated 1/11/22 indicated that Resident #1 had severe cognitive impairment and had 1 fall with no injury since admission, readmission, or prior assessment. Review of the nurse's note dated 1/2/22 at 10:06 AM revealed that the roommate alerted the staff that Resident #1 was on the floor. The resident was noted sitting on the floor and there was blood on her fingers from the skin tear on her elbow. MDS Nurses #1 & #2 were interviewed on 1/27/22 at 12:58 PM. MDS Nurse #1 reviewed the annual MDS dated 1/11/22 and the nurse's note dated 1/2/22 and verified that the MDS should have been coded for 1 fall with injury due to the skin tear.	F 641	•Resident #16's assessment for weight loss was corrected and resubmitted on 02-02-22. •Resident #1's assessment for fall was corrected and resubmitted on 02-21-22. •Resident #6's assessment for pressure ulcer was corrected and resubmitted on 02-16-22. •Resident #3's assessment for broken teeth was corrected and resubmitted on 02-16-22. •Resident #88's assessment for indwelling catheter was corrected and resubmitted on 01-26-22. All residents with the potential to be affected: All residents have the potential to be affected regarding accuracy of MDS assessments. The Director of Nursing will complete additional auditing of 100% of residents' MDS by 03-03-22 for accuracy. Upon completion of MDS assessments for accuracy the data will be corrected and resubmitted by Director of Nursing by 03-03-22. Results of these MDS audits will be reported to the Administrator by 03-03-2022. Systemic changes implemented to ensure practice will not recur: Root cause analysis determined MDS Nurses did not know the proper process of obtaining information for accuracy of assessments. On 02/17/22 and 02/25/2022 the Regional	

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F 641	Continued From page 48 The Director of Nursing and the Administrator were interviewed on 1/27/22 at 1:36 PM. The Administrator stated she would expect the MDS assessments to be coded accurately. 3) Resident #16 was admitted to the facility on 1/26/21 with diagnoses that included dementia, adult failure to thrive and anorexia. A quarterly Minimum Data Set (MDS) assessment dated 10/12/21 indicated Resident #16 had severe cognitive impairment. She was coded for weight gain of 5% or more in the last month or gain of 10% or more in the last 6 months. Resident #16's weight data revealed the following weights during the MDS assessment look back period of May 2021 to October 2021, which showed a 3.36% weight loss in a month and 12.11% weight loss in 6 months: 10/7/21- 98.3 pounds (lbs.) 9/1/21- 101.6 lbs. 5/2/21- 110.2 lbs. On 1/27/22 at 12:51 PM, an interview was conducted with MDS Nurse #1, who reviewed the MDS assessment dated 10/12/21 as well as the weight data for Resident #16. The MDS Nurse #1 indicated the assessment had been coded in error and should have reflected a weight loss and not a weight gain. During an interview with the Administrator and Director of Nursing on 1/27/22 at 1:34 PM, they both indicated it was their expectation for the MDS assessment to be coded accurately. 4. Resident #3 was admitted 11/11/20 with	F 641	MDS Consultant educated MDS Nurse Manager and MDS Nurses on accuracy of assessments. Beginning 02/25/2022, the facility altered the MDS review system for care plan timing and revisions to include the Director of Nursing auditing accuracy of assessments to ensure the problem does not recur. Monitor corrective actions and performance: Effective 03/07/22, the Director of Nursing will audit randomly: 5 residents for MDS accuracy of assessments weekly x 2 weeks for timeliness, (due 03/07/22 and 03/14/22). 5 residents for MDS accuracy of assessments every other week x 4 weeks (due 03/28/22 and 04/11/22) 5 residents for MDS accuracy of assessments monthly for 3 months for timeliness and revision (due 05-11/22, 06/11/22, & 07/11/22). Beginning February 25, 2022, the Director of Nursing will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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F 641	Continued From page 49	F 641		

cumulative diagnoses of Cerebral Vascular Accident (CVA) and Dysphagia (difficulty swallowing).
Review of his annual Minimum Data Set (MDS) dated 6/22/21 indicated moderate cognitive impairment, no behaviors, nutrition via a feeding tube and no broken natural teeth or pain.
Review of Resident #3's quarterly MDS dated 1/4/22 indicated moderate cognitive impairment, no behaviors, nutrition via a feeding tube and no broken natural teeth or pain.
An observation and interview with Resident #3 was completed on 1/24/22 at 2:19 PM. He was observed with missing and broken teeth to both upper and lower gums. He stated he was not experiencing any dental pain and stated his teeth "just fell out."
The facility was unable to find any documentation prior to 1/5/22 of a dental exam. The 1/5/22 dental exam indicated Resident #3 was missing 13 teeth.
An interview was conducted on 1/26/22 at 8:35 AM with Nursing Assistant (NA) #2. She stated she had worked several times with Resident #3 and noted his missing and broken teeth. NA #2 stated he did not complain of any oral pain during his oral care.
An interview was conducted with MDS Nurse #1 on 1/27/22 at 1:00 PM. She stated Resident #3 did have missing and broken teeth when the annual MDS was completed, and it should have been coded as such. She stated part of the MDS assessment included observation, but the error was an oversite.
An interview was conducted on 1/27/22 at 1:34 PM with the Administrator and the Director of Nursing (DON). Both stated they expected the MDS to reflect Resident #3's accurate dental status.

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F 641	Continued From page 50	F 641		

5. Resident #6 was admitted on 10/6/21 with a compression fracture to Thoracic vertebra 9 and 10, and an open unstageable pressure ulcer to her sacrum.
Review of Resident #6's hospital discharge orders dated 10/6/21 read she had an unstageable pressure ulcer to her sacrum with orders to clean her sacrum with an antibiotic and collagenase ointment to the necrotic tissue and a foam sacral border.
Review of Resident #6's admission orders dated 10/6/21 included orders for wound care to her unstageable pressure ulcer using collagenase ointment.
Review of her admission Minimum Data Set (MDS) dated 10/13/21 moderate cognitive impairment and she exhibited no behaviors. She was coded as having no pressure ulcers except a deep tissue injury on admission.
An interview was conducted with MDS Nurse #1 on 1/27/22 at 1:00 PM. She stated she thought Resident #6 only had a suspected deep tissue injury to her sacrum on admission. She stated her admission MDS dated 10/13/21 was inaccurate and she was unsure what happened.
An interview was conducted on 1/27/22 at 1:34 PM with the Administrator and the Director of Nursing (DON). Both stated they expected the MDS to reflect that Resident #6 was admitted with an open unstageable pressure ulcer.

6. Resident #88 was admitted to the facility on 6/7/2021 with diagnoses that included obstructive and reflux uropathy (urine can not drain from bladder and backs up into kidneys).

The resident's baseline care plan dated 6/17/2021 had a focus for altered pattern of

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F 641	Continued From page 51 urinary elimination with indwelling catheter(suprapubic). The resident's most recent comprehensive care plan, last updated on 12/23/2021 also indicated the resident had a suprapubic catheter. Resident #88's significant change Minimum Data Set (MDS) dated 12/16/2021 indicated the resident did not have any cognitive impairment and he was not coded for indwelling urinary catheter or suprapubic catheter. Resident #88's medical record contained a urology consult dated 7/22/2021. The urologist recommended the suprapubic catheter be changed out monthly and as needed for obstruction. On 1/24/2022 the resident was observed to have a urinary catheter drainage bag. During an interview he stated he had a suprapubic catheter when he was admitted to the facility. On 1/26/2022 at 8:52 AM an interview was conducted with nurse #2 who was assigned to Resident #88 that day. She confirmed the resident had a suprapubic catheter. An interview was conducted with MDS Nurse #1 on 1/26/2022 at 9:08 AM. She stated the change in condition MDS dated 12/16/2021 should have indicated the resident had a suprapubic catheter. She further stated it was an oversight.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		3/3/22

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F 656	Continued From page 52	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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F 656	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to develop a comprehensive care plan for Activities of Daily Living (ADL) assistance (Resident #31), for the use of a prophylactic antibiotic (Resident #64) and for a right-hand contracture (Resident #27). This was for 3 of 26 residents care plans reviewed. The findings included: 1) Resident #31 was admitted to the facility on 10/23/21 with diagnoses that included vascular dementia and chronic pain. The admission Minimum Data Set (MDS) assessment dated 10/28/21 indicated Resident #31 had severe cognitive impairment and required extensive assistance from staff for eating and bed mobility and was dependent on staff for personal hygiene, transfers, dressing, toileting, and bathing. Review of the active care plan dated 11/5/21 revealed Resident #31 was not care planned for the ADL assistance that she required. Review of the nursing progress notes from 10/23/21 to 1/26/22 indicated Resident #31 required extensive to total assistance from staff to complete ADL's. On 1/27/22 at 12:51 PM, an interview occurred with MDS Nurse #1 who reviewed Resident #31's active care plan. She confirmed an ADL assistance care plan had not been developed but should have been and stated it was an oversight.	F 656	F 656 483.21 Development / Implementation Comprehensive Care Plan For identified residents affected: Based on record reviews, observations, and staff interviews, the facility failed to develop a comprehensive care plan for Activities of Daily Living (ADL) assistance (Resident #31), for the use of a prophylactic antibiotic (Resident #64) and for a right-hand contracture (Resident #27). Resident #31's care plan was created on 01/07/22 to include ADL assistance by the MDS Nurse Manger. Resident #64's antibiotic was discontinued 01-28-22 and a care plan was created for "urinary incontinence problem" on 02/17/22 by MDS Nurse Manger. Resident #27's care plan regarding right hand contracture was created on 01/27/22 by the MDS Nurse Manager. All residents with the potential to be affected: All residents have the potential to be affected with the development/implementation of care plans. The Director of Nursing will audit 100% resident care plans for ADL assistance, antibiotic use, and contractures. This audit is to ensure that all residents requiring ADL assistance, antibiotic use, and	

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F 656	Continued From page 54 The Administrator and Director of Nursing were interviewed on 1/27/22 at 1:34 PM and stated it was their expectation for the care plan to be person centered and should have included assistance required with ADL's. 2) Resident #64 was admitted to the facility on 11/10/21 with diagnoses that included dementia, osteoarthritis, and diabetes type 2. A review of Resident #64's medical record revealed an order dated 11/10/21 for Macrodantin (an antibiotic) 100 milligrams (mg) 1 tab every night. Review of the active care plan, dated 11/16/21, revealed Resident #64 was not care planned for the use of an indefinite antibiotic. The admission Minimum Data Set (MDS) assessment dated 11/17/21 indicated Resident #64 had severe cognitive impairment, was frequently incontinent of bladder and occasionally incontinent of bowel. No infections were coded but she did receive 7 days of an antibiotic during the 7 day look back period. Review of the Medication Administration Records (MARs) from 11/10/21 until 1/24/22, showed Resident #64 received Macrodantin 100mg every night as ordered. On 1/27/22 at 12:51 PM, an interview occurred with MDS Nurse #1 who reviewed Resident #64's active care plan, verified a care plan was not present for the indefinite or prophylactic use of an antibiotic and felt it was an oversight.	F 656	contractures have a care plan in place. This audit will be completed by 03/03/22. Upon completion of MDS's development and implementation of comprehensive care plans, the data will be corrected and submitted by Director of Nursing to Administrator for review by 03/03/22. Systemic changes implemented to ensure practice will not occur: Root cause analysis determined MDS Nurses did not know the proper process of development / implementation of comprehensive care plans. On 02/17/22 and 02/25/2022 the Regional MDS Consultant educated MDS Nurse Manager and MDS Nurses on proper process of development / implementation of comprehensive care plans. Beginning 02/25/2022, the facility altered the MDS review system for proper process of development / implementation of comprehensive care plans to include the Director of Nursing auditing proper process of development / implementation of comprehensive care plans to ensure the problem does not recur. Monitor corrective actions and performance: Effective 03/07/22, the Director of Nursing will audit randomly: 5 residents' development and implementation of comprehensive care plans weekly x 2 weeks for timeliness, (due 03/07/22 and 03/14/22) 5 residents' development and	

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 656	Continued From page 55 The Administrator and Director of Nursing were interviewed on 1/27/22 at 1:34 PM and stated it was their expectation for the care plan to be person centered and should have included the use of the indefinite antibiotic. 3. Resident #27 was admitted on 7/11/11 and readmitted on 1/19/21 with cumulative diagnoses of a Cerebral Vascular Accident, hemiplegia and a right-hand contracture. His quarterly Minimum Data Set (MDS) dated 10/21/21 indicated severe cognitive impairment, no behaviors and supervision eating. All of his other activities of daily living required extensive to total staff assistance. He was not coded for any impairment to his upper extremities. Review of Resident #27's comprehensive care plan last revised on 10/14/21 did not include a care plan addressing his right hand contracture and limited range of motion. An observation was conducted on 1/25/22 at 12:15 PM of Resident #27. He was lying in bed with an obvious right-hand contracture. He was holding his right hand with his left raising his right arm up and manipulating his fingers on his right hand. An interview was conducted on 1/26/22 at 3:00 PM with Nursing Assistant (NA) #12. She stated Resident #27 had his right-hand contracture on admission and he performed his own range of motion with his left hand throughout the day. An interview was conducted with MDS Nurse #1 on 1/27/22 at 1:00 PM. She stated she had been doing MDS assessments and care plans for 3	F 656	implementation of comprehensive care plans every other week x 4 weeks (due 03/28/22 and 04/11/22) 5 residents' development and implementation of comprehensive care plans monthly for 3 months for timeliness and revision (due 05/11/22, 06/11/22, & 07/11/22). Beginning February 25, 2022, the Director of Nursing will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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F 656	Continued From page 56 MDS Nurse #1 stated she should have care planned Resident #27 for his right-hand contracture, but it was an oversight likely due staffing problems and staff being out sick with COVID. An interview was conducted on 1/27/22 at 1:34 PM with the Administrator and the Director of Nursing (DON). Both stated MDS Nurse #1 should have included Resident #27's right-hand contracture in Resident #27's comprehensive care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (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.	F 657		3/3/22

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F 657	Continued From page 57 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to revise the care plan in the areas of tube feeding (Resident #90) and falls (Resident #16) for 2 of 26 sampled residents reviewed. Findings included: 1. Resident #90 was admitted to the facility on 3/18/20 with multiple diagnoses including severe protein calorie malnutrition. The annual Minimum Data Set (MDS) assessment dated 12/10/21 indicated that Resident #90 had severe cognitive impairment and was on mechanically altered diet. Resident #90's care plan that was initiated on 8/5/20 revealed that the resident was receiving tube feeding. On 10/28/21, the attending physician had ordered to discontinue the tube feeding due to resident's refusal. Resident #90's care plan (revision date of 12/21/21) was reviewed. The care plan was not revised to address the discontinuation of the tube feeding. The care plan problem was "16 French Gastrostomy (G) tube to assist resident in maintaining or improving nutritional status". The care plan goal was "will be free from complications of G tube feeding".	F 657	F 657 483.21 Care Plan Timing and Revision For identified residents affected: During annual survey of the facility, the facility failed to revise the care plan in the areas of tube feeding (Resident #90) and falls (Resident #16) for 2 of 26 sampled residents reviewed. •Resident #90's care plan regarding gastrostomy tube was updated on 01/27/22 by MDS Nurse Manager. •Resident #16's plan of care was updated for falls on 2/16/22 and wedge cushion on 2/17/22 by the MDS Nurse Manager. All residents with the potential to be affected: All residents have the potential to be affected by the care plan timing and revisions. The Director of Nursing will audit 100% resident care plans for timeliness and revisions to include gastrostomy tubes, falls, and positioning cushions. The Director of Nursing with the MDS Nurse Manager will addresses all identified areas of concern to include revision of care plans or implementation of care plans. The audit will be completed by 03/03/22. The data will be corrected and	

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F 657	Continued From page 58 The care plan approaches included "tube feeding formula and water flushes as ordered by the physician, observe for signs/symptoms of tube feeding complications, observe respiratory rate following feeding, observe for dyspnea, respiratory distress during and following feeding and check for residual prior to feeding as ordered by the physician". MDS Nurses #1 & #2 were interviewed on 1/27/22 at 12:58 PM. They both verified that Resident #90's tube feeding was discontinued on 10/28/21. They stated that Resident #90's care plan was reviewed on 12/21/21 and the care plan problem, goals and approaches should have been revised to reflect the discontinuation of the tube feeding. The Director of Nursing and the Administrator were interviewed on 1/27/22 at 1:36 PM. The Administrator stated that facility had 3 MDS Nurses and she would expect the care plan to be reviewed and revised when there were changes and when a new MDS was completed. 2) Resident #16 was admitted to the facility on 1/26/21 with diagnoses that included dementia, fracture to the right leg and chronic pain. A quarterly Minimum Data Set (MDS) assessment dated 10/12/21 indicated Resident #16 had severe cognitive impairment, had 1 fall with no injury and 1 fall with major injury since the last MDS assessment was completed. Review of Resident #16's medical record revealed a Rehabilitation Screen dated 10/15/21 indicating the resident was screened following a	F 657	submitted by Director of Nursing to Administrator for review by 03/03/22. Systemic changes implemented to ensure practice will not recur: Root cause analysis determined MDS Nurses did not know the proper process of care plan timing and revision. On 02/17/22 and 02/25/2022 the Regional MDS Consultant educated MDS Nurse Manager and MDS Nurses on proper process of care plan timing and revision. Beginning 02/25/2022, the facility altered the MDS review system for care plan timing and revisions to include the Director of Nursing auditing care plan timing and revisions to ensure the problem does not recur. Monitor corrective actions and performance: Effective 03/07/22, the Director of Nursing will audit: 5 resident care plan timing and revisions weekly x 2 weeks for timeliness & revisions, (due 03/07/22 and 03/14/22). 5 resident care plans for timeliness & revisions, every other week x 4 weeks (due 03/28/22 and 04/11/ 22). 5 resident care plans for timeliness & revisions, monthly for 3 months for timeliness and revision (due 05/ 11/22, 06/11/22, & 07/11/22). Beginning February 25, 2022, the Director of Nursing will review results of this	

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F 657	Continued From page 59	F 657		

recent fall. The comments noted the therapist provided a positioning wedge for the left side of the bed to decrease rolling out and to decrease fall risk. Nursing was notified about the findings and recommendations.

An Investigational Summary form dated 10/18/21 indicated the Unit Manager fully investigated a fall that occurred 10/14/21 and noted the resident had tendency to move self to the edge of the bed. The form indicated the care plan was to be updated to ensure positioning device was in place.

Resident #16's active care plan revealed a focus area for risk for falls characterized by actual falls with injury, multiple risk factors related to: impaired mobility, tibia fracture. This was initiated on 10/4/21 and the latest revision date of 10/26/21. The interventions included the following :

" Bed in lowest position.
" Other: knee immobilizer and ortho consult as ordered.
" Position of bed with use of pillow/wedge with proper turning.
" Provide frequent staff observation of resident.

On 1/24/22 at 1:00 PM, an observation was made of Resident #16 in her bed. The positioning wedge was noted to the right side of the bed leaving the left side unprotected.

An interview occurred with the Unit Manager on 1/26/22 at 2:40 PM, who indicated she completed the falls investigation and updated resident care plans with new interventions. She verified after the therapy department completed a screen they would provide her with the Rehabilitation Screen

monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.

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F 657	Continued From page 60 form regarding any interventions they may have put into place as well. The Unit Manager reviewed Resident #16's care plan, confirmed the intervention to place a positioning wedge to the left side of the bed was not present and stated it was an oversight not to have updated the care plan when she completed the falls investigation on 10/18/21. The Director of Nursing was interviewed on 1/27/22 at 1:34 PM and stated it was her expectation for the interventions to be updated and accurate following the completion of a fall's investigation.	F 657		
F 658 SS=E	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 record review and staff interview, the facility failed to follow physician's order by not holding the Lantus and Lispro insulin (used to treat diabetes mellitus) for blood sugar of 150 or less for 1 of 8 sampled residents reviewed for medications (Resident #81). Findings included: Resident #81 was admitted to the facility on 6/18/19 with multiple diagnoses including diabetes mellitus (DM). The annual Minimum Data Set (MDS) assessment dated 12/1/21 indicated that Resident # 81 had moderate	F 658	F658 483.21 Services Provided Meet Professional Standards For identified residents affected: During annual survey of facility, observations were noted of facility failing to follow physician's orders by not holding insulin for blood sugar of 150 or less. Resident #81 continues to reside at the facility. Physician's orders stated to hold insulin if blood sugar less than 150 or less. There was no negative outcome to not administering insulin as ordered.	3/3/22

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F 658	Continued From page 61 cognitive impairment and he had received an insulin for 7 days during the assessment period. Resident #81 had physician's orders dated 5/23/20 for Lispo insulin 12 units subcutaneous (SQ) before meals for DM (8 AM, 12 PM & 5 PM) - hold for blood sugar less than 150 and on 7/7/21 for Lantus insulin 40 units SQ twice a day (9 AM & 9 PM) - hold for blood sugar equal or less than 150. The monthly drug regimen review (DRR) revealed that the Pharmacy Consultant had addressed drug irregularity to the Director of Nursing (DON) on 5/11/21 and 9/6/21. The consult sent to the DON was that Resident #81 had an order to hold all insulins for blood sugar equal or less than 150. Review of the Medication Administration Records (MARs) revealed that insulins were administered with the blood sugar of less than 150 on several occasions in April 2021 (4/1/21, 4/5/21 & 4/6/21 and in August 2021 (8/4/21, 8/11/21, 8/13/21, 8/14/21, 8/16/21, 8/23/21 & 8/27/21). The facility responded to the consult "had made order in bold on the MAR". Review of the nurse's notes and MARs from 11/2021 through 1/2022 revealed Resident #81 did not have any episodes of hypoglycemia documented. Review of the MARs for November 2021, December 2021 and January 2022 revealed that Lispro and Lantus insulins were administered for blood sugars (BS) less than 150 on the following dates: 11/7/21(BS 77) & 11/15/21 (BS 112) - 7:30 AM - Lispro was given	F 658	All residents have the potential to be affected: All residents receiving insulin have the potential to be affected. On 01/28/22 R.N.s, L.P.N.s and Unit Managers were educated by Director of Nursing on the importance of following M.D. orders and the need for reading orders clearly before administration, following physician orders and to notify physician if order was not administered as ordered or needing clarification of an order. Education will be provided by 03/03/2022. Any R.N. or L.P.N. that did not receive education and has not worked will be educated by Director of Nursing and/or Staff Development Coordinator before next scheduled shift. All new nurses hired will be educated on medication administration accuracy during orientation. On 02/04/2022, the Director of Nursing and/or Unit Manager completed an audit of all residents receiving insulin to monitor for compliance. The audit revealed there were no other insulin administration errors. The audit was completed on 02-04-22. Systemic changes implemented to ensure practice will not recur: Beginning 02/21/2022, monitoring of residents receiving insulin will be conducted by the Director of Nursing and/or Unit Manager on 5 residents randomly weekly for 2 weeks, then 5	

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F 658	Continued From page 62 11/16/21 (BS 128), 12/10/21 (BS 148),12/19/21 (BS 118), 1/3/22 (BS 111), 1/14/22 (BS 133), 1/6/22 (BS 141), 1/21/22 (BS 121) - 4:30 PM - Lispro was given 12/8/21 (BS 120), 1/6/22 (BS 113), & 1/21/22 (BS 98) - 11:30 AM - Lispro was given 12/11/21(121), 1/20/22 (BS 122), 1/21/22 (BS 86) & 1/22/22 (BS 92) - 7:30 AM - Lispro and Lantus were given 12/12/21 (BS 134), 12/13/21 (BS 130), 12/15/21 (BS 130), 12/30/21 (BS 120) - 8:00 PM - Lantus was given 12/19/21(BS 140), 1/2/22 (BS 77), 1/3/22 (BS 117) - 7:30 AM - Lispro was given 1/15/22 (149) & 1/20/22 (BS 149) - 8:00 PM - Lantus was given Nurse #5, assigned to Resident #81 on 1/3/22,1/20/22, 1/21/22 and 1/22/22, was interviewed on 1/27/22 at 11:05 AM. She stated that she started working at the facility in December 2021 as an agency nurse. She verified her initials on the MARs and stated that she was aware of the order to hold the insulins for Resident #81 for BS less than 150. She reviewed the MARs and indicated that she missed holding the insulins on the days she was assigned to the resident. The Director of Nursing (DON) was interviewed on 1/27/22 at 1:40 PM. The DON stated she started working at the facility as DON in December 2021. She stated that nobody had been monitoring the MARs to ensure that orders were followed. She indicated that she expected the nurses to follow physician's orders.	F 658	residents randomly 3 x week for 2 weeks, then 5 residents randomly weekly for 2 months. This audit is to ensure that physician orders are followed. The Director of Nursing will ensure substantial compliance with Provider's orders and any concerns will be immediately reported to provider and the Administrator for immediate corrective actions. Monitoring corrective actions and performance: The Director of Nursing of will ensure substantial compliance of insulin administration all residents receiving insulin, any concerns will be immediately reported to the Provider and facility Administrator for immediate corrective action. Beginning 02/21/2022, monitoring of residents receiving insulin will be conducted by the Director of Nursing and/or Unit Manager on 5 residents randomly weekly for 2 weeks, then 5 residents randomly 3 x week for 2 weeks, then 5 residents randomly weekly for 2 months. This audit is to ensure that physician orders are followed. On February 25, 2022, the Director of Nursing will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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F 677	Continued From page 63	F 677		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, family and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #36, and #52), failed to ensure resident's hair and nails were clean (Resident #91) and failed to provide showers as scheduled (Residents #31& #32). This was for 5 of 5 residents reviewed for dependency on staff for Activities of Daily Living (ADLs). The findings included: 1) Resident #36 was admitted to the facility on 1/19/21 with diagnoses that included a spinal cord injury and diabetes type 2. A quarterly Minimum Data Set (MDS) assessment dated 10/25/21 indicated Resident #36 was cognitively intact and was dependent on staff for personal hygiene. A review of Resident #36's active care plan, last reviewed on 11/9/21, revealed a focus area for ADL/personal care dependent on staff due to quadriplegia. The interventions included personal hygiene/grooming: provide total care for wash and dry face, skin, nails, hands, and perineum. A review of the nursing progress notes from 5/1/21 to 1/25/22 revealed no refusals of nail care	F 677	F677 483.24 ADL Care Provided for Dependent Residents For identified residents affected: During annual survey of facility, observations were noted of Facility failed to provide nail care (Residents #36 and #52) and nail and hair care (Resident #91) and showers as scheduled (Residents #31 and #32). Resident #36 continues to reside at the facility. Nail care was provided on 1/26/2022. Resident #52 does not reside at the facility anymore. Resident #91 continues to reside at the facility. He was given a full bed bath, but no shampoo, on 1/29/2022 addressing personal hygiene with no shampoo provided per his preference as care planned. Resident #31 continues to reside at the facility. Personal hygiene is being provided as resident allows; received a partial bath on 01/28/2022. Resident is resistant to baths and toileting. Care Plan is updated to reflect resident's behaviors. Resident #32 continues to reside at the facility. Personal hygiene is being	3/3/22

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F 677	Continued From page 64 documented. An observation was made of Resident #36 on 1/24/22 at 1:05 PM while he was lying in bed. He was noted to have long, clean, jagged fingernails to the left hand and long, clean nails to the right hand. Resident #36 stated his nails had not been cut in a while and he tried to bite the nails on the left hand which had resulted in jagged nails and could not get anyone to cut them. On 1/25/22 at 4:00 PM, Resident #36 was observed lying in his bed. His fingernails remained long and jagged. An interview occurred with Nurse Aide (NA) #10 on 1/26/22 at 11:18 AM. She stated she worked with an agency and had been assisting the facility since October 2021. NA #10 was familiar with Resident #36 and normally cared for him. She stated nail care would be completed if needed during personal care and was unaware he had long and jagged fingernails but would take care of them. Resident #36 was observed lying in his bed on 1/26/22 at 12:16 PM waiting for the lunch meal. His fingernails remained long and jagged and he stated that no one had come in to offer to cut them for him. The Unit Manager was interviewed on 1/26/22 at 2:40 PM and stated nail care should be completed during the residents scheduled shower and/or with daily personal care. She explained the NAs should ensure resident's nails were short, to the residents' preference, not jagged and clean. The Unit Manager stated she was unaware Resident #36 needed nail care.	F 677	provided as resident allows; received a partial bath on 01/27/2022. Resident is resistant to baths and toileting. Care Plan is updated to reflect resident's behaviors. All residents have the potential to be affected: All residents have the potential to be affected with the need for nail care and bath/ showers. On 2/16/2022, all Resident/ Resident Representative were audited on their bath/shower preference Director of Nursing. All resident's preferences were acknowledged and Director of Nursing and/or Unit Manager updated bath schedule. On 02/17/2022, Director of Nursing began education to all nursing staff (R.N.s, L.P.N.s and C.N.A.s) on use of a BATH AND SKIN ASSESSMENT form with implementation date of 2/21/2022. This includes baths, nail care, hair care and linen compliance DAILY for day shift and evening shift. Any nursing staff (R.N.s, L.P.N.s and C.N.A.s) that did not receive the education will receive education before next shift. All new hires (R.N.s, L.P.N.s and C.N.A.s) will receive education in orientation. Systemic changes implemented to ensure practice will not recur: Beginning 02/21/2022 monitoring of BATH AND SKIN ASSESSMENT form that indicates did resident receive bath as scheduled, nail care, hair care and linen	

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 677	Continued From page 65 NA #11 was interviewed on 1/26/22 at 3:30 PM. She indicated she worked the 3:00 PM to 11:00 PM shift and was familiar with Resident #36. NA #11 explained nail care should be completed when showers or personal care was rendered but at times it was difficult due to staffing. She went onto say that since the COVID-19 pandemic began, she had normally worked as the only aide to one and a half hallways and found it difficult to get nail care completed as well as scheduled showers. . On 1/27/22 at 1:34 PM, an interview was completed with the Director of Nursing (DON). She stated it was her expectation for nail care to be provided during personal care tasks and if a NA was not able to complete the task she would expect the nurse to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #36 as there was no documentation to show this had or had not been completed or attempted. 2) Resident #52 was admitted to the facility on 11/2/21 with diagnoses that included Alzheimer's disease. The admission Minimum Data Set (MDS) assessment dated 11/9/21 indicated Resident #52 had severe cognitive impairment and was dependent on staff for personal hygiene. A review of Resident #52's active care plan revealed a focus area for ADL/personal care dependent on staff due to hemiplegia and cognitive deficit, that was initiated on 11/15/21. The interventions included personal	F 677	change will be completed by assigned C.N.A. and Charge Nurse. The Unit Manager and/or Supervisor to monitor compliance of BATH AND SKIN ASSESSMENT form that indicates did resident received bath as scheduled, nail care, hair care and linen change daily. The Unit Managers will submit weekly to the Director of Nursing the completed BATH AND SKIN ASSESSMENT forms for review. The Director of Nursing and/or Unit Managers will ensure substantial compliance with bath/ showers and any concerns will be immediately reported to the facility Administrator. Monitoring corrective actions and performance: Beginning February 25, 2022, the Director of Nursing will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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F 677	Continued From page 66	F 677		

hygiene/grooming: provide total care for wash and dry face, skin, nails, hands, and perineum.

A review of the nursing progress notes from 11/2/21 to 1/25/22 revealed no refusals of nail care documented.

An observation was made of Resident #52 on 1/22/22 at 12:04 PM while she was sitting in a recliner chair in the hallway. She was noted to have a dark substance under fingernails to both hands.

An interview occurred with Nurse Aide (NA) #10 on 1/26/22 at 11:18 AM. She stated she worked with an agency and had been assisting the facility since October 2021. NA #10 was familiar with Resident #52 and normally cared for her. She stated nail care would be completed if needed during personal care and was unaware the resident had a dark substance under nails but would take care of them.

Resident #52 was observed lying in bed with her hands on top of the bed covers on 1/26/22 at 11:25 AM. Her fingernails remained with a dark substance under them.

The Unit Manager was interviewed on 1/26/22 at 2:40 PM and stated nail care should be completed during the residents scheduled shower and/or with personal care daily. She explained the NAs should ensure resident's nails were short, to the residents' preference, not jagged and clean. The Unit Manager stated she was unaware Resident #52 needed nail care.

NA #11 was interviewed on 1/26/22 at 3:30 PM. She indicated she worked the 3:00 PM to 11:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 67	F 677		

PM shift and was familiar with Resident #52. NA #11 explained nail care should be completed when showers or personal care was rendered but at times it was difficult due to staffing. She went onto say that since the COVID-19 pandemic started, she had normally worked as the only aide to one and a half hallways and found it difficult to get nail care completed as well as scheduled showers.

On 1/27/22 at 1:34 PM, an interview was completed with the Director of Nursing (DON). She stated it was her expectation for nail care to be provided during personal care tasks and if a NA was not able to complete the task she would expect the nurse to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #52 as there was no documentation to show this had or had not been completed or attempted.

3) Resident #31 was admitted to the facility on 10/23/21 with diagnoses that included vascular dementia and diabetes type 2.

The admission Minimum Data Set (MDS) assessment dated 10/28/21 indicated Resident #31 had severe cognitive impairment and was dependent on staff for bathing.

A review of the medical records indicated Resident #31 was to receive a shower every Wednesday and Saturday on the 7:00 AM to 3:00 PM shift.

A review of Resident #31's personal care records indicated she received 3 showers from 11/1/21 to 1/25/22. She was showered on 11/12/21, 12/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 68	F 677		

and 12/30/21. The personal care records indicated a refusal of bathing assistance on 1/8/22.

The nursing progress notes were reviewed from 11/1/21 to 1/25/22 and did not reveal any refusals of showers.

On 1/24/22 at 12:10 PM, a family member of Resident #31 was interviewed and stated she was concerned that Resident #31 was not receiving showers as scheduled but had not inquired about them.

On 1/25/22 at 11:52AM, NA #9 was observed coming out of Resident #31's room and stated that she had just provided her with a full bed bath and added she had never known Resident #31 to refuse showers or bed baths.

NA #7 was interviewed on 1/26/22 at 3:15 PM and stated she was frequently the only NA scheduled for the unit finding it difficult to get the showers completed as scheduled. She was unaware of Resident #31 refusing showers or bed baths.

An interview was completed with NA #14 who worked the 3:00 PM to 11:00 PM shift, on 1/26/22 at 3:20 PM. She was familiar with Resident #31 and stated it was not uncommon for her to be the only NA for the area that Resident #31 resided on. She stated when this occurred it was impossible to get showers completed as scheduled.

On 1/27/22 at 9:54 AM, NA #15 was interviewed. She worked the 7:00 AM to 3:00 PM shift in the area that Resident #31 resided. She was

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F 677	Continued From page 69	F 677		

unaware of Resident #31 refusing showers or bed baths but stated at times it was difficult to get showers completed as scheduled due to staffing needs.

The Director of Nursing (DON) was interviewed on 1/27/22 at 1:34 PM and stated she expected all residents to receive showers as requested and scheduled. If a resident refused, the NA should alert the nurse so a progress note could be written, and alternate means of a bath provided.

4) Resident #32 was admitted to the facility on 10/23/21 with diagnoses that included dementia, osteoarthritis, and insomnia.

The admission Minimum Data Set (MDS) assessment dated 10/29/21 indicated Resident #32 had severe cognitive impairment and was dependent on staff for bathing.

Resident #32's active care plan, dated 11/5/21, revealed a focus area for assistance with ADLs/Personal Care. The interventions included one-person total dependence for bathing.

A review of the medical records indicated Resident #32 was to receive a shower every Tuesday and Friday on the 3:00 PM to 11:00 PM shift.

A review of Resident #32's personal care records indicated she received 5 showers from 10/30/21 to 1/25/22. She was showered on 11/22/21, 11/23/21, 12/8/21, 12/15/21, and 12/21/21. The personal care records indicated a refusal of bathing assistance 3 times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 70	F 677		

The nursing progress notes were reviewed from 10/30/21 to 1/25/22 and did not reveal any refusals of showers.

On 1/25/22 at 11:52AM, NA #9 was interviewed and stated she had never known Resident #32 to refuse showers or bed baths.

NA #7 was interviewed on 1/26/22 at 3:15 PM and stated she was frequently the only NA scheduled for the unit finding it difficult to get the showers completed as scheduled. She was unaware of Resident #32 refusing showers or bed baths.

An interview was completed with NA #14 who worked the 3:00 PM to 11:00 PM shift, on 1/26/22 at 3:20 PM. She was familiar with Resident #32 and stated it was not uncommon for her to be the only NA for the area that Resident #32 resided on. She stated when this occurred it was impossible to get showers completed as scheduled.

On 1/27/22 at 9:54 AM, NA #15 was interviewed. She worked the 7:00 AM to 3:00 PM shift in the area that Resident #32 resided. She was unaware of Resident #32 refusing showers or bed baths but stated at times it was difficult to get showers completed as scheduled due to staffing needs.

The Director of Nursing (DON) was interviewed on 1/27/22 at 1:34 PM and stated she expected all residents to receive showers as requested and scheduled. If a resident refused, the NA should alert the nurse so a progress note could be written, and alternate means of a bath provided.
5. Resident #91 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 677	Continued From page 71	F 677		

12/14/18 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. The quarterly Minimum Data Set (MDS) assessment dated 12/10/21 indicated that Resident #91 had severe cognitive impairment and was dependent on the staff for bathing. The assessment further indicated that the resident needed extensive assistance with personal hygiene, and he had no behavior nor rejection of care.

Resident #91's current care plan for activities of daily living (ADL) was reviewed. The care plan indicated that the resident refused to bathe at times and prefers bed bath (initiated 7/10/19) and provide extensive assistance to total care with personal hygiene/grooming (combing hair, shave, wash, and dry face).

Resident #91 was observed in bed on 1/24/22 at 2:22 PM and on 1/25/22 at 12:50 PM. He was in bed and his fingernails on his left hand were dirty with brown colored matter underneath his nails. His right hand and arm were covered with compression stocking. His hair (chin length) was greasy and uncombed.

Nurse Aide (NA) #3, assigned to Resident #91, was interviewed on 1/26/22 at 10:56 AM. She stated that Resident #91 did not refuse care, he cussed though, but it depended on how you approached him. NA #3 added that night shift was responsible for providing bed baths to Resident #91, and she did not know if his hair was washed. She added that she was not assigned to the resident on 1/24/22 and 1/25/22. She added that when she checked him this morning, she did not notice his fingernails being dirty nor his hair greasy and uncombed.

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F 677	Continued From page 72 NA #6 was interviewed on 1/26/22 at 4:10 PM. NA #6 added that when she worked 11-7 shift, she provided Resident #91 a partial bed bath, she did not have the time to wash his hair. When she observed resident's hair on 1/26/22 at 4:11PM, she stated that "his hair needed to be washed and combed and his fingernails cleaned". On 1/27/22 at 1:40 PM, the Director of Nursing (DON) was interviewed. The DON reported that the facility was short of staff, but the administration was trying to hire more staff. The facility also was utilizing the agency for staffing needs. She reported that currently, the facility was using the agency staff on 7-3 shift only. She indicated that she would talk to the scheduler to start using the agency staff for 3-11 and 11-7 shift if needed. The DON added that she expected the staff to wash resident's hair and to clean fingernails when a bed bath was provided.	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, staff and Medical Director interviews, the facility failed to schedule a follow-up appointment with Orthopedic for 1 of 3	F 684	F 684 483.25 Quality of Care For identified residents affected:	3/3/22

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F 684	Continued From page 73 residents reviewed for well-being (Resident #16). The findings included: Resident #16 was admitted to the facility on 1/26/21 with diagnoses that included dementia, idiopathic aseptic necrosis of the left femur (a bone condition that results from poor blood supply to the hip bone) and disorder to the bone density and structure. A Significant Change in Status Minimum Data Set (MDS) assessment dated 7/13/21 indicated Resident #16 had severe cognitive impairment and was dependent on staff for all activities of daily living. Review of Resident #16's medical records indicated a fall occurred on 10/2/21 from her bed resulting in a laceration to her head. She was transported and assessed in the Emergency Room (ER). Review of the Emergency Room Physician Documentation report dated 10/2/21 indicated Resident #16 had a right knee x-ray revealing a right tibial (lower leg) fracture. A knee immobilizer was placed, a follow-up appointment was made with an Orthopedic provider for 10/6/21 and Resident #16 returned to the facility. Review of a Report of Consultation from an Orthopedic provider dated 10/6/21 revealed Resident #16 was seen for a fracture of the right tibia. The provider documented Resident #16 was to continue to wear the knee immobilizer and non-weight bearing status for 1 month. The recommendations were to follow-up in 1 month.	F 684	During annual survey of the facility, observations were noted that the facility failed to schedule a follow up appointment with Orthopedic physician (Resident #16). •Resident #16 still resides at the facility. On 10-16-2021, physician's orders were to follow up in one month with Orthopedic physician. The appointment was not scheduled at that time. The was no negative outcome from a delay in follow up appointment. •The appointment was scheduled, and the resident was taken to Orthopedic appointment on 01-27-2022. All residents with the potential to be affected: All residents have the potential to be affected that may have an order for an outside consultant or for a follow up appointment. By 03-03-22, the Director of Nursing will audit all resident's consultation reports for the last 30 days to ensure all follow up appointments were scheduled. Any noted follow up appointments not made will be immediately addressed. Systemic changes implemented to ensure practice will not occur: Beginning on 02-17-22, those responsible, Unit Managers and Transportation Aide were educated by the Director of Nursing regarding the procedure for communicating follow up consults or appointments. After 02-17-22, no Unit	

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F 684	Continued From page 74 The nurse assigned to Resident #16 on 10/6/21 was not available for interview. On 1/25/22 at 12:06 PM, Resident #16 was observed lying in bed. Able to respond when her name was called and shook her head "no" when asked if she had any discomfort. Immobilizer was present to her right leg. On 1/26/22 at 12:00 PM, an interview occurred with the Resident Transporter and Scheduler who stated there were no other appointments for Resident #31 to follow-up with the orthopedic provider. She stated Resident #16 required ambulance transfers to outside appointments. She explained when a resident went to an appointment, she would get a copy of the consultation form from the Unit Manager to schedule any follow-up appointments, arrange for transportation if needed and log on the calendar. She was unable to state if she had received the consultation form dated 10/6/21 for Resident #16. An interview was held with the Unit Manager on 1/27/22 at 10:47 AM, who explained when a resident returned from a provider appointment the nurse on duty would provide her with a copy of the consultation form so she could verify any new orders. In addition, she would provide a copy to the Resident Transporter and Scheduler so any follow-up appointments could be made, transportation scheduled and logged on the calendar. The Unit Manager was unable to recall if the Orthopedic consultation form dated 10/6/21 had been provided to the Resident Transporter and Scheduler. The Director of Nursing (DON) was interviewed on 1/26/22 at 1:00 PM and stated the Resident	F 684	Managers and Transportation Aide will work until they complete this education on scheduling follow-up appointments. Monitor corrective actions and performance: Unit Managers are responsible for auditing admission and/or daily orders to ensure follow through on all orders. During Interdisciplinary Team meetings 5 x week orders are reviewed by Unit Managers and any scheduled follow up orders for appointments are logged on CONSULT TRACKING TOOL form for monitoring of appointments. Effective 02-17-22, during Interdisciplinary Team meetings 5 x week orders will be reviewed by Unit Managers and any scheduled follow up orders for appointments are logged on CONSULT TRACKING TOOL form for monitoring of appointments. The Director of Nursing will ensure substantial compliance with follow up appointments and any concerns will be immediately reported to the Administrator for immediate corrective action Beginning On 02-25-22, the Director of Nursing will review results of CONSULT TRACKING TOOL form during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	

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F 684	Continued From page 75 Transporter and Scheduler had made a call to the Orthopedic provider and verified a follow-up appointment had not been made for Resident #16 after the 10/6/21 visit but had scheduled one for this week. The DON explained she had been in this role since 12/8/21 and felt it was an oversight for the Resident Transporter and Scheduler to not have received a copy of the consultation form in order to schedule a follow-up appointment. On 1/26/22 at 1:50 PM, the Medical Director was interviewed and stated he was unaware Resident #16 did not have follow-up with the orthopedic provider after the 10/6/21 appointment, however it would not have caused any serious outcome as she was already non-weight bearing prior to fracture. The Medical Director further stated he would expect residents to have follow-up appointments scheduled as recommended for any specialist.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		3/3/22

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 686	Continued From page 76 by: Based on observations, record reviews, interviews with the Nurse Practitioner (NP), residents and staff, the facility failed to obtain treatment orders for the right outer ankle pressure ulcer (Resident #81) and failed to identify and treat a pressure ulcer (Resident #50) for 2 of 3 sampled residents reviewed for pressure ulcers. The findings included: 1. Resident #81 was admitted to the facility on 6/18/19 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting unspecified side. Resident #81's pressure ulcer assessments were reviewed. The assessment dated 8/18/21 revealed a stage 2 pressure ulcer was identified to right outer ankle measuring 1.1-centimeter (cm.) x (by) 1 cm. x 0.1 cm (depth). On 9/8/21, the pressure ulcer was assessed as stage 3 due to the presence of eschar. On 1/20/22, the pressure ulcer remained as a stage 3 measuring 1.2 x 1 x 0.1 cm. Resident #81 had a doctor's order dated 9/10/21 to treat the right outer ankle pressure ulcer with Santyl (used to remove dead skin tissue and aid in wound healing) and alginate (highly absorbent and enhances wound healing) and to cover with dry dressing daily Monday through Friday for 2 weeks (9/10/21 - 9/24/21). There was no treatment ordered from 9/25/21 through 1/19/22. On 1/20/22, there was an order to clean the right outer ankle pressure ulcer with wound cleanser and to apply alginate and cover with dry dressing 3 times a week.	F 686	F686 483.25 Treatment/ Services to Prevent/ Heal Pressure Ulcer For identified residents affected: During annual survey of facility, observations were noted that the facility failed to obtain treatment orders for the right outer ankle pressure ulcer (Resident #81) and failed to identify and treat a pressure ulcer (Resident #50). Resident #81 still resides at the facility. The treatment order for iodoflex was not present on the medical record but has since been clarified and discontinued by the Treatment nurse. The Treatment Nurse received a clarification order on 01-26-22 for 11-22-21 to begin iodoflex order and discontinue on 12-31-21. On 12-31-21, the Treatment Nurse received an order to begin MediHoney and this order was discontinued on 01-20-22. Effective 01-20-22, the Treatment Nurse received an order for Calcium Alginate, which discontinued on 02-10-22. On 02-10-22, the new order was placed by Treatment Nurse for Anasept which is making a remarkable improvement in wound. Resident #50 still resides at the facility. He had 2 small areas on his buttock that were identified on 01-26-2022. Treatment orders were obtained and implemented on 01/26/2022 that included hydrocolloid dressing by Treatment Nurse. All residents have the potential to be affected:	

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F 686	Continued From page 77 The Treatment Administration Records (TARs) for Resident #81 were reviewed. The September 2021 and October 2021 TARs revealed that the right outer ankle pressure ulcer was treated with Santyl and alginate from 9/13/21 through 10/30/21. The November 2021, December 2021, and January 2022 (1/1//22 - 1/19/22) revealed that the right outer ankle pressure ulcer was treated with iodoflex (an antimicrobial and highly absorbent used to treat pressure ulcer). The annual Minimum Data Set (MDS) assessment dated 12/1/21 indicated that Resident #81 had moderate cognitive impairment and he had a stage 3 pressure ulcer that was not present on admission. Resident #81's care plan dated 12/4/21 was reviewed. The care plan problem was pressure ulcer to the right outer ankle, stage 3. The approaches included treatment as ordered by the physician. Resident #81 was observed during the dressing change on 1/26/22 at 11:20 AM. The pressure ulcer on the right outer ankle was observed to have no signs/symptoms of infection. The wound bed was red and there was no eschar/necrosis noted. The measurement was 1.2 x 1.5 x 0.2 cm. The Treatment Nurse was observed to clean the ulcer with wound cleanser, alginate was applied to the wound bed and covered with dry dressing. The Treatment Nurse was interviewed on 1/26/22 at 11:35 AM. The Treatment Nurse reviewed	F 686	All residents have the potential to be affected with skin breakdown according to their level of care. On 01-28-2022, the Treatment Administration Records (TARs) were audited by the Treatment Nurse for current treatment orders and appropriate interventions. All treatment orders were accurate and complete. On 02-17-2022, the Director of Nursing began education for C.N.A.s on ADL documentation which includes monitoring, reporting new skin breakdown to charge nurse, for the treatment nurse to evaluate and collaborate with Provider in treatment options. The education will be completed by date 03-03-22. Any CNA that has not worked and completed the education will complete upon next scheduled shift. On 02-17-2022, the Director of Nursing began education for all R.N.s, L.P.N.s, and Treatment Nurse for steps to follow regarding a skin referral, timely reporting of skin issues, importance of ensuring orders is written for all treatments and obtaining an order when treatment resolves and/or changes. Any R.N. and/or L.P.N. needing education will receive education prior to shift. The education will be completed by 03-03-22. Any Nurse that has not worked and completed the education will complete upon next scheduled shift. Starting 02-17-2022, the facility will act to protect residents in similar situations by ensuring when the Treatment Nurse is off treatments will be completed and treatment orders will be obtained by an	

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F 686	Continued From page 78 Resident #81's records and stated that she could not find any treatment ordered after 9/10/21 for the right outer ankle pressure ulcer. She explained that she was out on leave, and nobody had followed up after the order on 9/10/21 for 2 weeks was completed. She also reported that there was no order for the iodoflex in the resident's medical records. The Treatment Nurse stated that the Nurse on the floor was responsible for the treatment when she was out on leave. She was unable to remember the exact date when she was out on leave. She stated that she did not know who transcribed the order for the iodoflex. The Director of Nursing (DON) was interviewed on 1/27/22 at 1:40 PM. The DON stated that she started working as DON in December 2021. She indicated that she expected nursing to obtain treatment orders for residents with pressure ulcers. The DON reported that the facility was short of staff and was utilizing the agency for staffing needs. The Nurse Practitioner (NP) was interviewed on 2/3/22 at 8:55 AM. The NP stated that she was familiar and had been following up Resident #81's pressure ulcers. The NP stated that the resident was high risk for the development of pressure ulcer due to his condition, including immobility of the lower extremities and his non- compliant to his care. He was referred and was seen by the wound clinic but had refused to go starting in September 2021. The NP reported that she had called and involved his family regarding his care. She added when she visited Resident #81, his feet were elevated, however his right leg/foot was rotated outward, and it was hard to reposition due to pain. Resident #81 was on scheduled pain medication. She indicated that when she	F 686	R.N. or L.P.N. that has had the education provided by the Director of Nursing. In addition, the Treatment Nurse will attend Interdisciplinary Team IDT meeting which is held five days a week to review the pressure ulcers, treatment orders and new skin issues. On 02-24-22, 100% head to toe assessment was initiated on all residents to identify all wounds, ensure an order is in place to treat the wound, and ensure the order is being followed. The audit will be complete by date 03-03-22. Systemic changes implemented to ensure practice will not recur: Beginning 02-21-2022, monitoring of Alerts for New Skin Issues will be conducted by the Director of Nursing, Unit Managers, or Treatment Nurse daily x 5 days/week x 4 weeks then monthly x 2 months. The Director of Nursing, Unit Managers, or Treatment Nurse will ensure substantial compliance with New Skin Referrals and any concerns will be immediately reported to the facility Administrator or Director of Nursing for immediate corrective action. Beginning 02-21-2022 monitoring of Alerts for New Skin Issues will be conducted by Director of Nursing, Unit Manager, or Treatment Nurse daily in Interdisciplinary Team (IDT) meeting. Beginning on 2-26-22 The Director of Nursing will observe the treatment nurse complete dressing changes for accuracy and implementation of treatment regimen and ensure orders written clearly. This	

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F 686	Continued From page 79 examined his right ankle, it was hard to see the pressure ulcer due to his right foot positioning. She commented that she thought the development and the decline of the pressure ulcer were unavoidable. The NP did not comment on the missing treatment orders and the use of the iodoflex to the pressure ulcer. 2. Resident #50 was admitted to the facility 1/20/2021 with diagnoses that included venous insufficiency and chronic ulcer of the right foot. Resident #50's annual Minimum Data Set (MDS) dated 11/3/2021 indicated the resident had moderately impaired cognition, could understand others, and be understood by others. He required extensive assistance with bed mobility, activities of daily living, toileting, and personal hygiene. The resident was coded at risk for pressure injuries but had no pressure injuries at the time of the assessment. He had an indwelling catheter and was coded as occasionally incontinent of bowel. The resident's comprehensive care plan last updated 11/16/2021 included a focus for risk of skin breakdown or development of further pressure ulcers related to diabetes. Interventions included inspecting skin and notifying nurse of abnormal changes per facility protocol. On 1/25/2022 at 11:28 AM an interview was conducted with Resident #50. He stated he had a wound on his ankle that had been present for a long time. He then stated he thought he had a wound on his buttocks because he was experiencing pain when he sat in his chair or when the staff provided cleaned the area after toileting. Resident #50 stated he had frequent diarrhea, but he had no concerns with staff being available to assist him with toileting (bed pan) or	F 686	monitoring will be completed weekly x 4 weeks then monthly x 2 months. The above monitoring will be documented on a wound audit/order audit tool. Monitoring corrective actions and performance: In addition, beginning 02-25-2022, the Unit Manager will audit all current treatment orders to ensure all orders are accurate with appropriate interventions. Beginning February 25, 2022, the Director of Nursing will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. The Director of Nursing, Unit Manager, or Treatment Nurse will ensure substantial compliance for any residents with new skin issues and any concerns will be immediately reported to the facility Administrator or Director of Nursing for immediate corrective action.	

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F 686	Continued From page 80	F 686		

cleaning him in a timely manner.

Resident #50's most recent skin assessment completed 1/23/2022 included a chronic venous stasis ulcer and suprapubic catheter site. There was no documentation the resident had skin breakdown on his buttocks.

Resident #50's medical record revealed he had been treated by wound care providers outside the facility and had been evaluated by a vascular surgeon for the chronic non-healing venous stasis ulcer of the right foot and ankle. There was no documentation indicating the resident had a pressure injury to the buttocks.

On 1/26/2022 at 9:43 AM during observation of catheter care by NA #2 the resident requested the bed pan. When the resident was turned to place bed pan, two dime sized stage 2 pressure injuries were observed on the right and left buttocks. Observed barrier cream covering the sacral and both buttocks. When the resident was turned and cleaned, the skin breakdown was observed again. The resident voiced pain when NA #2 was cleaning the area. The NA made no comment regarding the skin breakdown. When asked if the resident was receiving care for the skin breakdown on his buttocks, she stated she was agency and she was not familiar with the resident. She knew he was receiving care for his leg wound but was not certain about his buttocks.

An interview was conducted with the wound nurse on 1/26/2022 at 10:13 AM. She stated the resident got protective cream for his skin due to diarrhea. She was not made aware of skin breakdown on his buttocks. She stated the resident had a history of skin breakdown in the

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F 686	Continued From page 81 area. She contributed the breakdown to chronic and frequent diarrhea. On 1/26/2022 at 2:30 PM an interview was conducted with NA# 3. NA#3 stated she was assigned to Resident #50 on 1/25/2022. She stated she aided with toileting multiple times on 1/25/2022. When asked if he had any skin breakdown, she stated he did have two very small spots on his buttocks. When asked if she reported the breakdown, she stated she thought she reported it to her nurse, Nurse #2. When asked if she reported to the wound nurse, she stated she did not but assumed her nurse would report it to the wound care nurse. An interview was conducted with Nurse #2 on 1/26/2022 at 2:45PM. She stated she was not made aware Resident #50 had skin breakdown on his buttocks.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide direct supervision and smoking apron while smoking to a resident assessed as unsafe smoker (Resident #81) and failed to implement a fall intervention as intended	F 689	F689 Free of Accident Hazards/Supervision/Devices For identified residents affected:	3/3/22

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F 689	Continued From page 82 (Resident #16) for 2 of 8 sampled residents reviewed for accidents. Findings included: The facility's smoking policy (last revised on 3/27/19) revealed that "smoking aprons, smoking blankets and fire extinguishers are provided as safety measures". The policy continued to indicate "a licensed nurse, upon admission, readmission or significant change, will assess each resident who desires to smoke, utilizing the smoking evaluation. Thereafter, residents determined to be unsafe smokers will be assessed at least quarterly and safe smokers at least monthly, utilizing the smoking evaluation by a licensed nurse. When the smoking evaluation identifies a resident with any potential hazard risk, including but not limited to a cognitive deficit, the resident will be allowed to smoke only during the facility ' s designated smoking times with direct staff supervision". 1. Resident #81 was admitted to the facility on 6/18/19 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting unspecified side. The annual Minimum Data Set (MDS) assessment dated 12/1/21 indicated that Resident #81 had moderate cognitive impairment and was currently using tobacco. Resident's #81's care plan initiated on 6/20/19 was reviewed. The care plan problem was "problematic manner in which resident acts characterized by inappropriate smoking or use of tobacco/tobacco substitute products (cigarettes) related to decreased safety awareness". The goal was "resident will smoke safely in	F 689	During annual survey of facility, observations were noted that the facility failed to provide direct supervision and smoking apron while smoking, to a resident assessed as unsafe smoker (Resident #81) and failed to implement a fall intervention as intended (Resident #16). Resident #81 on 02-13-2021 was found to have cigarette burns on abdomen and on thigh. At that time resident was determined by management to be a nonsmoker. The resident's Responsible Party agreed to this decision. This resident has a right to smoke if he chooses and if he needs assistance, it will be provided by staff. Resident assessed for the need for smoking supervision on 02-21-2022, by the Unit Manager. The smoking assessment determined resident #81 to be a supervised smoker. Resident care plan reflects supervised smoking. Resident #16 had a positioning wedge provided by therapy to decrease rolling out of bed. The resident care guide did not obtain the information for nursing assistants and device was noted on the right side of resident instead of left side. On 01-27-2022, bilaterally quarter side rails were applied. On 02-17-2022, after therapy and nursing assessed it was determined to discontinue positioning wedge and on care guide it directs staff to monitor position in center of bed before leaving room and during rounds. On 01-27-2022, a physical device use assessment was completed by the MDS	

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F 689	Continued From page 83 designated areas with supervision. The approaches included do not leave resident unattended while smoking". The approaches did not address the use of the smoking apron. Resident #81 had smoking assessments completed on 1/18/21 and he was deemed to be an unsafe smoker and required direct supervision while smoking. The incident report dated 2/13/21 at 7:30 AM was reviewed. The report indicated that the nurse was administering Resident #81's scheduled insulin in his abdomen when she noticed cigarette burn marks, 2 on his abdomen and 1 on his right thigh. Intervention put in place "called the Administrator and Director of Nursing - set plan of no smoking was put in place". The nurse who completed this report was no longer an employee of the facility. A nurse's note (written by Nurse # 3) dated 2/13/21 at 11:11 AM indicated that per the administrator, Resident #81 was no longer able to go out even with supervision to smoke. The family was made aware. Resident #81's nurse's note dated 2/13/21 at 12:22 PM revealed that while the nurse was giving Resident #81 his scheduled insulin in the morning, the nurse noticed two burn marks on the right side of his abdomen and another burn mark on the right thigh. The burn marks looked like they came from a cigarette. The resident was a frequent smoker. The resident did not complaint of any pain. The nurse informed the Director of Nursing, Nurse Practitioner, and the family. The writer of this note was no longer an employee of the facility.	F 689	Nurse to determine if residents side rails were a restraint or enabler. Upon completion, it was determined that the side rails were enablers per the assessment. All residents have the potential to be affected On 02-16-2022 an audit was completed by social services to ensure all residents that would like to smoke were being allowed/assisted with the desire to smoke. Any resident with specific accommodations will be updated on his/her care plan and/or care guide for staff knowledge/reference and a smoking assessment will be completed to determine supervision requirements. On 01-28-2022, Director of Nursing and Unit Managers was educated by Administrator on accommodating resident request to smoke (staff may have to assist resident with smoking). This education included updating resident care plans and care guides to reflect any resident specific accommodations. By 03-03-2022, 100% of falls within the past 30 days will be reviewed by the Director of Nursing to ensure falls interventions were initiated and addressed on the resident's care plan. Interventions will be initiated and addressed on the care plan during the audit for any identified areas of concern. By 03-03-2022, the education for nurses,	

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F 689	Continued From page 84	F 689		

A witness statement dated 2/16/21 was reviewed. The statement read" while I had (name of Resident #81) out smoking, he dropped his cigarette. I checked him and chair and grounds, didn't see it. ((name of resident) said he dropped it on the ground and not on himself". The writer of this statement was a NA who no longer works at the facility.

A Quality Assurance and Performance Plan (QAPI) was provided and was reviewed. The Plan was initiated on 3/13/21. The Summary of the event was Resident #81 dropped a lit cigarette on himself causing several small burn areas. The resident was not wearing a smoking apron while smoking. The plan was to educate the staff that all smoking residents must be assisted outside to smoke and must wear smoking apron while smoking. The monitoring was weekly smoking assessments on current smokers x (for) 4 weeks to monitor compliance. The QAPI meeting minutes and the QAPI coordinator signature were blank.

The staff in-service for smoking was completed by Nurse #3 and was reviewed. The subject covered on the in-service included all residents must wear a smoking apron at all times, staff were not to smoke at the same time - watch residents carefully".

On 1/26/22 at 9:50 AM, Nurse # 3 was interviewed. Nurse #3 was the weekend Unit Manager assigned to Resident #81. She stated that she was informed that Resident #81 was noted to have 3 cigarette burn marks on 2/13/21. The Administration was notified, and the Administrator had made the decision not to allow the resident to smoke. Nurse #3 further reported

to include MDS, will be completed by Director of Nursing and/or Staff Development accommodating resident request to smoke (staff may have to assist resident with smoking). This education also included referring to resident care plans and care guides to reflect any resident specific accommodations and asking Nurses, C.N.A. and Therapy for assistance and/or information on residents. Also, the education included completing an initial and monthly or quarterly smoking assessments to determine if the resident is a supervised or independent smoker with updates to the care plan as necessary. After 03-03-22, no nurses or MDS nurse will work until completing this in-service and this will be completed during new employee orientation.

By 03-03-2022, the Staff Development Coordinator will initiate 100% in-service with all nurses, to include MDS, regarding ensuring fall prevention interventions are initiated for residents at high risk for falls and addressed on the resident's care plan. After 03-03-2022, no nurses or MDS nurse will work until completing this in-service and this will be completed during new employee orientation.

Systemic changes implemented to ensure practice will not recur:

The Unit Manager will review all fall incident reports 5x per week x 4 weeks then weekly x 8 weeks and discuss in the

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F 689	Continued From page 85	F 689		

that the responsible party (RP) was called and informed of the plan to stop Resident #81 from smoking and the RP had agreed. Nurse #3 reviewed the QAPI plan was unable to remember who completed the form. She also reported that the staff involved during the smoking incident with Resident #81 were no longer employees of the facility. She added that the NA who assisted Resident #81 to smoke did not use a smoking apron and did not monitor the resident carefully while smoking. She reported that the burn marks were small, and they healed up without treatment. The resident did not complain of any pain.

On 1/27/22 at 1:40 PM, the Administrator was interviewed. She stated that the incident had happened before she was the administrator of the facility. She reviewed the QAPI plan and stated that somebody had started the plan but did not finish it. She reported that there was no monitoring completed and there was no staff signature who completed the QAPI plan.

2) Resident #16 was admitted to the facility on 1/26/21 with diagnoses that included dementia, fracture to the right tibia (lower leg), idiopathic aseptic necrosis of the left femur (a bone condition that results from poor blood supply to the hip bone) and disorder to the bone density and structure.

Review of Resident #16's medical record revealed she experienced a fall on 10/1/21 at 10:10 PM when she was found on the floor beside her bed.

A quarterly Minimum Data Set (MDS)

daily clinical meeting. The unit manager will ensure that interventions were put into place for all identified falls and addressed on the resident care plans. This will be documented on the falls audit tool. The Unit Manager will reeducate the nurse or MDS nurse and initiate an intervention and/or update the resident's care plan for any identified areas of concern during the audit.

To ensure residents are accommodated for his/her residents desire to smoke beginning 02-21-2022 Social Services or Supervisor will monitor residents desire to smoke on: 5 residents daily x 5 days week for 2 weeks (audits by 02-26-2022 & audits by 03-05-2022), 5 residents 3 x weekly for 2 weeks (audits by 03-19-2022), 5 residents weekly for 2 months (audits by 05-19-2022). This audit will include weekends. Social Services will ensure substantial compliance of residents are accommodated for his/her residents desire to smoke, any concerns will be immediately reported to the Administrator or Director of Nursing for immediate corrective action.

Beginning 02-25-2022, Social Services will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.

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F 689	Continued From page 86	F 689		

assessment dated 10/12/21 indicated Resident #16 had severe cognitive impairment, had 2 falls since the last MDS assessment was completed.

A nursing progress note dated 10/14/21 indicated Resident #16 was found on the floor beside her bed at 9:20 PM. The note indicated Resident #16 had been repositioned multiple times throughout the day due to being found close to the edge of the bed.

Review a Rehabilitation Screen dated 10/15/21 indicated Resident #16 was screened by therapy, following a recent fall. The comments noted the therapist provided a positioning wedge for the left side of the bed to decrease rolling out and to decrease fall risk. Nursing was notified about the findings and recommendations.

An Investigational Summary form dated 10/18/21 indicated the Unit Manager investigated a fall that occurred on 10/14/21 and noted the resident had a tendency to move herself to the edge of the bed. The form indicated the care plan was to be updated to ensure the positioning device was in place.

Resident #16's active care plan revealed a focus area for risk for falls characterized by actual falls with injury, multiple risk factors related to: impaired mobility, tibia fracture. This was initiated on 10/4/21 with the latest revision date on 10/25/21. The interventions included the following:

" Bed in lowest position.
" Other: knee immobilizer and ortho consult as ordered.
" Position of bed with use of pillow/wedge with proper turning.

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F 689	Continued From page 87 " Provide frequent staff observation of resident. The Resident Care Guide was initiated on 1/28/21 and last revised on 10/25/21. This guide was reviewed and did not contain an intervention to use the positioning wedge to the left side of the bed for falls safety. On 1/24/22 at 1:00 PM, an observation was made of Resident #16 in her bed. The positioning wedge was noted to the right side of the bed leaving the left side unprotected. Resident #16 was observed lying in bed on 1/25/22 at 11:15 AM and the positioning wedge was present to the right side of the bed. There was no positioning device nor pillows to the left side of the bed. An interview was conducted with Nurse Aide (NA) #10 on 1/26/22 at 11:18 AM, who indicated she worked through an agency and had been assisting the facility since October 2021. NA #10 was familiar with Resident #16; was aware a positioning wedge was present for her bed and stated it was placed to the right side of the bed so Resident #16 didn't lean against the wall. She added when she provided care to Resident #16, she ensured the bed was in the lowest position and she centered in the bed for safety. On 1/26/22 at 2:40 PM, an observation of Resident #16 occurred with the Unit Manager (UM). Resident #16 was lying in her bed with the positioning wedge to the right side of the bed and no positioning wedge or pillow to the left side of the bed. The UM was unable to state why the positioning wedge was not located on the left side of the bed as intended to prevent further falls.	F 689		

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F 689	Continued From page 88 She indicated she completed the falls investigation reports and reviewed them in the interdisciplinary team meeting every weekday morning. She further explained, if the therapy department completed a screen due to a fall, they would provide her with the Rehabilitation Screen form regarding any interventions they may have put into place as well. The Unit Manager added she updated the care plan and care guide with any new interventions but confirmed this had not occurred for Resident #16 after a fall on 10/14/21. NA #11 was interviewed on 1/26/22 at 3:30 PM and confirmed she was familiar with Resident #16 and provided her care on the 3:00 PM to 11:00 PM shift. NA #11 explained she was aware a positioning wedge was to be used on the left side of the bed as Resident #16 had a history of wiggling to the edge of the bed causing her to fall. She reviewed the Resident Care Guide and stated the information was not present on there but should be, so other NAs would know how to use the device as it was intended to be used for safety. The Director of Nursing was interviewed on 1/27/22 at 1:34 PM and stated it was her expectation for the safety interventions to be utilized as they were intended to be.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725		3/3/22

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F 725	Continued From page 89 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview with resident, family and staff, the facility failed to provide sufficient nursing staff to provide nail and hair care (Residents #36, #52 & #91) and showers as scheduled (Residents #31 & #32). This was for 5 of 5 sampled residents reviewed for Activities of daily living (ADL). Findings included: This tag is cross referenced to: F 677 - Based on record reviews, observations, resident, family and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #36, and #52), failed to ensure	F 725	F725 483.35 Sufficient Nursing Staff For identified residents affected: During annual survey of facility, observations were noted of Facility failed to provide nail care (Residents #36 and #52) and nail and hair care (Resident #91) and showers as scheduled (Residents #31 and #32). Resident #36 continues to reside at the facility. Nail care was provided on 1/26/2022. Resident #52 does not reside at the facility anymore. Resident #91 continues to reside at the	

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F 725	Continued From page 90 resident's hair and nails were clean (Resident #91) and failed to provide showers as scheduled (Residents #31& #32). This was for 5 of 5 residents reviewed for dependency on staff for Activities of Daily Living (ADLs). Nurse Aide (NA) #3 was interviewed on 1/26/22 at 10:56 AM. The NA reported that the staffing at the facility was bad and most of the time there was only 1 NA on the hall. Most of the residents needed 2-person assist for care. If a resident needed 2- person assist for shower/bath, it was impossible to provide the shower/bath if you're alone on the hall. NA #6 was interviewed on 1/26/22 at 4:10 PM. NA #6 stated that she was assigned on 100 (quarantine hall) and 200 halls with 23 total residents. She stated that the facility had been short of staff. She had been complaining to the administration, but she was told "it will get better". She works 3-11 shift but was asked to work double due to short staff. She reported that when 1 NA was assigned with 20+ residents, care was not provided such as showers, assisting residents to eat, call light not answered timely, incontinent rounds not done timely, and residents were not assisted in getting in and out of bed as requested. NA #6 further stated that most of the residents were 2-person assist due to their weight or behaviors. She added that she rushed all the time to be able to provide care to residents. The Director of Nursing (DON) was interviewed on 1/27/22 at 10:40 AM. The DON stated that she just started as the DON of the facility in December 2021. She reported that she was aware that the facility was short of staff and the administration had been trying to hire more staff.	F 725	facility. He was given a full bed bath on 1/29/2022 addressing personal hygiene with no shampoo provided per his preference as care planned. Resident #31 continues to reside at the facility. Personal hygiene is being provided as resident allows. Resident accepted assistance with a partial bath on 01/28/2022. Resident is resistant to baths and toileting. Resident's family and physician are aware of resident's bathing refusals. The care plan is updated to reflect resident's behaviors. Resident #32 continues to reside at the facility. Personal hygiene is being provided as resident allows. Resident accepted assistance with a partial bath on 01/27/2022. Resident is resistant to baths and toileting. Resident's family and physician are aware of resident's bathing refusals. The care plan is updated to reflect resident's behaviors. Residents having the potential to be affected: All residents have the potential to be affected by the deficient practice. Systemic changes implemented to ensure practice will not recur: On 12/15/2021 the facility stopped taking new admissions due to staffing issues. Admissions will resume once the facility has sufficient nursing staff to provide nursing and related services to meet resident needs as determined by resident assessments and individual plans of care.	

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F 725	Continued From page 91 She added that the facility had been utilizing the agency to help with the staffing needs. The Administrator was interviewed on 1/27/22 at 1:35 PM, The Administrator stated that she just started as administrator of the facility in December 2021. She was aware of the staffing shortage at the facility and had been working to hire and to retain more staff.	F 725	Beginning 2/15/2022 a new Staffing Coordinator was hired to assist with scheduling and began training with the Director of Nursing regarding staffing requirements for the building. Also there is a Staffing Meeting that will be held after IDT meeting in the mornings to ensure adequate staffing for the day. After 2/15/22, any new Staffing Coordinator or other staff assisting with staff scheduling will be trained by the Director of Nursing or the Administrator on scheduling sufficient nursing staff. As of 2/17/2022 the facility currently utilizes 12 agencies to retain staffing to adequately staff the building. Beginning on 02/17/2022 the Director of Nursing (DON) educated the registered nursed (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) on use of a BATH AND SKIN ASSESSMENT form with implementation date of 2/21/2022. After 2/21/22 RNs, LPNs, and CNAs will not be allowed to work until having this in-service. All new hires will also receive this education in orientation. Monitoring corrective actions and performance: Beginning 02/21/2022, monitoring of the staffing schedule will occur 5 times per week. The staff meeting participants will include the Administrator and/or DON and at least one nursing staff person (RN or LPN) and Scheduler who will review the census and any critical needs.	

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F 725	Continued From page 92	F 725	Beginning 02/25/2022, the Director of Nursing and/or Administrator will review results of this staffing monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance with sufficient nursing staff.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		3/3/22

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F 756	Continued From page 93 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with staff, Pharmacy Consultant, Psychiatric Nurse Practitioner and Medical Director, the Pharmacy Consultant failed to identify the facility's need to monitor target behaviors and side effects of psychotropic medications (Residents #29, #86, #50, #54, #64, and #81) and failed to identify the use of an indefinite antibiotic (Resident #64). This deficient practice affected 6 of 8 residents whose medication were reviewed. Findings included: 1.Resident #50 was admitted to the facility 1/20/2021 with diagnoses that included major depressive disorder and anxiety disorder. The resident's annual Minimum Data Set (MDS) dated 11/3/2021 indicated Resident #50 was moderately cognitively impaired, could understand other, be understood by others, and had no moods or behaviors during the assessment period. Resident #50 had a physician's order for citalopram 20 milligrams (mg) orally daily for	F 756	F756 Drug Regimen Review, Report Irregular, Act On For identified residents affected: During annual survey of facility, observations were noted of Pharmacy not taking steps to identify irregularities that require urgent action to protect the resident. Resident #50 continues to reside at the facility. Documentation of behavior monitoring for psychotropic medication use will begin 02-18-2022. Resident #29 continues to reside at the facility. Documentation of behavior monitoring for psychotropic medication use will begin 02-18-2022. Resident #54 continues to reside at the facility. Documentation of behavior monitoring for psychotropic medication use will begin 02-18-2022.	

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F 756	Continued From page 94 depression. Resident #54's Medication Administration Record (MARs) from 11/1/2021 to 1/25/2022 indicated he received citalopram as ordered. The MAR did not list any side effect monitoring for Resident #50. A review of Resident #50's medical record to include nursing progress notes from 11/01/2021 until 1/25/22 revealed no monitoring of side effects to the psychotropic medication. On 1/24/2022 at 3:13 PM Resident #50 was observed lying in bed with his eyes closed making a repetitive rolling movement with his mouth. 1/26/2022 at 10:21 AM an interview was conducted with Nurse #2. She stated she had not noticed any behaviors related to depression with Resident #50. She stated there was not an area in the medical record that specified what behaviors to monitor or what side effects to look for. When asked about the rolling motion the resident made with his mouth, she stated she had noticed it but was not sure if it was a side effect of his medication or just a behavior he had. When asked if she had documented the observation, she stated she had mentioned it to the nurse practitioner a while back, but she had not documented the observation. The Director of Nursing (DON) was interviewed on 1/26/22 at 10:40 AM and stated behavior and side effect monitoring for psychotropic medications was documented in the nursing progress notes when observed. She further stated she would expect the Pharmacy Consultant to identify any irregularities and to monitor side effects that could occur due to	F 756	Resident #64 continues to reside at the facility. Documentation of behavior monitoring for psychotropic medication use will begin 02-18-2022. Resident #86 continues to reside at the facility. Documentation of behavior monitoring for psychotropic medication use will begin 02-18-2022. Resident #81 continues to reside at the facility. Documentation of behavior monitoring for psychotropic medication use will begin 02-18-2022. Residents having the potential to be affected: All residents with orders for psychotropic medications have the potential to be affected. Systemic changes implemented to ensure practice will not recur: On 02-25-2022 in-service education was provided by the Director of Pharmacy Services for the Consultant Pharmacist regarding F756. Specifically, the requirement for medical record review at least monthly with pharmacist notification of irregularities to the Attending Physician, Director of Nursing, and Medical Director was discussed. The facility's approach to psychoactive medication monitoring and the importance of confirming the presence of supporting indications for medication therapy were also reviewed. The	

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F 756	Continued From page 95 psychotropic medications. On 1/27/2022 at 10:44 AM The psychiatric Nurse Practitioner was interviewed. She stated she expected target behaviors and side effects to be monitored daily to determine if a gradual dose reduction (GDR) would be beneficial. Review of monthly drug regimen reviews from 11/1/8/2021 and 12/8/2021 revealed the pharmacy consultant did not identify the need for side effects monitoring. The pharmacy consultant was interviewed on 1/27/2022 at 11:40 AM the Pharmacy Consultant stated that she expected target behaviors to be identified and monitored. She also stated she felt staff were aware of the resident's behaviors. She further stated she expected staff to monitor the side effects of the psychotropic medications. 2.Resident #29 was admitted to the facility on 9/17/2020 with multiple diagnoses including depression, general anxiety and insomnia. The resident's quarterly Minimum Data Set (MDS) dated 10/4/2021 indicated Resident #29 was severely cognitively impaired and displayed no moods or behaviors during the assessment period. The resident received antianxiety medications 1 out of 7 days and antidepressant medications 7 out of 7 days during the assessment period. Resident #29's comprehensive care plan, updated 11/4/2021, had a focus for use of psychotropic medications with the potential for	F 756	consultant pharmacist voiced understanding of these considerations. By 03-03-2022, Director of Nursing, Unit Managers, corporate registered nurse, and/or Pharmacy Consultant will complete an audit/audit of results on psychotropics. The results of the audit(s) will be reviewed by the Director of Nursing, Administrator, nurse practitioner, and/or medical director. On 02-17-2022, R.N.s and L.P.N.s were educated on use of the DOCUMENTATION OF BEHAVIOR tool for monitoring of behaviors and side effects from psychotropic medication use by the Staff Development Coordinator and/or Director of Nursing. Any R.N. or L.P.N. who did not receive this training will be educated before their next shift. This education will also be a part of orientation for all new hired R.N.s and L.P.N.s. The Pharmacy Consultant will review the DOCUMENTATION OF BEHAVIOR tool as a communication tool and drug regimen review aid to identify irregularities. Any concerns or irregularities will be reported to Administrator and Director of Nursing during the exit meeting for immediate corrective action. The DOCUMENTATION OF BEHAVIOR tool will not become part of the resident's electronic or paper medical record and will be kept on file with the Pharmacist's Recommendations report. Monitoring corrective actions and	

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F 756	Continued From page 96 side effects. Interventions included monitoring for effectiveness and side effects and observe resident's mental status on an ongoing basis. The resident's active orders included a physician's order for paroxetine (antidepressant) 10mg orally daily, and duloxetine (antidepressant) 60mg orally daily. Resident #29's nursing progress notes from 6/1/2021 through 1/25/2022 revealed no monitoring of side effects of the psychotropic medication. Review of monthly drug regimen reviews completed on 8/9/2021, 9/6/2021, 10/13/2021, 11/11/2021, and 12/8/2021 revealed the pharmacy consultant did not identify the need for side effects monitoring. The Director of Nursing (DON) was interviewed on 1/26/2022 at 10:40 AM. The DON stated that nursing staff were not monitoring the resident's behaviors and side effects on an ongoing basis. The nursing staff was documenting behaviors by exception. The pharmacy consultant was interviewed on 1/27/2022 at 11:40 AM the Pharmacy Consultant stated that she expected target behaviors to be identified and monitored. She also stated she felt staff were aware of the resident's behaviors. She further stated she expected staff to monitor the side effects of the psychotropic medications. The pharmacy consultant added that staff are documenting resident's behaviors by exception.	F 756	performance: Beginning 02-21-2022, monitoring of DOCUMENTATION OF BEHAVIOR tool will be conducted by the Director of Nursing, Administrator, and/or Unit Manager on 5 residents daily x 5 days/week for 2 weeks, the 5 residents 3 x week for 2 weeks, the 5 residents weekly for 2 months. By 03-03-2022, Administrator and Director of Nursing will have an exit conference monthly with the Pharmacist consultant to review recommendations and findings. The exit conference will occur for three months to identify trends and/or need to continue exit meetings with the pharmacist. Beginning 03-03-2022, to assess compliance with F756, a pharmacist supervisor will conduct supplemental medication regimen reviews for 20% of the facility's residents following the Consultant Pharmacist's review of all residents' medical records. The pharmacist supervisor will review findings with the Consultant Pharmacist and provide a report of the findings to the facility's Quality Assurance & Performance Improvement Committee. These monthly supplemental medication regimen reviews will begin following the next scheduled medication regimen review and will continue for a minimum of three months, then as directed by the facility's Quality Assurance & Performance Improvement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 756	Continued From page 97 2) Resident #54 was admitted to the facility on 11/2/21 with diagnoses that included dementia with behavioral disturbance, major depressive disorder, anxiety disorder and mood disorder. A review of the physician's orders revealed an order dated 11/2/21 for Seroquel (an antipsychotic medication) 25 milligrams (mg) by mouth twice a day. The admission Minimum Data Set (MDS) assessment for 11/9/21 indicated Resident #54 had severe cognitive impairment and displayed physical and verbal behavioral symptoms towards others 1 to 3 days during the 7 day look back period. He was coded as receiving 6 days of an antipsychotic medication. A review of Resident #54's medical record to include nursing progress notes from 11/2/21 until 1/25/22 revealed no monitoring of side effects to the antipsychotic medication. The nursing notes included a few episodes of verbal and physical aggression towards staff and other residents and agitated behavior. A review of the Pharmacy Consultant medication review notes from 11/2/21 to 1/25/22 did not reflect the need for monitoring side effects of the antipsychotic medication. Resident #54's Medication Administration Record (MARs) from 11/2/21 to 1/25/22 indicated he received Seroquel as ordered. The MAR did not list any side effect monitoring that may be displayed from Resident #54 or the medication. On 1/25/22 at 11:50 AM, Resident #54 was	F 756	Beginning 02-25-2022, the Director of Nursing, Administrator, and/or pharmacy consultant will review results of monitoring during the Quality Assurance Performance Improvement meetings for three months to identify trends and/or a need for additional monitoring/updates to maintain regulatory compliance.	

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 756	Continued From page 98	F 756		

observed ambulating in the hallway of the memory care unit without any behaviors noted.

The Director of Nursing (DON) was interviewed on 1/26/22 at 10:40 AM and stated behavior and side effect monitoring for antipsychotic medications was documented in the nursing progress notes when observed. She further stated she would expect the Pharmacy Consultant to identify any irregularities regarding Resident #54, to include the need to monitor side effects that could occur due to the antipsychotic medication.

A phone interview occurred with the Pharmacy Consultant on 1/27/22 at 11:40 AM, who stated she referred to the nursing and physician progress notes to monitor for behaviors related to psychotropic medications and felt the staff were aware of Resident #54's behavior. She added that she would expect the staff to monitor the side effects of the antipsychotic medication and document as well.

3a) Resident #64 was admitted to the facility on 11/10/21 with diagnoses that included dementia, major depressive disorder, insomnia, and anxiety disorder.

A review of the physician's orders revealed an order dated 11/10/21 for Ativan (an antianxiety medication) 0.5 milligrams (mg) by mouth twice a day.

The admission Minimum Data Set (MDS) assessment dated 11/17/21 indicated Resident #64 had severe cognitive impairment and displayed no behaviors. She was coded as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 756	Continued From page 99	F 756		

receiving 7 days of an antianxiety medication.

A review of the Pharmacy Consultant medication review notes from 12/9/21 and 1/12/22 did not reflect the need for monitoring side effects of the psychotropic medication.

Review of Resident #64's medical records including the nursing notes from 11/10/21 to 1/25/22 revealed no monitoring of side effects to the antianxiety medication.

Resident #64's Medication Administration Record (MARs) from 11/10/21 to 1/25/22 indicated she received Ativan as ordered. The MAR did not list side effect monitoring that may be displayed from Resident #64 or the medication.

On 1/25/22 at 11:57 AM, Resident #64 was observed sitting in the dining room waiting for the lunch meal. She was easy to engage and smiled during conversation.

The Director of Nursing (DON) was interviewed on 1/26/22 at 10:40 AM and stated side effect monitoring for psychotropic medications would be documented in the nursing progress notes if observed. She further stated she would expect the Pharmacy Consultant to identify any irregularities regarding Resident #64, to include the need to monitor side effects that could occur due to the psychotropic medication.

A phone interview occurred with the Pharmacy Consultant on 1/27/22 at 11:40 AM, who stated she referred to the nursing and physician progress notes to monitor for behaviors related to psychotropic medications and felt the staff were aware of Resident #64's behavior. She added

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 756	Continued From page 100	F 756		

that she would expect the staff to monitor the side effects of the psychotropic medication and document as well.

3b) Resident #64 was admitted to the facility on 11/10/21 with diagnoses that included dementia, osteoarthritis, and diabetes type 2.

A review of Resident #64's medical record revealed an order dated 11/10/21 for Macrodantin (an antibiotic) 100 milligrams (mg) 1 tab by mouth every night.

The admission Minimum Data Set (MDS) assessment dated 11/17/21 indicated Resident #64 had severe cognitive impairment, was frequently incontinent of bladder and occasionally incontinent of bowel. No infections were coded but she did receive 7 days of an antibiotic.

A review of the Pharmacy Consultant medication review notes from 12/9/21 and 1/12/22 did not reflect the need for an adequate clinical indication for the antibiotic.

Review of the Medication Administration Records (MARs) from 11/10/21 until 1/24/22, showed Resident #64 received Macrodantin 100mg every night as ordered.

On 1/26/22 at 1:50 PM, the Medical Director was interviewed and stated he would have expected the Pharmacy Consultant to identify any irregularities regarding Resident #64's medication to include the need for an adequate clinical indication for the use of Macrodantin.

A phone interview occurred with the Pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 756	Continued From page 101	F 756		

Consultant on 1/27/22 at 12:35 PM who stated she wouldn't have made any recommendations to the physician regarding the indefinite use of an antibiotic as the medication was effective and Resident #64 had displayed no side effects. The Pharmacy Consultant stated it was an oversight not to have made a recommendation regarding a clinical indication for its use.

The Director of Nursing (DON) was interviewed on 1/270/22 at 1:34 PM and stated would have expected the Pharmacy Consultant to identify any irregularities regarding Resident #64, to include the need of a clinical indication for the use of an antibiotic.

4. Resident #86 was originally admitted 6/23/17 and readmitted on 12/9/21 with cumulative diagnoses of anxiety, depression, an eating disorder and mood effective disorder.

Review of Resident #86's admission physician orders dated 12/9/21 included the following medication orders:

Lexapro 10 milligrams (mg) daily (antidepressant and antianxiety medication)

Remeron 15 mg at night (antidepressant)

Trazadone 50 mg at night (antidepressant and sedative)

Buspar 15 mg three times daily (antianxiety)

Ativan 1 mg every 8 hours as needed for anxiety for 90 days

Resident #86 admission Minimum Data Set (MDS) dated 12/16/21 indicated moderate cognitive impairments and no behaviors. She was coded as taking antianxiety and antidepressant medications for 7 of 7 days of the look back assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 756	Continued From page 102	F 756		

Resident #86's psychotropic Care Area Assessment(CAA) dated 12/16/21 read she was on a routine antianxiety and antidepressant medications. Staff were to observe for changes, keep the Physician updated, administer medications as ordered and document any behavioral symptoms. The goal read she would tolerate her psychotropic medications without side effects.

Review of Resident #86's January 2022 Physician orders were unchanged from her admission orders dated 12/9/21 with the exception of her Ativan increase to 1 mg every 6 hours as needed on 1/6/22.

Review of a pharmacy note dated 1/12/22 at 11:07 AM read that medication review was completed and recommendations were sent to the Physician. Review of the pharmacy recommendations dated 1/12/22 included the following: Resident #86's new order for Ativan dated 1/6/22 needed a stop date.

An interview was conducted on 1/26/22 at 10:40 AM with the Director of Nursing (DON). She stated had only been the DON for a little over a month. The DON stated the electronic medical records did not include the Physician orders or the medication administration records (MARs). She stated all the medication orders and documentation of administration of medications were documented on paper. The DON stated the consultant Pharmacist had electronic access to the Physician notes, the psychiatric NP notes, nursing notes and care plan but she would have to review the Physician orders and MAR's in the hard chart. She stated only the Physician's standing orders were in the electronic medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 756	Continued From page 103	F 756		

record

An telephone interview was conducted on 1/27/22 at 11:40 AM with the consultant Pharmacist. She stated she was coming onsite to the facility to do her monthly and new admission medication reviews She stated she completed a medication review for Resident #86 on 1/12/22. She stated she reviewed the electronic medical record which included the nursing notes, care plan and provider notes and interviewed staff as part of her review. She stated she was not aware that the Physician orders and MAR's were not part of the electronic medical record but rather in a hard chart.

An interview was conducted on 1/27/22 at 1:34 PM with the Administrator and the Director of Nursing (DON). Both stated the consultant Pharmacist should have included a review of the Physician orders and MAR's in the hard cart in order to complete a medication review.

5. Resident #81 was admitted to the facility on 6/18/19 with multiple diagnoses including paranoid schizophrenia. The annual Minimum Data Set (MDS)) assessment dated 12/1/21 indicated that Resident # 81 had moderate cognitive impairment and had no behaviors. The assessment further indicated that the resident had received an antipsychotic drug for 7 days during the assessment period.

Resident #81's care plan dated 12/1/21 was reviewed. The problem was the use of psychotropic drug. The goal was for the resident not to show side effects of the medications. The approaches included to evaluate the effectiveness and side effects of medications for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 756	Continued From page 104 possible reduction/elimination of psychotropic drugs and to monitor resident's mood/behaviors with documentation per facility policy. Resident #81 had a doctor's order dated 6/18/19 for Seroquel (an antipsychotic drug) 500 milligrams (mgs.) at bedtime for paranoid schizophrenia. Review of Resident #81's medical records including the nurse's notes from 5/2021 through 12/2021 revealed no monitoring of resident's behaviors and side effects of the antipsychotic drug. Review of the monthly drug regimen reviews (DRR) from 5/2021 through 12/2021, the Pharmacy Consultant did not identify the need for the behavior and side effects monitoring for Resident #81. The Director of Nursing (DON) was interviewed on 1/26/22 at 10:40 AM. The DON stated that nursing staff were not monitoring the resident's behaviors and side effects of the drug on a regular basis, they only document behaviors and side effects by exception. The Pharmacy Consultant was interviewed on 1/27/22 at 11:40 AM. The Pharmacy Consultant stated that she expected target behavior identified and monitored but felt the staff were aware of the resident's behaviors. She also expected the staff to monitor the side effects of the antipsychotic drug. She added that staff were monitoring resident's behaviors and documented the behaviors by exception.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs	F 757		3/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 757	Continued From page 105 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, Medical Director and staff interviews, the facility failed to have an adequate clinical indication for the use of an antibiotic (Resident #64). This was for 1 of 8 residents whose medications were reviewed. The findings included: Resident #64 was admitted to the facility on 11/10/21 with diagnoses that included dementia, osteoarthritis, and diabetes type 2. There was no diagnosis of recurrent urinary tract infections (UTIs) or history of UTI.	F 757	F757 483.45 For identified residents affected: During annual survey of facility, observations were noted of Facility failed to have adequate indication for the use of an antibiotic. Resident #64 continues to reside at the facility. On 01/28/22, the physician gave an order to discontinue the antibiotic treatment for Resident #64. The indication	

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 757	Continued From page 106 A physician's order for Resident #64 dated 11/10/21 indicated Macrodantin (used to treat or prevent urinary tract infections) 100 milligrams (mg) 1 tab every night with no indication of use or a stop date. A review of the Medication Administration Records (MARs) revealed Resident #64 was administered Macrodantin 100mg every night from admission (11/10/21) through 1/25/22. The January 2022 MAR physician's orders revealed the Macrodantin order continued to be active, had no clinical indication for use or stop date. A review of Resident #64's medical record from 11/10/21 until 1/25/22 did not reveal any urinalysis completed or urology appointments since her admission. A physician progress note for 11/12/21 did not reveal any comments regarding the use of Macrodantin or its clinical indication. The admission Minimum Data Set (MDS) assessment dated 11/17/21 indicated Resident #64 had severe cognitive impairment, was frequently incontinent of bladder and occasionally incontinent of bowel. No infections were coded but she did receive 7 days of an antibiotic during the 7 day look back period. A physician's progress note indicated on 12/8/21 Resident #64 was assessed due to routine follow-up. There was no mention of urinary tract concerns in her past medical history, or the clinical indication for the continued use of an antibiotic.	F 757	of use for the antibiotic was to prevent recurrent urinary tract infections per the physician. All residents have the potential to be affected: On 02/28/2022, the Infection Preventionist, Unit Managers, and Nurses (R.N.s and L.P.N.s) were educated by the Administrator and Director of Nursing regarding the need for both stop dates and indication of use for all antibiotic orders. The in-service was completed by 03/03/2022. Any nurse that has not worked and not received the in-service will receive the in-service prior to the next scheduled shift. Any new Assistant Director of Nursing, Infection Preventionist, Unit Manager, or Nurses (R.N.s and L.P.N.s) will receive this education during orientation. On 01/28/2022, the Assistant Director of Nursing performed an audit on all antibiotics currently in use in the facility and ensured all antibiotics have stop dates and indications for use documented. There were no concerns identified during the audit. Systemic changes implemented to ensure practice will not recur: Beginning 02/28/2022, monitoring of antibiotics will be conducted by Director of Nursing or Designee on 5 residents randomly daily x 5 days/week for 2 weeks,	

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F 757	Continued From page 107	F 757		

A Nurse Practitioner progress note dated 12/30/21 did not indicate a clinical indication for the continued use of an antibiotic.

A physician progress note for 1/1/22 made no mention of any urinary tract concerns in Resident #64's past medical history or current issues. The progress note did not indicate a clinical indication for the continued use of an antibiotic nor was the antibiotic mentioned in the Plan section of the note.

Review of a Nurse Practitioner progress note dated 1/18/22 did not indicate a clinical indication for the continued use of an antibiotic.

A physician progress note dated 1/23/22 did not include any urinary concerns in Resident #64's past medical history and did not note a clinical indication for the continued use of an antibiotic.

An interview was conducted with Nurse #7 on 1/25/22 at 3:33 PM, who was familiar with Resident #64. She stated she was unaware of the reason why Resident #64 continued to receive an antibiotic. Nurse #7 reviewed Resident #64's record and verified there was no clinical rationale for the use the antibiotic and that Resident #64 had no active infections since her admission.

On 1/26/22 at 1:00 PM, an interview occurred with the Assistant Director of Nursing (ADON) who also served as the Infection Control (IC) Nurse. She reported it was not normal practice to utilize an antibiotic without an adequate clinical indication. Resident #64's physician orders and MARs were reviewed with the IC Nurse, who indicated Resident #64 was on the antibiotic at the time of admission to the facility. She was

then 5 residents randomly 3 x weekly for 2 weeks, then 5 residents randomly weekly for 2 months. The Director of Nursing will ensure substantial compliance with antibiotic stewardship to include antibiotic orders have a clinical indication of use and a stop date. Any identified areas of concerns will be immediately reported to the facility Administrator for immediate corrective action by the Director of Nursing.

Monitoring corrective actions and performance:

The Director of Nursing will review results of this monitoring during the next Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.

Beginning 02/28/2022, monitoring of residents on antibiotic will be conducted by Director of Nursing or Designee:
5 residents randomly daily x 5 days/week for 2 weeks (10 by March 4, 2022)
5 residents randomly 3 x weekly for 2 weeks (6 by March 18, 2022)
5 residents randomly weekly for 2 months (8 by May 13, 2022)
The Director of Nursing will ensure substantial compliance with antibiotic stewardship to include antibiotic orders have a clinical indication for use and a stop date. Any identified areas of concerns will be immediately reported to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 108 unable to state why the antibiotic did not have adequate clinical indication for its use. An interview occurred with the Medical Director on 1/26/22 at 1:50 PM. He stated there should be better documentation to support the use of an antibiotic for Resident #64 since she had not been seen by a urologist nor had been symptomatic of a urinary tract infection since her admission. The Medical Director was unable to state why this had not been addressed when Resident #64 was admitted to the facility or during any of the follow-up exams. The Director of Nursing was interviewed on 1/27/22 at 1:34 PM and stated she expected use of antibiotics to have an adequate clinical indication.	F 757	the facility Administrator or Director of Nursing for immediate corrective action.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		3/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 758	Continued From page 109 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with staff, psychiatric nurse practitioner, and medical director, the facility failed to identify target behaviors, failed to complete ongoing monitoring of identified behaviors, and failed to monitor for side effects of a psychotropic medication (Residents #29, #86, #50, #54, #64, and #81). The deficient practice affected 6 of 8 residents	F 758	F758 483.45 Free from Unnecessary Drugs For identified residents affected: During annual survey of facility, observations were noted of Pharmacy not taking steps to identify irregularities that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 758	Continued From page 110 reviewed for medications. Findings included: 1. Resident #50 was admitted to the facility 1/20/2021 with diagnoses that included major depressive disorder and anxiety disorder. The resident's annual Minimum Data Set (MDS) dated 11/3/2021 indicated Resident #50 was moderately cognitively impaired, could understand other, be understood by others, and had no moods or behaviors during the assessment period. Resident #50 had a physician's order for citalopram 20 milligrams (mg) orally daily for depression. Resident #54's Medication Administration Record (MARs) from 11/1/2021 to 1/25/2022 indicated he received citalopram as ordered. The MAR did not list any side effect monitoring for Resident #50. A review of Resident #50's medical record to include nursing progress notes from 11/01/2021 until 1/25/22 revealed no monitoring of side effects to the psychotropic medication. On 1/24/2022 at 3:13 PM Resident #50 was observed lying in bed with his eyes closed making a repetitive rolling movement with his mouth. 1/26/2022 at 10:21 AM an interview was conducted with Nurse #2. She stated she had not noticed any behaviors related to depression with Resident #50. She stated there was not an area in the medical record that specified what behaviors to monitor or what side effects to look	F 758	require urgent action to protect the resident. Resident #50 continues to reside at the facility. Documentation of behavior monitoring for psychotropic medication use will begin by 02/18/22. Resident #29 continues to reside at the facility. Documentation of behavior and side effect monitoring for psychotropic medication use will begin by 02/18/22. Resident #54 continues to reside at the facility. Documentation of behavior and side effect monitoring for psychotropic medication use will begin by 02/18/22. Resident #64 continues to reside at the facility. Documentation of behavior and side effect monitoring for psychotropic medication use will begin by 02/18/22. Resident #86 continues to reside at the facility. Documentation of behavior and side effect monitoring for psychotropic medication use will begin by 02/18/22. Resident #81 continues to reside at the facility. Documentation of behavior and side effect monitoring for psychotropic medication use will begin by 02/18/22. All residents have the potential to be affected: On 02/28/2022, the Director of Nursing completed a 100% audit of psychotropic medications. This audit was to ensure that all psychotropic medications for all	

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	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 758	Continued From page 111 for. When asked about the rolling motion the resident made with his mouth, she stated she had noticed it but was not sure if it was a side effect of his medication or just a behavior he had. When asked if she had documented the observation, she stated she had mentioned it to the nurse practitioner a while back, but she had not documented the observation. The Director of Nursing (DON) was interviewed on 1/26/22 at 10:40 AM and stated behavior and side effect monitoring for antipsychotic medications was documented in the nursing progress notes when observed. She further stated she would expect the Pharmacy Consultant to identify any irregularities and to monitor side effects that could occur due to psychotropic medications. The Medical Director was interviewed on 1/26/22 at 1:40 PM, stated he would expect side effect monitoring for psychotropic medications. On 1/27/2022 at 10:44 AM The psychiatric Nurse Practitioner was interviewed. She stated she expected target behaviors and side effects to be monitored daily to determine if a gradual dose reduction (GDR) would be beneficial. 2. Resident #29 was admitted to the facility on 9/17/2020 with multiple diagnoses including depression, general anxiety, and insomnia. The resident's quarterly Minimum Data Set (MDS) dated 10/4/2021 indicated Resident #29 was severely cognitively impaired and displayed	F 758	residents to include resident # 50, 29, 54, 64, 86, and 81 for identifying a target behavior, monitoring for ongoing behaviors, and monitoring side effects with documentation in the clinical record. The Director of Nursing and/or Unit Managers will address all identified areas of concern identified during the audit to include notification of the attending physician or prescribing practitioner for further orders to include identifying a target behavior, monitoring for ongoing behaviors, and monitoring side effects with documentation in the clinical record. On 01/28/2022, R.N.s, L.P.N.s and Unit Managers will be educated by Administrator and Director of Nursing of the need for behavior and side effect monitoring of residents that are currently on psychotropic medications. In-service will be completed by 03/03/2022. The Administrator or Director of Nursing will educate any nurse that has not worked and not received the education prior to the start of next scheduled shift. All new hires will be educated during orientation. On 02/17/2022, nurses were educated by the Director of Nursing on use of the Documentation of Behavior tool for monitoring of behaviors and side effects from psychotropic medication use. Staff Development Coordinator will include education for all new nurses in orientation. The Director of Nursing will educate any nurse that has not worked and not received the education prior to the start of next scheduled shift.	

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F 758	Continued From page 112 no moods or behaviors during the assessment period. The resident received antianxiety medications 1 out of 7 days and antidepressant medications 7 out of 7 days during the assessment period. Resident #29's comprehensive care plan, updated 11/4/2021, had a focus for use of psychotropic medications with the potential for side effects. Interventions included monitoring for effectiveness and side effects and observe resident's mental status on an ongoing basis. The resident's active orders included a physician's order for paroxetine 10 milligrams (mg) orally daily for depression, and duloxetine 60mg orally daily for depression. Resident #29's nursing progress notes from 6/1/2021 through 1/25/2022 revealed no monitoring of target behaviors or side effects of the psychotropic medications. On 1/26/2022 at 2:31 PM an interview was conducted with nurse assistant (NA) #3. She stated she worked with Resident #29 and had never known her to have behaviors. She described the resident as pleasant but liked things done her way. She did not know what behaviors to monitor or side effects to watch for and she did not know where to look for information on behaviors and side effects for Resident #29. Interview was conducted with Nurse #2 who was assigned to Resident #29 on 1/26/2022 at 2:35 PM. She stated the resident had behaviors in the past but had been doing well for a while. She stated she was not certain what the resident's	F 758	On 02/17/2022, Nursing Department began utilizing Documentation of Behavior Interdisciplinary Team (IDT) tool for monitoring of behaviors and side effects of psychotropic medication use. On 02/28/2022, an audit will be completed by Administrator to ensure use of Documentation of Behavior IDT tool on all residents that have a use of psychotropic medications. Systemic changes implemented to ensure practice will not recur: Beginning 02/21/2022 monitoring of Documentation of Behavior tool will be conducted by Director of Nursing or Designee on 5 residents randomly daily x 5 days/week for 2 weeks, then 5 residents randomly 3 x weekly for 2 weeks, then 5 residents randomly weekly for 2 months. The Director of Nursing will ensure substantial compliance of the use of the Documentation of Behavior tool, any concerns will be immediately reported to the facility Administrator for immediate corrective action. Monitoring corrective actions and performance: Beginning 02/25/2022, the Director of Nursing will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI)	

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F 758	Continued From page 113 target behaviors were or where to find target behaviors, but she believed they included yelling out. 2) Resident #54 was admitted to the facility on 11/2/21 with diagnoses that included dementia with behavioral disturbance, major depressive disorder, anxiety disorder and mood disorder. A review of the physician's orders revealed an order dated 11/2/21 for Seroquel (an antipsychotic medication) 25 milligrams (mg) by mouth twice a day. The admission Minimum Data Set (MDS) assessment for 11/9/21 indicated Resident #54 had severe cognitive impairment and displayed physical and verbal behavioral symptoms towards others 1 to 3 days during the 7 day look back period. He was coded as receiving 6 days of an antipsychotic medication. A review of Resident #54's active care plan, dated 11/15/21, included the following focus areas: - Problematic manner in which resident acts characterized by ineffective coping; verbal/physical aggression or agitated, combativeness, history of aggressive behavior toward others, also flirty at times. The interventions included to document summary of each episode and to monitor and document behavior per facility protocol. - Use of psychotropic drugs with the potential for or characterized by side effects of cardiac, neuromuscular, gastrointestinal systems: due to diagnoses of dementia, anxiety, major depressive disorder. The interventions included to administer	F 758	Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Beginning 02/21/2022 monitoring of Documentation of Behavior Interdisciplinary Team (IDT) tool for all residents on psychotropic medications will be conducted by Director of Nursing or Designee: 5 residents randomly daily x 5 days/week for 2 weeks (10 by March 4, 2022) 5 residents randomly 3 x weekly for 2 weeks (6 by March 18, 2022) 5 residents randomly weekly for 2 months (8 by May 13, 2022) The Director of Nursing will ensure substantial compliance of Documentation of Behavior Interdisciplinary Team (IDT) tool for any residents on psychotropic medications, any concerns will be immediately reported to the Administrator or Director of Nursing for immediate corrective action.	

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F 758	Continued From page 114	F 758		

medications per physician's order, monitor vital signs per facility protocol, observe interaction of resident with others for appropriateness and observe resident's gait for steadiness, balance, muscle coordination, ability to position and turn.

A review of Resident #54's medical record including nursing notes from 11/2/21 until 1/25/22 revealed no monitoring of side effects to the antipsychotic medication. The nursing progress notes indicated Resident #54 had displayed a few episodes of verbal and physical aggression towards staff and other residents and agitated behavior.

Resident #54's Medication Administration Record (MARs) from 11/2/21 to 1/25/22 indicated he received Seroquel as ordered. The MAR did not list any side effect monitoring that may be displayed from the medication.

On 1/25/22 at 11:50 AM, Resident #54 was observed ambulating in the hallway of the memory care unit without any behaviors noted.

Nurse #3, who was assigned to Resident #54, was interviewed on 1/26/22 at 8:50 AM. She explained there was no specific area to document side effect monitoring but nursing staff would document a progress note if any were observed and report to the physician.

The Director of Nursing (DON) was interviewed on 1/26/22 at 10:40 AM, who stated there was no side effect monitoring for psychotropic medications but rather the nurses would document a progress note if any were observed. The DON added, a DISCUS test (Dyskinesia Identification System Condensed User Scale-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 758	Continued From page 115	F 758		

used to identify drug-induced movement disorders) was completed every 6 months for residents on psychotropic medications and would capture any side effects to the medications.

The Medical Director was interviewed on 1/26/22 at 1:40 PM, stated he would expect side effects to be monitored for psychotropic medications as it would be helpful when reviewing for effectiveness of the medication.

A phone interview was completed with the Psychiatric Nurse Practitioner (NP) on 1/27/22 at 10:44 AM. She stated it would be an expectation for side effects to be monitored for psychotropic medications. The NP added monitoring would be beneficial when assessing for effectiveness and the possibility of gradual dose reduction (GDR).

3) Resident #64 was admitted to the facility on 11/10/21 with diagnoses that included dementia, major depressive disorder, insomnia, and anxiety disorder.

A review of the physician's orders revealed an order dated 11/10/21 for Ativan (an antianxiety medication) 0.5 milligrams (mg) by mouth twice a day.

The admission Minimum Data Set (MDS) assessment dated 11/17/21 indicated Resident #64 had severe cognitive impairment and displayed no behaviors. She was coded as receiving 7 days of an antianxiety medication.

A review of Resident #64's active care plan dated 11/16/21, included a focus area for use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page 116	F 758		

psychotropic drugs with the potential for side effects of cardiac, neuromuscular gastrointestinal due to diagnosis of anxiety and depression and routine use of antidepressant and antianxiety medications. The interventions included to administer medications per physician's order, monitor resident's mood/behaviors with documentation per facility policy and notify physician of any significant changes and observe resident's mental status functioning on an ongoing basis.

A review of Resident #64's medical record including nursing notes from 11/10/21 until 1/25/22 revealed no monitoring of side effects to the antianxiety medication.

Resident #64's Medication Administration Record (MARs) from 11/10/21 to 1/25/22 indicated she received Ativan as ordered. The MAR did not list any side effect monitoring that may be displayed from Resident #64.

On 1/25/22 at 11:57 AM, Resident #64 was observed sitting in the dining room waiting for the lunch meal. She was easy to engage and smiled during conversation.

Nurse #3, who was assigned to Resident #64, was interviewed on 1/26/22 at 8:50 AM. She explained there was no specific area to document side effect monitoring but nursing staff would document a progress note if any were observed and report to the physician.

The Director of Nursing (DON) was interviewed on 1/26/22 at 10:40 AM, who stated there was no side effect monitoring for psychotropic medications but rather the nurses would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page 117	F 758		

document a progress note if any were observed. The DON added, a DISCUS test (Dyskinesia Identification System Condensed User Scale- used to identify drug-induced movement disorders) was completed every 6 months for residents on psychotropic medications and would capture any side effects to the medications.

The Medical Director was interviewed on 1/26/22 at 1:40 PM, stated he would expect side effect monitoring for psychotropic medications as it would be helpful when reviewing for effectiveness of the medication.

A phone interview was completed with the Psychiatric Nurse Practitioner (NP) on 1/27/22 at 10:44 AM. She stated it would be an expectation for side effects to be monitored for the use of psychotropic medications. The NP added this would be beneficial when assessing for effectiveness and the possibility of gradual dose reduction (GDR).

5. Resident #86 was originally admitted 6/23/17 and readmitted on 12/9/21 with cumulative diagnoses of anxiety, depression, an eating disorder and mood effective disorder.

Review of Resident #86's admission physician orders dated 12/9/21 included the following medication orders:

Lexapro 10 milligrams (mg) daily (antidepressant and antianxiety medication)

Remeron 15 mg at night (antidepressant)

Trazadone 50 mg at night (antidepressant and sedative)

Buspar 15 mg three times daily (antianxiety)

Ativan 1 mg every 8 hours as needed for anxiety for 90

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 758	Continued From page 118	F 758		

Resident #86 admission Minimum Data Set (MDS) dated 12/16/21 indicated moderate cognitive impairments and no behaviors. She was coded as taking antianxiety and antidepressant medications for 7 of 7 days of the look back assessment.

Resident #86's psychotropic Care Area Assessment(CAA) dated 12/16/21 read she was on a routine antianxiety and antidepressant medications. Staff were to observe for changes, keep the Physician updated, administer medications as ordered and document any behavioral symptoms. The goal read she would tolerate her psychotropic medications without side effects.

Review of Resident #86's nursing notes from 12/9/21 to 1/26/22 included the following:
12/17/21 at 2:55 PM, Resident #6 was observed playing with her feeding tube and connectors caused the feeding to spill on to the bed.
12/26/21 at 12:39 AM, Resident #6 refused her tube feeding.
12/29/21 at 2:50 AM, Resident #6 refused her tube feeding.

Review of Resident #86's January 2022 Physician orders were unchanged from her admission orders dated 12/9/21 with the exception of her Ativan increase to 1 mg every 6 hours as needed on 1/6/22.

Review of a Physician progress note dated 1/6/22 read Resident #86 was being seen due to staff reporting her picking on her skin, arms and forehead. Staff report Resident #86 was "more anxious." The note revealed Resident #86 stated she was feeling more anxious but was unsure as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 758	Continued From page 119	F 758		

to why. New orders were given to increase her Ativan to 1 mg every 6 hours as needed for anxiety for 30 days and a psychiatric referral to assess her "current issues and behaviors."

An interview was conducted on 1/25/22 at 3:40 PM with Nurse #6. He stated he was an agency nurse and it was his first day working at the facility in a while. He stated he had little knowledge of Resident #86's behaviors. He stated he had worked in other facilities as an agency nurse and behavior and side effect monitoring were a part of the electronic MARs. Nurse #6 stated he did not know where he should document behaviors and side effects. He stated the only behavior he had noted was her repeatedly asking for her Ativan

An interview was conducted on 1/26/22 at 10:40 AM with the Director of Nursing (DON). She stated the only side effect monitoring she was aware of was the DISCUS completed every 6 months and the nurses documented any behaviors in the nursing notes.

An interview was conducted on 1/26/22 at 1:40 PM with the Medical Director (MD). He stated he was unaware that the facility was not doing ongoing monitoring for behaviors and side effects. The MD stated most of the facility staff knew Resident #86 behaviors but with all the agency staff and new staff, they would be unfamiliar with Resident #86. He stated he was very familiar with Resident #86's behaviors and often reviewed the psychiatric provider notes and staff interviews. The MD stated he expected the facility to have identified the need for monitoring of behaviors and side effect monitoring for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345146	A. BUILDING _____ B. WING _____	C 02/03/2022

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BETHANY WOODS NURSING AND REHABILITATION CENTER	33426 OLD SALISBURY ROAD BOX 1250 ALBEMARLE, NC 28002

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F 758	Continued From page 120	F 758		

Resident #86 psychotropic medications. He stated if there was ongoing target behaviors monitoring, it would provide evidence of a possible gradual dose reduction of some of her psychotropic medications

An telephone interview was conducted on 1/27/22 at 10:44 AM with the Psychiatric NP. She stated she last saw Resident #86 on 11/24/21 for a re-evaluation. She documented that Resident #86 continued to refuse tube feedings by turning off the feeding tube pump and refused meals. She did not exhibit any signs of aggression, agitation or depression at the time of this visit. She stated it would benefit Resident #86 for monitoring of behaviors to show evidence of a possible GDR of some of her psychotropic medications.

An interview was conducted on 1/27/22 at 1:34 PM with the Administrator and the Director of Nursing (DON). Both stated the facility should have identified the need for ongoing monitoring of behaviors and the need to monitor for side effects.

6. Resident #81 was admitted to the facility on 6/18/19 with multiple diagnoses including paranoid schizophrenia. The annual Minimum Data Set (MDS)) assessment dated 12/1/21 indicated that Resident # 81 had moderate cognitive impairment and had no behaviors. The assessment further indicate that the resident had received an antipsychotic drug for 7 days during the assessment period.

Resident #81's care plan dated 12/1/21 was

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F 758	Continued From page 121	F 758		

reviewed. The problem was the use of psychotropic drug. The goal was for the resident not to show side effects of the medications. The approaches included to evaluate the effectiveness and side effects of medications for possible reduction/elimination of psychotropic drugs and to monitor resident's mood/behaviors with documentation per facility policy.

Resident #81 had a doctor's order dated 6/18/19 for Seroquel (an antipsychotic drug) 500 milligrams (mgs.) at bedtime for paranoid schizophrenia.

Review of Resident #81's medical records including the nurse's notes from 5/2021 through 12/2021 revealed no monitoring of resident's behaviors and side effects of the antipsychotic drug.

Nurse # 4, assigned to Resident #81, was interviewed on 1/25/22 at 12:45 PM. The nurse stated that resident's behaviors and side effects of the antipsychotic drugs were documented in the nurse's notes if any. When asked for the target behavior to be monitored for Resident #81, she replied "I am not sure".

The Director of Nursing (DON) was interviewed on 1/26/22 at 10:40 AM. The DON stated that nursing staff were not monitoring the resident's behaviors and side effects of the drug on a regular basis, they only document behaviors and side effects by exception.

Interview with the Psychiatric Nurse Practitioner (NP) was conducted on 1/27/22 at 10:44 AM. The NP stated that she expected target behaviors identified and monitored including the side effects

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F 758	Continued From page 122 of the psychotropic drugs. She commented that the monitoring was beneficial for possible gradual dose reduction (GDR) of the psychotropic drugs.	F 758		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide effective oversight to ensure the facility provided a dignified dining experience by the use of disposable plates and utensils for all residents who received meals from the kitchen. The findings included: During the initial kitchen tour on 1/24/22 at 12:10 PM, the kitchen staff were serving meals on disposable plates and using disposable utensils. The Dietary Manager (DM) stated the rationale for using disposable plates and utensils was because of COVID. Observations conducted on all 7 halls revealed all the residents except for the tube feeding residents were served meals on disposable plates and utensils for lunch and dinner on1/24/22, breakfast, lunch and dinner on 1/25/22, breakfast, lunch and dinner on 1/26/22, breakfast and lunch on 1/27/22.	F 835	F835 483.70 Administration For identified residents affected: During annual survey of facility, observations were noted of facility serving resident meals on disposable dinnerware. Based on observations, resident and staff interviews and record review, the Administrator failed to provide effective oversight to ensure the facility provided a dignified dining experience by the use of disposable plates and utensils for all residents who received meals from the kitchen. All residents have the potential to be affected On 01-29-2022 Dietary Manager was educated to serve residents on regular dinnerware by the facility Administrator. In the event disposable dinnerware is	3/3/22

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F 835	Continued From page 123 An interview was conducted on 1/27/22 at 1:34 PM with the Administrator. She stated she had only been at the facility a few months and she was not aware that the residents were eating off of disposable plates and using disposable utensils. The Administrator stated there was no reason for the residents to being eating from disposable items.	F 835	required, the Dietary Manager must notify the facility Administrator and residents will be informed by the Administrator. On 01-29-2022 Dietary Department began serving residents on regular dinnerware as directed by Administrator and is a continued practice. On 02-16-2022 an audit of the facility was completed by Administrator to ensure all residents were being served on regular dinnerware unless disposable dinnerware was required. There were no concerns identified during the audit. Systemic changes implemented to ensure practice will not recur: Beginning 02-16-2022 monitoring of residents to be served meals to promote a dignified dining experience will be conducted by Dietary Manager on 5 residents randomly daily x 5 days/week for 2 weeks, then 5 residents randomly 3 x weekly for 2 weeks, then 5 residents randomly weekly for 2 months. The Administrator will ensure substantial compliance of residents to be served meals to promote a dignified dining experience, any concerns will be immediately reported in Quality Assurance Performance Improvement (QAPI)Committee for immediate corrective action. Monitoring corrective actions and performance:	

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F 835	Continued From page 124	F 835	Beginning 02-25-2022, the Administrator will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance. Beginning 02-16-2022 monitoring of residents to be served meals to promote a dignified dining experience will be conducted by Dietary Manager: 5 residents randomly daily x 5 days/week for 2 weeks (10 by March 02, 2022) 5 residents randomly 3 x weekly for 2 weeks (6 by March 16, 2022) 5 residents randomly weekly for 2 months (8 by May 11, 2022) The Administrator will ensure substantial compliance of residents to be served meals to promote a dignified dining experience, any concerns will be immediately reported to the facility Administrator or Director of Nursing for immediate corrective action.	
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.	F 947		3/3/22

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F 947	Continued From page 125 §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide nurse's aides (NAs) with annual dementia training for 3 of 5 sampled NAs reviewed for required in-service training (NAs #7, #8 & #9). Findings included: NA #7 was hired on 11/7/18. Review of her in-service records revealed that she was not provided the annual dementia training. NA #8 was hired on 7/26/04. Review of her in-service records revealed that she was not provided the annual dementia training. NA #9 was hired on 2/12/96. Review of her in-service records revealed that she was not provided the annual dementia training. On 1/26/22 at 1:31 PM, the Staff Development Coordinator (SDC) was interviewed. The SDC stated that she had reviewed the in-service records for NAs #7, #8 & #9 and she could not	F 947	F947 483.10 For those Nursing Assistants affected. During annual survey, survey team noted facility failed to provide Nurse Aides (NAs) with annual dementia training for 3 of 5 sampled NAs reviewed for required in-service training (#7, #8, & #9). Nurse Aide #7 will be educated by the Staff Development Coordinator on dementia training by 02-18-22. Nurse Aide #8 will be educated by the Staff Development Coordinator on dementia training by 02-18-22. Nurse Aide #9 will be educated by the Staff Development Coordinator on dementia training by 02-18-22. All Nursing Assistants, all staff, and all residents have the potential to be affected.	

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F 947	Continued From page 126 find documentation that they were provided dementia and behavioral health training last year. She added that they had attended the exit seeking behavior training. On 1/26/22 at 3:01 PM, NA #7 was interviewed. She stated that she had been assigned to work in the dementia unit (SPARKS). NA #7 indicated that she could not remember if she had attended the annual dementia training. On 1/27/22 at 10:41 AM, NA # 9 was interviewed. She stated that she had been working at the facility's dementia unit and could not remember if she had attended the annual dementia training.	F 947	Systemic changes implemented to ensure practice will not recur. The Staff Development Coordinator will audit 100% of all Nursing Assistants for training for dementia training. A 100% dementia training will be provided to all staff and nursing assistants by Staff Development Coordinator by 03-03-2022. The Staff Development Coordinator will ensure all new hires are provided dementia training during orientation. The Staff Development Coordinator will ensure all current staff and nursing assistants have dementia training by 03-03-2022. Any staff that did not receive education and has not worked will be educated by the Staff Development Coordinator before next scheduled shift. All new staff hired will be educated on dementia training during orientation. Monitoring corrective actions and performances. Beginning February 25, 2022, the Staff Development Coordinator will review results of this monitoring during the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring/updates to maintain regulatory compliance.	