STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 03/31/2022

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 3/28/22 through 3/31/22. Substandard Quality of Care was identified at: CFR 483.25 at tag F684 at a scope and severity (H) CFR 483.25 at tag F690 at a scope and severity (H) A partial extended survey was conducted. The following intakes were investigated NC00186210, NC00186588, NC00187157, NC00187392, NC00187384, NC00186112, NC00187346, NC00186554, NC00186336, NC00187627 and NC00187896. 7 of the 19 complaint allegations were substantiated resulting in deficiencies. Tag F690, F684 constituted substandard quality of care. Event ID# 9UBI11.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		4/26/22

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

Electronically Signed | 04/21/2022

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F 580	Continued From page 1	F 580		

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, nurse practitioner, and physician interviews, the facility failed to notify the resident's representative about the changes in medication administration regimen for Zyprexa (antipsychotic) for 1 of 1 resident reviewed for notification (Resident #6). Findings included: Resident #6 was re-admitted to the facility on 1/14/21. Review of Resident 6's recent Annual Minimum Data Set (MDS) assessment, dated 1/11/22, revealed that Resident #6 was cognitively intact. Record review revealed the Psychiatric Nurse Practitioner (NP#1) visit note dated 2/3/22 indicated that Resident #6 had clinical indications for a gradual dose reduction (GDR) trial. For this purpose, on 2/3/22, NP #1 ordered to reduce Zyprexa from 10 mg to 5 mg by mouth at bedtime. Review of the physician's order for Resident #6 revealed an order dated 2/3/22 to discontinue Zyprexa 10 mg by mouth daily and start Zyprexa 5 mg by mouth daily for (GDR). Review of the Medication Administration Record (MAR) for Resident #6 for February 2022 revealed on 2/3/22 the order to discontinue Zyprexa 10 mg was completed as ordered, but the new order for Zyprexa 5 mg was not transcribed to the MAR until 2/16/22. Zyprexa was not administered from 2/4/22 to 2/15/22. Record review of the nurses' notes, dated 2/16/22, revealed that Resident #6's family	F 580	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F580 Resident #6□s RP was made of aware of the changes in resident□s antipsychotic medication. A 30-day review will be completed to ensure residents□ RP was notified when changes were made in the resident□s antipsychotic medications. Licensed nurses will be educated by DON/designee on notification of RP of medications changes including changes in the antipsychotic medications with documentation of the notification in the medical record. Any licensed nurse/new outside agency staff/new hires who have not educated will not be allowed to work until education is completed. DON/designee will audit progress notes and order listing to ensure notifications of changes in antipsychotic medications	

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F 580	Continued From page 3 member stated she was not notified about changes for medication administration of Zyprexa and had a concern about possible withdrawal syndrome (unpleasant reaction to abrupt drug ceasing) for the resident. Record review revealed the Psychiatric Nurse Practitioner (NP#1) visit note, dated 2/17/22, indicated she had a phone conversation with Resident #6's family, apologized for the notification issue. On 3/28/22 at 9:45 AM during an interview, Resident #6 indicated that she received several medications every day and did not know all of them. The resident preferred the staff to notify her daughter about any changes because the "daughter knows better." On 3/28/22 at 1:55 PM, during an interview, Unit Manager indicated that on 2/3/22, NP #1 changed Resident #6's the order for Zyprexa discontinuing 10 mg daily and initiating an order for 5 mg per day. The floor nurse (Nurse #11) who received the new order failed to transcribe the new order for 5 mg Zyprexa daily and also failed to notify the family about medication regimen changes and document it in the medical records. On 3/28/22 at 11:25 AM, during an interview, Director of Nursing (DON) confirmed Nurse #11 had not notified Resident #6 ' s family of changes with her Zyprexa order. The DON expected the staff to notify the family about changes in the medication administration regimen and document it in the chart. DON stated that Nurse #11 left the facility and was not available for an interview. On 3/29/22 at 12:00 PM, during the phone	F 580	have been made to the resident□s RP. Audits will be done 5x weekly x 4 weeks, then weekly x 8 weeks, then monthly x 3. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Completion April 26, 2022	

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F 580	Continued From page 4 interview, Medical Director, expected the staff to notify the resident's family about changes in medication regimen at all the time. On 3/28/22 at 3:30 PM, during the phone interview, NP #1 confirmed that it was her expectation for the nurses to notify the family about changes in the medication administration regimen. On 2/16/22, NP #1 contacted the resident's family, apologized for no notification of medication administration changes, and explained that Resident #6 received other psychotropic medications and did not have withdrawn syndrome.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, the facility failed to implement the abuse policy in the area of investigation for 1 of 1 sampled resident who had an allegation of abuse (Resident #1). The findings included:	F 607	F607 Resident #1 is no longer a resident in the center. Current residents in the center have the potential to be affected. The Administrator and DON were educated by Regional Director of Clinical	4/26/22

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F 607	Continued From page 5 Review of the policy titled "Abuse/Investigative Reporting: Abuse/Neglect/Misappropriation/Crime" revised 2/11/22, read in part: "section 10: The administrator or designee must immediately initiate an investigation. This investigation includes interviewing all staff involved, any family involved, and all patients involved." Resident #1 was admitted to the facility 7/21/21. His quarterly Minimum Data Set (MDS) dated 1/21/22 indicated he was cognitively intact. A written statement dated 3/16/22 completed by the Talk Therapist described a report from Resident #1 of verbal abuse on 3/15/22 in which a male Nurse Aid (NA #5) told Resident #1 "if you weren't sick, I would beat you" while providing care in his room. The therapist did not witness the verbal abuse. In a written interview of NA #5 by the Administrator dated 3/17/22, Na #5 denied any inappropriate language or comments toward Resident #1. Na #5 could not be reached for interview. The facility's Administrator and Director of Nursing (DON) provided the following related to their investigation: a documented telephone interview with NA #5, documentation of an interview with Resident #1 and his roommate. A letter dated 3/22/22 submitted to the State Agency described the allegation and investigation and concluded the allegation was unsubstantiated. Resident #1 no longer resided in the facility.	F 607	Services/designee on the center□s policy on abuse and neglect including how to conduct a thorough investigation. FRIs will be audited by Regional Director of Clinical Services/designee to ensure a thorough investigation was completed 3x weekly x 4 weeks, then weekly x 8weeks, then monthly x 3. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Completion April 26, 2022	

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F 607	Continued From page 6 During an interview on 3/29/22 at 10:35 AM, the Administrator recalled interviewing Resident #1 and his roommate following the allegation of verbal abuse. She revealed they did not interview all residents that NA #5 had worked with, only Resident #1 and his roommate. The investigation did not include interviews of staff members working with NA #5. The Administrator indicated that NA #5 was let go and she did not feel the need to interview other residents since the named employee no longer worked at the facility. She felt all residents involved included Resident #1 and his roommate.	F 607		
F 656 SS=H	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (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	F 656		4/26/22

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F 656	Continued From page 7 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Director interviews, the facility failed to develop and implement effective interventions when the resident manipulated and taped his condom catheter; when the resident refused ADL (activities of daily living) care; when the resident refused full body skin assessments for 1 of 8 residents, (Resident #7). On 3/13/22 Resident #7 arrived at the Emergency Department (ED) with significant swelling of his scrotum and groin and his condom catheter was extensively taped with medical tape. The skin assessment in ED described multiple excoriated lesions to his foreskin with active bleeding, multiple skin discolorations, two sacral pressure ulcers and abrasions over the body. One Resident #7's toenails lifted up from the nail bed when his compression hose were removed.	F 656	F656 Resident # 7 is no longer a resident in the facility Current residents in the center with documented refusals of ADL care, refusals of skin assessments, manipulation of catheters and providing care to self that could lead to harm to self or infection have the potential to be affected. The resident□s most recent OBRA MDS completed in the quarter will be reviewed for coding of above-mentioned behaviors. Current residents will be reviewed for documented refusals of ADL care, refusals of skin assessments, manipulation of catheters and providing care to self that could lead to harm or infection will be care planned with interventions to address issues. In	

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F 656	Continued From page 8 Findings included: Resident #7 was admitted to the facility on 1/16/20. His quarterly Minimum Data Set (MDS) assessment, dated 12/4/21, revealed his intact cognition. Resident #7's diagnoses included hereditary spastic paraplegia (paralysis of the legs and lower body), neuromuscular dysfunction of the urinary bladder, encounter for fitting and adjustment of urinary device, major depressive disorder, and fungal feet infection. The MDS assessment indicated the resident required extensive assistance with ADL, was always incontinence of bowel and bladder, and used a condom (external) catheter. He exhibited rejection of care 1 to 3 days during the 7-day look back. Record review of Resident #7's plan of care, dated 3/6/22, revealed he exhibited adverse behavioral symptoms as resistive to care. The interventions were to administer medications as ordered, monitor, and document for side effects and effectiveness. The resident had an ADL self-care performance deficit. The resident often refused repositioning in bed, bed baths and incontinence care, skin observations and assessments. There were no effective interventions related to refusing assistance with ADL. Record review of Resident #7's plan of care, dated 3/6/22, revealed he had a condom catheter, manipulated his condom catheter, and wrapped it with tape regardless of education. The interventions were to change the condom catheter per the physician's order, position 36	F 656	addition any behaviors coded on the MDS will be reviewed and care planned. The resident□s care plans will be updated to include specific interventions to address and manage the behaviors by April 26, 2022. MDS Nurses and Nursing Administration Team was educated by Regional Director of Clinical Services /designee regarding the updating and completion of the comprehensive care plan to reflect the resident□s current physical and psychological functioning to include interventions related to behaviors Regional MDS Nurse/ designee will audit 5 MDS and care plans for behavior interventions weekly for 5 MDS for weekly for 4 weeks, biweekly for 8 weeks, and then monthly times two weekly Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Completion April 26, 2022	

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mm (millimeter) condom catheter bag and tubing below the level of the bladder, monitor for signs of discomfort in urination and frequency and pain due to the catheter. There were no interventions, related to wrapping the condom with tape and possible negative outcomes.

Record review of Resident #7's plan of care, dated 3/6/22, revealed he often refused skin observations and assessments. There were no effective interventions to address the resident refusing skin assessments.

Record review of Resident #7's plan of care, dated 3/6/22, revealed he often refused the compression hose application and removal per schedule. The plan of care did not show interventions to address the resident's refusal and noncompliance.

On 3/29/22 at 11:50 AM, during an interview, Nurse #12, MDS Nurse, indicated that she was responsible for care planning and conducting resident assessments. Nurse #12 mentioned that she worked a long time on the floor with Resident #7 and was very familiar with his refusal behavior. The plan of care reflected the resident ' s current interventions for refusal behavior to provide medications per order and monitoring. Nurse #12 confirmed that the interventions, included in the plan of care, were discussed with Director of Nursing (DON), the Unit Manager. Nurse #12 mentioned that the effectiveness of interventions was limited.

Review of the physician's orders for February - March 2022 for Resident #7 revealed the orders: to complete weekly skin assessment and document it;

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Record review of multiple nurses' notes for 2022 revealed that Resident #7 often refused ADL assistance, including incontinence care, bed baths, and skin assessments. The resident often did not allow the staff to apply the condom catheter, assess his genitalia for a skin break down or provide catheter care. The resident constantly manipulated his condom catheter and wrapped it with white, adhesive tape that was not provided by the facility. The resident was educated about the possible negative outcome of his manipulation with tape but continued the same behavior. The resident did not allow the staff to remove the compression hose from his lower legs at noon, according to the physician's order. The staff educated the resident that the lengthy compression hose application could cause numbness, tingling, and rashes in the legs. Resident #7 would agree but would not allow the staff to remove the ted hose. The resident often refused full body skin assessment, skin check of his back area, and lower legs skin for compression hose application. The staff attempted to offer the skin assessment later with the same result.

On 3/28/22 at 1:45 PM, during an interview, Nurse #6, Unit Manager, indicated that Resident #7 was alert/oriented, and could make his own decisions. He was known for refusal and manipulative behavior. Based on his psychiatric diagnoses, the resident received psychiatric visits and treatment. The Interdisciplinary Team discussed his situation and agreed with current interventions that were partially effective for the resident.

On 3/29/22 at 7:10 AM, during an interview,

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Nurse #5 indicated that Resident #7 refused routine ADL care, skin assessments and compression hose applications. The resident did not allow the staff to provide overall condom catheter care and manipulated with white tape around his condom catheter very often.

3/29/22 at 9:00 AM, during the phone interview, Nurse #8 indicated that she was assigned for Resident #7 on third shift. He refused his condom catheter care and incontinence care. The resident became agitated with repeated offers. On 3/9/22, the resident requested to have more white tape to apply on his condom catheter. The resident was confused. Nurse #8 reoriented him and reminded him that he placed the tape around the condom himself and he refused to remove the tape from his condom catheter. Nurse #8 did not know how the resident received the white tape.

On 3/30/22 at 8:30 AM, during an interview, Nurse Aide (NA) #6 indicated that on first shift of 3/8/22, Resident #7 refused to change his adult brief, refused the bed bath or repositioning in bed. The resident stated, "he received it yesterday".

On 3/30/22 at 8:40 AM, during the phone interview, NA #2 indicated that she worked with Resident #7 on night shift of 3/12/22. The resident refused care, became agitated, and did not allow the staff to touch him in bed. She could observe resident's upper body, not covered with blanket, and the resident refused full body skin observation.

On 3/30/22 at 8:40 AM, during the phone interview, NA #7 indicated that he worked with Resident #7 on 3/7/22, 3/9/22, 3/11/22 and 3/12/22 during first shift. NA #7 stated the

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F 656	Continued From page 12	F 656		

resident often refused incontinence care, often applied the white tape around the condom and did not want to remove it. NA #7 did not know how the resident received the tape and observed the roll of white tape in resident's room.

On 3/30/22 at 9:30 AM, during an interview, NA #8 indicated that she worked with Resident #7 on first shift of 3/10/22. Nurse Aide #8 attempted several times to offer the incontinence care and the resident refused it. At the end of shift, the resident accepted incontinence care, and the nurse aide observed the condom catheter had come off. The penis, scrotum and perineal area were dark color, with dry skin and no skin issues. There was "some redness" noted on the glans penis without discharge. The resident stated it did not bother him at all. NA #8 stated this was reported to the floor nurse.

Hospital records review revealed that on 3/13/22, Resident #7 arrived at the Emergency Department (ED) with significant swelling of his scrotum and groin and his condom catheter was extensively taped with medical tape. The skin assessment in ED described multiple excoriated lesions to his foreskin with active bleeding, multiple skin discolorations, two sacral pressure ulcers and abrasions over the body. The staff in ED found an identification band "embedded" in his back skin and during removal of compression hose a toenail partially lifted from the nail bed.

On 3/28/22 at 2:15 PM, during an interview, the Director of Nursing (DON) indicated that Resident #7 was alert, oriented, and his own responsible party. His plan of care reflected his diagnoses and behavioral problems. The interventions were to provide treatment per physician ' s orders and

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F 656	Continued From page 13 monitor and report episodes of adverse behavior. The DON stated regardless of education and psychiatric treatment, the resident continued his resistance to care and refusal behavior. On 3/28/22 at 3:40 PM, during the phone interview, Psychiatric Nurse Practitioner (NP #1) indicated that Resident #7, according to his mental status assessment, was cognitively intact and made his own decisions. He had psychiatric diagnoses with refusal, resistance to care/treatment, and manipulative behavior, and received psychotropic medications and psychotherapy with very little progress. NP #1 adjusted the resident's psychotropic medication regimen with limited and temporary effects on his behavior.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff, nurse practitioner, and physician interviews, the facility failed to administer Zyprexa (antipsychotic medication) as ordered by the physician for 12 days. The failure occurred for 1 of 1 resident, reviewed for the provision of care according to professional standards (Resident #6). Findings included: Resident #6 was re-admitted to the facility on	F 658	F658 Resident #1 is currently receiving medications as per physician orders. A 30 day audit will be conducted to ensure residents who are on antipsychotic medications are receiving the antipsychotic medications as per physician orders including those orders written for gradual dose reductions. Licensed Nurses will be educated by Director of Nursing/designee will be	4/26/22

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F 658	Continued From page 14 1/14/21with diagnoses that included dementia with behavioral disturbance. A review of Resident 6's recent Annual Minimum Data Set (MDS) assessment, dated 1/11/22, revealed that Resident #6 was cognitively intact. She received antipsychotic medication. Record review revealed the Psychiatric Nurse Practitioner (NP #1) visit note dated 2/3/22 indicated that Resident #6 had clinical indications for a gradual dose reduction (GDR) trial. For this purpose, on 2/3/22, reduce Zyprexa (antipsychotic medication) by mouth at bedtime from 10 milligrams (mg) to 5 mg. A review of the physician's order for Resident #6 revealed: an order date dated 2/3/22 to discontinue Zyprexa 10 mg by mouth daily and start Zyprexa 5 mg by mouth daily for gradual dose reduction (GDR). A review of the Medication Administration Record (MAR) for Resident #6 for February 2022 revealed on 2/3/22 the order to discontinue Zyprexa 10 mg was completed as ordered, but the new order for Zyprexa 5 mg was not transcribed to the MAR until 2/16/22. Zyprexa was not administered from 2/4/22 to 2/15/22. Record review of the multiple nurses' notes for 2/4/22 - 2/16/22 revealed that the staff monitored Resident #6 ' s condition/behavior, and she did not exhibit withdrawal syndrome (unpleasant reaction to abrupt drug ceasing). On 3/28/22 at 1:55 PM during an interview, the Unit Manager indicated on 2/3/22 the psychiatric NP #1 changed Resident #6's order for Zyprexa	F 658	education on transcription of physician orders including those orders written for gradual dose reductions. Licensed Nurses/outside agency staff/ new hires who are not educated will not be allowed to work until education received. Director of Nursing or designee will audit all gradual dose reductions of antipsychotic medications done 5x weekly x 4 weeks, then weekly x 8 weeks, then monthly x 3 Results of all audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Completion Date: 04/26/2022	

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F 658	Continued From page 15	F 658		

from 10 mg to 5 mg. The floor nurse (Nurse #11) who received the new order, discontinued 10 mg of Zyprexa and did not transcribe the new order for 5 mg. As a result, Resident #6 did not receive Zyprexa until the resident's family called nursing staff on 2/16/22, and the situation was corrected. From 2/4/22 to 2/15/22, the resident continued receiving other psychotropic medications and did not show withdrawal symptoms.

Record review revealed NP #1's visit note, dated 2/17/22, indicated a phone conversation was conducted with Resident #6's family. NP #1 explained the purpose of a GDR and apologized that the order for Zyprexa was not transcribed correctly. As a result, the resident did not receive Zyprexa for twelve days.

On 3/28/22 at 11:25 AM during an interview the Director of Nursing (DON) indicated that in February 2022, for Resident #6 ' s GDR trial, NP #1 discontinued 10 mg of Zyprexa and ordered 5 mg of Zyprexa. Nurse #11 documented in the MAR the order to discontinue 10 mg of Zyprexa but did not transcribe the new order for 5 mg Zyprexa on 2/3/22. DON stated that Nurse #11 left the facility and was not available for an interview.

On 3/29/22 at 12:00 PM, during the phone interview, Medical Director expected the staff to follow the physician's order and transcribe it to the MAR on time.

On 3/28/22 at 3:30 PM, during the phone interview, NP #1 indicated that a GDR trial was ordered on 2/3/22 for Resident #6 and she changed the order for Zyprexa from 10 mg to 5 mg by mouth daily. On 2/16/22, the staff reported

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F 658	Continued From page 16 that by mistake, Zyprexa was discontinued on the MAR, and Resident #6 did not receive it from 2/4/22 to 2/15/22. On 2/16/22, the facility corrected the medication order error, and NP #1 contacted the resident's family with an apology for the mistake. NP #1 stated that the resident did not have withdrawal syndrome because she received other scheduled and as needed psychotropic medications.	F 658		
F 684 SS=H	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, and Medical Director interviews, the facility failed to complete full body skin assessments, including resident's genitalia, back and lower legs for 1 of 8 sampled residents (Resident #7). On 3/13/22, Resident #7 was sent to the emergency department (ED) for evaluation and the ED records indicated the Resident had significant swelling of his scrotum and groin, multiple excoriations to his foreskin with active bleeding, two sacral pressure ulcers and multiple skin discolorations over the body. In addition, an identification band (ID) band was imbedded in his back and a toenail partially lifted when they removed his compression hose.	F 684	F684 Resident # 7 is no longer a resident in the facility Current residents will have complete skin observation completed by nurse leadership team to include residents back, genitalia and lower legs. Skin observations will be completed by 04/26/2022 Licensed nurses will be educated by DON/designee on performing thorough skin assessments weekly with documentation in the medical records. A skin assessment will be conducted for residents who are transferred out to the	4/26/22

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F 684	Continued From page 17 Findings included: Resident #7 was admitted to the facility on 1/16/20. His discharge Minimum Data Set (MDS) assessment, dated 3/13/22, revealed intact cognition. Resident #7's diagnoses included hereditary spastic paraplegia (paralysis of the legs and lower body), neuromuscular dysfunction of the urinary bladder, encounter for fitting and adjustment of urinary device, major depressive disorder, and fungal feet infection. The resident received extensive assistance with ADL, was always incontinent for bowel and bladder, and used a condom (external) catheter. He exhibited rejection of care 1 to 3 days during the 7-day look back, and received psychotropic medications and psychotherapy. Review of Resident #7's plan of care, dated 3/6/22, revealed that due to his diagnosis of major depression, he exhibited adverse behavioral symptoms: resistive to care, agitation, refusing medications and treatment. The interventions were to administer medications as ordered, monitor, and document for side effects and effectiveness. Review of the physician's orders for February - March 2022 for Resident #7 revealed the orders: to complete a weekly skin assessment every Friday's day shift and document it; to apply condom catheter, provide catheter care, validate anchor for the catheter and privacy bag every shift, change it as needed; to apply the compression hose in the morning and remove it at noon. Record review of the skin assessments for	F 684	hospital prior to the transfer. Any Licensed Nurse/outside agency staff/new hires who is not educated will not be allowed to work until education received. DON or designee will audit skin observations to ensure completeness of skin observation and timeliness of skin observation 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further if needed. Completion April 26, 2022	

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Resident #7 revealed his last documented full skin assessment, dated 3/4/22. Nurse #5, who conducted the assessment, documented the resident's skin was intact.

On 3/28/22 at 11:50 AM, during an interview, Nurse #12 indicated that on first shift of 3/11/22, she was assigned to Resident #7 and he refused the skin assessment. The nurse came back with the same offer twice during her shift with the same result. Nurse #12 did not notify the physician she did not complete the skin assessment due to the resident's refusal.

On 3/29/22 at 7:10 AM, during an interview, Nurse #5 indicated that Resident #7 refused skin assessments very often. Before his discharge to the hospital on 3/13/22, the last time Nurse #5 completed his full body assessment was on 3/4/22, and did not find skin issues.

Review of the care tracker for March 2022 revealed that on 3/2/22, 3/3/22, 3/8/22, and 3/11/22, nurse aides observed Resident #7 ' s skin without new skin conditions.

Review of the nurses' notes, dated 3/13/22 at 4:32 AM, revealed that Resident #7 complained of the abdominal pain. Upon assessment, the resident ' s penis and scrotum were purple and swollen, and purple urine was observed in the catheter drainage bag. Nurse #7 reported this to the physician on call. She received an order for the hospital evaluation, which the resident refused when the Ememrgency Medical Service (EMS) team arrived. After conversation with EMS team and floor staff, the resident agreed to go to the hospital.

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F 684	Continued From page 19	F 684		

Nurse #7 was not available for interview.

Hospital records review revealed that on 3/13/22, Resident #7 arrived at the Emergency Department (ED) with significant swelling of his scrotum and groin, and his condom catheter was extensively taped with medical tape. The skin assessment in ED described multiple excoriated lesions to his foreskin with active bleeding, multiple skin discolorations, two sacral pressure ulcers and abrasions over the body. The staff in ED found an ID (identification) band "embedded" in his back skin and during removal of compression hose a toenail partially lifted from the nail bed.

On 3/28/22 at 2:15 PM, during an interview, Director of Nursing (DON) expected weekly skin assessments to be done weekly as ordered by the physician. She was aware of skin assessments not being completed per schedule or in full due to Resident #7's resistance to care behavior. The DON could not provide Resident #7's skin assessment documentation after 3/4/22 through when he was discharged on 3/13/22. The DON confirmed that the facility did not utilize the armbands. She did not know how the resident "could get the armband embedded in his back" as hospital nurses described.

On 3/28/22 at 3:40 PM, during the phone interview, Psychiatric Nurse Practitioner (NP #1), indicated that Resident #7 was cognitively intact and made his own decisions. NP #1 was aware that he refused care, including skin assessments. The NP #1 stated she had adjusted the resident's psychotropic medication regimen with limited and temporary effects on his behavior.

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F 684	Continued From page 20 On 3/29/22 at 12:00 PM, during an interview, the Corporate Nurse Consultant indicated that Resident #7's skin assessment and documentation should have been completed weekly and as needed. On 3/29/22 at 12:00 PM, during a phone interview, the Medical Director stated he was aware of Resident #7's behavior issues. The Medical Director further stated that the staff could not forcefully push alert/oriented, cognitively intact residents "to do or not to do tasks" until it became dangerous for himself or others. The interview further revealed staff continued to educate the resident about possible negative outcomes of his non-compliance and provide psychiatric evaluation and treatment with monitoring.	F 684		
F 690 SS=H	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		4/26/22

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F 690	Continued From page 21 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on the record review, staff, Nurse Practitioner, and Medical Director interviews, the facility failed to manage the care for a condom catheter; the facility had knowledge the resident was applying a condom catheter independently without a physician's order, and wrapping medical tape around the condom catheter; the facility failed to consider alternative interventions for the resident's urinary incontinence for 1 of 2 residents reviewed for urinary catheters (Resident # 7). On 3/13/22 Resident #7 arrived at the Emergency Department (ED) with significant swelling of his scrotum and groin and his condom catheter was extensively taped with medical tape. The condom catheter was removed immediately on arrival due to concerns for compromised circulation to the penis and scrotal area. Blood was observed coming from his penis when the catheter was removed. The skin assessment in ED described multiple excoriated lesions to his foreskin with active bleeding. Resident #7 was admitted due to	F 690	F690 Resident # 7 is no longer at the facility. Current residents with condom catheters will be audited by DON/designee for appropriate orders and appropriate care orders. Alternative interventions will be provided if condom catheter is not appropriate Clinical staff will be educated by DON / designee on care of condom catheters and alternative interventions to condom catheters. Any Licensed Nurse who is not educated will not be allowed to work until education received Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation process DON or designee will audit all condom catheters for orders and alternative	

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F 690	Continued From page 22 suspected septic shock. Findings included: Record review revealed the facility's policy, "Urinary Catheter Care and Catheterization," dated 11/1/19, indicated for licensed nurses the procedure of application of the condom catheter in accordance with the standard of practice. The nurse should assess the penis for skin discoloration, swelling and signs of impaired circulation several times each shift, and document in the progress notes the date/time of procedure, size of the catheter, skin and penis condition during the external catheter application, any unusual findings, and urine appearance and amount. Resident #7 was admitted to the facility on 1/16/20. His quarterly Minimum Data Set (MDS) assessment, dated 12/4/21, revealed his intact cognition. Resident #7's diagnoses included hereditary spastic paraplegia (paralysis of the legs and lower body), neuromuscular dysfunction of the urinary bladder, encounter for fitting and adjustment of urinary device, and major depressive disorder. The MDS indicated the resident required extensive assistance with activities of daily living (ADL), was always incontinent for bowel and bladder, and used a condom (external) catheter. He exhibited rejection of care 1 to 3 days during the 7-day look back, and received psychotropic medications and psychotherapy. Record review of Resident #7's plan of care, dated 3/6/22, revealed that he had a condom catheter, manipulated his condom catheter, and wrapped it with tape regardless of education "that	F 690	interventions if needed 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Completion April 26, 2022	

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F 690	Continued From page 23	F 690		

this is not appropriate and can lead to injury." The interventions were to change the condom catheter per the physician's order, position the condom catheter bag and tubing below the level of the bladder, and monitor for signs of discomfort in urination and frequency and pain due to the catheter. The same plan of care indicated that the resident exhibited adverse behavioral symptoms as resistive to care. The interventions were to administer medications as ordered, monitor, and document for side effects and effectiveness.

Review of the physician's orders for Resident #7, dated 12/3/21, revealed the orders to apply condom catheter, provide catheter care, validate the anchor for the catheter and privacy bag every shift, and change it as needed.

Records review revealed the written statement of the Director of Nursing (DON), dated 2/15/22, indicate that DON "educated Resident #7 regarding the risks and consequences of continuous refusal of care and inappropriate actions witnessed with regard to taped condom catheter and serious danger of this action up to including death." Resident #7 replied "If I die, I die."

Records review of the nurses' notes, dated 2/16/22, revealed that Resident #7 asked this to put his condom catheter back on because it came off. Nurse #12 applied the condom catheter and the resident requested to put tape around his penis. The Nurse #12 refused to do it, explained the hazard in using tape and that it could cause serious skin issues, and was encourage not to use it. Resident #7 stated he would use it anyway.

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On 3/28/22 at 1:25 PM, during an interview, Social Worker (SW) was aware that Resident #7 often did not allow the staff to apply condom catheter. SW remembered in February 2022, the resident asked her for tape, which he would apply to the condom. SW replied that the facility employed experienced staff for condom catheter application, according to the standard of care. SW mentioned that using the tape could lead him to "bad and scary consequences." Resident #7 verbalized that SW "probably right", but he "does not like anyone but him touching his catheter." The SW notified the floor nurse (could not recall the name).

On 3/29/22 at 9:00 AM, during the phone interview, Nurse #8 indicated that Resident #7 refused condom catheter application and care very often and preferred to complete this task himself. On 3/9/22, he was observed with white tape around the condom. When the nurse asked to remove it, the resident became agitated, confused, and requested to have more white tape. The nurse reoriented him to the place and reminded him that he had placed the tape around the condom himself. The resident fell back to sleep and did not allow Nurse #8 to remove the tape from his condom catheter. Nurse #8 did not know where the resident received the white tape. There was no edema or discoloration of resident's genitalia noted. On 3/9/22, Nurse #8 did not notify the nurse practitioner or physician because it was well known and the resident's routine behavior.

Review of the nurses' notes, dated 3/13/22 at 4:32 AM, revealed that Resident #7 complained of the abdominal pain. Upon assessment, the resident had purple, swollen private area, and

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	345420	A. BUILDING _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

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purple urine in the catheter drainage bag and presented symptoms of upper abdominal pain. Nurse #7 reported it to the physician on call. She received an order for the hospital evaluation, which resident refused when the Emergency medical Service (EMS) team arrived. After additional conversation with the EMS team and floor staff, the resident agreed to go to the hospital.

The Nurse #7, who was assigned for Resident #7 on 3/13/22, was not available for interview.

On 3/28/22 at 1:45 PM, during an interview, Nurse #6, Unit Manager, indicated the nurses reported that Resident #7 refused assistance with condom catheter application and skin assessment of his private area, and constantly manipulated with white tape around the condom. The staff educated the resident about possible poor outcomes, but he continued the same behavior. Nurse #6 reported it to the Director of Nursing (DON) and Nurse Practitioners several times. On 3/13/22, Nurse #7 reported that the resident complained of abdominal pain. Upon assessment, his genitalia were enlarged, swollen, and purple. Nurse #7 communicated this to the physician on call and obtained an order to send the resident to the hospital.

Record review of the EMS report, dated 3/13/22, revealed the team observed Resident #7 to have a condom catheter that was taped extensively to his penis with medical tape. His scrotum was also noted to be enlarged and tight. The urine in the drainage bag was purple.

Hospital records review revealed that on 3/13/22, Resident #7 arrived at the Emergency

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Department (ED) with significant swelling of his scrotum and groin and his condom catheter was extensively taped with medical tape. There was purple colored urine in the drainage bag. The skin assessment in ED described multiple excoriated lesions to his foreskin with active bleeding. It was also noted the condom catheter was removed immediately on arrival due to concerns for compromised circulation to the penis and scrotal area. Blood was observed coming from his penis when the catheter was removed. Resident #7 was admitted due to suspected septic shock.

Records review revealed the written statement of the Administrator, dated 3/28/22, indicated that Nurse #7, assigned for the Resident #7 on 3/13/22, reported she assessed the resident: his private area was red/purple and swollen with purple urine in the drainage bag. Nurse #7 called Emergency Medical Service (EMS). The resident refused to go to the hospital, but after additional conversation, EMS team took the resident to the Emergency Department (ED).

On 3/28/22 at 3:40 PM, during the phone interview, Psychiatric Nurse Practitioner (NP #1) indicated that Resident #7 was cognitively intact and made his own decisions. NP #1 was aware that he refused care, including condom catheter care. NP #1 indicated the resident's psychotropic medication regimen was adjusted with limited and temporary effects on his behavior.

On 3/29/22 at 7:10 AM, during an interview, Nurse #5 indicated that Resident #7 did not allow the staff to provide overall condom catheter care and manipulated with white tape around his condom catheter very often.

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On 3/29/22 at 11:50 AM, during an interview, Nurse #12, indicated that Resident #7 did not comply with condom catheter application and care. He constantly manipulated his condom catheter, did not allow the staff to provide catheter care, used white tape around the condom, and rejected the genitalia skin check. The Nurses #12 did not document in the nurses notes each time she observed the tape around resident's condom catheter. She did not notify the NP or Medical Director every time the resident applied the tape on his condom catheter.

On 3/30/22 at 8:40 AM, during the phone interview, Nurse Aide #7 indicated that Resident #7 often applied the white tape around the condom and did not want to remove it. Nurse Aide #7 did not know how the resident received the tape and observed the roll of tape in the resident's room. Nurse Aide #7 did not touch the tape on the condom catheter because nurses provided the condom catheter application, adjustment, and removal procedures. The resident was well known for tape application around his condom catheter, so Nurse Aide #7 did not notify the nurses when he observed tape on the condom catheter.

On 3/30/22 at 9:30 AM, during an interview, Nurse Aide #8 indicated that she often observed Resident #7 with tape around his condom catheter. He did not allow the staff to remove it. Nurse Aide #8 did not know where and how the resident received the tape, he used for his condom catheter. Nurse Aide #8 stated at times she reported it to the floor nurses, who would come to talk to the resident.

On 3/30/22 at 2:55 PM, during an interview, the

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DON stated she was aware that Resident #7 was not in compliance with condom catheter application and care. The staff reported he applied tape around the condom and refused to remove it. The staff did not provide the tape to the resident. The DON stated most likely, he ordered it online and had it delivered to the facility. The Resident's behavior, risks, and consequences of continuous refusal of care, inappropriate actions witnessed with regard to taped condom catheter, with possible serious danger of this action, was discussed with NP #1 and Medical Director. On 2/2/22 and 2/24/22, during the visits, NP #1 adjusted the psychotropic medication regimen without significant changes in the resident behavior. When Nurse #7 assessed the resident with swollen genitalia and purple urine in the drainage bag, she sent the resident to the ED per the physician's order.

On 3/29/22 at 12:00 PM, during the phone interview, Medical Director was aware of Resident #7's behavior issues, including not following the physician's orders for a condom catheter. Medical Director stated that the staff could not forcefully push alert/oriented, cognitively intact residents "to do or not to do tasks" until it becomes dangerous for himself or others. The Medical Director mentioned he did not visit the Resident #7 but discussed his situation with NP#1. In the case like that, the Medical Director would contact the resident's family, but the staff reported the Resident #7 was estranged from his family and had no support. Therefore, the NP#1 adjusted the psychotropic treatment, and the staff continued to educate the resident about possible negative outcomes of his non-compliance and provided monitoring.