STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING ______ B. WING ______	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 11/28/22 through 12/1/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# SG5H11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 11/28/22 through 12/1/22. Immediate Jeopardy was identified at CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of care Immediate Jeopardy began on 11/22/22 and was removed on 12/2/22. An extended survey was conducted Nineteen of the 32 complaint allegations were substantiated resulting a federal deficiencies. See NC00190075, NC00190775, NC00192085, NC00192302, NC00192468, NC00194329, NC00194590, NC00189975, NC00194692, NC00195127 and NC00195372 for Event # SG5H11.	F 000		
F 550 SS=G	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.	F 550		12/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/23/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without 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 record review, observation and resident and staff interview, the facility failed to promote dignity by failing to address resident's repeated request for incontinence care (Resident	F 550	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction	

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F 550 Continued From page 2

#60) and by ignoring resident's request and allowing a resident to lay in a wet pad (Resident #51) for 2 of 3 sampled residents reviewed for dignity (Residents #60 & #51). The facility's failure to promote dignity made Resident #60 angry and made Resident #51 feel deserted.

The findings included:

1. Resident #60 was admitted to the facility 9/5/2022 with diagnoses that included cerebral infarct (stroke).
Resident #60's quarterly Minimum Data Set (MDS) dated 11/15/2022 indicated the resident was cognitively intact, had clear speech, understood others and could be understood by others. She was coded as requiring extensive assistance for all activities of daily living and dependent upon staff for toileting during the assessment period.

The resident's comprehensive care plan, last revised 11/18/2022, had a focus for assistance with activities of daily living related to weakness and overall deconditioning. Interventions included provide incontinence care on routine rounds and in a timely manner.

On 11/30/2022 at 9:09 AM Resident #60 was heard yelling out for "someone help me". The resident also made the statement, "I am wet. Someone come help me". Resident #60 was sitting on the side of her bed in a pajama top and nothing but an incontinent brief on her lower body. The incontinent brief was visibly wet and the resident's bed linens were visibly wet with urine (yellow in color). When standing at the threshold of the room, a strong smell of urine was present and there was a pile of wet clothing on

F 550

is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

F550

On 11/30/2022, the Activity Director, Medication Aide #4 and Nursing Assistant #9 were educated on resident rights and promoting of dignity in a resident who is incontinent. On 11-30-2022, an in-service was initiated to all nursing staff, licensed nurses, medication aides and certified nursing assistants on promoting dignity and completing incontinent care, to include a wet under pad related to the concern of resident #51 and calling out for help on resident #60. In servicing was conducted by the Director of Nursing and Regional Clinical Manager. The Vice President of Operations interviewed resident #51 and resident# 60 on 12-5-2022,no issues were identified since 11-30-2022.

All incontinent residents have the potential to be affected. Interviews of all alert and oriented residents and non alert and oriented residents responsible parties were conducted by the Regional Clinical Manager and completed on 12/21/2022, with no concerns identified related to

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F 550	Continued From page 3 the floor next to the resident's feet. The resident was easily visible from the hall where other residents, staff, and family could see her sitting in a wet brief. At 9:09 AM when resident was yelling out for assistance, there was a housekeeper and a medication aide (MA) observed in the hall outside her door. At 9:15 AM Resident #60 called out again for assistance. The activity director entered the room and offered the resident a newspaper. The resident stated she wanted to talk to the "lady from the state". The activity director told the resident she would let the lady from the state know. The activity director did not acknowledge the resident was sitting in urine or that her call bell was on the floor next to her bed. She did not offer the resident assistance or offer to find assistance for the resident. At 9:25 AM Medication Aide (MA) #4 entered Resident #60's room and administered medications to her roommate. Resident #60 was observed making derogatory comments regarding the facility and the staff for letting her sit in a wet bed with a wet brief. These comments were made while MA#4 was in the room. The MA exited the room without acknowledging the resident's condition or offering to get assistance for the resident. An interview was conducted with the MA on 11/30/2022 at 9:30AM. She stated she did not hear Resident #60 calling out for assistance and when she went into the room to administer medications to the roommate, she did not see that Resident #60 was sitting in a wet incontinent	F 550	dignity for incontinence care. On 12/1/2022, the Regional Clinical Manager continued with education to all staff on resident rights and promoting of dignity. This education included answering call lights, calling out for assistance, seeking assistance for a resident when asking for incontinent care and completing incontinent care thoroughly to include changing under pads or clothing if necessary. This education was completed on 12/30/2022. Any staff member who did not receive this education by 12/30/2022 will not be allowed to work until complete. The Director of Nursing added this education to the new hire orientation on 12/15/2022. The Administrator or designee will conduct 10 resident and/or responsible party interviews weekly x 4 weeks, then 5 interviews x 4 weeks, then 2 interviews monthly x 1 month for validation of dignified care for the incontinent. Interviews will be conducted weekly for resident #51 and #60 by the Administrator or designee to ensure dignity is maintained. These audits will continue x 12 weeks. The Director of Nursing or designee will randomly audit 10 residents weekly x 4 weeks then 5 resident weekly x 4 weeks then 2 residents monthly x 1 month for care of the incontinent resident in a timely manner and completion of tasks. The Administrator or designee will bring these audit results to the Quality	

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F 550

Continued From page 4

brief, nor did she smell urine while she was in the room.

At 9:45 AM NA #9 was observed entering Resident #60's room. The NA closed the door and provided incontinence care.

An interview was conducted with NA #9 on 11/30/2022 at 10:45. She stated she was in another room and did not hear Resident #60 calling out. The activity director let her know the resident needed assistance. She stated when she entered Resident #60's room there was a strong smell of urine and she found the resident sitting in a wet and soiled incontinent brief with wet bed linens and there was wet clothing on the floor. She stated the resident does typically use the call bell for assistance, but her call bell had fallen on the floor next to her bed and she did not believe the resident was able to reach the call bell.

On 11/30/2022 at 11:00AM an interview was conducted with Resident #60. She stated it makes her angry and sad when staff leave her in a wet bed with wet brief smelling of urine after she asked repeatedly for help. She stated she would have cleaned herself up if she could have, but she could not.

An interview was conducted with the Regional Nurse Consultant on 12/1/2022 at 4:08PM. She stated all residents should be treated with dignity and provided incontinent care when requested.

2. Resident # 51 was admitted to the facility on 12/23/19 with multiple diagnoses including cerebrovascular accident (CVA) with left hemiplegia. The quarterly Minimum m Data Set

F 550

Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.

Date of Compliance: 12/30/2022

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F 550	Continued From page 5 (MDS) assessment dated 11/15/22 indicated that Resident #51's cognition was intact, and she did not have any behaviors. The assessment further indicated that Resident #51 was always incontinent of bowel and bladder, and she needed extensive assistance from the staff with personal hygiene. Review of Resident #51's active care plan, last reviewed on 11/18/22 was conducted. The care plan problem was "resident has potential for skin breakdown related to functional and mobility deficits with incontinence". The approaches included "provide assistance with toileting as needed, monitor for incontinence on routine rounds and provide incontinent care in a timely manner". On 11/28/22 at 11:20 AM, Resident #51 was interviewed. She reported that on 11/27/22 between 3 and 4 PM, she was soaking wet, from her gown to the bed. She used her call light to call for assistance and had waited for 2 hours (pointed the clock on the wall) and nobody came. Finally, a Nurse Aide (NA) (didn't know her name) came, provided her with incontinent care and changed her wet gown. She requested the NA to change her pad as it was also wet but the NA ignored her and left the room. She again pushed her call light for assistance to change her wet pad. Resident #51 stated that she had to lay in a wet pad until the corporate staff member came and changed the wet pad. The resident had shared the name of the corporate staff member who had changed her wet pad. On 11/29/22 at 12:05 PM, the Division Vice President (VP) of Operation was interviewed. He reported that he remembered changing Resident	F 550		

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F 550	Continued From page 6 #51's wet pad, but he could not remember the date and time. He indicated that the resident did not inform him of what had happened, she just requested her pad changed since it was wet. On 11/29/22 at 12:50 PM, Resident #51 was again interviewed. The resident was consistent with her story. She reported same information she shared on 11/28/22 interview. She stated that the delay in answering the call light and incontinent care and laying in a wet pad made her feel deserted and she felt like "staff don't care about me". On 12/1/22 at 8:21 AM, the VP of Clinical Operation was interviewed. She stated that Nurse Aide (NA) #10 was assigned to Resident #51 on 11/27/22. She indicated that NA #10 was a traveler from other sister facility and the facility did not have her telephone number. On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected staff to provide dignity to all residents.	F 550		
F 561 SS=D	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,	F 561		12/30/22

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F 561	Continued From page 7 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 reviews, observations, resident, family, and staff interviews, the facility failed to honor residents ' choices related to showers (Resident #24) and additional milk with meals (Resident #12) for 2 of 6 residents reviewed for choices. Findings include: 1. Resident #24 was admitted to the facility on 09/26/22 with diagnosis that included right hip fracture due to a fall, diabetes (DM), end stage renal disease (ESRD) on dialysis. An admission Minimum Data Set (MDS) assessment dated 10/03/22 indicated Resident #24 was cognitively intact, needed extensive assistance from two staff members with all transfers and was totally dependent for one staff member assistance with bathing.	F 561	Resident # 24 was discharged home from the facility on 12/7/22. Resident # 12 tray preferences for 3 milks for each meal was added on 12/2/2022, and diet order was changed on 12/14/2022. 100% of all alert and oriented residents were interviewed on shower preferences and beverage preferences for meals. This audit was conducted on 12/2/22 by the Director of Clinical Resources. On 12/21/2022 the Regional Clinical nurse completed interviews for all non-alert and oriented residents responsible party for the shower and beverage preferences. For any resident who had a change in shower preference or beverage preference, this change was made by 12/30/2022 by the Unit Supervisor or the Dietary Manager	

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A review of grievance dated 10/10/22 was filed by Resident #24 related to not receiving showers since she was admitted on 09/26/22. The investigation and findings listed on the grievance was that Resident #24 had orders for non-weight bearing at this time. The resolution included staff was educated on giving showers and what to do for a refusal.

A review of Resident #24's active care plan, last reviewed 10/11/22, included a focus area for decreased ability to perform Activities of Daily Living (ADLs) related to right hip fracture with functional and mobility deficits present.

A review of Resident #24's nursing progress notes from 09/27/222 to present revealed no refusals of showers documented. The nursing progress notes also revealed an entry on 11/18/22 at 02:54 PM that Resident #24 ' s daughter was called and made aware about her receiving a shower.

A review of the active physician ' s orders indicated Resident #24 attended dialysis on Tuesday, Thursday, and Saturday.

A review of the "Shower Schedule" indicated Resident #24 was to receive a shower every Monday and Thursday on first shift (7:00 AM to 3:00 PM). The shower schedule is in the shower binder at the nurse ' s station. It lists the room numbers with the shift the shower is to be done on.

On 11/29/22 hard copy shower sheets were provided by Med Aide #3/Central Supply for 10/05/22 through 10/27/22. The shower sheets

F 561

100% all staff were in-serviced by the Regional Clinical manager on honoring resident choice and preferences. This in-service was completed on 12/30/2022. Any staff who did not receive the education by 12/30/2022 will not be allowed to work until the education is complete. The Director of Nursing added this education to the new hire orientation on 12/15/2022.

The Director of Nursing will audit shower preferences and completion of 10 residents per week for 4 weeks then 5 residents per week x 4 weeks, then 5 residents per month x 1 month. The Dietary manager will audit 10 residents meal trays for beverage preferences x 4 weeks, then 5 resident meal trays x 4 weeks then 5 resident meal trays x 1 month.

The Director of Nursing and the Dietary Manager and/or designee will bring these audits to the Quality Assurance Committee meeting x 3 consecutive months. The Quality Assurance Committee will determine if further monitoring is necessary.
Date of Completion: 12/30/2022

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F 561	Continued From page 9 revealed no shower was documented as provided, instead a bed bath was provided. They indicated they could not locate any additional shower sheets for Resident #24. An interview with Resident #24 was conducted on 11/28/22 at 10:26 AM. Resident #24 ' s hair was combed and appeared well-kept. She stated her shower days were every Monday and Thursday, but she had dialysis every Thursday which interfered with her Thursday shower day. She stated she left the facility between 09:00 AM and 10:00 AM and normally returned between 03:00 PM and 04:00 PM from dialysis. She revealed she would receive a bed bath, but she has had only one shower since admission. She further stated that she has refused once when the staff offered a shower because her "hired help" was coming in to wash her hair. She also stated her family member had to hire a friend to come in to wash her hair because she was not getting her showers. She stated her family member had called the facility about the showers and she thought they had fixed the problem. She stated she had asked the Nursing Assistants (unable to recall specific staff names) and Charge Nurse #1 to change the Thursday shower to a different day due to dialysis and fatigue after dialysis. She further stated they never got back to her, and she filed the grievance on 10/10/22. An interview was conducted on 11/28/22 at 11:48 AM with Charge Nurse #1. She stated she was not aware Resident #24 ' s dialysis day interfered with her shower day. She also stated her shower day should have been changed to a day that she did not have dialysis. A phone interview was conducted on 11/29/22 at	F 561		

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02:32 PM with Resident #24 ' s family member. She stated Resident #24 would call her and tell her that she had not received a shower at all. She had not received one for the first month and a half of being at facility. The family member stated she now pays someone to come in to wash resident ' s hair and it shouldn't be that way.

An interview was conducted on 11/29/22 at 05:55 PM with Nurse Aide #5. He stated he would switch Resident #24 ' s shower days with another room and correct it on the shower sheet. He further stated he would switch it with an empty room so there was no conflict. He stated Resident #24 was tired upon returning from dialysis and frequently asked to be laid down. He did not recall Resident #24 refusing a shower, but he normally worked 2nd shift (3PM-11PM) and her shower days were on 1st shift (7AM-3PM).

Interview with Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP) on 11/30/22 at 12:10 PM. She stated she observed Resident #24 being taken to the shower room on 11/18/2022. She then stated she called Resident #24 ' s family member to follow up with her previous grievance and to let her know Resident #24 was receiving a shower at that time.

Interview was conducted on 11/30/22 at 07:42 PM with Nurse Aide #8. Has worked at facility for 4 months. She stated it was hard to get showers done when they are short staffed. There were times the showers did not get done so she would give bed baths.

Interview was conducted on 12/01/22 at 11:20 AM with Nurse Aide #6. She stated that on most days

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F 561		F 561		

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staff was unable to provide showers because of being short staffed. She also stated she would report to 2nd shift, but they were short as well. She further stated she gave bed baths when short staffed. She then stated she set the resident up with a wash basin, soap, and water so they could start their bed bath then she would assist them in completing the bed bath.

The Regional Nurse Consultant was interviewed on 12/01/22 at 4:13 PM. She stated she expected Resident #24 ' s showers to be offered and provided on her scheduled days. She added that if dialysis interfered with the shower schedule, she expected the shower days to be adjusted. She stated she expected nursing staff to provide ADL assistance, to include showers, at the resident ' s preferred time.

2. Resident #12 was admitted to the facility on 05/12/22.

A Quarterly Minimum Data Set (MDS) assessment dated 11/07/22 indicated Resident #24 was cognitively intact.

An interview was conducted with Resident #12 on 11/28/22 at 11:01 AM. He stated he requested over a month ago for Charge Nurse #1 to have dietary send him 3 small cartons of milk on every meal tray. He also stated as of today, he had not received 3 milks on his meal trays from dietary. He further stated he had to ask staff for the additional milk, sometimes they would bring it to him and sometimes they would not.

An interview was conducted with Charge Nurse #1 on 11/29/22 at 10:07 AM. She stated that Resident #12 had requested to have 3 milks on

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F 561	Continued From page 12 his meal trays, but she did not fill out a diet request ticket. She stated the kitchen brings a bin with milk in it on ice to the hall with meals and the NAs can grab the milk out and give the residents how many they want. She stated she will give Resident #12 extra milk when she is working. An interview was conducted with the Dietary Manager on 11/29/22 at 11:16 AM. She stated the kitchen brings out bins of milk for breakfast only and if the residents wanted additional milk or other items a diet request ticket would need to be filled out and brought to the kitchen. She stated she had not received a diet request ticket for Resident #12 to receive 3 milks on his meal trays. Resident # 24 ' s diet order read; low concentrated sweets (LCS)/no added salt (NAS), Mechanical Soft, Special Instructions: Large portion proteins at all meals. Resident #24 was not on fluid restrictions, diet restrictions, or any reason the facility could not honor his request for additional milk. An interview was conducted with Med Aide #6 on 12/01/22 at 11:34 AM She stated she assisted the NA ' s with answering call lights, passing meal trays, and provide resident care. She also stated she was familiar with Resident #12, and he did ask for additional milk with meals. She further stated that she would give him the milk when he requested it. The Regional Nurse Consultant was interviewed on 12/01/22 at 04:13 PM. She stated she expected nursing staff to assist residents with notifying the correct individuals of requests such as foods and additional milk or coffee if their diet permitted the change. She indicated that the request for additional milk for Resident #12	F 561		

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F 561	Continued From page 13 should have been submitted to dietary per his request if his diet permitted it.	F 561		
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. (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,	F 623		12/30/22

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F 623	Continued From page 14 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 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	F 623		

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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 interviews with staff, the facility failed to provide the resident and/or Responsible Party (RP) written notification of the reason for a hospital transfer for 3 of 4 residents reviewed for hospitalization (Residents #18, #66 and #325).

The findings included:

1. Resident #18 was admitted to the facility on 8/25/16.

Resident #18's medical record revealed he was transferred to the hospital and readmitted to the facility for respiratory issues on 8/6/22 to 8/17/22 and 8/21/22 to 9/1/22. There was no documentation that written notices of transfers

F 623 (Provider's Plan of Correction)

On 12-16-22, Social Worker notified resident #18 and/or RP for reason of transfer to hospital 8-6-22 to 8-17-22 and transfer 8-21-22 to 9-1-22. This notification was completed by phone, RP did not wish to receive written notification for the transfers. On 12-16-22, Social Worker updated resident # 325□s RP of the failure to provide written notification of hospital transfers in October and November 2022. Responsible Party did not wish to receive written notification at this time. Resident # 66 was discharged from the facility on 12-16-22 to home.

On 12-9-22, Social Worker completed a 100% audit of any in house resident that

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were provided to the resident and/or RP for the reasons of the transfers.

A Significant Change in Status Minimum Data Set (MDS) assessment dated 9/13/22, indicated Resident #18 was cognitively intact.

A review of Resident #18's medical record revealed he was transferred to the hospital on 9/30/22 for respiratory issues. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer. Resident #18 returned to the facility on 10/5/22.

Charge Nurse #1 was interviewed on 11/30/22 at 10:15 AM and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, medication list, transfer form, any other pertinent documents and a Bed Hold policy were sent with the resident when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. Charge Nurse #1 stated she was unaware of a written notification of transfer being provided to the RP and/or resident.

On 11/30/22 at 11:51 AM, an interview was conducted with the Social Worker (SW). She was familiar with the regulation to provide a written reason for hospital transfer to the resident and/or RP as this was her responsibility but explained she hasn't done this since June 2022 as she became busy with other things.

The Regional Operations Manager was interviewed on 12/1/22 at 1:45 PM and stated she would expect the SW to provide the resident/and or RP notification in writing for the reason of the

F 623

was transferred to the hospital since 11-1-22. Notification was provided to the resident or the Responsible party of the failure to send written notification and documented in chart. This was completed by 12-16-22.

The Director of Clinical Resources provided an in-service to the Social Worker on the requirement of notification in writing to the resident and/or responsible party for any unplanned discharge to include location of discharge, date of discharge and reason for discharge. The in-service was completed on 12-16-22.

The Administrator or designee will audit all unplanned discharges for verification of written notification to the resident and/or RP weekly x 12 weeks.

The Administrator or designee will bring the audit results to the Quality Assurance Committee meeting for 3 consecutive meetings. At this time, the committee will determine if any further monitoring is required of the notification process.

Date of Compliance : 12/30/2022

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hospital transfer per the regulation.
2. Resident #66 was admitted to the facility on 10/17/22.

Resident #66's medical record revealed he was transferred to the hospital on 10/24/22 and returned to the facility on 10/28/22. Further review revealed he was again transferred to the hospital on 11/15/22 and returned to the facility on 11/17/22. There was no documentation discovered in the resident ' s medical record of written notices of transfers provided to the resident and/or Responsible Party (RP) regarding the transfers.

An Admission Minimum Data Set (MDS) assessment dated 11/04/22, indicated Resident #66 was cognitively intact.

A review of Resident #66's medical record revealed he was transferred to the hospital on 10/24/22 for altered mental status and tremors. There was no documentation that a written notice of transfer was provided to the resident and/or RP for the reason of the transfer. Resident #66 returned to the facility on 10/28/22. Further review of the medical record revealed there was no documentation of a written notice of transfer provided to the resident and/or RP for the reason of the transfer. Resident #66 returned to the facility on 11/17/22.

Charge Nurse #1 was interviewed on 11/30/22 at 10:15 AM and stated a copy of the face sheet, code status, medication list, transfer form, any other pertinent documents and a Bed Hold policy were sent with the resident when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and

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F 623	Continued From page 18	F 623		

reason for the transfer. Charge Nurse #1 stated she was unaware of a written notification of transfer being provided to the RP and/or resident.

On 11/30/22 at 11:51 AM, an interview was conducted with the Social Worker (SW). She was familiar with the regulation to provide a written reason for hospital transfer to the resident and/or RP as this was her responsibility but explained she hasn't done this since June 2022 as she became busy with other things.

The Regional Operations Manager was interviewed on 12/1/22 at 1:45 PM and stated she would expect the SW to provide the resident/and or RP notification in writing for the reason of the hospital transfer per the regulation.

3. Resident #325 was admitted to the facility on 02/22/22.

Resident #325's medical record revealed he was transferred to the hospital and readmitted to the facility for elevated respirations and increased oral secretions on 10/24/22 to 10/30/22 and for decreased oxygen saturations and increased heart rate on 11/12/22 to 11/21/22. There was no documentation that written notices of transfers were provided to the resident and/or RP for the reasons of the transfers.

A Quarterly Minimum Data Set (MDS) assessment dated 10/10/22, indicated Resident #325 was rarely/never understood and his cognitive skills for daily decision making was moderately impaired.

A review of Resident #325's medical record revealed he was transferred to the hospital on

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F 623	Continued From page 19 10/24/22 for elevated respirations and increased oral secretions. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer. Resident #325 returned to the facility on 10/30/22. A review of Resident #325's medical record revealed he was transferred to the hospital on 11/12/22 for decreased oxygen saturations and increased heart rate. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer. Resident #325 returned to the facility on 11/21/22. Charge Nurse #1 was interviewed on 11/30/22 at 10:15 AM and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, medication list, transfer form, any other pertinent documents and a Bed Hold policy were sent with the resident when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. Charge Nurse #1 stated she was unaware of a written notification of transfer being provided to the RP and/or resident. On 11/30/22 at 11:51 AM, an interview was conducted with the Social Worker (SW). She was familiar with the regulation to provide a written reason for hospital transfer to the resident and/or RP as this was her responsibility but explained she hasn't done this since June 2022 as she became busy with other things. The Regional Operations Manager was interviewed on 12/1/22 at 1:45 PM and stated she would expect the SW to provide the resident/and or RP notification in writing for the reason of the	F 623		

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F 623	Continued From page 20 hospital transfer per the regulation.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change Minimum Data Set (MDS) after 6 areas of decline on consecutive MDS assessments for 1 (Resident #64) of residents reviewed for a significant change in status. The findings included: Resident #64 was admitted on 12/3/21 with cumulative diagnoses of Dementia, Diabetes, anxiety and major depression. Review of the care plan dated 12/10/21 and last revised on 9/2/22 indicated Resident #64 was care planned for assistance with her activities of daily living related to weakness and over all deconditioning. The quarterly MDS dated 9/1/22 indicated	F 637	Resident #64 had a significant change assessment completed on 12-9-22 by the Minimum Data Set Nurse. This assessment was transmitted on 12-16-22 by the Minimum Data Set Nurse. All current residents on census as 12/8/22 were audited for compliance with Significant Change assessment for decline in Activities of Daily Living, Cognition and Continence (physical and mental condition). This audit was completed on 12/16/22 by the Regional Minimum Data Set Manager. No other residents were affected by the same deficient practice. Minimum Data Set Coordinator was educated by the Regional Minimum Data	12/30/22

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F 637	Continued From page 21 Resident #64 was cognitively intact, required supervision with dressing, hygiene, toileting and bathing. She was also coded as being continent of bladder and bowel. Review of a Program of All-Inclusive Care for the Elderly (PACE-a Medicare/Medicaid program for older adults and people over age 55 living with disabilities) social worker note dated 10/6/2 indicated the family was made aware of continuing decline due to her chronic kidney disease but the family refused dialysis. The next MDS assessment was another quarterly MDS assessment dated 10/31/22. Resident #64 was now coded with moderate cognitive impairment, requiring extensive staff assistance with dressing hygiene, toileting and total assistance with bathing. Resident #64 was also coded as frequently incontinent of bladder and bowel. An interview was completed on 12/1/22 at 10:40 AM with the Regional Reimbursement Manager in the absence of the facility ' s MDS Nurse. He stated a significant change in status MDS assessment should have been completed for the 10/31/22 QMDS review. He was unable to answer why this was not completed. An interview was conducted on 12/1/22 at 3:05 PM with the Regional Nurse Consultant. She stated the expectation was to follow the guidance and an significant change MDS should have been completed on 10/31/22 rather than a quarterly assessment.	F 637	Set Manager on 12/9/2022. This education includes timing and completion of Significant Change within 14 days of a significant change in resident's physical and mental condition. This education will be included on any new Minimum Data Set staff hired at the time of orientation. The Regional minimum data set Manager or designee will conduct 5 chart audits weekly on residents with a change in physical and mental condition for 4 weeks, then 3 chart audits weekly for 4 weeks, and then 2 chart audits weekly for 4 weeks. The Administrator will bring the audit for Significant Change Assessment related to decline in physical and mental condition to the Quality Assurance Committee monthly for 3 months. At that time, the Quality Assurance Performance Improvement committee will evaluate the effectiveness of the training to determine if continued auditing is necessary to maintain compliance. Date of completion 12/30/22	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		12/30/22

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§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 reviews, observations and interviews with the Nurse Practitioner and staff, the facility failed to transcribe the correct medication administration route for a resident with a feeding tube (Resident #18) and failed to transcribe a Physician's order (Resident #51) and a new diet order (Resident #12) accurately for 3 of 15 resident's records reviewed.
The findings included:

1. Resident #18 was originally admitted to the facility on 8/25/16 with a recent readmission date of 10/5/22. His diagnoses included a stroke with left sided paralysis and dysphagia (difficulty swallowing).

A significant change in status Minimum Data Set (MDS) assessment dated 9/13/22 indicated Resident #18 was cognitively intact with a feeding tube present. The assessment indicated the majority of Resident #18's calories and fluids were provided via a feeding tube.

The active November 2022 physician orders included an order dated 10/31/22 for Hydroxyzine (an antihistamine) 25 milligrams (mg) 1 tablet by mouth every 8 hours as needed. All other medications were written to be provided through the gastric feeding tube.

A review of the November 2022 Medication

F 658 (Provider's Plan of Correction)

Resident #18 hydroxyzine was discontinued on 11-30-2022 by the Geriatric Nurse Practitioner. Resident # 51 Pantoprazole was discontinued by the Nurse Practitioner on 12/1/2022 and an order for Famotidine 20 mg by mouth twice a day as needed was entered by the nurse on the floor. Resident #12 diet was changed in the medical record on 11/29/2022 by the Floor nurse.

On 12-21-2022, the Director of Clinical Resources completed a 100% audit of all in house resident with gastric tubes for correct route of medications. No other issues were identified.
The Lead Consultant Pharmacist, on 12/6/2022, conducted a 100% audit of all in house residents to ensure pharmacy recommendations for the previous 6 months were completed accurately. Any discrepancies were given to the Regional Clinical manager on 12/6/2022, who made the corrections or recommendations per the physician orders.
On 12-13-2022, the Rehab Director conducted a 100% audit of all diet orders. Any resident diets that were inconsistent with any speech therapy recommendation, were corrected by the Unit Supervisor and entered into the Dietary Tray system by

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Administration Record (MAR) indicated Resident #18 had not received a dose of the Hydroxyzine.

On 11/30/22 at 3:45 PM, an interview was conducted with Medication Aide (MA) #2 who confirmed Resident #18 received all medications via the feeding tube.

The Unit Manager was interviewed on 11/30/22 at 4:15 PM. She reviewed Resident #18's active physician orders and confirmed the Hydroxyzine route of administration was by mouth. The Unit Manager explained when an order was first entered into the Electronic Medical Record (EMR) the default route was by mouth and should have been changed to gastrostomy tube (G-tube/feeding tube). She added Resident #18 received all medications via feeding tube.

An interview occurred with Charge Nurse #2 on 12/1/22 at 9:36 AM. She was the nurse that transcribed the order for Resident #18 and explained when the provider put the order into the EMR, the system defaults to the by mouth route. She would have gone in to verify and activate the order ensuring the correct administration route was present. Charge Nurse #2 stated it was an oversight not to have changed the medication route to via G-tube for Resident #18 as he took all medications via the feeding tube.

The Regional Nurse Consultant was interviewed on 12/1/22 at 1:45 PM. She reviewed Resident #18's physician orders and confirmed the route for the Hydroxyzine was entered as oral instead of via G-tube. She further explained when entering the medication into the EMR the default route was oral and she felt it was an oversight that the nurse failed to change the route to

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the Dietary Manager by 12-16-2022.

The Regional Clinical Manager initiated education on the correct route of medications for residents with gastric tubes and changing diet orders based on therapy recommendations and physician orders. This education was provided to all medication aides and licensed nurses and completed on 12/30/2022. Any licensed nurse or medication aide who did not receive the education prior to 12/30/3022 will not be allowed to work until the education has been completed. This education was added to the new hire orientation for medication aides and licensed nurses on 12/15/2022 by the Director of Nursing.
The Consultant Pharmacist was in serviced by the Regional Clinical Manager on 12/5/2022, to ensure that the recommendations have been carried out according to the physician order. The Director of Nursing and Nurse Supervisors were in service on completing the pharmacy recommendations according to the physician orders. This in-service was conducted by the Consultant Pharmacist and the Director of Clinical Resources on 12/6/2022.

The Director of Nursing or designee will conduct a weekly audit on all in house residents with gastric tubes weekly x 12 weeks for correct route of medications.
The Director of Nursing or designee will audit all pharmacy recommendations for accuracy of order entry into the EMR monthly x 3 months.

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F 658	Continued From page 24 G-tube. The Regional Nurse Consultant stated it was her expectation for all medication administration routes to be entered correctly when the order was received and/or activated. 2. Resident # 51 was admitted to the facility on 12/23/19 with multiple diagnoses including gastroesophageal reflux disease (GERD). Resident #51 had a doctor's order dated 9/22/20 for Pantoprazole (Protonix) 40 milligrams (mgs.) once a day for GERD. On 6/14/22, the Pharmacist had recommended to discontinue Pantoprazole due to long term use had been associated with increased risk of Clostridium difficile (C diff) colitis and to replace it with Famotidine (Pepcid) 20 mgs twice a day as needed (PRN) for indigestion/heartburn. The attending physician had responded "agree, please write order" to the recommendation on 6/17/22. On 6/26/22, the former Director of Nursing (DON) entered the order in the computer for Famotidine 20 mgs twice a day (scheduled) instead of BID PRN. Review of the Medication Administration Records (MARs) from June through November 2022, revealed that the Famotidine was administered to Resident #51 twice a day (scheduled). On 12/1/22 at 9:40 AM, Charge Nurse #2 was interviewed. She stated that the once the doctor agreed and signed the recommendation of the Consultant Pharmacist, it was considered a doctor's order. The Nurse was expected to enter the order in the computer for the pharmacy to dispense the medication. The Charge Nurse	F 658	The Director of Nursing or designee will audit all residents on speech therapy for diet changes weekly x 12 weeks. The Director of Nursing or designee will be responsible for bringing the results of these audits to the Quality Assurance Meeting x 3 consecutive meetings. The Quality Assurance Committee will determine if further monitoring is necessary. Date of Completion: 12/30/2022	

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reviewed the Consultant Pharmacist Communication to Physician form and the doctor's order for the Famotidine and stated that it was a transcription error. The former Director of Nursing (DON) transcribed the Famotidine as twice a day (scheduled) instead of twice a day PRN as ordered.

On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected nursing to enter orders in the computer correctly.

3. Resident #12 was admitted to the facility on 05/12/22 with diagnosis diagnoses that included diabetes mellitus with diabetic neuropathy and dysphagia.

An interview was conducted with Speech Therapy on 11/29/22 at 10:24 AM. She stated she evaluated Resident #12 on 11/03/22. She then stated she wrote a new order on 11/3/22 for his diet to be changed to solids (regular consistency) with directions for staff to assist with cutting meat when requested. She also stated she gave the order to the nurse at the nursing station, although she could not recall the nurses name, and to the Dietary Manager. She further stated at that time if there was a change in a diet order, the order was given to the nurse at the nurse ' s station and then she took a copy to the Dietary Manager. She indicated the nurse would enter the order into the system. She stated she was not aware the diet was not updated.

A Quarterly Minimum Data Set (MDS)

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assessment dated 11/07/22 indicated Resident #24 was cognitively intact.

Review of Resident #12 ' s active diet on 11/28/22 read; low concentrated sweets (LCS)/no added salt (NAS), Mechanical Soft, Special Instructions: Large portion proteins at all meals.

Review of Resident #12 ' s active diet on 11/30/22 read; Regular special instructions: large portion proteins at all meals, assist with cutting meat when requested- low concentrated sweets (LCS)/no added salt (NAS).

An interview was conducted with Resident #12 on 11/28/22 at 11:01 AM. He stated he was evaluated by Speech Therapy (ST) a month ago. He also stated ST told him his meat consistency was going to be changed to whole meats and staff could assist him cutting the meats up if needed, but the meat on his meal tray was still minced.

An interview was conducted on 11/29/22 at 11:16 AM with the Dietary Manager. She stated when Speech Therapy (ST) brings a diet change to dietary she enters the information into the system so it will print on the ticket. She also verbally informs the dietary staff of the diet change. She then stated the new diet order for resident #12 was not entered into the system therefore the ticket did not indicate the change. She stated she remembers Speech Therapy bringing the order to dietary and it was an oversite that the order did not get entered into her system.

An interview was conducted with Med Aide #6 on 12/01/22 at 11:34 AM She stated she was working on 11/03/22 on 100 hall and she did not

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F 658	Continued From page 27 receive a diet order for Resident #12. She further stated Speech Therapy (ST) would give diet orders to the nurse. An interview was conducted on 11/29/22 at 12:32 PM with Charge Nurse #1. She stated if Speech Therapy (ST) changed a diet order, the order was given to the nurse at the nurse ' s station and that nurse enters the order into the system. She was unaware of the new diet order for Resident #12. An interview was conducted on 12/01/22 at 02:56 PM with Charge Nurse #2. She stated she was working on 11/03/22 from 7AM-7PM but did not recall receiving an order for a diet change for Resident #12. The Regional Nurse Consultant was interviewed on 12/01/22 at 04:13 PM. She stated her expectation was that nursing staff enter orders when they are given to them by Speech Therapy (ST).	F 658		
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 review, observation and resident and staff interview, the facility failed to provide nail care to residents who needed extensive assistance and/or were dependent for activities of daily living (ADL) for 4 of 6 sampled residents reviewed for ADL care (Residents #3, #51, #18 & #67).	F 677	On 12/1/2022, resident #3, #51, #18 and #67 nails were cleaned, trimmed and filed by the Unit Supervisor. 100% audit of all in house residents for nail length preference was completed on 12/21/2022 by the Regional Clinical	12/30/22

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Findings included:

1. Resident #3 was admitted to the facility on 1/27/21 with multiple diagnoses including dementia.

The quarterly Minimum Data Set (MDS) assessment dated 9/26/22 indicated that Resident #3's cognition was intact, and he had no behavior of rejection of care. The assessment further indicated that Resident #3 needed extensive assistance from the staff with personal hygiene.

Review of Resident #3's active care plan, last reviewed on 9/27/22 was conducted. The care plan problem was "resident requires assistance from the staff with activities of daily living (ADL) related to weakness and overall deconditioning and dementia". The goal was "resident will have his needs met daily". The approaches included "prefers to keep a clean shave and short nails and provide ADLs".

Review of the nursing notes from the October through November 2022, revealed no refusal of nail care documented.

Resident #3 was observed on 11/28/22 at 11:26 AM with long fingernails on both hands with a brown substance noted underneath his nails. He did not know when the last time his nails were trimmed.

On 11/29/22 at 9:10 AM and 12:50 PM, Resident #3's fingernails were again observed. His nails remained unchanged from previous observation.

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manager. For residents who were not able to communicate his/her preference, the responsible party was interviewed by the Regional Clinical Manager and completed on 12/21/2022 for resident nail preference. A visual audit was conducted on 12/22/2022 by the Director of Nursing, Assistant Director of Nursing, Regional Clinical Manager, and Unit Supervisors for nail length preference and cleanliness of nails. Any resident found to have nails that were long, jagged, or dirty were trimmed to meet his/her preference, filed, and cleaned. No concerns were identified during the audit.

On 12/9/2022 an in-service was initiated by the Regional Clinical Manager for all nurses, certified nursing assistants, medication aides, and Personal care aides on nail care. This in service included preferences of nail length and cleanliness. This in service was completed on 12/30/2022, any staff who did not receive the in service, will not be allowed to work until complete. This education was added to the New Hire Orientation on December 15, 2022, by the Director of Nursing.

The Director of Nursing or designee will interview and/or visually check 10 residents weekly x 4 weeks, then 5 residents weekly x 4 weeks and then 5 residents monthly x 1 month.

The Director of Nursing or designee will bring these audit results to three consecutive Quality Assurance Committee

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On 11/29/22 at 12:50 PM, Nurse Aide (NA) #9, assigned to Resident #3, was interviewed. She stated that nail care was provided during showers. NA #9 observed the resident's nails and confirmed that they were long and dirty and needed to be cleaned and trimmed. She added that the resident had not been refusing care. NA #9 was unable to explain why the resident's nail care had not been completed.

On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected nursing to provide nail care to residents when needed.

2. Resident #51 was admitted to the facility on 12/23/19 with multiple diagnoses including cerebrovascular accident (CVA) with left hemiplegia. The quarterly Minimum Data Set (MDS) assessment dated 11/15/22 indicated that Resident #51's cognition was intact, and she had no behavior of rejection of care. The assessment further indicated that Resident #51 needed extensive assistance from the staff with personal hygiene.

Review of Resident #51's active care plan, last reviewed on 11/28/22 was conducted. The care plan problem was "resident requires assistance from the staff with activities of daily living (ADL) related to functional and mobility deficit and history of CVA with left side hemiplegia". The goal was "resident will have her needs met daily". The approaches included "prefers to keep her nails long and assist resident with cleanliness of nails as needed".

Review of the nursing notes from the October

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meetings, at which time, a determination will be made if further monitoring is necessary.

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through November 2022, revealed no refusal of nail care documented.

Resident #51 was observed on 11/28/22 at 11:20 AM with long fingernails on both hands with a brown substance noted underneath her nails. She did not remember when the last time her nails were cleaned. She stated that she preferred to have long nails, but she needed help to clean them. She reported the staff cleaned her nails during showers but since she did not have a shower for months, they had not been cleaned.

On 11/29/22 at 10:15 AM, Resident #51's fingernails were again observed. Her nails remained unchanged from previous observation.

On 12/29/22 at 12:5 PM, Nurse Aide (NA) #9, assigned to Resident #51, was interviewed. She stated that nail care was provided during showers. NA #9 observed the resident's nails and confirmed that they were dirty and needed to be cleaned. She added that the resident had not been refusing care. NA #9 was unable to explain why the resident's nail care had not been completed.

On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected nursing to provide nail care to residents when needed.

3. Resident #18 was originally admitted to the facility on 8/25/16 with diagnoses that included a stroke affecting the left side and contracture to the left hand.

A significant change in status Minimum Data Set

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(MDS) assessment dated 9/13/22 indicated Resident #18 was cognitively intact and displayed no behaviors or refusal of care. He required extensive assistance from staff for personal hygiene.

A review of Resident #18's active care plan, last reviewed on 9/14/22, included a focus area for requiring assistance from staff for Activities of Daily Living (ADL) care secondary to history of a stroke with left sided paralysis and left upper extremity contracture, right above the knee amputation, obesity, and overall functional and mobility deficits. One of the interventions included he preferred short nails.

A review of Resident #18's nursing progress notes from 5/1/22 to 11/30/22 revealed no refusals of nail care documented.

On 11/28/22 at 10:31 AM, Resident #18 was observed while lying in bed. He was noted to have long fingernails to the right and left hand as well as a dark substance under the nails to the right hand. The left hand was contracted with fingernails observed touching the palm of his hand.

Resident #18 was observed on 11/29/22 at 10:41 AM, while lying in bed. His nails remained unchanged from previous observations.

On 11/29/22 at 10:55 AM, an interview occurred with Nurse Aide (NA) #2 who was familiar with Resident #18. She stated she was not assigned to care for him, but nail care should be rendered on shower days and during personal care if the need was present. She was unable to state why his nail care had not been completed.

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An interview occurred with NA #3 on 11/29/22 at 12:10 PM, who was assigned to care for Resident #18. During an observation of Resident #18's fingernails, the NA confirmed they were long, and the right hand had a dark substance underneath them. She added she had not noticed the need during Resident #18's morning care. NA #3 stated nail care should be completed during showers and personal care if the need was present.

NA #4 was interviewed on 11/29/22 at 3:30 PM and was assigned to care for Resident #18 on the evening shift (3:00 PM to 11:00 PM). She explained Resident #18 readily accepted care from her and had no refusals. Nail care was to be done during showers/complete bed baths and as needed but she couldn't recall the last time she had performed nail care for Resident #18.

The Regional Nurse Consultant was interviewed on 12/1/22 at 1:45 PM and stated nail care should be rendered during shower days and during personal care when needed.

4. Resident #67 was admitted to the facility on 4/12/22 with diagnoses that included Parkinson's disease, dementia, and weakness.

A quarterly Minimum Data Set (MDS) assessment dated 10/10/22 indicated Resident #67 had severe cognitive impairment and displayed no behaviors or refusal of care. He required extensive assistance from staff for personal hygiene.

A review of Resident #67's active care plan, last

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reviewed on 10/12/22, included a focus area for requiring assistance from staff for Activities of Daily Living (ADL) care related to Parkinson's with weakness and deconditioning. One of the interventions included to provide assistance with ADL's, mobility and transfers as needed being careful not to overwhelm resident.

A review of Resident #67's nursing progress notes from 5/1/22 to 11/30/22 revealed no refusals of nail care documented.

On 11/29/22 at 8:55 AM, Resident #67 was observed sitting upright in bed. He was noted to have long fingernails to the right and left hand with a dark substance under them.

On 11/29/22 at 10:55 AM, an interview occurred with Nurse Aide (NA) #2 who was familiar with Resident #67. She stated she was not assigned to care for him, but nail care should be rendered on shower days and during personal care if the need was present. She was unable to state why his nail care had not been completed.

An interview occurred with NA #3 on 11/29/22 at 12:15 PM, who was assigned to care for Resident #67. During an observation of Resident #67's fingernails, the NA confirmed they were long and had a dark substance underneath them. She added she had not noticed the need during Resident #67's morning care. NA #3 stated nail care should be completed during showers and personal care if the need was present.

NA #4 was interviewed on 11/29/22 at 3:30 PM and was assigned to care for Resident #67 on the evening shift (3:00 PM to 11:00 PM). She explained Resident #67 readily accepted care

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F 677	Continued From page 34 from her and had no refusals. Nail care was to be done during showers/complete bed baths and as needed but she couldn't recall the last time she had performed nail care for Resident #67. The Regional Nurse Consultant was interviewed on 12/1/22 at 1:45 PM and stated nail care should be rendered during shower days and during personal care when needed.	F 677		
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 by: Based on record review, observations, Wound Nurse Practitioner and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 1 of 4 residents reviewed for pressure ulcers (Resident #56). The findings included: Resident #56 was admitted to the facility 2/22/21	F 686	Resident #56 air mattress was corrected to the pressure for the resident weight. This was completed on 12-2-22 by the Director of Clinical Resources. On 12-6-22, the Director of Clinical Resources completed an 100% visual audit of all in house resident for those on-air mattresses. Any resident that had an air mattress at an incorrect setting was	12/30/22

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with diagnoses that included adult failure to thrive and dementia.

Resident #56's active physician orders included an order dated 9/29/22 for an alternating pressure air mattress to the bed. Nursing to check every shift to ensure properly functioning and/or settings are in place.

A significant change in status Minimum Data Set (MDS) assessment dated 10/11/22 indicated Resident #56 had severely impaired decision-making skills, one stage 3 pressure ulcer and a pressure reducing device to the bed.

A review of Resident #56's active care plan, last reviewed 10/28/22, included a focus area for potential for further skin breakdown secondary to mobility deficits with incontinence. One of the interventions included pressure relieving device to bed and wheelchair, if indicated.

A review of Resident #56's medical record revealed from 7/29/22 to 11/3/22 wound care was provided to a sacral pressure ulcer.

Resident #56's weight on 11/3/22 was 94.1 pounds (lbs.).

The November 2022 Treatment Administration Record (TAR) revealed nursing staff had been documenting the alternating pressure air mattress was functioning properly.

On 11/28/22 at 10:15 AM, an observation was made of Resident #56. She was lying in bed with her eyes closed. The alternating pressure reducing mattress machine was set at 600 to 1000 plus lbs. weight setting. The machine

F 686

corrected on 12-2-2022 by the Director of Clinical Resources.

On 12-6-22, the Regional Clinical Manager initiated an in-service to the Director of Nursing, and Nurse Supervisors on the air mattress setting per the resident pressure requirements. All licensed nurses were in-serviced by the Regional Clinical Manager, on verification of the air mattress settings for each resident ordered an air mattress. This in-service was completed on 12/30/2022, any licensed nurse who did not receive the in-service will not be allowed to work until completed. This information was added to the new hire orientation on 12/30/22 by the Director of Nursing.

The Director of Nursing or designee will conduct a weekly audit on all resident with orders for an air mattress for verification and correct settings for each resident. This audit will be conducted weekly x 12 weeks.

The Director of Nursing or designee will bring the audit results to 2 consecutive Quality Assurance Committee meetings, at which time, the determination will be made if further monitoring is necessary.

Date of Compliance: 12/30/2022

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F 686		F 686		

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indicated to set according to the resident's weigh per pounds.

Resident #56 was observed sitting up in her wheelchair on 11/28/22 at 11:41 AM. The alternating pressure reducing mattress machine was set at 600 to 1000 plus lbs.

An observation occurred of Resident #56 on 11/29/22 at 8:50 AM, while she was lying in bed. The alternating pressure reducing mattress machine was set at 600 to 1000 plus lbs.

On 11/30/22 at 12:10 PM, an observation was made with Medication Aide (MA) #2 of Resident #56's alternating pressure reducing mattress machine, confirming it was set at 600 to 1000 plus lbs. The MA stated she checked the functionality of the air mattress daily during her rounds to make sure the connections were secured, and the mattress was inflated. The MA stated the former Treatment Nurse was the one that set up the pressure reducing mattresses and set the weights.

The Wound Nurse Practitioner (NP) was interviewed on 11/30/22 at 12:13 PM and stated she would expect the alternating pressure reducing mattress machines to be checked daily and set according to the resident's weight as stated on the machine. She added large gaps between the resident's weight and the weight on the machine would not be a useful intervention.

On 12/1/22 at 1:45 PM, an interview was held with the Regional Nurse Consultant, who stated she expected the alternating pressure reducing mattress machine to be set according to the resident's weight as stated on the machine. She

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F 686	Continued From page 37 further added that due to recent staff turnover, education regarding pressure reducing mattresses was needed. Multiple phone calls were placed to the former Treatment Nurse from 11/30/22 to 12/1/22 with no return call received.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide application of a left-hand splint according to therapy recommendations (Resident #18) for 1 of 1 resident reviewed for limited range of motion. The findings included:	F 688	Resident #18 was re-evaluated by Occupation Therapy for splint on 12/1/2022. Resident refuses to wear splint, order was discontinued and Occupational Therapy continues to work with resident #18 on stretches and attempts for splint placement.	12/30/22

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Resident #18 was originally admitted to the facility on 8/25/16 with the most recent readmission date of 10/5/22. His diagnoses included a history of a stroke with left sided paralysis and contracture to the left hand.

An Occupational Therapy (OT) initial evaluation dated 9/6/22 indicated Resident #18 would receive therapy for a left-hand contracture.

A significant change in status Minimum Data Set (MDS) assessment dated 9/13/22 indicated Resident #18 was cognitively intact and had limited range of motion to one upper extremity. He was not coded with any behaviors or refusals of care.

The care plan, last reviewed 9/14/22, revealed a problem area for being at risk for decreased range of motion secondary to current contracture of the left upper extremity/hand.

An OT discharge summary dated 9/29/22 indicated Resident #18 received OT therapy for a left-hand contracture. Upon discharge, the OT recommendation was for the resident to wear a left resting hand splint up to two hours a day as tolerated. Staff were to perform passive range of motion (PROM) to the left hand prior to placing on the splint and to complete a skin assessment to the left hand to ensure there was no skin breakdown, edema, or redness present.

Review of a In-Service Training Report dated 9/29/22, indicated nursing staff were educated on the left-hand splint for Resident #18. The in-service record indicated to perform PROM before applying the left resting hand splint on in the morning for up to three hours as tolerated.

F 688

On 12/15/2022, Occupational Therapy completed an audit for all in house residents who have been ordered splint devices. Any resident who has an order, the order was validated in the Electronic Medical Record or the resident is currently under therapy services for splint evaluation and treatment, this was completed by 12-30-2022 by the Director Rehabilitation and Unit Supervisor.

On 12/9/2022, the Regional Clinical Manager initiated an in service to all licensed nurses, medication aides and certified nursing assistants on applying the splint for each resident that has been recommended by therapy. This in-service was completed on 12/30/2022. Any licensed nurse, medication aide or certified nursing assistant who did not receive the education prior to 12/30/2022 will not be allowed to work until the in service is completed. This education was implemented into the new hire orientation for licensed nurses, medication aides and certified nursing assistants on 12/15/2022 by the Director of Nursing. The therapy staff was educated by the Regional Clinical Manager on using the Nursing Communication form for residents being discharged from therapy with a splint. This form is brought to morning meeting and given to the Director of Nursing or designee. This education was completed by 12/30/2022. Any therapy staff who did not complete the education will not be allowed to work until completed after 12/30/2022.

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F 688	Continued From page 39 Return to the mesh bag and place in his closet when the splint was removed. The form indicated the training was provided by OT , however there was no indication of who gave the in-service or what specific nursing staff were educated. A review of the active Nurse Aide care guide revealed no information related Resident #18's splint. An observation of Resident #18 was completed on 11/28/22 at 10:31 AM, while he was lying in bed. The left wrist/hand was observed to be flexed inwards, with his fingers folded towards the palm of his hand. Resident #18 was unable to straighten his fingers and there was no splinting device located in Resident #18's room. On 11/29/22 at 10:41 AM, Resident #18 was observed lying in his bed with his hands on top of the covers. There was no splinting device to his hand. Nurse Aide (NA) #3 was interviewed on 11/29/22 at 12:10 PM and regularly cared for the resident during the day shift. She stated "sometimes" Resident #18 wore a brace to his left hand, but she thought the therapy department placed it on the resident. She could not recall the last time she saw the splint on his left hand. On 11/29/22 at 12:15 PM an interview occurred with Medication Aide (MA) #2 who cared for resident regularly and stated she had not seen a hand splint for Resident #18 and was unaware he was to wear one. MA #2 stated normally splints would have a physician's order and they would sign off on the application and removal on the Treatment Administration Record.	F 688	The Director of Nursing or designee will audit 5 residents weekly x 4 weeks for application of ordered splints, then 3 residents weekly x 4 weeks and two residents monthly x 1 month. The Director of Nursing or designee will bring the audit results to the Quality Assurance meeting x 3 consecutive months. The Quality Assurance Committee will determine if further monitoring is necessary. Date of Completion: 12/30/2022	

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F 688	Continued From page 40 NA #4 was interviewed on 11/29/22 at 3:30 PM, who cared for resident regularly on the evening shift and stated she was unaware Resident #18 had a left-hand splint. The Rehab Director was interviewed on 11/30/22 at 10:00 AM and stated she had been at the facility since October 2022. She reviewed Resident #18's therapy records and stated he was treated by OT for a left-hand contracture from 9/6/22 until 9/29/22. She shared Resident #18 should have had a left resting hand splint to be worn daily up to three hours as tolerated. Upon discharge from therapy, nursing staff were educated and trained on the application of the left-hand splint. The Rehab Director added the therapy department typically didn't enter orders into the resident's chart regarding splinting devices but would have provided a referral to the nursing department when the resident was discharged, and nursing would have entered the order. The Regional Nurse Consultant was interviewed on 12/1/22 at 1:45 PM and explained if a resident wore a splinting device there would be an order in the chart. She reviewed Resident #18's medical record and stated there was not an order for the left-hand splint when he was discharged from OT on 9/29/22. She further stated she would expect an order to be written for hand splints following discharge from OT by the nursing staff.	F 688		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		12/30/22

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F 689	Continued From page 41 §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, observation and staff interview, the facility failed to provide supervision to prevent a severely cognitively impaired resident from exiting the facility unsupervised, failed to ensure the resident was safe in the parking lot, and failed to report that a cognitively impaired resident was in the parking lot for 1 of 5 sampled residents reviewed for accidents (Resident #59). Resident #59, who was in his wheelchair, was found by Nurse Aide (NA) #1 in the parking lot unsupervised, didn't intervene and then, the resident was found to have gone out to the road. The resident was discovered by the Housekeeper on a 2-lane road where the speed limit was 55 miles per hour (MPH) west bound and was a quarter mile away from the facility's front door. In addition, the facility failed to ensure medications were not left unattended for 2 of 2 observations during the medication pass. Immediate jeopardy began on 11/22/22 when Resident #59 was observed out in the parking lot unsupervised in his wheelchair. Immediate jeopardy was removed on 12/2/22 when the facility provided and implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure the facility completes all staff training and ensure	F 689	The facility failed to provide supervision to prevent a cognitively impaired resident from exiting the facility unsupervised. (Resident #59). Resident #59 was admitted to the facility on 11-7-22 with a diagnosis of Hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side, and dementia. Cognition BIMS score was 5, no noted behavior and used a wheelchair for mobility. An elopement assessment was completed on 11-8-22 and was not identified as an elopement risk at that time. Resident #59 was observed outside in the parking lot by Nursing assistant (NA) #1 on 11-22-22 at approximately 2:45pm. NA#1 reported she thought the resident was with family and proceeded inside the facility to work. Resident was last seen in the facility at approximately 1PM during medication pass. The investigation of the incident revealed Resident #59 is able to push open the door and maneuver the wheelchair over the threshold. The resident demonstrated a slow steady rock to roll over the threshold. This was observed by the Vice President of Clinical Services. The date of	

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F 689 Continued From page 42

monitoring systems put into place are effective. Example #2 was cited at scope and severity of "D."

Findings included:

1. Resident #59 was admitted to the facility on 11/7/22 with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side and dementia.

Resident #59 was assessed for elopement on 11/8/22 and he did not present an elopement risk. He was not care planned for elopement risk on admission.

The admission Minimum Data Set (MDS) assessment dated 11/14/22 indicated that Resident #59 had severe cognitive impairment. The assessment further indicated that the resident needed extensive assistance with transfer and used a wheelchair for mobility. Resident #59 was not coded for wandering.

A nurse's note dated 11/22/22 at 3:22 PM and was recorded as late entry on 11/25/22 at 6:27 PM by the former Treatment Nurse revealed that "Resident #59 was noted attempting to go out of the front door of facility by the staff. The staff followed the resident out and redirected back in. The staff assisted the resident back inside the door safely at which time a wander guard was placed. The Director of Nursing (DON) and the Unit Manager were present and were aware".

Several attempts to interview the former Treatment Nurse via phone were unsuccessful.

F 689

this observation was 12-1-22.

NA#1 failed to notify the facility that resident #59 was unsupervised in the parking lot in his wheelchair.

At approximately 3:15pm, the facility received a call from a passerby, that a resident in a wheelchair was on the road with a staff member. Several staff members exited the facility to find the resident with a housekeeping staff member on the side of the road. The housekeeper was leaving work at approximately 3:00pm when she turned out of the facility and found the resident in his wheelchair on the road, approximately 1/4 mile from the facility. The housekeeper stayed with the resident until additional staff came to assist the resident.

The resident was returned to the facility in his wheelchair, accompanied by staff at approximately 3:30pm. The resident was assessed for any injury, and no injury was identified. Once assessed, a wander guard, door alarm bracelet was applied to resident. Resident information was then placed in the facility elopement books. The elopement books are located at each nursing station, and the front reception desk. These books are accessed by all staff. The elopement books contain pictures and face sheets for all residents who have triggered as an elopement risk.

An elopement assessment was completed at approximately 4:05pm by

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A new elopement assessment was completed for Resident #59 by the Unit Manager (UM). The assessment had an event date of 11/22/22 and completion date of 11/30/22. The assessment indicated that Resident #59 was found outside the front door and was redirected back in. A wander guard was applied on resident. The evaluation indicated "event still open".

Review of Resident #59's care plan revealed that on 11/23/22, a care plan for elopement risk was initiated. The care plan problem was "resident has a wander guard secondary to wandering/elopement risk". The goal was "resident will not leave secured area unattended". The approaches included "check functioning of alarm every shift, check placement of alarm and monitor skin under alarm for any indication of skin breakdown, contact physician and family if resident attempts to leave facility, if resident becomes confused and attempts to exit secure unit/facility, attempts diversional activities as able, observe resident's whereabouts when out of bed, personal secure alarm (wander guard) as ordered and redirect resident as indicated and as needed".

The MDS Nurse was interviewed on 11/30/22 at 10:25 AM. She stated that she had interviewed the Housekeeper who found Resident #59 outside the facility on the road. When the resident was back to the facility, a wander guard was placed on his ankle. She indicated that the administration was aware and had investigated the elopement incident dated 11/22/22 with Resident #59. She added that she initiated the care plan for elopement on 11/23/22 after the elopement incident. She stated that a new elopement assessment was completed on

F 689

the Unit Supervisor, and all notifications to Responsible party, and medical provider were initiated. The Responsible party did not return the phone call. Another call was to the responsible party on 11-23-22, with no response. Additional calls were placed to the Responsible party by the Director of Nurses, and floor nurse with the last attempt being on 11-25-22, and all calls left unanswered.

The facility completed a census to resident count at approximately 3:45pm. All residents were accounted for. The Director of Nursing and Nurse Supervisor initiated 100% of all in house resident reevaluation of elopement risk assessments. These audits were completed on 11-22-22 by the Director of Nursing and the Unit Supervisor, at approximately 7:15pm.

On 11-30-22, NA#1 was educated on residents outside the facility left unsupervised and ensuring their safety. The Vice President of Clinical Services educated NA#1.

On 11-22-22, The Director of Nursing and Unit Supervisor completed a re assessment of elopement risks of all in house residents. No other residents who were not previously an elopement risk were identified. Residents who previously triggered elopement risks were validated to have pictures and face sheets in each elopement book, care plans were verified for wandering behaviors and interventions. On 11-22-22, the Director

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F 689	Continued From page 44 11/22/22 for Resident #59 and he was added to the wander guard book. On 11/30/22 at 12:30 PM, Nurse Aide (NA) #1 was interviewed. She stated that she was familiar with Resident #59. She was assigned to him in the past. He was confused and disoriented, and wheelchair bound. She reported that on 11/22/22, she was coming in to work on 3-11 shift. She observed Resident #59 in the parking lot around 2:45 PM. There were visitors on the porch, and she thought Resident #59 was with his family. The NA stated that she did not attempt to confirm if the resident was being supervised while he was outside, and she did not report that the resident was in the parking lot. She proceeded to enter the facility to work. The Regional Operation Manager, in the absence of the Administrator, was interviewed on 11/30/22 at 11:10 AM. She reported that Resident #59 was found outside the building on 11/22/22. She stated that the incident was investigated by the Vice President (VP) of clinical Operation. The Regional Operation Manager provided the investigation report including the timeline, the corrective actions, and the written statements from the staff for review. On 12/1/22 at 8:20 AM, the Vice President (VP) of Clinical Operation, in the absence of the Director of Nursing (DON) was interviewed. She reported that she had investigated the elopement incident that occurred on 11/22/22 with Resident #59. She reported that the front door was locked from 8 PM to 8 AM every day and there was a receptionist assigned at the front desk from 8 AM to 8 PM every day.	F 689	of Nursing initiated in-servicing on elopement and wander guard books to include locations of each book to all staff. The wander guards books are located at each nursing station and include the front reception desk. The Director of Nursing or designee will be responsible for keeping the elopements books up to date with all residents who trigger as an elopement risk. Any staff who did not complete the in service prior to 11-30-22, are not allowed to work until this in service has been completed. The Regional Operations Manager will track the in-services to ensure all staff have received. On 11-22-22, the Regional Clinical manager in serviced the Director of Nursing, Assistant Director of Nursing and Nurse (Unit) Supervisors on what an elopement is. The Director of Nursing began an Inservice on 11-22-22 for all staff on elopements and completed it on 11-30-22. Any staff that did not receive the in service will not be allowed to work after 11-30-22 until the Inservice has been completed. The Regional Operations Manager is responsible for tracking the completion of the in-service. On 11-30-22, The Regional Operations Director in serviced all Department Heads on ensuring residents safety when unsupervised outside. This service includes staying with a resident until staff can ensure the resident is not at risk of endangerment. 100% of staff were in serviced on 11-30-22 by the Department	

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F 689	Continued From page 45 The investigation report indicated that Resident #59's elopement incident happened on 11/22/22. The resident was seen during lunch in his room by the Wellness Coordinator/Nurse Aide (NA), was seen during medication pass at 1 PM by the former Treatment Nurse, was seen between 2:45 and 3:00 PM by NA #1, and was seen at 3:15 PM by a passerby who called the facility to inform them that a resident in a wheelchair was on the road with a staff member (Housekeeper). The written statement from the Housekeeper dated 11/22/22 revealed "(Name of Housekeeper) reported that when she left work on 11/22/22, she left the facility and turned left and noted a resident in his wheelchair on the road. The Housekeeper stayed with resident until additional staff came to assist the resident". On 11/30/22 at 12:20 PM, the Housekeeper was interviewed. Due to language barrier, she was interpreted by Med Aide #5. She stated that it was around 3:04 PM she was leaving from work. She was driving and when she was turning from the parking lot to the main road, she saw Resident #59 on the main road. He was in his wheelchair. She parked her car and went to the resident. She pushed the resident to the side of the road on the grass. Staff members then came and assisted the resident back to the facility. The written statement from the Business Office Manager (BOM) revealed "on 11/22/22 we received a call at the front desk that there was a man in a wheelchair with a woman in scrubs on the side of the road. The caller stated that he looked like he could be one of our residents. I walked out to the road to see, and I did see a man with a woman on the side of the road, so I	F 689	Heads on ensuring resident safety when unsupervised outside and staying with residents until a staff member can ensure resident is not at risk of endangerment. Any staff member who did not receive the Inservice on 11-30-22 will not be allowed to work until the in service has been completed. The Regional Operations Manager is responsible for tracking any staff that needs to be in-service. This education has been added to the new hire orientation process effective 11-30-22, by the Director of Nursing. As of 12-1-22, all residents who have been identified by the nurse to be safe and unsupervised while outside will have a profile maintained at the receptionist desk. This profile will include picture identification. The receptionist will monitor residents, between the hours of 8AM and 8PM, wishing to exit the facility by verifying the resident profile. Any resident who has been identified as being unsafe and needs supervision while outside will be provided with facility staff to accompany them. The receptionist will notify the nurse that the unsafe resident wishes to go outside, and a staff member will be assigned to the resident. The staff member will remain with the resident while outside. The facility will also provide education on elopement, elopement risk changes, and ensuring resident safety when outside during the monthly staff meeting x 3 months starting with the next all staff	

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proceeded to go help assist. The resident is fine and alert, so I assisted nursing with pushing him back into the facility."

On 11/30/22 at 2:01 PM, the BOM was interviewed. He stated that the facility had received a call from a passerby that a resident in a wheelchair was on the side of the road with a woman. He went outside to the end of the parking lot and saw Resident #59 in his wheelchair and a Housekeeper on the side of the road. The distance from the front door to where the resident was located was about a quarter of a mile. He added that the weather was partly sunny and was not cold. The resident was fine.

The written statement from the Wellness Coordinator revealed that "On 11/22/22, I was alerted in the hall by a staff member that there was a resident that was on the road in a wheelchair. I immediately ran down to where the resident was sitting in his wheelchair. The BOM and another staff member were already standing with him in the road. This resident was not in any kind of distress. I pushed the resident back up to the facility in his wheelchair. Once inside, a wander guard was placed on him, and he was redirected."

On 11/30/22 at 1:20 PM, the Wellness Coordinator was interviewed. She reported that she was helping as a Nurse Aide (NA) on the floor on 11/22/22. She reported that she had seen Resident #59 in his room eating lunch on 11/22/22. She indicated that she was notified that the resident was outside (unable to remember exact time). When she went outside in the parking lot, she saw the resident in wheelchair, the Housekeeper, and the Business Office

F 689

meeting scheduled for 12/7/22.

The Administrator or designee will audit the wander guard book weekly x 8 weeks then monthly x 1 month. The Director of Nursing will audit nursing progress notes 5x a week for 4 weeks for change in elopement risk assessments, then 3x weekly x 4 weeks then monthly x 1 month. The Director of Nursing or designee will be responsible for bringing these audit results to the Quality Assurance Committee for 3 consecutive months. The Quality Assurance Committee will evaluate and determine if any further interventions or monitoring is needed.

Date of Compliance 12/1/2022

The facility failed to ensure medications were not left unattended on medication cart. Medication Aide #4 discarded the unattended medications on 11-29-2022. The Charge Nurse #2 secured the unattended medication bottles on 11-30-2022

On 11-30-22, the Director of Nursing, and Supervisor ensured there were no other medications left unattended on medication carts. No medications were found to be left unattended.

On 12/1/2022, education was initiated to all licensed nurses and medication aides on ensuring medications are secured on the medication cart or disposed of when the medication cart is left unattended.

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Manager (BOM) on the side of the road. She reported that the resident was not in any distress. He was wearing a shirt and a pair of pants. She said the weather was not cold, it was partly sunny. She indicated that the distance from the front door to where the resident was located was about a quarter of a mile.

The Social Worker (SW) was interviewed on 11/30/22 at 10:30 AM. She reported that Resident #59 had eloped on 11/22/22 and was found on the road by the Housekeeper. The SW reported that the resident did not have any history of elopement or attempts of leaving the facility.

On 11/30/22 at 1:35 PM, the facility's Maintenance Director was requested to measure the distance from the front door to the location where Resident #59 was located. The Maintenance Director reported that the distance was a quarter of a mile.

On 11/30/22 at 3:30 PM, the location where Resident #59 was found was observed. The same location was identified by the Housekeeper, the Wellness Coordinator and by the BOM as the exact location where the resident was located. The side of the road where the resident was found was grassy. The location was not visible from the front door.

Review of the www.wunderground.com revealed that the weather on 11/22/22 was partly sunny and the highest temperature was 61 degrees Fahrenheit (F).

On 11/30/22 at 12:24 PM, Medication Aide (Med Aide) #5 was interviewed. She stated that she was familiar with Resident #59. She was

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This education was completed on 12/30/2022. No licensed nurse or medication aide will be allowed to work if they have not completed the education prior to 12/30/2022 until they have completed.

The Director of Nursing or designee will conduct 10 random audits weekly x 4 weeks for observation of medication carts and securing of medications when the cart is unattended. Then 5 random audits x 4 weeks then 5 random audits monthly x 1 month.

The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting x 3 consecutive meetings. The Quality Assurance Committee will determine if further monitoring is necessary.

Date of Completion: 12/30/2022

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assigned to the resident, and he would always say "door, door, door." She also stated the resident was wheelchair bound and was confused and disoriented.

On 11/28/22 at 12:50 PM, Resident #59 was observed up in wheelchair in his room. His speech was mumbled and hard to understand and he was unable to answer to questions appropriately.

On 11/29/22 at 9:30 AM, Resident #59 was observed up in wheelchair, wheeling self-up and down the hall saying," door, door, door." He was wearing a wander guard to his ankle.

Review of the education records including the sign in sheets revealed that facility had in-serviced the staff from 11/22/22 through 11/30/22 on elopement, elopement risk changes, and ensuring resident's safety when outside and wander guard book.

The facility's Quality Assurance and Performance Improvement (QAPI) plan for the elopement incident that occurred on 11/22/22 was reviewed. The interventions to correct the problem included:
1. Resident was identified outside in front of the facility with an employee from housekeeping. No injuries were noted. 11/22/22
2. A facility head count was completed, and all residents were accounted for. 11/22/22
3. A 100% audit of elopement risk observation will be completed for changes in risk by the Director of Nursing (DON) and Nurse Supervisor. 11/22/22
4. Facility staff in serviced by the DON on what an elopement is, the use of the wander guard books prior to letting someone out of a locked

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door, and placement of the wander guard.
11/22/22

5. The Regional Clinical Manager in-serviced the DON, the Assistant DON, Nurse Supervisor, and MDS Coordinator on making sure elopement assessments are accurate and done timely. The Regional Clinical Manager in-serviced the Social Worker on accuracy of the wander guard books and placement of books. 11/22/22

6. The DON will assign quarterly wandering assessments to a specific nurse and specific shift, when due. This will be done weekly x 12 weeks. The ADON or Nurse Supervisor will complete a weekly audit on all residents with wander guards to assure orders are accurate, functionality and placement are completed daily per shift, this will be completed weekly x 12 weeks. The Social Worker Director will complete a weekly audit of the wander guard books to ensure accuracy and updated information is available. This will be done weekly x 12 weeks.
1/14/23

7. The Administrator will bring the results of these audits to the Quality Assurance Committee monthly x 3 months.

The Regional Operations Manager and the Division Vice President (VP) of Operation were notified of the immediate jeopardy on 11/30/22 at 5:45 PM.

The facility's VP of Operation provided the following credible allegation for immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

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F 689	Continued From page 50 The facility failed to provide supervision to prevent a cognitively impaired resident from exiting the facility unsupervised (Resident #59). Resident #59 was admitted to the facility on 11/7/22 with diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side and dementia. Cognition score was 5, no noted behavior and used wheelchair for mobility. An elopement assessment was completed on 11/8/22 and was not identified as an elopement risk at that time. Resident #59 was observed outside in the parking lot by NA #1 on 11/22/22 at approximately 2:45 PM. NA #1 reported she thought the resident was with his family, proceeded inside the facility to work. Resident was last seen in the facility at approximately 1 PM during the medication pass. The investigation of the incident revealed Resident #59 was able to push the door and maneuver the wheelchair over the threshold. The resident demonstrated a slow steady rock to roll over the threshold. This was observed by the Vice President of Clinical Services. The date of this observation was 12/1/22. NA #1 failed to notify the facility that resident #59 was unsupervised in the parking lot in his wheelchair. At approximately 3:15 PM, the facility received a call from a passerby that a resident in a wheelchair was on the road with a staff member. Several staff members exited the facility to find the resident with a housekeeping staff member on the side of the road. The housekeeper was leaving work at approximately 3:00 PM when she turned out of the facility and found the resident in his wheelchair on the road, approximately a quarter mile from the facility. The housekeeper stayed with the resident until additional staff came	F 689		

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F 689	Continued From page 51 to assist the resident. The resident was returned to the facility in his wheelchair accompanied by staff at approximately 3:30 PM. The resident was assessed for any injury and no injury was identified. Once assessed, a wander guard, a door alarm bracelet, was applied to resident. Resident information was then placed in the facility elopement books. The elopement books are located at each nurse's station and the front reception desk. These books are accessed by all staff. The elopement books contain pictures and face sheets for all residents who have triggered as an elopement risk. An elopement assessment was completed at approximately 4:05 PM by the Unit Supervisor and all notifications to Responsible Party and Medical Director were initiated. The Responsible Party did not return the phone call. Another call was placed to Responsible Party on 11/23/22 with no response. Additional calls were placed to the Responsible Party by the Director of Nursing and floor Nurse with the last attempt being on 11/25/22 and all calls left unanswered. The facility completed a census to resident count at approximately 3:45 PM. All residents were accounted for. The Director of Nursing and Nurse Supervisor initiated a 100% of all in house resident's reevaluation of elopement risk assessments. These audits were completed on 11/22/22 by the Director of Nursing and the Unit Supervisor at approximately 7:15 PM. On 11/30/22, NA #1 was educated on residents outside the facility left unsupervised and ensuring their safety. The Vice President of Clinical Services educated NA #1. Specify the action the entity will take to alter the process or system failure to prevent a serious	F 689		

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F 689	Continued From page 52 adverse outcome from occurring or recurring, and when the action will be complete: On 11/22/22, the Director of Nursing and Unit Manager completed a reassessment of elopement risks of all in-house residents. No other residents who were not previously an elopement risk were identified. Residents who previously triggered elopement risk were validated to have pictures and face sheets in each elopement books, care plan s were verified for wandering behaviors and interventions. On 11/22/22, the Director of Nursing initiated in-servicing on elopement and wander guard books to include locations of each book to all staff. The wander guard books are located at each nurse's stations and the front receptions desk. The Director of Nursing or designee will be responsible for keeping the elopement books up to date with all residents who trigger as an elopement risk. Any staff who did not complete the in-service prior to 11/30/22 are not allowed to work until this in-service has been completed. The Regional Operation Manager will track the in-services to ensure all staff have received. On 11/22/22, the Regional Clinical Manager in-serviced the Director of Nursing, Assistant Director of Nursing and Nurse Unit Supervisors on what an elopement is. The Director of Nursing began an in-service on 11/22/22 for all staff on elopement and completed on 11/30/22. Any staff that did not receive the in-service will not be allowed to work after 11/30/22 until the in-service has been completed. The regional Operation Manager is responsible for tracking the completion of the in-service. On 11/30/22, the Regional Operation Director in-serviced all department heads on ensuring residents safety when unsupervised outside. This in-service includes staying with a resident until	F 689		

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F 689	Continued From page 53	F 689		

staff can ensure the resident is not at risk of endangerment. 100% of staff were in-serviced on 11/30/22 by the Department heads on ensuring resident's safety when unsupervised outside and staying with resident until a staff member can ensure resident is not at risk of endangerment.
Any staff member who did not receive the in-service on 11/30/22 will not be allowed to work until the in-service has been completed. The Regional Operations Manager is responsible for tracking any staff that needs to be in-serviced.

This education has been added to the new hire orientation process effective 11/30/22, by the Director of Nursing.

As of 12/1/22, all residents who have been identified by the nurse to be unsafe and unsupervised while outside will have a profile maintained at the receptionist desk. This profile will include picture identification. The receptionist will monitor residents, between the hours of 8AM and 8 PM, wishing to exit the facility by verifying the resident profile. Any resident who has been identified as being unsafe and needs supervision while outside will be provided with facility staff to accompany them. The receptionist will notify the nurse that the unsafe resident wishes to go outside, and a staff member will be assigned to the resident. The staff member will remain with the resident while outside.

The facility will also provide education on elopement, elopement risk changes, and ensuring resident safety when outside during the monthly staff meeting x 3 months starting with the next all staff meeting.

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F 689	Continued From page 54 IJ removal date 12/2/22 On 12/1/22, the facility's credible allegation for immediate jeopardy removal was validated by observation of the wander guard books at each nurse's stations and at the front reception desk. The residents who were identified as elopement risk had their pictures and face sheets in the wander guard books. Multiple staff interviews including administrative staff and the receptionist were conducted and revealed that they had received in-services on elopement, wander guard books and ensuring resident's safety when unsupervised outside. Care plan of residents identified as elopement risk were initiated and reviewed and sign in sheets for the in-services were reviewed. Immediate jeopardy was removed on 12/2/22. 2. a. On 11/29/2022 at 8:45 AM Medication Aide (MA) #4 was observed during medication administration. When approaching the MA's medication cart there were three pills in a clear medication cup and a nicotine patch sitting on the cart. MA#4 pulled medications for another resident and left the cart to administer those medications. The three pills in the medication cup and the nicotine patch were left unattended on her medication cart. At the time the medications were unattended, Resident #59, a severely cognitively impaired resident, was observed sitting in his wheelchair next to the medication cart. Immediately after completing the medication administration, MA #4 was interviewed. She stated the three pills and nicotine patch were for another resident who refused their medications.	F 689		

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She further stated she should not leave medications on the cart unattended. Instead, she should have disposed of the medications or secured them in the locked cart until she had time to dispose of them.

On 11/30/2022 at 4:08PM and interview was conducted with the Regional Operations Manager. She stated medications should never be left unsecured on the medication cart.

2. b. On 11/30/2022 at 10:45AM an observation of medication administration with Charge Nurse #2 was completed. Charge Nurse #2 was observed pulling Medications for Resident #325. The Charge nurse stated the resident had an order for Ferrous Sulfate solution 300milligrams (mg) per 5 milliliters (ml) but the solution on the cart was not 300mg/5ml, it was 220mg/5ml. Charge Nurse #2 asked another staff member to look in the medication storage room for Ferrous Sulfate. The staff member returned with another bottle of 300mg/5ml solution. The Charge Nurse stated she would need to call the provider prior to administering the medication for clarification. She placed both bottles on top of the medication cart and left them unattended while she went down the hall to administer medications to Resident #325.

On 11/30/2022 at 11:15AM and interview was conducted with Charge Nurse #2. She stated she did not realize she left the medications on the cart unattended. She should have secured the medications prior to leaving the cart.

On 11/30/2022 at 4:08PM and interview was conducted with the Regional Operations Manager. She stated medications should never

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F 689	Continued From page 56 be left unsecured on the medication cart.	F 689		
F 690 SS=D	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 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.	F 690		12/30/22

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F 690	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on record review, observations, Nurse Practitioner and staff interviews, the facility failed to obtain a urology consult ordered by the medical director for 1 of 1 resident (Resident #70) reviewed for urinary catheters. The findings included: Resident # 70 was admitted to the facility on 9/26/2022 with diagnoses that included urinary retention. Resident #70's admission Minimum Data Set (MDS) dated 10/18/2022 indicated the resident was moderately cognitively impaired, required assistance with activities of daily living, and was dependent with toileting. Additionally, the resident had an indwelling urinary catheter during the assessment period. The resident's comprehensive care plan was last revised on 10/22/2022 and contained a focus for an indwelling urinary catheter related to urinary retention and benign prostatic hyperplasia (enlarged prostate). Resident #70's medical record included a physician's order for urology consult dated 11/4/2022. The order was entered by Nurse #6. The medical record did not indicate the resident had been seen by urologist. On 11/29/2022 at 4:28 PM an interview was conducted with Charge Nurse #1. She was aware of the order but did not know if it was followed up on. She stated she did not recall the resident going to urology. She further stated the nurse	F 690	On 12/9/2022, an appointment for urology was scheduled for Resident #70 by the appointment scheduler. The appointment is scheduled for 1/18/2023. On 12/17/2022 an audit for all in house residents who have a foley catheter was conducted by the Director of Clinical Resources to ensure no appointments for urology had been missed. The audit addressed the previous 3 months. Any resident who was consulted to have an appointment for urology secondary to the foley catheter, an appointment was scheduled with the urology office to be seen at the earliest convenience. These calls were made by 12-30-2022 by the appointment scheduler. On 12/9/2022, the appointment scheduler was provided an in-service on arranging appointments for urology per physician orders by the Director of Clinical Resources. An in service by the Regional Clinical Manager was initiated 12/5/2022 which includes providing appointment orders to the appointment scheduler for arrangement of appointments. Any licensed nurse who did not complete this education by 12/30/2022, will not be allowed to work until this in-service has been completed. This information was added to the New Hire Orientation on 12/15/2022by the Director of Nursing. The Director of Nursing or designee will review all physician orders and progress notes twice a week x 12 weeks for urology	

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F 690	Continued From page 58 who entered the order, Nurse #6, should have notified transportation to make the appointment. Attempts to contact Nurse #6 were not successful. An interview was conducted with the transporter on 11/29/2022 at 4:39 PM . She stated she was not made aware the resident needed a urology appointment therefore the resident did not have a urology appointment scheduled at that time. On 12/01/2022 at 12:53 PM an interview was conducted with the Nurse Practitioner. She stated she has had issues with getting consults scheduled and completed. She stated she inquired about the urology consult two or three times already. The NP was told the nurse who entered the order should have printed the order and placed it in the transporter's box so she could make the appointment. The NP stated she recently created and began using her own excel spread sheet to follow up on consults and labs. On 12/01/2022 at 4:12 PM an interview was conducted with the Regional Nurse Consultant. She stated the nurse who entered the order did not follow the process in place. She should have printed the order for the consult and given the copy to the transporter who would have scheduled the appointment.	F 690	appointments for residents with foley catheters. The Director of Nursing or designee will bring the results of the audits to the Quality Assurance Committee monthly x 3 consecutive months. The Quality Assurance Committee will determine if further monitoring is necessary. Completion Date: 12/30/2022	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		12/30/22

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F 692	Continued From page 59 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and interviews with Nurse Practitioner and Registered Dietitian, the facility failed to obtain admission weight, readmission weight, and weekly weights on a resident per physician's order, and failed to notify the NP or RD of excessive weight loss for 1 of 1 resident's (Resident #70) reviewed for nutrition. Findings included: 1. Resident #3 was admitted to the facility on 1/27/21 with multiple diagnoses including dementia and dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 9/26/22 indicated that Resident #3's cognition was intact, and he needed supervision with eating. The assessment further indicated that the resident weighed 171 pounds (lbs.) and had a weight loss of 5% or more in the last month or 10% or more	F 692	Resident #70 was weighed on 11/28/2022. Nurse Practitioner evaluated resident #70 on 11/30/2022, Registered Dietician evaluated resident on 12/12/2022. Orders obtained on 11/30/2022 and 12/12/2022 were completed on date of order. Weights were obtained on 100% all in house residents, except for residents who refused to allow the weight to be obtained by 12/20/2022. Any resident who had an order for weekly weights were reviewed by the Director of Clinical Resources and the Nurse Practitioner for continual need of monitoring on 12/22/2022. The Director of Nursing and the Registered Dietician reviewed the weights for residents who are potentially showing a weight loss on 12/19/2022. The Director of Clinical	

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Continued From page 60

in the last 6 months and was not on the physician prescribed weight loss regimen.

Review of Resident #3's care plan for nutrition reviewed on 11/28/22 was conducted. The care plan problem was "resident at risk for nutritional decline related to diagnoses". The goal was "resident will remain free from significant weight changes through next review". The approaches included refer to Registered Dietician (RD) as needed, monitor weights per facility protocol and provide diet/supplements as ordered.

Review of the electronic weight record revealed that Resident #3 weighed 183 lbs. on 8/27/22 and 171 lbs. on 9/24/22, a weight loss of 12 lbs. in one month.

The RD notes were reviewed. The note dated 9/7/22 revealed that Resident #3 had a significant weight loss of 8% in 30 days. He was at risk for weight fluctuations related to fluid shifts due to diuretic therapy. Weights with overall downward trend despite overall good intake of meals. The RD recommended to add a sandwich twice a day with lunch and dinner for additional kilocalories/protein and to continue weekly weights due to significant weight loss. The note dated 9/26/22 revealed that Resident #3 continued to lose weight with a 6.5% loss in 30 days. The recommendation was to continue the weekly weights. The note dated 10/3/22 revealed that Resident #3's current weight was 174 lbs. with no significant weight loss. The RD indicated Resident #3 was at risk for weight fluctuations related to fluid shifts due to diuretic therapy. The recommendation was to continue weekly weights.

Documentation of Resident #3's weights for

F 692

Resources reviewed any new admission or readmission since 11-22-2022, and remains in house, for weekly weight monitoring. Any resident who did not have weight obtained an order was added on 12-22-2022 by the Director of Nursing or designee.

The Regional Clinical Manager initiated an in-service on 12/9/2022 for all licensed nurses, medication aides and certified nursing assistants on obtaining weights on new admissions, readmissions and residents who are ordered weekly weights. All licensed nurses also received training on notification to the provider and the registered dietician for weight changes. This in service was completed on 12-30-2022. Any licensed nurse, medication aide or certified nursing assistant who did not receive the training by 12-30-2022 will not be allowed to work until the education is completed. This education was added to the licensed nurse, medication aide and certified nursing assistant new hire orientation on 12-15-2022 by the Director of Nursing.

The Director of Nursing or designee will monitor admission, readmission and weekly weights using the weight audit tool. This audit will be conducted weekly for 12 weeks.
The Director of Nursing or designee will bring the audit results to the Quality Assurance Committee meeting x 3 consecutive months. The Quality Assurance Committee will determine if further monitoring is necessary.

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October 2022 and November 2022 were reviewed. There was only 1 weight recorded for October 2022 (10/1/22 - 174 lbs.) and there were no weights recorded for November 2022.

Attempts to interview the RD were unsuccessful.

On 12/1/22 at 9:40 AM, Charge Nurse #2 was interviewed. She reviewed the RD notes and her recommendations for weekly weights. She also reviewed the recorded weights for Resident #3. She verified that the RD had recommended for weekly weights and there were no weekly weights recorded in the resident's records for October and November 2022. She stated that she did not know who was responsible for the weekly weights.

On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected the weekly weights obtained as recommended by the RD.

2.Resident # 70 was admitted to the facility on 9/26/2022 with diagnoses that included dementia and dysphagia.

Resident #70's admission Minimum Data Set (MDS) dated 10/18/2022 indicated the resident was moderately cognitively impaired, required assistance with activities of daily living, and required some assistance with eating.

The resident's comprehensive care plan was last revised on 10/22/2022 and contained a focus for risk of nutritional decline related to diagnoses of dementia, dysphagia, and history of malnutrition. Resident #70's medical record revealed the resident was in the hospital from 10/3/2022

Date of Completion: 12/30/2022

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through 10/11/2022. There was no admissions weight on 9/26/2022 and there was no readmission height or weight documented on Resident #70 on 10/11/2022. The record also contained a physician's order to weight resident weekly. The order was dated 10/11/2022.

The medical record contained documentation by the Registered dietitian (RD) dated 10/3/2022. On 10/3/2022 the RD noted the resident was out of the facility and requested a readmission height and weight when resident returned since an admissions height and weight were no completed upon admission on 9/26/2022.

On 10/13/2022 the RD completed the admissions assessment and again requested a readmission height and weight on the resident. She noted the resident's hospital laboratory results indicated the resident had low albumin. The RD recommended supplemental nutrition through Glucerna three times daily and weekly weights for four weeks.

The resident's medical record included the following dates and weights:

On 10/20/2022 at 7:11 AM the resident's weight was 130.8 pounds (lbs)
On 10/31/2022 at 10:51 PM the resident's weight was 125 lbs.
On 11/28/2022 at 3:35 PM the resident's weight was 101.6 lbs.

A phone interview was conducted with the RD on 11/30/2022 1:17 PM. She stated she did not know why Resident #70 was not weighed weekly as requested or why there was no admission weight and height. She further stated she was in the facility on 11/28/2022 and there was not a recent

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weight on the resident when she was in the facility. She further stated staff did not call her and report the weight. The RD reported she was in the facility weekly and would have seen the weight loss when she reviewed resident weights the following week. She stated sometimes staff would call her with weight loss concerns but mostly she catches it on her weekly reviews and makes recommendations. She stated she would expect staff to report a weight loss of 24 lbs over 28 days to either her or the Nurse Practitioner (NP).

On 11/29/2022 at 2:42 PM an interview was conducted with Medication Aide #9 who weighed Resident #70 on 11/28/2022. She stated she works with the resident frequently. She stated she did not know why the resident did not get an admission weight and she did not recall why he did not get weighed weekly as ordered. She stated it may have been missed due to low staffing. When asked if she reported resident's weight loss to anyone, she stated she did not report the weight loss but she did report his poor appetite to the NP.

An interview was conducted with the NP on 12/01/2022 at 12:53 PM. The NP stated she felt there was not sufficient staff in the building and that is why weights are not done. The NP stated she did not get a call on 11/28/2022 regarding Resident #70's weight loss. She stated she saw his weight when she was in the building on 11/30/2022 and reached out to the family regarding options and expectations. She stated she would have liked to have gotten a notification, but she did not believe there was a policy that mandated staff call the NP with excessive weight loss. She would have expected the RD to have

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F 692	Continued From page 64 been made aware so interventions could have been put into place. On 12/01/2022 at 4:12 PM an interview was conducted with the Regional Nurse Consultant. She stated it was her expectation that staff weight residents per physician's orders.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with the Nurse Practitioner and staff, the facility failed to obtain a Physician's order for a resident's use of continuous oxygen (Resident #18). This was for 2 of 5 residents reviewed for respiratory care. Additionally, the facility failed to secure oxygen tanks that were not in use for 1 of 4 observations. The findings included: 1. Resident #18 was originally admitted to the facility on 8/25/16. He was hospitalized 9/30/22 until 10/5/22 for respiratory distress. His diagnoses included chronic respiratory failure with hypoxia (inadequate oxygen), congestive heart failure (CHF) and chronic obstructive pulmonary	F 695	On 11/29/2022, resident # 18 had an order for oxygen entered the Physician orders by the Minimum Data set Nurse. The unsecured oxygen cylinders were put in the secure storage devices on 11/28/2022 by the charge nurse. On 12-4-22, 100% of all in house residents were visualized by the Director of Nursing or the Unit Supervisor to ensure any resident who required oxygen had an order for oxygen and at the correct setting. Any resident with oxygen and did not have an order or had inaccurate settings, were corrected immediately. A room-to-room audit was conducted on 12-5-22 by the Unit Supervisor to ensure	12/30/22

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disease (COPD).

A Significant Change in Status Minimum Data Set (MDS) assessment dated 9/13/22 indicated Resident #18 was cognitively intact and was coded with the use of oxygen.

Resident #18's active care plan, last reviewed 9/14/22, included a focus area for received oxygen therapy secondary to COPD and chronic respiratory failure. One of the interventions was to administer oxygen as ordered.

A Physician's progress note dated 9/30/22 indicated Resident #18's baseline oxygen level was 3 liters via nasal cannula.

Review of the hospital discharge summary dated 10/5/22 revealed Resident #18 had been weaned back to his baseline oxygen level of 3 liters at the time of discharge.

Review of a Physician's progress note dated 10/7/22 indicated Resident #18 was on 3 liters of oxygen via nasal cannula continuously.

Review of Resident #18's nursing progress notes from 4/1/22 until 11/30/22 revealed he was using oxygen continuously.

A review of Resident #18's October 2022 and November 2022 Physician orders did not include any orders for oxygen.

In an observation on 11/28/22 at 10:31 AM, Resident #18 was lying in bed with oxygen running at 2 liters flow via concentrator. He indicated he used oxygen all the time.

F 695

no oxygen cylinders were left unsecure. No others issues were identified in the audit.

On 12/1/2022, the Regional Clinical Manager initiated an in-service for all Licensed Nurses, Medication Aide, and Certified Nursing Assistants for oxygen use orders, correct settings for oxygen and the storage of oxygen cylinders. This in-service was completed on 12/30/2022, any staff who did not receive the in service will not be allowed to work until complete. The Department heads were in serviced by the Regional Clinical Manager on 12/1/2022 on oxygen storage. Any department head who did not receive this in-service by 12/30/2022 will not be allowed to work until this education is completed. This education was added to the New Hire Orientation on 12/15/2022 by the Director of Nursing.

The Director of Nursing or designee will audit 5 residents 3x times weekly x 4 weeks for oxygen orders and correct oxygen settings, then weekly x 4 weeks, then monthly x 1 month. The Administrator or designee will complete a full facility observation 5 times a week for 4 weeks, then twice a week for 4 weeks then one time x 1 month for unsecure oxygen cylinders.

The Director of Nursing will bring the results of these audits will be brought to the Quality Assurance Committee for 3 consecutive months, at which time, the determination will be made if further

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F 695	Continued From page 66 Resident #18 was observed lying in bed watching TV on 11/29/22 at 10:41 AM. Oxygen was being used at 2 liters via a concentrator. On 11/30/22 at 11:36 AM, a phone interview occurred with Nurse #1, who was the readmitting nurse on 10/5/22 for Resident #18. The hospital discharge summary and physician orders for Resident #18 were reviewed and Nurse #1 stated it was an oversight not to have included an order for oxygen as he was on continuous oxygen before the hospitalization and when he returned from the hospital. The Nurse Practitioner (NP) was interviewed on 12/1/22 at 12:40 PM. She reviewed Resident #18's hospital discharge summary from 10/5/22 as well as his active physician orders and stated she would have expected the nursing staff to ensure oxygen was included in his active orders based on the discharge summary and his prior use of 3 liters. In an interview on 12/1/22 at 1:45 PM, the Regional Nurse Consultant stated Resident #18 required continuous oxygen for his COPD, CHF, and chronic respiratory failure. The Regional Nurse Consultant verified there was no order for the continuous oxygen when he was readmitted to the facility on 10/5/22 and there should have been. She felt it was an oversight. 2. The facility provided a paper copy of a policy and procedure titled Fire Safety and Prevention. The policy was dated May 2021. The policy read in part, "store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands when not in use. On 11/28/2022 at 12:00 PM. Two green oxygen	F 695	monitoring is necessary. Date of Compliance 12/30/2022	

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F 695	Continued From page 67 E- cylinders (E cylinders are 24.9 inches in height, weight 7.9 pounds, and have a capacity of 680 liters) were observed in a vestibule. The cylinders were observed to be ½ full. The cylinders were not secured in a wheeled cart or other securement device. Nurse assistant (NA)#1 was observed going in and out of the vestibule several times, passing the unsecured oxygen cylinders each time. On 11/28/2022 at 12:05 PM and interview was conducted with NA#1. The NA stated she was unaware about the facility's policy regarding storage of oxygen cylinders. NA#1 stated she did not know who the tanks belonged to, where they came from, or what she should do with them. An interview was conducted with Charge Nurse #1 on 11/28/2022 at 12:15 PM. She walked down the hall to the vestibule and observed the 2 unsecured oxygen cylinders. She stated she did not know where the cylinders came from or why they were in the vestibule unsecured. She stated oxygen cylinders that were not in use should be stored in a secure rack in the storage area across from the nurse's station. Charge Nurse #1 removed the 2 green oxygen cylinders from the vestibule and placed them in a secured rack in the storge area across from the nurse's station. On 12/01/22 at 3:44 PM an interview was conducted with the Regional Operations Manager. She stated she expected oxygen cylinders that were not in use to be secured in the storeroom.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		12/30/22

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F 697	Continued From page 68 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with Pharmacy and staff, the facility failed to have prescribed pain medication on hand to administer as needed (PRN) per Physician ' s orders for 1 of 2 residents (Resident #425) reviewed for pain management. Findings included: Resident #425 was admitted to the facility on 03/09/22 with diagnosis that included malignant neoplasm of prostate (cancer), neuropathy, pain, type 2 diabetes mellitus with foot ulcer, cirrhosis of liver, and end stage renal disease requiring hemodialysis. The Quarterly Minimum Data Set (MDS) assessment dated 06/14/22 indicated Resident #425's cognition was intact. He had no behaviors and no rejection of care. Resident #425 received scheduled pain medications and PRN pain medications during the MDS review period. He reported he had occasional pain that did not make it difficult to sleep at night or limit his day-to-day activities. He rated his pain at 04 on a numeric rating scale and a verbal descriptor was not coded. He received opioid medications on 5 of 7 days during the MDS review period. Review of the resident's care plan, last revised 06/15/22, revealed a focused area that Resident	F 697	Resident #425 discharged from the facility on 8-31-22. On 12/21/2022 the Regional Clinical Manager conducted an audit for Physician order of pain medication to the pain medication on medication cart for all in house residents. Any resident who did not have the prescribed pain medication, the medication was ordered by 12/21/2022. No other residents were identified during this audit. On 12/9/2022 the Regional Clinical manager initiated an in-service for All licensed nurses and medication aides to the importance of having prescribed medication available for the resident. In the event the pain medication is low in stock or not in stock, the pharmacy, or the PACE program if PACE, is to be notified and the medication ordered per physician order or back up pharmacy is to be notified to fill medication. Any licensed nurse or medication aide that did not receive this in service by 12/30/2022 will not be allowed to work until this is completed. This in-service was added to the new hire orientation for licensed nurses and medication aides on 12/15/2022 by the Director of Nursing.	

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F 697

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#425 was at Risk for Pain: Alteration in comfort related to chronic low back pain and neuropathy in addition to stage 4 prostate cancer with bone metastasis (cancer cells spread from their original site to a bone). The care plan included interventions that included pain medications to be given per orders and to assess location, duration, frequency, and intensity of pain. Report any noted increased pain.

Resident #425's physician ' s orders included an order dated 05/31/220 for scheduled hydromorphone (narcotic pain medication) 2 milligrams (mg) every 8 hours. Order was changed on 06/07/22 to discontinue scheduled hydromorphone 2 mg three times a day and to continue hydromorphone 2mg, ½ tablet every 4 hours PRN for pain and respiratory distress. Fentanyl 12micrograms (mcg)/hour pain patch; apply 1 patch to skin every 72 hours.

The June 2022 electronic Medication Administration Record (MAR) for Resident #425 indicated he was administered scheduled hydromorphone 19 times and 17 PRN doses of hydromorphone. The MAR did not require the nurse to assess and document Resident #425 ' s numerical pain level prior to administration or the numerical pain level effectiveness of the pain medication after its administration. The MAR also revealed hydromorphone was not administered from 06/12/22 through 06/16/22.

A review was conducted of the June 2022 hard copy Controlled Medication Utilization Record for Resident #425. This record indicated Resident #425 was administered scheduled hydromorphone 19 times and PRN hydromorphone 23 times in June 2022. This form

F 697

The Director of Nursing or designee will audit the Physician orders to the medication cart for all prescribed pain medications once weekly x 4 weeks, then once every 2 weeks x 4 weeks then once a month x 1 month.

The Director of Nursing will bring these audits to the Quality Assurance Committee for 3 consecutive months x 3 months. The Quality Assurance Committee will determine if further monitoring is necessary.

Completion Date: 12/30/2022

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required the nurse to document the date and time of the pain medication administration. This form had not required the nurse to indicate the numerical pain level prior to administration nor did it require the numerical pain level of effectiveness of the medication after it's administration. The June 2022 Controlled Medication Utilization Record was compared to the June 2022 MAR for Resident #425. This revealed 6 instances when the PRN hydromorphone administration was documented on Resident #425's Controlled Medication Utilization Record, but not on the MAR.

A review was conducted of the June 2022 Medication Administration Record (MAR) revealed hydromorphone was not administered from 06/13/22 through 06/16/22. The hard copy Controlled Medication Utilization Record revealed hydromorphone was not available or given to Resident #425 from 06/12/22 at 09:51 PM through the late afternoon/evening of 06/14/22. According to the Controlled Medication Utilization Record the last available dose of hydromorphone was administered on 06/12/22 at 05:51 PM. The facility received a delivery of 84 hydromorphone 2mg tabs on the late afternoon/evening of 06/14/22.

An interview was conducted with Charge Nurse #1 on 11/29/22 at 12:42 PM. She stated the process for administering as needed (PRN) narcotic pain medication included a pain assessment. She then stated the medication was administered, documented on the MAR, and documented on the Controlled medication Utilization Record. She stated Resident #425 often voiced pain. She further stated she was not aware he was out of hydromorphone and that he

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F 697

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needed it for his pain control.

A phone interview was conducted on 11/30/22 at 03:30 PM with Nurse #2. She stated if a resident runs out of a medication, she would check the Pixis (dispensing system for back-up medications) first and see what was available, then call the Residents physician so he can give an order for a medication that was available until the original order arrived. She then stated she would call the pharmacy to have them deliver the medication as soon as possible and a resident should not run out of his/her pain medication. She further stated she was not aware Resident #425 was close to running out of his pain medication on the last day she worked which was 06/11/22. She also stated Resident #425 often voiced pain.

Interview with Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP) was conducted on 11/30/22 at 03:42 PM. She stated if a resident runs out of a medication, she would check the Pixis (dispensing system for back-up medications) first to see if the medication is available. If it was not available, she would see what was available, call the physician so he can give an order for a medication that is available until the original order arrives and he can fax the pharmacy a script. Then she stated she would call the pharmacy to have them deliver the medication as soon as possible.

A phone interview was conducted with Med Aide #8 on 11/30/22 at 04:24 PM. She stated if a resident runs out of a narcotic pain medication, she would notify the nurse so she can check the Pixis (dispensing system for back-up medications) to see if that medication was

F 697

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F 697	Continued From page 72 available or to see what was available, and she would then notify the physician so an order for an alternative medication can be obtained. She also stated Resident #425 often voiced pain. She administered Tylenol to Resident #425 on 06/13/22 for complaints of pain all over because he was out of hydromorphone. She further stated that the Tylenol was slightly effective, but that Resident #425 needed the hydromorphone instead of the Tylenol. He shouldn't have run out. She revealed she thinks she notified Charge Nurse #1 on 06/13/22 that Resident #425 was out of pain medication but was not positive. A phone Interview with Program of All-inclusive Care for the Elderly (PACE) Pharmacist and Unit Manager was conducted on 12/01/22 at 02:14 PM. PACE Pharmacist stated 84 hydromorphone 2mg tablets were filled on 05/11/22 and on 06/14/22 and sent to facility. No notification was documented of facility notifying pharmacy that they were out of hydromorphone on or around 06/12/22. Unit Manager stated if a resident was out of a medication, she expected the nurse or Med Aide to call pharmacy and have medications delivered as soon as possible. Interview with Regional Nurse Consultant on 12/01/22 at 04:13 PM. She stated her expectation was for nursing staff to reorder medication prior to it running out. If it does run out, she expected the nurse to call pharmacy and have it delivered as soon as possible. She also stated she expected staff to document the administration of narcotic pain medication on the Controlled Medication Utilization Record and on the Medication Administration Record (MAR).	F 697		
F 698 SS=D	Dialysis	F 698		12/30/22

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F 698

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CFR(s): 483.25(l)

§483.25(l) Dialysis.
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview with staff, the facility failed to review the dialysis communication sheet used to exchange information regarding resident's treatment and care resulting in missed recommendation from dialysis physician for 1 of 1 resident reviewed for dialysis (Resident #6).

The findings included:

Resident #6 was admitted to the facility on 9/20/2019 with diagnoses that included end stage renal disease.

The resident's quarterly Minimum Data Set (MDS) dated 11/21/2022 indicated the resident was cognitively intact, required assistance for all activities of daily living, and received dialysis during the assessment period.

Resident #6's comprehensive care plan was last updated on 11/21/2022 and included a focus for dialysis services secondary to end stage renal disease. Interventions included communicating with dialysis center before and after each visit for continuation of care and to inform physician with any changes as needed.

Resident #6's active physician orders included

F 698

On 12/20/22, the Unit Supervisor audited the last 6 months of resident #6 dialysis communication sheets. Any order or recommendation not carried out previously, was verified with the physician and orders were corrected on 12/20/22 by the Unit Supervisor.

No other residents in the facility attend Dialysis.

On 12/5/22, the Regional Clinical Manager initiated in services for all licensed nurses on reviewing the dialysis communication sheets for each resident upon return and carry out any orders written. Any licensed nurse who did not receive this education by 12/30/2022 will not be allowed to work until this education has been completed. This education was added to orientation on 12/15/22 by the Director of Nursing.

The Director of Nursing or designee will monitor all dialysis resident's communication sheets weekly x 12 weeks.

The Director of Nursing or designee will

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several medications to lower her blood pressure including isosorbide 45 milligrams (mg) orally twice daily. The order had a start date of 9/13/2022.

Resident #6's dialysis communication notebook included a dialysis communication record dated 11/25/2022. The communication record included a communication from the dialysis center indicating the resident's blood pressure was "extremely low" and they were unable to remove any fluid, instead fluids were given. The dialysis center documented the resident's blood pressure was 76/45 on arrival. The dialysis center gave the resident 1050 milliliters (ml) of normal saline. The communication included a note to discontinue isosorbide "per physician's order".

On 11/28/2022 a review of Resident #6's Medication Administration Record (MAR) for November 2022 revealed the isosorbide was still an active order.

An interview was conducted with Charge Nurse #1 on 11/29/2022 at 4:39PM. The charge nurse stated when residents return from dialysis, they return through the front entrance with their dialysis communication notebook. She stated the notebook is brought to the nurse station where the charge nurse reviews the log and acts on any new orders or recommendations. The communication notebooks are kept at the nurse's station. She further stated she was working on 11/25/2022 and she did not recall looking at the dialysis communication notebook for Resident #6 on that date. She did not recall seeing the note regarding the resident's blood pressure being low and did not call the Physician or Nurse Practitioner and notify them of the order from the

F 698

bring these audits to the Quality Assurance Committee Meeting for 3 consecutive months. The Quality Assurance Committee will determine if further monitoring is needed.

Completion Date: 12/30/2022

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F 698	Continued From page 75 dialysis physician to discontinue the isosorbide. She stated she was not sure how she missed the communication. On 11/30/22 at 12:16 PM an interview was conducted with the Director of Nursing (DON). She stated she discontinued the isosorbide order on 11/29/2022 at 2:53PM when she saw the communication form and realized it had not been discontinued. She stated the process was not followed. The charge nurse should have reviewed the communication form on 11/25/2022 and called the facility Medical Director (MD) or Nurse Practitioner (NP) and made the necessary changes. The DON stated she did not know why the process was not followed. She stated she called the facility MD on 11/29/2022 and made him aware and got a verbal order to discontinue the medication. On 12/01/2022 at 4:10 PM an interview was conducted with the Regional Nurse Consultant who stated she expected the Charge Nurse to check the dialysis communication log when the resident returns from dialysis and call the MD with any new orders or recommendations.	F 698		
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on staff interviews, Program of All-Inclusive Care for the Elderly (PACE-a	F 744	Resident #64 was seen by Psychiatry Services on 12/19/2022. Medication	12/30/22

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Medicare/Medicaid program for older adults and people over age 55 living with disabilities) Site Director interview and record review, the facility failed to obtain ordered psychological consultation due to a new diagnosis onset of dementia with behaviors to include hallucinations and delusions. This was for 1 (Resident #64) of 1 residents reviewed for behavioral, emotional and mood concerns. The findings included:

Resident #64 was admitted on 12/3/21 with cumulative diagnoses of dementia without behaviors, anxiety and major depression.

A nursing note dated 8/2/22 at 6:30 PM indicated that Resident #64 had an episode of delusion/hallucination by dialing 911 telling the dispatcher that she was told to dial 911 by someone calling her name on the loud speaker. PACE was notified of her new behaviors with no new orders.

A nursing note dated 8/3/22 at 5:34 PM indicated that Resident #64 demonstrated hallucinations by referencing someone in the room with her but nobody was there. She remained calm and was easily redirected.

A new order dated 8/3/22 was received from PACE for Seroquel (antipsychotic) 25 milligrams (mg) at bedtime.

Review of Resident #64 ' s comprehensive care plan included a new problem with behavioral symptoms of visual and audible hallucinations and delusions as of 8/3/22. The intervention dated 8/3/22 read to obtain a psychological consult if eligible, notify psychological services of her behaviors and the facility SW to visit her as

F 744

changes were completed by the Geriatric Nurse Practitioner on 12/19/2022.

On 12/22/2022, the Director of Clinical Resources audited all in house residents with an active diagnosis of Dementia with behaviors to include hallucination and delusions for the need of psychiatric services. No other resident presented with a new diagnosis of Dementia with behaviors with recommendations for Psychiatric Services.

The Vice President of Operations provided education to the Administrator and Social Worker on 12/15/2022, that the facility maintains the responsibility to provide necessary services to residents with diagnosis of Dementia with behaviors, such as Psychiatry. The Vice President of Operations on 12/20/2022, spoke with Program for All-inclusive Care for the Elderly Director and the necessity of providing the services for residents in the facility.

The Director of Nursing or designee will audit 5 residents charts per week x 4 weeks for new onset diagnosis of dementia with behaviors and the recommendation of psychiatry services, then 3 resident charts x 4 weeks and then 2 resident charts monthly x 1 month.

The Director of Nursing or designee will bring the audits to the Quality Assurance Committee meeting x 3 consecutive months. The Quality Assurance Committee will determine if further

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needed to identify appropriate coping mechanisms.

A nursing note dated 8/5/22 at 6:45 AM indicated Resident #64 she packed her belongings and could not stay because someone had put a "spell" on her and she remained awake the majority of the night. Another note dated 8/5/22 at 2:10 PM read she again packed her personal items and stated a family member was coming to get her. There were signs of anxiety to include restlessness and staff were concerned of her increased fall risk. PACE gave orders for Ativan (an antianxiety medication) 0.5 mg daily and another dose in 4 hours for persistent agitation.

A nursing note dated 8/10/22 at 6:44 PM indicated Resident #64 called 911 several times during the shift stating the staff was putting a spell on her.

A nursing note dated 8/11/22 at 12:21 PM indicated Resident #64 called 911 stating she wanted to get her hair done. PACE notified and ordered a dose of Ativan 0.5mg and continue to monitor.

A Social Worker (SW) note dated 8/15/22 at 12:30 PM read the PACE staff encouraged gospel music, personal items added to her room and walks to reduce the medication use and a psychologist evaluation consult was also placed with the PACE psychological service provider.

Review of a PACE SW note dated 8/16/22 at 1:15 PM read a psychiatry consult has been ordered by the PACE Physician for further evaluation.

Review of a PACE nursing note dated 8/25/22 at

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monitoring is necessary.

Date of Compliance: 12/30/2022

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1:32 PM read Resident #64 reported a poor appetite and staff reported she was refusing meals and made statements about wanting to leave.

A nursing note dated 8/28/22 at 12:00 AM indicated Resident #64 was observed sitting in the staff breakroom stating she wanted to go home. She was redirected back to her room and a wanderguard (a discreet bracelet that triggers an alarm while locking a monitored door to prevent elopement) was placed on her left lower extremity with the consent of her family member. PACE staff were notified.

A nursing note dated 8/30/22 at 3:23 AM indicated Resident #64 was observed sticking her finger down her throat and vomited after receiving her medications. She denied the event but stated she was being poisoned. PACE and family were notified.

Resident #64 was care planned 8/30/22 for the use of a wanderguard.

Review of a PACE Physician note dated 8/31/22 at 10:37 AM read the evaluation today was consistent with depression with psychotic behavior. Resident #64 has been unhappy and trying to leave the facility. The intervention was to reach out to recreational therapy for her activities of interest.

Review of an email correspondence dated 8/31/22 at 12:44 PM sent by the facility ' s SW to the PACE Site Director read that she was asked to consult the facility ' s psychological services provider who stated they were unable to assist because Resident #64 was on the PACE program

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and they provided her psychological services through the PACE program.

Review of the reply email dated 8/31/22 at 2:31 PM from the PACE Site Director to the facility SW read the PACE contract person had not been able to get a response from the facility ' s psychological services provider.

The quarterly Minimum Data Set (MDS) dated 9/1/22 indicated Resident #64 had moderate cognitive impairment, no mood symptoms, exhibited hallucinations, delusions, rejection of care and wandering. Resident #64 was coded as receiving an antipsychotic and antidepressant.

The care plan was revised in 9/1/22 to include the following behaviors: exit-seeking, belief she was being poisoned, attempts to vomit up her medications, repeatedly packing to go home and calling 911.

Review of a SW note dated 9/1/22 at 11:42 AM read as follows: Resident #64 remains at facility for long term care (LTC) followed by PACE and has had some changes with her dementia and behaviors. She believed she was being poisoned when given her medications, she attempted to throw up medications, she called 911 to have her hair done, she was exit-seeking, wandering to break room and trying to get out of unit. Resident #64 also packed up her belongings and stated she was going home and PACE providers were aware. The SW note read the PACE Site Director asked her to have the facility psychological service provider see Resident #64. The note read the facility SW notified their psychological services provider who stated they were unable to see a PACE participant and the PACE Site

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	345534	A. BUILDING ______ B. WING ______	C 12/01/2022

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 744		F 744		

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Director was made aware on 8/31/22 and informed that if PACE provided a contract with the facility ' s psychological provider, the facility could move forward. The note read Resident #64 had lost interest in their 1:1 meetings and she was also noted still rummaging and packing her belongings.

A PACE Physician note dated 9/8/22 at 8:50 AM read Resident #64 had significant unhappiness staying at the facility.

A nursing note dated 9/8/22 at 3:46 AM indicated Resident #64 was hallucinating that children were running around in her room as well as a male peeping in her window. She was sitting at the nurses station at the time.

Review of a PACE SW note dated 10/5/22 read Resident #64 presented with a flat affect congruent to her mood and conversation. She was also observed during lunch and she barely touched her meal. The PACE SW would continue to monitor her mood and offer support as needed.

The quarterly Minimum Data Set (MDS) dated 10/31/22 indicated Resident #64 had moderate cognitive impairment, reported feeling down and lacked energy. She was not coded for hallucinations, delusions, rejection of care or wandering. Resident #64 was coded as receiving an antipsychotic and antidepressant.

Review of a SW note dated 10/31/22 at 11:22 AM read Resident #64 continued on PACE services and was wearing a wanderguard due to wandering and an elopement risk. Resident #63 stated that she wished she had someone to talk

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to and reported mild depression. The PACE provider was still trying to obtain a psychological services provider to meet Resident #64 ' s needs.

Review of an email correspondence dated 10/26/22 at 2:50 PM to the PACE Physician and the PACE Site Director from the PACE operational provider read there was a continued effort to find a psychological provider for Resident #64.

An interview was completed on 11/29/22 at 12:15 PM with Resident #64. She stated she no longer felt that her food was poisoned and staff were assisting her with her activities of daily living (ADLs). Resident #64 stated she had not attended PACE since sometime in September that she could recall. She verified the facility and PACE SW had been coming a few times a week to talk with her but she still wanted to go home and was unhappy in the LTC setting.

An interview was completed on 11/29/22 at 5:02 PM with the facility SW. She stated she had worked at the facility for 11 years and was familiar with the PACE program and how it related to the facility ' s residents. She stated when a resident was admitted on the PACE program, the PACE Physician and staff were responsible for all of her care. The SW stated the facility often reminded PACE of the need for them to provide the PACE Physician ordered consults to include psychological services. She stated PACE staff stated they could not find a provider and the facility ' s contracted psychological services provider would not contract with the PACE program. The SW stated if the PACE provider would agree to allow the facility to bill for the psychological services, they would reach out and

F 744 Continued From page 82 F 744

confirm that this option was agreed upon by the facility ' s psychological service provider but to date, that had not occurred. The SW stated to her knowledge, they have not procured a psychological service provider so she had taken it upon herself to visit Resident #64 at least three times a week to allow her to talk and voice her feelings and concerns. She stated she began this as soon as her behavioral symptoms started in early August 2022. The SW stated there had been improvement in her hallucinations, delusions and noncompliance with care but she still reporting feeling down and wanted to go home.

An interview was conducted on 11/30/22 at 12:20 PM with Nursing Assistant (NA) #11. She stated she had worked at the facility for 3 years. She stated she was very familiar with Resident #64 and there had been improvement in her hallucinations but she still on occasion would refuse to eat her food for fear of being poisoned and voiced her sadness about not being able to go home.

An interview was completed on 11/30/22 at 12:30 PM with Nurse #5. She stated she had worked at the facility for 4 years. She stated Resident #64 ' s behaviors and mood over the last several months had worsened but she noted improvement with getting her to take her medications or calling 911. She stated she still experienced the occasional hallucination and delusion. Nurse #5 stated Resident #64 ' s care was overseen by the PACE provider and PACE physician.

In a telephone interview on 11/30/22 at 5:03 PM, the PACE Site Director stated she was aware that

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F 744	Continued From page 83 Resident #64 had not been provided the psychological services ordered by the PACE Physician and were continuously working to obtain a contract with a psychological service provider. She stated the PACE provider would work out payment outside of their lack of a contract and that she would have the PACE physician to call surveyor. At the time of the survey exit on 12/1/22, there were no return calls from the PACE physician. An interview was conducted on 12/1/22 at 3:05 PM with the Regional Nurse Consultant. She stated the expectation was for Resident #64 to receive all consults and services ordered for her well-being to include psychological services but it was difficult when Resident #64 ' s care was provided by the PACE program.	F 744		
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	F 756		12/30/22

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F 756	Continued From page 84 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview with the Consultant Pharmacist and staff, the Consultant Pharmacist failed to identify and to report drug irregularity to the Director of Nursing or the Attending Physician regarding the transcription error for the Famotidine (used to treat Gastroesophageal reflux disease (GERD)) for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #51). Findings included: Resident # 51 was admitted to the facility on 12/23/19 with multiple diagnoses including GERD.	F 756	On 12/1/2022, resident #51 order for Pantoprazole was discontinued by the Nurse Practitioner and an order for Famotidine 20mg po twice a day as needed was entered by the nurse on the floor. No other concerns were identified. The Lead Consultant Pharmacist, on 12/6/2022, conducted an 100% audit of all in house residents to ensure pharmacy recommendations for the previous 6 months were completed accurately. Any discrepancies were given to the Regional Clinical manager on 12/6/2022, who made the corrections or recommendations per the physician orders.	

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Resident #51 had a doctor's order dated 9/22/20 for Pantoprazole (Protonix) 40 milligrams (mgs.) once a day for GERD.

On 6/14/22, the Pharmacist had recommended to discontinue Pantoprazole due to long term use had been associated with increased risk of Clostridium difficile (C diff) colitis and to replace it with Famotidine (Pepcid) 20 mgs twice a day as needed (PRN) for indigestion/heartburn. The attending physician had responded "agree, please write order" to the recommendation on 6/17/22.

On 6/26/22, the former Director of Nursing (DON) entered the order in the computer for Famotidine 20 mgs BID (scheduled) instead of BID PRN as ordered.

Review of the Medication Administration Records (MARs) from June through November 2022, revealed that the Famotidine was administered to Resident #51 twice a day (scheduled).

Resident #51's drug regimen was reviewed by the Consultant Pharmacist on 7/27/22, 8/15/22, 9/22/22, 10/10/22 and 11/14/22 and missed to identify that the Famotidine was administered BID (scheduled) instead of BID PRN as ordered.

On 12/1/22 at 4:00 PM, the Consultant Pharmacist was interviewed. He reviewed his recommendation for the Famotidine in June 2022 and verified that the attending physician had agreed to discontinue the Pantoprazole and to replace it with Famotidine 20 mgs twice a day as needed. He also reviewed that the Famotidine was entered in the computed on 6/26/22 to be given twice a day (scheduled) instead of BID

F 756

The Consultant Pharmacist was in serviced by the Regional Clinical Manager on 12/5/2022, to ensure that the recommendations have been carried out according to the physician order. The Director of Nursing and Nurse Supervisors were in serviced on completing the pharmacy recommendations according to the physician orders. This in service was conducted by the Consultant Pharmacist and the Director of Clinical Resources on 12/6/2022.

The Director of Nursing or designee will audit all pharmacy recommendations for accuracy of order entry into the EMR monthly x 3 months.

The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting x 3 consecutive months. The Quality Assurance Committee will determine if further monitoring is needed.

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F 756	Continued From page 86 PRN. He indicated that he did not catch this irregularity, he missed it. On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected the Consultant Pharmacist to identify and to report any drug irregularity to the Director of Nursing or the Physician.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs 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 and Nurse Practitioner (NP) and staff interview, the facility failed to transcribe the Famotidine (used to treat	F 757	On 12/1/2022, resident #51 order for Pantoprazole was discontinued by the Nurse Practitioner and an order for	12/30/22

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F 757 Continued From page 87

gastroesophageal reflux disease (GERD)) as ordered resulting in the administration of Famotidine twice a day instead of twice a day as needed (PRN) for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #51).

Findings included:

Resident # 51 was admitted to the facility on 12/23/19 with multiple diagnoses including GERD.

Resident #51 had a doctor's order dated 9/22/20 for Pantoprazole (Protonix) (used to treat GERD) 40 milligrams (mgs.) once a day for GERD.

On 6/14/22, the Pharmacist had recommended to discontinue Pantoprazole due to long term use had been associated with increased risk of Clostridium difficile (C diff) colitis and to replace it with Famotidine (Pepcid) 20 mgs twice a day as needed (PRN) for indigestion/heartburn. The attending physician had responded "agree, please write order" to the recommendation on 6/17/22.

On 6/26/22, the former Director of Nursing (DON) entered the order in the computer for Famotidine 20 mgs BID (scheduled) instead of BID PRN as ordered.

Review of the Medication Administration Records (MARs) from June through November 2022, revealed that the Famotidine was administered to Resident #51 twice a day (scheduled) instead of twice a day PRN.

On 12/1/22 at 9:40 AM, Charge Nurse #2 was

F 757

Famotidine 20mg po twice a day as needed was entered by the nurse on the floor. No other concerns identified.

The Lead Consultant Pharmacist, on 12/6/2022, conducted an 100% audit of all in house residents to ensure pharmacy recommendations for the previous 6 months were completed accurately. Any discrepancies were given to the Regional Clinical manager on, who made the corrections or recommendations per the physician orders.

The Director of Nursing and Nurse Supervisors were in serviced on completing the pharmacy recommendations according to the physician orders. This in service was conducted by the Consultant Pharmacist and the Director of Clinical Resources on 12/6/2022.

The Director of Nursing or designee will audit all pharmacy recommendations for accuracy of order entry into the EMR monthly x 3 months.

The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting x 3 consecutive months. The Quality Assurance Committee will determine if further monitoring is needed.

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F 757	Continued From page 88 interviewed. She stated that the once the doctor agreed and signed the recommendation of the Consultant Pharmacist, it was considered a doctor's order. The Nurse was expected to enter the order in the computer for the pharmacy to dispense the medication. The Charge Nurse reviewed the Consultant Pharmacist Communication to Physician form and the doctor's order for the Famotidine and stated that it was a transcription error. The former Director of Nursing (DON) transcribed the Famotidine as twice a day (scheduled) instead of twice a day PRN as ordered. She added that she would inform the NP of the transcription error on Resident #51. On 12/1/22 at 12:44 PM, the NP was interviewed. The NP stated that she was informed by the Charge Nurse regarding the transcription error for the Famotidine on Resident #51. She stated that she expected nursing to enter orders in the computer correctly to prevent unnecessary medications. She stated that she would write an order to administer the Famotidine BID PRN. On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected nursing to enter orders in the computer correctly.	F 757		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		12/30/22

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F 759	Continued From page 89 by: Based on observations, record reviews, and staff interviews the facility failed to have a medication error rate of less than 5% as evidenced by 4 medication errors out of 37 opportunities, resulting in a medication error rate of 10.81% for 3 of 5 residents (Resident #26, Resident #46, and Resident #18) observed during medication administration. The findings included: 1.Resident #26 had a physician's order for ipratropium-albuterol solution for nebulization, 0.5 milligram (mg) per 3 milliliters (ml), three times daily for seven days. On 11/30/2022 at 8:30 AM Medication Aide (MA) #5 was observed administering medications to Resident #26. The MA was observed picking the nebulizer mask up out of the bedside chair and loading the medication chamber with 3ml of ipratropium-albuterol solution. MA#5 placed the mask on Resident #26 and pressed the start button on the nebulizer machine. MA#5 then left the resident's room and began to move her medication cart to the next room. When asked to go back into Resident #26's room and examine the nebulizer mask, the MA stated the medication would take 15 minutes to administer. The surveyor pointed out to the MA, the tubing was not connected to the nebulizer machine and therefore the resident was not getting the medication. MA#5 stated she should have checked the nebulizer mask and tubing to ensure they were connected before she left the room. 2. Resident #46 had a physician's order for lactulose, 10 Gram (G) per 15ml solution daily.	F 759	MA#5 was educated on 11/30/2022 on problem solving the nebulizer machine for resident #26 by the Director of Nursing. MA#4 was educated on 11/30/2022 by the Director of Nursing on the use of separate cups between medications for resident #46 to prevent cross contamination of medications. The ADON resigned her position prior to receiving education on 11/30/2022 for administering medications through a g tube. Every resident has the potential to be affected by medication errors. On 12/7/2022, the Regional Clinical manager initiated an in service to all licensed nurses and medication aides on medication administration for nebulizer machines, crushing of medications and putting medication through a g tube. This education was completed by 12/30/2022. Any licensed nurse or medication aide who did not receive the education prior to 12/30/2022 will not be allowed to work until complete. The Director of Nursing added this education to the new hire orientation on 12/15/2022. The Director of Nursing or designee will conduct 5 med pass observations on licensed nurses or medication aides for resident who receive nebulizers, crushed medication, or medications through g tubes. These audits will be conducted weekly x 4 weeks, then 3 med pass observations x 4 weeks then 2 med pass observations monthly x 1 month.	

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On 11/30/2022 at 8:45 AM MA #4 was observed administering medications to Resident #46. Upon approaching the MA and the medication cart, she was observed crushing medications and placing them in a clear 30 milliliter (ml) medication cup. She then poured the crushed medication into a larger cup with water for administration. There were small remnants of medication still in the cup and on the cart around the medication cup. The MA began to pull medications for Resident #46 and poured 15ml of lactulose into the clear 30ml medication cup, she previously used, with remnants of crushed medication. MA#4 took the lactulose and other medications into the resident's room where she was instructed by the surveyor not to administer the lactulose. MA#4 was interviewed and stated she did not realize she used the same medication cup for the lactulose and the crushed medications. She stated separate cups should have been used to prevent cross contamination of medications.

3. Resident #18 had a physician's order to flush the percutaneous gastrostomy tube (G-tube) with 30 ml of water pre and post medication. Additionally, the resident had an order for isosorbide 30mg to be crushed and administered four times daily and valproic acid, 10ml of 250ng per 5ml solution to be given three times daily.

On 11/30/2022 at 1:35 PM the ADON was observed administering medication to Resident #18. Resident #18 had a percutaneous gastrotomy tube for medication administration. The ADON was observed crushing the isosorbide and the valproic acid and placing them in clear 30ml cups. The ADON placed the clear medication cups with the isosorbide and the valproic acid on the bedside table and retrieved

F 759

The Director of Nursing will bring the results of the audits to the Quality Assurance Committee meeting for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.

Date of Compliance: 12/30/2022

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F 759	Continued From page 91 two larger cups from the medication cart. She took the two cups containing isosorbide and valproic acid into the bathroom and set them on the back of the toilet while she filled two cups with water. She brought the cups of isosorbide and valproic acid back to the bedside table and diluted each medication cup with a small amount of water. She then stated she needed more water to flush the tube. She took both medication cups with isosorbide and valproic acid back into the bathroom and again set them on the back of the commode while she got more water in the larger cups. She then took both cups of medication with her and exited the room. After several minutes, the ADON returned with the medication cups of isosorbide and valproic acid. The ADON opened the stopcock, attached a syringe, and flushed the tube with 30ml of water. The ADON poured the first cup of diluted isosorbide into the syringe followed by the second cup with diluted valproic acid. She flushed the tube with 30ml of water and turned the stopcock to the off position. The ADON was interviewed immediately after the medication administration was completed. She further stated she should have flushed between each medication.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		12/30/22

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F 761	Continued From page 92 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to: 1) discard expired medications on 1 of 3 medication carts observed (the 400 Hall Med Cart) and in 1 of 2 medication storage rooms (the 100 Med Storage Room) 2) keep a medication refrigerated per manufacturer guidelines on 1 of 3 medication carts 3) label medications with the date they were opened on 3 of 3 medication carts (the 100, 300 and 400 Hall Med Carts) and 4) to keep 100-hall treatment cart locked and secured. Findings included: 1-a) An observation was conducted on 11/30/22 at 10:30AM of the 400-hall medication cart in the presence of Med Aide #2. The observation revealed an expired multi-dose vial of Admelog Insulin that was opened on 10/26/22, it had a sticker that read, "expires on 11/23/22" on the insulin vial. (Admelog Insulin expires 28 days	F 761	On 11-30-22, the Nurses on the medication carts, removed the undated, unrefrigerated, and expired medications and discarded. The Director of Nursing and the Nurse Administrative team audited all medication carts and medication rooms for expired and undated medications on 12/1/22. Any items found to be affected were removed immediately and discarded by the Director of Nursing or Nurse Administration. On 12/9/2022, the Director of Nurses (DON) and Regional Clinical Manager initiated education to all Licensed Nurses and Medication Aides on dating medications, insulin storage and checking expirations of medications and locking medication and treatment carts. Additional education on these topics was being	

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F 761	Continued From page 93 after opening). Med Aide #2 confirmed the medications should not have been on the medication cart and discarded the items. 1-b) An observation was conducted on 11/30/22 at 11:20 AM of the medication storage room on 100-hall in the presence of Med Aide #4. The observation revealed 11 expired prefilled Heparin 300units/3ml- flush syringes. All 11 syringes had 3ml of Heparin in them. The Heparin flushes were given to Charge Nurse #1 to be discarded. Charge Nurse #1 confirmed the medications should not have been in the medication storage room and discarded the items. 2-a) An observation was conducted on 11/30/22 at 10:30AM of the 400-hall medication cart in the presence of Med Aide #2. The observation revealed a 250 ML (milliliter) opened bottle of Gabapentin 250mg/5ml liquid with a sticker on bottle that read, "KEEP REFRIGERATED" in a drawer on the med cart. Med Aide #2 confirmed the Gabapentin was opened and had a sticker that read Keep Refrigerated on the bottle. She stated she did not realize it was supposed to be in the refrigerator. She gave the bottle to the Unit Manager for discard. 3-a) An observation was conducted on 11/30/22 at 10:40 AM of the 300-hall medication cart in the presence of Med Aide #2. The observation revealed a multi-dose bottle of Simbrinza 1%-2% eye drops with no opened date. Med Aide #2 confirmed the medication should not have been on the medication cart and discarded the item. 3-b) An observation was conducted on 11/30/22 at 11:05 AM of the nurse ' s med cart on 100-hall. Charge Nurse #1 unlocked cart at stood at the	F 761	taught by the Nurse Administration team. Any licensed nurse or medication aide who did not complete this education by 12/30/2022 will not be allowed to work until complete. This education was included in the new hire orientation on 12/15/2022 by the Director of Nursing. The DON and/or Nurse Administration will all 5 medication carts/storage rooms weekly times 4 weeks, then 3 medication carts/storage rooms weekly times 4 weeks then 1 medication cart/storage room weekly times 4 weeks. The DON will report the findings of these audits to the Quality Assurance Committee for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance. Date of Compliance: 12/30/2022	

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F 761		F 761		

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nurse ' s station. The observation revealed one multi-dose vial of Admelog insulin and one multi-dose vial of Levemir Insulin with no open dates documented on vials. Charge Nurse #1 wrote a date on the bottom of the vials and put the vials back on the medication cart.

3-c) An observation was conducted on 11/30/22 at 11:05 AM of the nurse ' s med cart on 100-hall. Charge Nurse #1 unlocked cart at stood at the nurse ' s station. The observation revealed one multi-dose Admelog Insulin pen with no opened date. Charge Nurse #1 wrote a date on the side of the multi-dose insulin pen and put the pen back on the medication cart.

3-d) An observation was conducted on 11/30/22 at 11:05 AM of the nurse ' s med cart on 100-hall. Charge Nurse #1 unlocked cart at stood at the nurse ' s station. The observation revealed one multi-dose package of Salonpas pain patches with no opened date. Charge Nurse #1 wrote a date on the package and returned the package to the medication cart. Charge Nurse #1 returned to the medication cart and removed and discarded the Salonpas pain patches.

3-e) An observation was conducted on 11/30/22 at 11:05 AM of the nurse ' s med cart on 100-hall. Charge Nurse #1 unlocked cart at stood at the nurse ' s station. The observation revealed one multi-dose tube of Genteal tears eye ointment with no opened date. Charge Nurse #1 discarded the tube of Genteal tears eye ointment.

4-a) An observation was conducted on 11/30/22 at 10:19 AM of the 100 hall nurses station treatment cart unlocked. No staff noted at treatment cart or at nurse ' s station. A continuous

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F 761	Continued From page 95 observation was conducted on 11/30/22 from 10:45 AM through 11:22 AM and revealed the 100 hall nurses station treatment cart being unlocked. Charge Nurse #1 at nurse ' s station. Treatment cart out of view of Charge Nurse #1. Notified Charge Nurse #1 that treatment cart was unlocked, she became verbally aggressive as she slammed the lock closed on the treatment cart. An interview was conducted on 11/30/22 at 02:00 PM with the Unit Manager. She revealed that Nurses and Medication Aides were responsible for writing open dates on required medications and removing expired medications from medication carts and medication storage room as needed. An interview was conducted on 12/01/22 at 04:13 PM with VP Clinical Operation. It is her expectation that Medication Aides and Nurses date required medications upon opening and to discard expired medications as needed. She reported that Nurses and Medication Aides should be reviewing expiration dates when administering medications.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and	F 867	The facilitys Quality Assurance Committee failed to maintain implemented	12/30/22

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Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a complaint investigation dated 2/8/21 for one deficiency in the area of accidents and a recertification survey and complaint investigation dated 5/6/21 for 6 deficiencies in the areas of resident choices, activities of daily living (ADLs), accidents, respiratory care, influenza/pneumococcal vaccinations and the pharmacist not acting on irregularity of a medication review. In addition, the QAPI committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a complaint investigation dated 3/9/22 for one deficiency in the area of pressure ulcers and for the current recertification survey and complaint investigation dated 12/1/22 for 6 deficiencies in the areas of resident choices, ADLs, accidents, pressure ulcers, pharmacist not acting on irregularity of a medication review and influenza/pneumococcal vaccinations.

Findings included.

This tag is cross referenced to:

F561-Based on record reviews, observations, resident and staff interviews, the facility failed to honor a resident's choice related to showers (Resident #24) for 1 of 6 residents reviewed for choices. In addition, the facility failed to honor a resident's choice to receive additional milk on his meal trays (Resident #12) for 1 of 6 resident's reviewed for choices.
*F561-cited 5/6/21-Based on record reviews, observations and interviews with residents and

F 867

procedures and monitor the interventions the facility put into place following the recertification survey complaint surveys and recertification surveys between the years 2021 and 2021. facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a complaint investigation dated 2/8/21 for one deficiency in the area of accidents and a recertification survey and complaint investigation dated 5/6/21 for 6 deficiencies in the areas of resident choices, activities of daily living (ADLs), accidents, respiratory care, influenza/pneumococcal vaccinations and the pharmacist not acting on irregularity of a medication review. In addition, the QAPI committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a complaint investigation dated 3/9/22 for one deficiency in the area of pressure ulcers and for the current recertification survey and complaint investigation dated 12/1/22 for 6 deficiencies in the areas of resident choices, ADLs, accidents, pressure ulcers, pharmacist not acting on irregularity of a medication review and influenza/pneumococcal vaccinations.

Plans of correction were put into place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount

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staff, the facility failed to honor residents' choices related to showers. This was for 3 of 3 residents reviewed for choices.

F677-Based on record review, observation and resident and staff interview, the facility failed to provide nail care to residents who needed extensive assistance and/or were dependent for activities of daily living (ADL) for 4 of 6 sampled residents reviewed for ADL care (Residents #3, #51, #18 & #67).

*F677-cited 5/6/21-Based on observations, staff and family interviews and record review, the facility failed to provide ADL assistance for resident who were dependent on staff for assistance with nail care. This was for 2 of 5 residents reviewed for ADLs.

F686- Based on record review, observations, Wound Nurse Practitioner and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 1 of 4 residents reviewed for pressure ulcers (Resident #56).
*F686-cited 3/9/22-Based on observation, record review, resident interview, staff interviews, and Nurse Practitioner interview the facility failed to assure pressure sore treatment was done per order and the functioning of a wound vac was monitored for 1 of 2 residents reviewed for pressure ulcers.

F689-Based on record review, observation and staff interview, the facility failed to provide supervision to prevent a severely cognitively impaired resident from exiting the facility unsupervised, failed to ensure the resident was safe in the parking lot, and failed to report that a

F 867

of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued.

The Administrator initiated an in-service to all administrative staff on 12/19/2022 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education.

The QAPI Committee will review the compliance audits to evaluate continued compliance. This plan of correction was initiated on 12-27-22 by the Administrator. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has

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F 867	Continued From page 98 cognitively impaired resident was in the parking lot for 1 of 5 sampled residents reviewed for accidents (Resident #59). In addition, the facility failed to ensure medications were not left unattended for 2 of 2 observations during the medication pass. Resident #59, who was in his wheelchair, was found by Nurse Aide (NA) #1 in the parking lot unsupervised, didn't intervene and then, the resident was found to have gone out to the road. The resident was discovered by the Housekeeper on a 2-lane road where the speed limit was 55 miles per hour (MPH) west bound and was a quarter mile away from the facility's front door *F689-cited 2/8/21-Based of observations and staff interviews the facility failed to ensure resident bed remote control cords were in good repair to prevent residents injury. This was for 4 of 7 residents beds reviewed for accidents. *F689-cited 5/6/21-Based on record review, observation and staff interview, the facility failed to determine root causes of each fall and to revise the care plan intervention after each fall and also failed to put effective interventions in place following each fall to prevent repeated falls. This was for 2 of 5 residents reviewed for falls. F695- Based on record review, observations and interviews with the Nurse Practitioner and staff, the facility failed to obtain a Physician's order for a resident's use of continuous oxygen (Resident #18) and failed to store a reusable nebulizer mask (Resident #26). This was for 2 of 5 residents reviewed for respiratory care. *F695-cited 5/6/21-Based on record reviews, observations, and staff interviews, the facility failed to administer oxygen at the prescribed rate. This was for 2 of 2 residents reviewed for respiratory care.	F 867	achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: 12/30/2022	

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F 867	Continued From page 99	F 867		

F756 - Based on record review and interview with the Consultant Pharmacist and staff, the Consultant Pharmacist failed to identify and to report drug irregularity to the Director of Nursing or the Attending Physician regarding the transcription error for the Famotidine (used to treat gastroesophageal reflux)for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #51).
*F756-cited 5/6/21- Based on record reviews, observations, and interviews with staff, Pharmacy Consultant, and facility Physician's Assistant, the Pharmacy Consultant failed to identify the facility's need to identify target behavioral symptoms, to monitor those symptoms and the need to monitor residents for side effects of psychotropic medications. In addition, the facility failed to act upon recommendations made by the Pharmacy Consultant. This was for 5 of 9 residents reviewed for medications.

F883 - Based on record review and staff interview, the facility failed to assess the resident for their vaccination status and failed to offer the influenza and pneumococcal vaccination upon admission per their facility policy for 2 of 2 sampled residents reviewed for influenza and pneumococcal immunizations (Residents #59 & #66).
*F883-cited 5/6/21-Based on record review and staff interview, the failed to administer pneumococcal vaccine to 1 of 5 sampled residents reviewed for immunizations.

An interview was completed on 12/1/22 at 4:00 PM with the Division Vice President of Operations. He stated the facility's Administrator

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F 867	Continued From page 100 ended her employment over the weekend and he was the acting Administrator until the Regional Operation Manager obtained her North Carolina Administration licenses. He also stated his Director of Nursing (DON) and Assistant DON were recently hired, no Staff Development Coordinator, no treatment nurse and only one unit manager. He stated it was possible that the significant turn over in the facility management team could have resulted in the instability of the monitoring for compliance in the areas of repeated citations.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		12/30/22

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§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or
infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.

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F 880	Continued From page 102 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to perform hand hygiene after performing incontinence care prior to touching medical equipment and a resident's personal items in a resident's room for 1 of 1 (Resident #325) reviewed for incontinence care. The facility failed to disinfect multiple use medical equipment between residents for 2 of 4 medication administration observations (Charge Nurse #2 and Medication Aide #5). Findings included: 1. Review of the facility's policy titled "Handwashing/Hand Hygiene" last reviewed on April 2020 revealed the following statement: Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before moving from a contaminated body site to a clean body site during resident care After contact with blood or bodily fluids An observation was made on 11/29/2022 at 11:20 A.M. During the observation, the Interim Wound Nurse donned clean gloves and applied the wound dressing to an open area on Resident #325's buttock. The Interim Wound Nurse and Nurse Aide #12 removed a soiled washable incontinent pad from under Resident #325 and placed the incontinence pad in a trash bag. The Interim Wound Nurse touched the head of bed controller, adjusted the bed linen, placed the call light within reach, and then restarted Resident	F 880	The Interim Wound Nurse was educated on 11/29/2022 by the Director of Nursing regarding hand hygiene practices. MA#5 and Charge Nurse #2 were educated on 12/1/2022 by the Director of Nursing on disinfecting reusable patient care equipment. On 12/12/2022, the Infection Preventionist and the Director of Nursing initiated education on all Nursing staff including certified nursing assistants, medication aides and licensed nurses on hand hygiene and disinfecting reusable patient care equipment. The Director of Nursing and Infection Preventionist completed hand hygiene education and read back disinfecting reusable patient care equipment by 12/30/2022. Any members of nursing staff who did not complete this education by 12/30/2022, will not be allowed to work until complete. This education and hand hygiene observation will be included in the new hire orientation. The Director of Nursing or designee will observe 10 nursing staff members on hand hygiene and disinfecting of reusable patient care equipment weekly x 4 weeks, then 5 nursing staff members weekly x 4 weeks then 2 nursing staff members monthly x 1 month. The DON will bring the results of these audits to the Quality Assurance	

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F 880	Continued From page 103 #325's tube feeding. Just prior to exiting Resident #325's room, the Interim Wound Nurse removed her gloves, and performed hand hygiene. An interview conducted on 11/30/2022 at 2:53 P.M. with the Interim Wound Nurse indicated her gloves should be replaced with clean gloves when the gloves were soiled and when going from a dirty to a clean area on a resident. During the interviews, the Interim Wound Nurse indicated she should have changed her gloves after she completed incontinence care on Resident #325 before she touched Resident #325's medical equipment and the personal items in his room. She indicated she was trained on the infection control policies and was unsure why she had not followed the policy. An interview was conducted on 12/1/2022 at 2:19 P.M. with the Regional Nurse Consultant. During the interview the Regional Nurse Consultant indicated staff should follow the facility's hand washing policy and always change their gloves after incontinence care was provided to a resident. 2.a. The facility provided a copy of the policy and procedure for cleaning of non-critical, reusable patient care equipment. The policy was dated April 2020 and read in part, Sandstone Health and Rehabilitation will implement and maintain processes to ensure all non-critical, reusable patient care equipment is cleaned before and after reuse. On 11/30/2022 at 8:35 AM Medication Aide (MA)#5 was observed using a monitor to obtain blood pressure and oxygenation on Resident #26. After she completed medication administration,	F 880	Committee meeting x 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 12/30/2022	

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F 880	Continued From page 104 she rolled the monitor into the hall and plugged the monitor into an outlet. MA#5 then preceded to another room to provide care. She did not disinfect the equipment after use. At 8:40 AM on 11/30/2022 an interview was conducted with MA#5. She stated she did not clean or disinfect the equipment prior to plugging the monitor into the outlet and leaving it. She started she should have disinfected the monitor and the blood pressure cuff prior to leaving it for someone else to use. An interview was conducted on 12/1/2022 at 2:19 P.M. with the Regional Nurse Consultant. During the interview the Regional Nurse Consultant indicated staff should follow the facility's policy on cleaning of reusable patient care equipment. b. The facility provided a copy of the policy and procedure for cleaning of non-critical, reusable patient care equipment. The policy was dated April 2020 and read in part, Sandstone Health and Rehabilitation will implement and maintain processes to ensure all non-critical, reusable patient care equipment is cleaned before and after reuse. On 12/1/2022 at 11:00 AM Charge Nurse #2 was observed obtaining blood pressure and oxygenation on Resident #325. She was using a wrist blood pressure monitor. After she obtained the blood pressure and oxygenation, she exited the room and left the equipment on a medication cart. She did not disinfect the equipment prior to leaving it for another employee to use. At 11:45 AM on 12/1/2022 an interview was conduced with Charge Nurse #2. She stated she	F 880		

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F 880	Continued From page 105 did not disinfect the wrist blood pressure monitor or the pulse oximetry after she used them or before she laid them on the medication cart. She further stated she should have cleaned them prior to leaving them for another employee to use. An interview was conducted on 12/1/2022 at 2:19 P.M. with the Regional Nurse Consultant. During the interview the Regional Nurse Consultant indicated staff should follow the facility's policy on cleaning of reusable patient care equipment.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		12/30/22

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F 883	Continued From page 106 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assess the resident for their vaccination status and failed to offer the influenza and pneumococcal vaccination upon admission per their facility policy for 2 of 2 sampled residents reviewed for influenza and pneumococcal immunizations (Residents #59 & #66).	F 883	On 11/30/2022, resident # 66 and Resident #59 consents for the influenza and pneumococcal vaccine were completed by the Admissions Coordinator. Resident # 66 received the influenza vaccine on 12-8-22 and the pneumococcal vaccine on 12/12/2022 by the Unit Supervisor. Resident # 59 received the pneumococcal and influenza	

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F 883 Continued From page 107

Findings included:

The facility's policy on "Vaccination of Residents" dated October 2022 was reviewed. The policy read in part "all new admission shall be assessed for current vaccination status upon admission. The resident or the resident's legal representative may refuse vaccine for any reasons. If vaccines are refused, the refusal shall be documented in the resident's medical records".

1. Resident # 66 was admitted to the facility on 10/17/22.

Review of Resident #66's vaccination records revealed no documentation that he had received the influenza nor the pneumococcal vaccination prior to admission to facility. There was no documentation in the records that the resident nor the Responsible party (RP) had refused both vaccinations.

The facility's Immunization Informed Consent form for pneumococcal and influenza vaccine was reviewed. The form included a question as to when the date of the last vaccination, the option to receive or refuse the vaccinations and the education which included the risk and benefits of the vaccines. Resident #66 did not have an Immunization Informed Consent form in his medical record.

On 11/30/22 at 8:40 AM, the Unit Manager (UM) was interviewed. The UM stated that the Admission Director was responsible for assessing and offering the vaccines on admission. She explained that on admission, the resident or the RP had to complete and sign the Immunization Informed consent form. Once the form was

F 883

vaccine on 12-8-22, by the Unit Supervisor.

On 12/6/2022, the Director of Clinical Resources completed an 100% audit of all in house new admissions over the past 60 days. The audit was conducted to verify the consent or decline for influenza or pneumococcal vaccine after admission. Any resident who was found not to have been completed, was completed by 12/10/2022 by the Unit Coordinator or floor nurse. No other residents were identified during the audit.

On 12/6/2022, the Director of Clinical Resources initiated an in-service to the Administrator, Admissions Coordinator, Director of Nursing and Nurse Supervisors on assessing a new admission within 5 days for influenza, and pneumococcal vaccine status. This in-service was completed on 12/15/2022.

The Director of Nursing or designee will conduct an audit on all new admissions within 3 days of admission x 3 months.

The Director of Nursing or designee will bring the results of the audits to the Quality Assurance committee for 2 consecutive months, at which time the determination will made if further monitoring is necessary.

Date of Compliance: 12/30/2022

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F 883	Continued From page 108	F 883		

signed, the UM or the Infection Preventionist would enter the information in the computer as to when the last vaccination received, consent to receive, or to refuse the vaccine. The UM added that Resident #66 did not have a signed Immunization Informed Consent form on admission.

On 11/30/22 at 8:45 AM, the Admission Director was interviewed. He stated that he started as the Admission Director of the facility a month ago. He stated that he was trained to provide the resident or the RP the Immunization Informed Consent form to complete on admission. The Admission Director stated that he could not find the signed form for Resident #66, or he might have missed giving it to the resident or the RP on admission. He added that he was still learning the process.

On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected the facility's policy on vaccination to be followed.

The Infection Preventionist was not available for interview during the survey.

2. Resident #59 was admitted to the facility on 11/7/22.

Review of Resident #59's vaccination records revealed no documentation that he had received the influenza nor the pneumococcal vaccination prior to admission to facility. There was no documentation in the records that the resident nor the Responsible party (RP) had refused both vaccinations.

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F 883	Continued From page 109	F 883		

The facility's Immunization Informed Consent form for pneumococcal and influenza vaccine was reviewed. The form included a question as to when the date of the last vaccination, the option to receive or refuse the vaccinations and the education which included the risk and benefits of the vaccines. Resident #59 did not have an Immunization Informed Consent form in his medical record.

On 11/30/22 at 8:40 AM, the Unit Manager (UM) was interviewed. The UM stated that the Admission Director was responsible for assessing and offering the vaccines on admission. She explained that on admission, the resident or the RP had to complete and sign the Immunization Informed consent form. Once the form was signed, the UM or the Infection Preventionist would enter the information in the computer as to when the last vaccination received, consent to receive, or to refuse the vaccine. The UM added that Resident #59 did not have a signed Immunization Informed Consent form on admission.

On 11/30/22 at 8:45 AM, the Admission Director was interviewed. He stated that he started as the Admission Director of the facility a month ago. He stated that he was trained to provide the resident or the RP the Immunization Informed Consent form to complete on admission. The Admission Director stated that he could not find the signed form for Resident #59, or he might have missed giving it to the resident or the RP on admission. He added that he was still learning the process.

On 12/1/22 at 3:20 PM, the Regional Clinical

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F 883	Continued From page 110 Manager was interviewed. She stated that she expected the facility's policy on vaccination to be followed. The Infection Preventionist was not available for interview during the survey.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19	F 887		12/30/22

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F 887	Continued From page 111 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assess the vaccination status and to offer the resident or the responsible party (RP) the COVID-19 vaccine upon admission per their facility policy for 2 of 2 sampled residents reviewed for COVID 19 immunizations (Residents #59 & #66).	F 887	On 11/30/2022, resident # 66 and Resident # 59 consents for the COVID-19 vaccine were completed by the Admissions Coordinator. On 12/7/2022, resident # 66 received the COVID vaccine by the Clinic staff and Resident # 59 refused the COVID vaccine when	

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F 887	Continued From page 112 The findings included: The facility's policy on "Vaccination of Residents" dated October 2022 was reviewed. The policy read in part "all new admission shall be assessed for current vaccination status upon admission. The resident or the resident's legal representative may refuse vaccine for any reasons. If vaccines are refused, the refusal shall be documented in the resident's medical records". 1. Resident #66 was admitted to the facility on 10/17/22. Review of Resident #66's vaccination records revealed no documentation of previous vaccinations prior to admission to facility. There was no documentation in the records that the resident nor the Responsible party (RP) had refused the COVID 19 vaccine. The facility's COVID 19 vaccine consent form was reviewed. The form included the type of vaccine and the date received outside the facility, and the option to receive or to refuse the COVID 19 vaccine. Resident #66 did not have a COVID-19 vaccine consent in his medical record. On 11/30/22 at 8:40 AM, the Unit Manager (UM) was interviewed. The UM stated that the Admission Director was responsible for assessing and offering the vaccines on admission. She explained that on admission, the resident or the RP had to complete and sign the COVID 19 vaccine consent form. Once the form was signed, the UM or the Infection Preventionist would enter the information in the computer as to the type of vaccine and date received, if any, and whether	F 887	attempted by the pharmacy. On 12/6/2022, the Director of Clinical Resources completed an 100% audit of all in house new admissions over the past 60 days. The audit was conducted to verify the consent or decline for COVID-19 vaccine within 5 days after admission. Any resident who was found not to have been completed, was completed by 12/7/2022 by the Unit Coordinators or designee. No other residents were identified during the audit. On 12/6/2022, the Director of Clinical Resources initiated an in-service to the Administrator, Admissions Coordinator, Director of Nursing and Nurse Supervisors on assessing a new admission within 5 days for COVID-19 vaccine status. This in-service was completed on 12/15/22. The Director of Nursing or designee will conduct an audit on all new admissions within 3 days of admission x 3 months. The Director of Nursing or designee will bring the results of the audits to the Quality Assurance committee for 2 consecutive months, at which time the determination will made if further monitoring is necessary. Date of Compliance: 12/30/2022	

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F 887	Continued From page 113	F 887		

the resident or the RP had consented to receive, or to refuse the vaccine. The UM added that Resident #66 did not have a signed COVID 19 vaccine consent form on admission.

On 11/30/22 at 8:45 AM, the Admission Director was interviewed. He stated that he started as the Admission Director of the facility a month ago. He stated that he was trained to provide the resident or the RP the COVID 19 vaccine consent form to complete on admission. The Admission Director stated that he could not find the signed form for Resident #66, or he might have missed giving it to the resident or the RP on admission to sign. He added that he was still learning the process.

On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected the facility's policy on vaccination to be followed.

The Infection Preventionist was not available for interview during the survey.

2. Resident #59 was admitted to the facility on 11/7/22.

Review of Resident #59's vaccination records revealed no documentation of previous vaccinations prior to admission to facility. There was no documentation in the records that the resident nor the Responsible party (RP) had refused the COVID 19 vaccine.

The facility's COVID 19 vaccine consent form was reviewed. The form included the type of

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F 887	Continued From page 114	F 887		

vaccine and the date received outside the facility, and the option to receive or to refuse the COVID 19 vaccine. Resident #59 did not have a COVID-19 vaccine consent in his medical record.

On 11/30/22 at 8:40 AM, the Unit Manager (UM) was interviewed. The UM stated that the Admission Director was responsible for assessing and offering the vaccines on admission. She explained that on admission, the resident or the RP had to complete and sign the COVID 19 vaccine consent form. Once the form was signed, the UM or the Infection Preventionist would enter the information in the computer as to the type of vaccine and date received, if any, and whether the resident or the RP had consented to receive, or to refuse the vaccine. The UM added that Resident #59 did not have a signed COVID 19 vaccine consent form on admission.

On 11/30/22 at 8:45 AM, the Admission Director was interviewed. He stated that he started as the Admission Director of the facility a month ago. He stated that he was trained to provide the resident or the RP the COVID 19 vaccine consent form to complete on admission. The Admission Director stated that he could not find the signed form for Resident #59, or he might have missed giving it to the resident or the RP on admission to sign. He added that he was still learning the process.

On 12/1/22 at 3:20 PM, the Regional Clinical Manager was interviewed. She stated that she expected the facility's policy on vaccination to be followed.

The Infection Preventionist was not available for interview during the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING ______ B. WING ______	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	**2702 FARRELL ROAD** **SANFORD, NC 27330**

(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