STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING _____ B. WING _____	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONVILLE	400 THOMPSON STREET HENDERSONVILLE, NC 28792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/06/23 through 02/10/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#GHLQ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/06/23 through 02/10/23. Event ID#GHLQ11. The following intakes were investigated: NC00197678, NC00197039, NC00197430, NC00196781, NC00194981, NC00190247, NC00194269, NC00194147, and NC00194316. 11 of 22 complaint allegations resulted in deficiency. 2/27/23 Posting of the 2567 was delayed until today due to no active epoc user on 2/24/23.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to assess the ability of a resident to self-administer medications for 1 of 1 resident reviewed for self-administration of medication (Resident #27). Findings included: Resident #27 was admitted to the facility 10/06/22 with diagnoses including hyperlipidemia (high	F 554	Identified Concern/Issue: The facility failed to access the ability of a resident to self-administer medications for 1 of 1 resident reviewed for self-administration of medications (Resident #27). 1. How corrective action will be accomplished for those residents found to	3/26/23

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

Electronically Signed | 03/06/2023

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F 554	Continued From page 1 cholesterol) and hypertension (high blood pressure). The quarterly Minimum Data Set (MDS) dated 01/12/23 revealed Resident #23 was cognitively intact. Review of the medical record revealed no documentation that Resident #27 had been assessed for self-administration of medications. An observation of Resident #27's overbed table on 02/06/22 at 10:38 AM revealed 1 white pill and 1 green pill lying on a napkin on the table. An interview with Resident #27 on 02/10/23 at 10:39 AM revealed the green pill was for cholesterol and she wasn't sure what the white pill was for. She stated the nurses usually stayed with her while she used her inhaler but frequently left her pills on her bedside table for her to take when she was ready. An interview with Nurse #1 on 02/06/23 at 10:43 AM revealed she usually watched each resident take their medications but she placed Resident #27's medication on her overbed table the morning of 02/06/23 around 09:50 AM and was called away. Nurse #1 confirmed she did not watch Resident #27 take all of her morning medications and did not follow-up with Resident #27 to make sure she took all of her morning medications. She stated the white pill was probably magnesium oxide (a magnesium supplement) 400 milligrams (mg) and the green pill was probably pravastatin 40 mg (a medication for high cholesterol). An interview with the Regional Director of Clinical	F 554	have been affected by the deficient practice. On 3/1/23, the Director of Nursing (DON) provided education to Nurse #1 on “Administration of Medication” and “Self-Administration of Medication” polices to ensure medications are not left at beside and/or ensure residents will be reviewed for self-administration of medication. On 3/1/23, the DON reviewed the Self-Administration of Medication policy with Resident #27. Resident #27 declined the need for Self-Administration of Medication. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/1/23, the Executive Director (ED) and DON met with the Interdisciplinary Team (IDT) and determined there were no other active residents requesting Self-Administration of Medications. Self-Administration of Medications are addressed at admission, and has not been inquired about by residents in care plan meetings and/or resident council. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? The DON, Assistant Director of Nursing (ADON), Staff Development Coordinator	

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F 554	Continued From page 2 Services (RDCS) was conducted on 02/10/23 at 04:20 PM. The RDCS stated she had been filling in wherever there was a need due to the DON leaving in October 2022 and confirmed there were no residents who had been assessed to self-administer medications. She stated if a resident wanted to self-administer medications the resident would be assessed by nursing to make sure they were able to administer their own medications and an order would be obtained from the Physician for the resident to administer their own medications. The RDCS stated since Resident #27 had not been assessed to self-administer her medications the administering nurse should have stayed with Resident #27 until all her medications were taken and should not have left medications unattended at the bedside.	F 554	(SDC), and/or licensed nurse will implement the POC and will provide education to all licensed nurses on "Administration of Medication" and "Self-Administration of Medication" polices to ensure medications are not left at beside and/or ensure residents will be reviewed for self-administration of medication. Education will be completed by 3/26/23. Any associate who has not completed education by 3/26/23, will not be allowed to provide direct resident care until education is completed. The DON, and/or a licensed nurse will provide education to all licensed nurses upon hire, annually, and as needed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON, ADON, SDC, and/or licensed nurse will conduct random visual observations of 10 residents' rooms per shift to ensure medications are not left at the bedside, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. DON will provide education for any incidents of non-compliance. Results of the audits will be reported by	

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F 554	Continued From page 3	F 554	the DON and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 5. Date when corrective action will be completed. 3/26/23	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		3/26/23

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F 584	Continued From page 4 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility: 1) failed to ensure personal care equipment was labeled and covered and a bathroom was clean that had a strong odor of urine for 3 of 22 resident bathrooms (Rooms 501, 510 and 305) and 2) failed to maintain a homelike environment in 1 of 12 resident rooms observed to have debris and stains on the floor (Room 311). This deficient practice affected 2 of 5 resident halls (300 and 500 Halls). Findings included: 1. a. An observation of the shared bathroom of Room 501 on 02/06/23 at 10:49 AM revealed 3 gray bath basins, unlabeled and uncovered, stacked inside each other and sitting on the	F 584	Identified Concern/Issue: The facility (1) failed to ensure personal care equipment was labeled and covered and a bathroom was clean that had a strong odor of urine for 3 of 22 resident bathrooms (Rooms 501, 510, and 305) and (2) failed to maintain a homelike environment in 1 of 12 residents rooms observed to have debris and stains on the floor (Room 311). This deficient practice affected 2 of 5 resident halls (300 and 500 Halls). 1. How corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 584	Continued From page 5 bathroom shelf. Additional observations conducted of the shared bathroom of Room 501 on 02/07/23 at 8:29 AM, 02/08/23 at 5:43 PM, and 02/09/23 at 12:24 PM revealed the gray bath basins remained stacked inside each other on the shelf, unlabeled and uncovered. b. An observation of the shared bathroom of Room 510 on 02/06/23 at 10:44 AM revealed a gray bath basin, unlabeled and uncovered, sitting on the bathroom shelf and 2 gray bath basins, unlabeled and uncovered, stacked inside of each other on the floor beside the toilet. There were also 2 uncovered toilet plungers placed on the floor in between the bath basins and toilet. Additional observations of the shared bathroom of Room 510 on 02/08/23 at 5:44 PM and 02/09/23 at 12:25 PM revealed the bath basin on the shelf and the 2 bath basins on the floor remained unlabeled and uncovered. Also, the 2 toilet plungers remained uncovered on the floor between the bath basins and toilet. An interview and tour conducted with the Regional Director of Clinical Services on 02/10/23 at 1:40 PM revealed the conditions of the shared bathrooms in Rooms 501 and 502 remained unchanged. The Regional Director of Clinical Services explained the Nurse Aides were aware of how personal care equipment should be stored when not in use. She further stated resident's personal care equipment should be labeled, individually covered in a clear, plastic bag, and stored off the floor. 2. During an observation on 02/07/23 at 1:44 PM	F 584	practice. On 3/1/23, the Central Supply Director replaced the three (3) grays bath basins on the bathroom shelf in Room 501, with two (2) new, labeled and covered bath basins. On 3/1/23, the Central Supply Director replaced the gray bath basin on the bathroom shelf in Room 510, with new, labeled and covered bath basin and threw away the 2 gray bath basins on the floor. On 3/1/23, the housekeeper removed the two toilet plungers from the bathroom in 501. On 2/10/23, the Director of Maintenance repaired the bathroom flooring (removed toilet, flooring, toilet flange and replaced flange, installed flooring, re-installed toilet, and new cove base, and caulked around toilet) in Room 305. On 2/10/23, the Director of Environmental Services threw away the plastic necklace on the floor under the head of the bed of Room 311B. On 2/27/23, the Director of Environmental Services the circular dried purple stain on the floor in front of B bed of Room 311B. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/1/23, the Central Supply Director, member of Environmental Services, and	

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F 584	Continued From page 6	F 584		

the bathroom in Room #305 had a strong odor resembling urine. The caulking at the base of the toilet had black colored stains and areas where the caulking was missing. The odor was noted to linger out into the hallway.

An interview and observation were conducted on 02/10/23 at 2:00 PM with Housekeeper #1 (HK). Observation of the bathroom in Room #305 with HK #1 revealed the bathroom floor was dry and appeared clean but continued to have an odor resembling urine. HK #1 revealed she noticed the odor in the bathroom smelled like urine on 02/09/23 while she cleaned the floor and indicated the odor seemed to be coming from underneath the tile at the base of toilet where the caulking was stained and missing. HK #1 revealed she notified her boss, the Director of Environmental Services and thought maintenance was aware of the issue. HK #1 explained when she noticed environment issues, she either told her boss verbally or wrote the concern on a paper document staff used to inform maintenance of any issues. HK #1 stated she verbally told the Director of Environmental Services about the odor issues in Room #305, and he wanted her to write a concern form but then said he would.

An interview and observation were conducted on 02/10/23 at 2:25 PM with the Director of Environmental Services. Observation of the bathroom in Room #305 with the Director of Environmental Services revealed the floor was not wet and appeared clean. The caulking at the base of the toilet was either missing or stained black and there was strong odor resembling urine continued to linger into the hallway. The Director of Environmental Services revealed the issues he was aware of for Room #305 was HK staff had to

hospitality aid completed a visual inspection of all active resident's rooms to ensure all bed pans, bath basins, and urinals are clean, labeled, and covered.

On 3/1/23, the Director of Maintenance and the Assistant Director or Maintenance completed a visual inspection of all resident's bathrooms to ensure the caulking/flooring is in good repair.

On 3/1/23, the Director of Maintenance and the Assistant Director or Maintenance completed a visual inspection of all resident's rooms to ensure there are no other dried purple stains on the floor.

3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur?

The Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), and/or licensed nurse will implement the POC and will provide education to all associates on "Keeping a Resident's Room in Order" policy to ensure personal care equipment is labeled and covered and to maintain a homelike environment free of debris and stains. Education will be completed by 3/26/23.

Any associate who has not completed education by 3/26/23 will not be allowed to provide direct resident care until education is completed.

The DON and/or a licensed nurse will

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F 584	Continued From page 7	F 584		

clean the bathroom every day because of urine and feces being on the floor. The Director of Environmental Services revealed he wasn't aware the caulking at base of toilet was an issue but was under the impression HK #1 had reported concerns to maintenance. The Director of Environmental Services stated he had not reported issues for Room #305 and thought it was a miscommunication between him and HK #1.

An interview and observation were conducted on 02/10/23 at 2:31 PM with the Maintenance Director. Observation of the bathroom in Room #305 with the Maintenance Director revealed there was no change and a strong odor resembling urine continued to linger into the hallway. The Maintenance Director explained he would have to remove the old caulking and assess for leaks around the base of the toilet and may have to cut the linoleum floor and replace to get rid of the odor. The Maintenance Director revealed he just received a call from Director of Environmental Services informing him about the bathroom in Room #305 related to the caulking around the base of toilet and a possible leak. The Maintenance Director revealed he did quarterly room audits that included review of the bathrooms in resident rooms and received either verbal or written work orders from other staff who noticed environment issues.

3. An observation of room 311-B on 02/07/23 at 09:13 AM revealed a circular dried purple stain on the floor in front of B bed and a plastic necklace on the floor under the head of the bed.

An observation of room 311-B on 02/08/23 at 03:21 PM revealed a circular dried purple stain on

provide education to all facilities associates upon hire, annually, and as needed.

4. How the facility plans to monitor its performance to make sure that solutions are sustained.
The DON, ADON, SDC, Central Supply Director, and/or licensed nurse will conduct random visual observations of 10 resident's rooms, to ensure personal care equipment is labeled and covered and to maintain a homelike environment free of debris and stains, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks.

DON and/or licensed nurse will provide education for any incidents of non-compliance.

Results of the audits will be reported by the DON and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.

5. Date when corrective action will be completed.
3/26/23

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F 584	Continued From page 8	F 584		

the floor in front of B bed and a plastic necklace on the floor under the head of the bed.

An observation of room 311-B on 02/09/23 at 08:14 AM revealed a circular dried purple stain on the floor in front of B bed and a plastic necklace on the floor under the head of the bed.

An observation of room 311-B on 02/10/23 at 01:39 PM revealed a circular dried purple stain on the floor in front of B bed and a plastic necklace on the floor under the head of the bed.

An interview with Housekeeper #1 on 02/10/23 at 01:52 PM revealed she worked Monday through Friday on the 08:00 AM to 04:00 PM shift and was usually assigned to the 200 hall. Housekeeper #1 stated she was assigned 200 hall and rooms 301 to 306 on 02/09/23 but did not recall what her room assignments were other days of the week beginning 02/06/23. She explained daily cleaning of resident rooms involved sweeping, mopping, and cleaning the bathroom and was unable to recall if she cleaned room 311-B during the week beginning 02/06/23.

An interview with the Director of Environmental Services on 02/10/23 at 02:03 PM revealed resident rooms were supposed to be swept and mopped daily and he expected floors in resident rooms to be clean and free of items on the floor. He stated recently a member of the housekeeping staff left employment that was usually assigned to the 300 hall. The Director of Environmental Services explained it may not have been clear to housekeeping staff who was assigned to clean 300 hall the week beginning 02/06/23 since the usual housekeeper had left employment, and he should have followed-up to

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F 584	Continued From page 9 make sure housekeeping staff understood which rooms they were assigned so all rooms were cleaned.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff, the facility failed to ensure the comprehensive care plan was updated in the	F 657	Identified Concern/Issue: The facility failed to ensure the	3/26/23

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F 657	Continued From page 10 area for the use of palm guards for 1 of 1 resident reviewed for limited range of motion (Resident #15). The findings included: Resident #15 was admitted to the facility on 09/01/22 with diagnoses including bilateral contractures of multiple sites and paralytic syndrome following a cerebrovascular accident. Review of the physician's order dated 09/23/22 provided instructions for Resident #15 to wear bilateral palm guards. Review of the quarterly Minimum Data Set dated 12/06/22 revealed Resident #15 was assessed as having moderately impaired cognition and needed extensive to total assistance with activities of daily living. Review of the care plan revised on 01/17/23 revealed Resident #15 was at risk for alterations in skin integrity related to decreased and impaired mobility and fragile skin. An observation of Resident #15 was made on 02/06/23 at 2:38 PM. Resident #15's fingers on both hands curled inward towards the palm of the hand. There were no palm guards in place. An observation made on 02/07/23 at 1:52 PM revealed no palm guards were in place. Resident #15 fingers continued to curl inward towards the palm of the hand. An interview was conducted on 02/07/23 at 4:16 PM with the Assistant Director of Rehab. The Assistant Director of Rehab revealed Resident	F 657	comprehensive care plan was updated in the area for the use of palm guards for 1 of 1 resident reviewed for limited range of motion (Resident #15). 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/27/23, the Regional Director of Clinical Services (RDCS) updated the care plan for Resident #15 to reflect use of palm guards. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/1/23, the Director of Rehab (DOR) reviewed all active Residents with orthotic devices (palm guards), to ensure the comprehensive care plan was updated. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Director of Nursing (DON) and/or licensed nurse will provide education to all licensed nurses on the facility “Comprehensive Care Plans and Revisions” policy and “Person Centered Care Planning” policy to ensure the comprehensive care plan is updated as indicated. Education will be completed by 3/26/23. The DON, DOR, and/or licensed nurse	

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F 657	Continued From page 11 #15 was admitted with flexor tone meaning both hands curl inward and the fingers into the palm. The Assistant Director of Rehab stated the Occupational Therapist worked with Resident #15 to increase upper extremity tone and gave directions for the use of palm guards to prevent Resident #15's fingers from going into the palm to help prevent skin breakdown and possible bacterial infection. The Assistant Director of Rehab revealed initially therapy applied the palm guards and then nursing took over after the staff were provided education. An interview was conducted on 02/07/23 at 4:28 PM with the Director of Rehab. The Director of Rebab stated the palm guards were initiated upon Resident #15's admission due to bilateral hand contractures to prevent skin breakdown and wound development and increase hygiene. The Director of Rehab revealed she trained the Nurse Aide (NA) staff to don and doff the palm guards and stated Resident #15 tolerated wearing them. The Director of Rehab revealed the right hand was worse and really needed the palm guard. An observation and interview were conducted on 02/07/23 at 4:33 PM with the Director of Rehab. The Director of Rehab confirmed Resident #15's palm guards were not in place and observed there was no skin breakdown. The Director of Rehab explained if the NA didn't feel comfortable applying or couldn't find the palm guards, they should notify therapy and all therapy staff were trained and knew how to apply Resident #15's palm guards. An interview was conducted on 02/07/23 04:47 PM with NA #4. NA #4 confirmed he was assigned to provide care for Resident #15 on	F 657	will provide education to all licensed nurses, Certified Nurse Assistant (CNA)s, and rehab department on the “Orthotic Device Documentation and Communication” process. Education will be completed by 3/26/23. Any associate who has not completed education by 3/26/23. Will not be allowed to provide direct resident care until education is completed. The DON and/or a licensed nurse will provide education to licensed nurses, CNAs, and rehab associates upon hire, annually, and as needed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON and/or licensed nurse will review all new orders for orthotic devices (palm guards) to ensure the comprehensive care plan and Kardex are updated as indicated, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. DON and/or licensed nurse will provide education for any incidents of non-compliance. Results of the audits will be reported by the DON and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI	

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F 657	Continued From page 12 02/06/23 and 02/07/23 and he was aware the palm guards were to be donned each day. NA #4 revealed he had not put the palm guards on because he could not find them. NA #4 revealed when he could not find the palm guards, he left them off and did not notify the nurse or therapy. NA #4 confirmed he knew how to place the guards on Resident #15 hands and was comfortable doing so. An interview was conducted on 02/10/23 at 5:03 PM with the Regional Director of Clinical Services. The Regional Director of Clinical Services revealed the care plan intervention for the palm guards should be implemented by staff. The Regional Director of Clinical Services stated anyone who updated the care plan needed to ensure the care guide used by the NA staff was also updated to ensure the NA staff were aware to don Resident #15's palm guards.	F 657	Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 5. Date when corrective action will be completed. 3/26/23	
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge	F 661		3/26/23

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F 661	Continued From page 13 medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a recapitulation of stay for 3 of 4 closed records reviewed for discharge (Resident #264, Resident #63, and Resident #61). Findings included: 1. Resident #264 was admitted to the facility 03/04/22 with diagnoses including hypertension (high blood pressure) and heart failure. The discharge Minimum Data Set (MDS) dated 07/04/22 revealed Resident #4 was severely cognitively impaired and was discharged to the community. Review of the medical record revealed Resident #264 was discharged home 07/04/22. Review of the "Discharge Information Summary" dated 07/04/22 for Resident #264 revealed the only areas completed under section E titled "Recapitulation of Stay" was the Dietary	F 661	Identified Concern/Issue: Facility failed to complete a recapitulation of stay for 3 of 4 closed records reviewed for discharge (Resident #264, Resident #63, and Resident#61). 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 264 was discharged on 7/4/22. Resident #63 was discharged on 1/10/23. Resident #61 was discharged on 1/17/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	

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F 661	Continued From page 14 Discharge Summary which stated Resident #264 was on a regular diet with easy to chew foods and thin liquids and Activity Discharge Summary which stated Resident #264 could complete activities with assistance. The areas of Social Service Discharge Summary, Nursing (course of treatment while in facility including complications), Pertinent Lab Tests and Results, Pertinent Consultation Findings and Recommendations, Pertinent Radiology and Other Tests and Results, and Rehabilitation/Therapy parts of section E were blank. An interview with the Social Services Director on 02/09/23 at 02:24 PM revealed he usually opened the "Discharge Summary Information" document, and each department was responsible for completing their section. He stated he was not aware there was an area for Social Services to document information under the "Recapitulation of Stay". The Social Services Director stated he was not sure who was responsible for ensuring the recapitulation of stay was completed before a resident was discharged home. An interview with the Regional Director of Clinical Services (RDCS) on 02/10/23 at 04:20 PM revealed she had been filling in wherever she was needed since the Director of Nursing (DON) left employment in October 2022. She stated the DON was responsible for ensuring recapitulations of stay were completed before a resident was discharged and she was not sure why the recapitulation of stay was not completed for Resident #264. 2. Resident #63 was admitted to the facility 12/16/22 with diagnoses including fracture (broken bone) of the left patella (knee) and heart	F 661	3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Director of Nursing (DON), Social Service Director (SSD) and/or licensed nurse will be responsible for completion and provided education to complete the recapitulation of stay to the facility Interdisciplinary Team (Executive Director (ED), DON, Assistant Director of Nursing (ADON), SSD, Activity Director (AD), Dietary Manager (DM), Director of Rehab (DOR)) on the facility “Discharge Summary” policy. Education will be completed by 3/26/23. Any associate who has not completed education by 3/26/23 will not be allowed to provide direct resident care until education is completed. The DON, SSD and/or a licensed nurse will provide education to all interdisciplinary associates upon hire, annually, and as needed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON, SSD, and/or licensed nurse will review the anticipated resident discharges to ensure the residents recapitulation of stay is completed, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks.	

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F 661	Continued From page 15 failure. The admission Minimum Data Set (MDS) dated 12/22/22 revealed Resident #63 was cognitively intact and an active discharge plan was in place for her to return to the community. Review of the medical record revealed Resident #63 was discharged to the community 01/10/23. Review of the "Discharge Summary Information" dated 01/10/23 for Resident #63 revealed the only area completed under section E titled "Recapitulation of Stay" was the Activity Discharge Summary which stated Resident #63 was discharged home with her husband and would continue with activities of her choice. The areas of Dietary Discharge Summary, Social Service Discharge Summary, Nursing (course of treatment while in facility including complications), Pertinent Lab Tests and Results, Pertinent Consultation Findings and Recommendations, Pertinent Radiology and Other Tests and Results, and Rehabilitation/Therapy parts of section E were blank. An interview with the Social Services Director on 02/09/23 at 02:24 PM revealed he usually opened the "Discharge Summary Information" document, and each department was responsible for completing their section. He stated he was not aware there was an area for Social Services to document information under the "Recapitulation of Stay". The Social Services Director stated he was not sure who was responsible for ensuring the recapitulation of stay was completed before a resident was discharged home. An interview with the Regional Director of Clinical	F 661	DON and/or licensed nurse will provide education for any incidents of non-compliance. The Executive Director (ED) and/or DON will provide education for any incidents of non-compliance. Results of the audits will be reported by the DON and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. The Director of Nursing (DON), Social Service Director (SSD) will ensure the POC is implemented. 5. Date when corrective action will be completed. 3/26/23	

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F 661	Continued From page 16	F 661		

Services (RDCS) on 02/10/23 at 04:20 PM revealed she had been filling in wherever she was needed since the Director of Nursing (DON) left employment in October 2022. She stated the DON was responsible for ensuring recapitulations of stay were completed before a resident was discharged and since there had not been a DON from October 2022 until February 6, 2023, there was not a staff member that had been making sure recapitulations of stay were completed during that time. The RDCS stated she was going to work with the new DON to develop a process to ensure recapitulations of stay were completed before residents were discharged.

3. Resident #61 was admitted to the facility 12/18/22 with diagnoses including fracture (broken bone) and multiple traumas.

The admission Minimum Data Set (MDS) dated 12/21/22 revealed Resident #61 was cognitively intact and there was an active discharge plan in place for her to return to the community.

Review of the medical record revealed Resident #61 was discharged to the community 01/17/23.

Review of the "Discharge Summary Information" dated 01/17/23 for Resident #61 revealed the only areas completed under section E titled "Recapitulation of Stay" were the Dietary Discharge Summary which stated Resident #61 was on a regular diet with thin liquids and Nursing (course of treatment while in facility including complications) which stated Resident #61 required assistance with activities of daily living (ADL), received physical therapy (PT) services, and received antibiotic treatment. The areas of Activity Discharge Summary, Social Service

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F 661	Continued From page 17 Discharge Summary, Pertinent Lab Tests and Results, Pertinent Consultation Findings and Recommendations, Pertinent Radiology and Other Tests and Results, and Rehabilitation/Therapy parts of section E were blank. An interview with the Social Services Director on 02/09/23 at 02:24 PM revealed he usually opened the "Discharge Summary Information" document, and each department was responsible for completing their section. He stated he was not aware there was an area for Social Services to document information under the "Recapitulation of Stay". The Social Services Director stated he was not sure who was responsible for ensuring the recapitulation of stay was completed before a resident was discharged home. An interview with the Regional Director of Clinical Services (RDCS) on 02/10/23 at 04:20 PM revealed she had been filling in wherever she was needed since the Director of Nursing (DON) left employment in October 2022. She stated the DON was responsible for ensuring recapitulations of stay were completed before a resident was discharged and since there had not been a DON from October 2022 until February 6, 2023, there was not a staff member that had been making sure recapitulations of stay were completed during that time. The RDCS stated she was going to work with the new DON to develop a process to ensure recapitulations of stay were completed before residents were discharged.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		3/26/23

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F 677	Continued From page 18 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with Family Members, residents, and staff the facility failed to provide oral hygiene assistance for 2 of 8 dependent residents reviewed for activities of daily living (Resident #20 and #41). The findings included: 1. Resident #20 was admitted to the facility on 08/03/22 with diagnoses including cerebrovascular accident and hemiplegia (paralysis on one side of the body). Review of the care plan initiated on 08/18/22 revealed Resident #20 had oral and dental health problems. Interventions included provide mouth care daily. Review of the significant change in status Minimum Data Set (MDS) dated 11/18/22 revealed Resident #20 was assessed as having severely impaired cognition and needed extensive assistance with personal hygiene. The MDS revealed the oral and dental status of Resident #20 included obvious or likely cavities or broken natural teeth. An observation on 02/07/23 at 8:39 AM revealed Resident #20's upper and lower teeth had a white colored buildup surrounding the gums and teeth. An electric toothbrush was being stored in the bathroom and available for use.	F 677	Identified Concern/Issue: The facility failed to provide oral hygiene assistance for 2 of 8 dependent residents reviewed for activities of daily living (Resident #20 and #41). 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #41 was discharged on 2/11/23. On 3/2/23, the Regional Director of Clinical Services (RDCS) set up oral care schedule twice a day and prn on Resident #41's CNA task list. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? Process Change New Oral Care Tab created in Point Click Care (PCC) for Certified Nursing Assistants (CNA) documentation of oral	

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F 677	Continued From page 19 An observation and interview were conducted on 02/08/23 at 9:28 AM with Resident #20. Resident #20's teeth and gums continued to have a white colored buildup around the teeth and gums. Resident #20 stated staff at the facility did not assist him with brushing his teeth. Resident #20 revealed Family Member #1 visited every day and would clean his teeth. An interview was conducted on 02/08/23 at 10:51 AM with Family Member #1. Family Member #1 revealed she visited Resident #20 daily and usually arrived around 9:30 AM and left at 1:30 PM. Family Member #1 stated she setup the electric toothbrush for Resident #20 to brush his own teeth. Family Member #1 revealed she had asked someone at the facility who was responsible for helping setup the toothbrush but never got an answer and noticed it was not being done. Family Member #1 revealed when she noticed Resident #20's oral hygiene wasn't being done she started cleaning his teeth. Family Member #1 revealed Resident #20 didn't get out of bed and needed someone to assist with oral hygiene. An interview was conducted on 02/08/23 at 10:59 AM with Nurse Aide (NA) #1. NA #1 confirmed she was assigned to assist Resident #20 with activities of daily living. NA #1 revealed Resident #20 was dependent and needed extensive assistance with activities of daily living including personal hygiene. NA #1 revealed staff were to assist residents with brushing their teeth as part of their personal hygiene. NA #1 revealed she hadn't offered to assist Resident #20 with oral hygiene and stated Family Member #1 did it. A joint interview was conducted on 02/10/23 at	F 677	care twice a day and prn. The Director of Nursing (DON) and/or licensed nurse will implement the POC and provided education to all licensed nurses and CNAs on the facility “Activities of Daily Living (ADLs)” policy to ensure oral hygiene assistance is provided to residents. Education will be completed by 3/26/23. Any associate who has not completed education by 3/26/23, will not be allowed to provide direct resident care until education is completed. The DON and/or a licensed nurse will provide education to all licensed nurses and CNAs upon hire, annually, and as needed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON and/or licensed nurse will review oral care documentation in PCC to ensure resident oral hygiene assistance, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The DON, and/or licensed nurse will conduct random visual observations of 5 residents per shift (7-3 and 3-11) to ensure resident oral hygiene assistance provided as documented, five (5) times a	

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F 677	Continued From page 20 5:12 PM with the Regional Director of Clinical Services and the Director of Nursing (DON). The Regional Director of Clinical Services and DON revealed NA staff should be offering residents assistance with mouth care twice a day, once in the morning and again at bedtime. 2. Resident #41 was admitted to the facility on 09/02/22 with diagnoses including heart failure and debility. Review of the significant change in status MDS dated 01/20/23 revealed Resident #41 was assessed as having severely impaired cognition and needed extensive assistance with personal hygiene. The MDS revealed no oral and dental status assessment for Resident #41 was done due to not being able to examine. Review of the care plan initiated on 01/26/23 revealed Resident #41 was at risk for altered nutrition related to variable intake of meals and hospice. Interventions included provide oral hygiene at least every shift and as needed. During an observation on 02/06/23 at 2:57 PM Resident #41's teeth, gums, and tongue had a significant amount of white colored buildup. NA #2 was observed attempting to clean the mouth of Resident #41 using a glycerin swab to wipe the around the teeth and gums. During oral care Resident #41 begun to get upset and stuck her tongue out and repeated the word nasty over and over. NA #2 offered sips of water and cued Resident #41 to swish the water in her mouth then spit out. NA #2 offered several sips of water and Resident #41 continued to swish and spit. NA #2 offered oral hygiene using a toothbrush and toothpaste and begun to clean the teeth, gums,	F 677	week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. DON and/or licensed nurse will provide education for any incidents of non-compliance. The Executive Director (ED) and/or DON will provide education for any incidents of non-compliance. Results of the audits will be reported by the DON and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 5. Date when corrective action will be completed. 3/26/23	

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and tongue for Resident #41. Resident #41 was accepting of oral hygiene care and easily followed the cues from NA #2. NA #2 brushed the teeth, gums, and tongue and was able to easily remove the white colored buildup using the toothbrush.

An interview was conducted on 02/06/23 at 2:57 PM with NA #2. NA #2 revealed she typically used the glycerin swabs to provided mouth care for Resident #41. NA #2 revealed she wasn't assigned to provide Resident #41's care on 02/06/23 and indicated assistance was offered after surveyor made her aware the condition of Resident #41's mouth. NA #2 stated Resident #41 couldn't brush her own teeth and staff needed to do it for her each day. NA #2 confirmed there was a significant amount or white colored buildup on the resident's gums, teeth, and tongue that was easy for her to remove using the toothbrush.

An interview was conducted on 02/08/23 at 5:34 PM with NA #3. NA #3 revealed she was assigned morning care for Resident #41 on 02/06/23 and provided oral care using the glycerin swabs. NA #3 stated she cleaned Resident #41's mouth and did notice the white colored buildup and indicated the resident accepted oral care.

An interview was conducted on 02/08/23 at 7:59 PM with Family Member #2. Family Member #2 revealed she would visit Resident #41 most days and would assist with brushing the resident's teeth. Family Member #2 revealed staff didn't provide setup for Resident #41 to brush her own teeth when first admitted or provide oral hygiene after the resident's abilities declined. Family Member #2 stated Resident #41 shouldn't have to

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F 677	Continued From page 22 go without basic hygiene needs. A joint interview was conducted on 02/10/23 at 5:12 PM with the Regional Director of Clinical Services and the DON. The Regional Director of Clinical Services and DON revealed NA staff should be offering residents assistance with mouth care twice a day, once in the morning and again at bedtime.	F 677		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the Medical Director and staff the	F 693	Identified Concern/Issue:	3/26/23

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F 693	Continued From page 23 facility failed to monitor the water flush settings on the feeding pump to ensure those were consistent with the physician's order as transcribed on the Medication Administration Record to flush 23 milliliters every hour for 1 of 1 resident reviewed for tube feeding (Resident #15). The findings included: Resident #15 was admitted to the facility on 09/01/22 with diagnoses including dysphasia, tracheostomy, and paralytic syndrome following a cerebrovascular accident. Review of the care plan initiated on 09/07/22 revealed Resident #15 required tube feedings via percutaneous endoscopic gastrostomy tube (a feeding tube placed in the stomach) related to swallowing problems. Interventions included review physician orders for current feeding orders and indicated Resident #15 was dependent with tube feeding and water flushes. Review of the physician order for Resident #15's water flush dated 10/17/22 provided directions to flush 23 milliliters (ml) of water every hour. Review of the quarterly Minimum Data Set dated 12/06/22 revealed Resident #15 was assessed as having moderately impaired cognition with no speech and being totally dependent for assistance with eating and received fluids and nutrition via a feeding tube. An observation was made on 02/06/23 at 1:53 PM of Resident #15's feeding pump. The feeding pump setting for water flushes read flush 23 milliliters (ml) every 4 hours.	F 693	Facility failed to monitor the water flush settings on the feeding pump to ensure those were consistent with the physician’s order as transcribed on the Medication Administration Record to flush 23 milliliters every hour for 1 of 1 resident reviewed for tube feeding (Resident #15) 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/9/23, Nurse #2 changed the setting on Resident #15’s feeding pump to deliver 23 ml of water every hour. The Director of Nursing (DON) and/or licensed nurse provided education on 03/08/2023 to Nurse #2 on facilities “Enteral Nutritional Therapy (Tube Feeding) policy (including the Lippincott notes) to ensure verification of practitioner’s order including volume and frequency of water flushes. Education was completed by 3/26/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with a feeding tube have the potential to be affected. On 03/01/2023 audit of feeding pumps/tubers showed no other resident was identified with a feeding tube. 3. What measure will be put into place or systemic changes made to ensure that	

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F 693	Continued From page 24 An observation was made on 02/07/23 at 1:55 PM of Resident #15's feeding pump. The water flush settings continued at 23 ml every 4 hours. An observation and interview were conducted on 02/09/23 at 10:34 AM with Nurse #2. Observation of Resident #15's feeding pump with Nurse #2 revealed the water flush settings continued at 23 ml every 4 hours. Nurse #2 revealed she was the assigned nurse for Resident #15 and explained the night shift nurses were responsible for replacing the water used to flush the feeding pump. Nurse #2 revealed the feeding pump settings were checked and signed off on the Medication Administration Record (MAR) during each shift to ensure those were correct. After review of the physician order transcribed on Resident #15's MAR, Nurse #2 revealed she had initialed to indicate the feeding pump settings were correct and delivering 23 ml of water every hour. Nurse #2 stated she didn't notice the setting on feeding pump for the water flush was incorrectly set to deliver 23 ml every 4 hours. Nurse #2 changed the setting on Resident #15's feeding pump to deliver 23 ml of water every hour. During an interview on 02/10/23 at 1:16 PM the Medical Director revealed the physician's order for Resident #15's water flush needed to be followed. He explained he wasn't concerned it caused any harm related to the resident's hydration status, but the water flush was in place mainly to keep the feeding pump patent to ensure the tubing didn't clog. The Medical Director stated it would be difficult to replace the feeding tube for Resident #15 if it was clogged.	F 693	the deficient practice will not recur? The Director of Nursing (DON) and/or licensed nurse will implement the POC and provided education to all licensed nurses on the facilities "Enteral Nutritional Therapy (Tube Feeding) policy (including the Lippincott notes) to ensure verification of practitioner's order including volume and frequency of water flushes. Education will be completed by 3/26/23. Any associate who has not completed education by 3/26/23, will not be allowed to provide direct resident care until education is completed. The DON and/or a licensed nurse will provide education to all licensed nurses upon hire, annually, and as needed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON and/or licensed nurse will validate the practitioner's tube feeding order including volume and frequency of water flushes to the resident feeding pump settings, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The DON and/or licensed nurse will provide education for any incidents of non-compliance. Results of the audits will be reported by the DON and/or Executive Director (ED)	

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F 693	Continued From page 25 An interview was conducted on 02/10/23 at 5:17 PM with the Director of Nursing (DON). The DON stated the nurse staff should check the water flush on the feeding pump to ensure the setting was correct and the same as the physician order transcribed on the MAR if they initialed it was.	F 693	to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 5. Date when corrective action will be completed. 3/26/23	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		3/26/23

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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 staff, Consultant Pharmacist, and Medical Director interviews, the facility failed to follow-up on the monthly pharmacist consultation reports for 2 of 5 residents reviewed for unnecessary medications (Residents #32 and #27).

Findings included:

1. Resident #32 admitted to the facility on 02/08/22 with diagnoses that included depression.

An active physician's order dated 04/06/22 for Resident #32 read, Zoloft (antidepressant medication) 75 milligrams (mg) by mouth one time a day for depression.

Review of a "Consultation Report" issued on 10/20/22 read, Resident #32 "has received an antidepressant, Sertraline (generic form of Zoloft

Identified Concern/Issue:

The facility failed to follow-up on the monthly pharmacist consultation reports for 2 of 5 residents reviewed for unnecessary medications (Residents #32 and #27).

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 2/28/23, the practitioner declined the pharmacist recommendation for Gradual Dose Reduction (GDR) for Resident #32.

On 2/16/23, Fenofibrate was discontinued, and Citalopram was decreased to 20 milligram (mg) by mouth (po) daily for Resident #27.

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F 756	Continued From page 27 medication) 75 mg one time a day for management of depressive symptoms, since 04/07/22. Please attempt a Gradual Dose Reduction (GDR) for Sertraline to 50 mg one time a day." The bottom of the form where the provider would accept or deny the GDR recommendation and sign the form was blank. The quarterly Minimum Data Set (MDS) assessment dated 11/17/22 revealed Resident #32 had severe impairment in cognition and received antidepressant medication daily during the 7-day MDS assessment period. The Medication Administration Records (MARs) for November 2022, December 2022, January 2023 and February 2023 revealed Resident #32 received Zoloft 75mg once daily as ordered. During a phone interview on 02/10/23 at 11:46 AM, the Consultant Pharmacist explained he typically made notes when completing his monthly medication reviews and followed up on any outstanding recommendations verbally during the exit call with the Director of Nursing (DON). The Consultant Pharmacist confirmed he submitted a recommendation on 10/20/22 for a GDR of Zoloft 75 mg for Resident #32 but could not recall the date when he had followed up with facility staff on the recommendation. He added the recommendation for Resident #32 dated 10/20/22 was still open. During a phone interview on 02/10/23 at 1:16 PM, the Medical Director (MD) explained due to turnover in facility staff, there had been some confusion as to where the pharmacy recommendations were going when received from the Consultant Pharmacist. The MD further	F 756	2. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/21/23, the Regional Director of Clinical Services (RDCS) reviewed and followed-up on the February 2023 monthly pharmacist consultation reports. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? The RDCS will provide education to the Director of Nursing (DON) on the facility "Pharmacy Services and Medication Regimen Review" policy and Omnicare "Medication Regimen Review" policy to ensure pharmacy recommendation were addressed with in the time of the pharmacy next review (30 days). Education will be completed by 3/26/23. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The Executive Director (ED) will implement POC and will audit the monthly pharmacy consultation report to ensure the Pharmacist recommendations have been reviewed and addressed by the practitioner timely, monthly times three (3) months. The ED will provide education for any incidents of non-compliance. Results of the audits will be reported by	

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F 756	Continued From page 28 explained typically, the DON would be the person responsible for ensuring the pharmacy recommendations were placed in the physician communication book to be addressed. The MD did not recall receiving a pharmacy recommendation for a GDR for Resident #32's Zoloft medication and if he had, he would have addressed. During an interview on 02/10/23 at 4:31 PM, the Regional Director of Clinical Operations revealed the DON was the person responsible for ensuring the physician received pharmacy recommendations from the Consultant Pharmacist. The Regional Director of Clinical Operations explained the DON made a copy of the recommendation, placed the original in the physician's communication book to be addressed and when the recommendation was returned by the physician, the DON discarded the copy and followed up on any recommendations not addressed. The Regional Director of Clinical Operations could not explain why the pharmacy recommendation for Resident #32 dated 10/20/22 was not addressed and stated she felt the process had fallen apart in October 2022 when the DON left employment. During an interview on 02/10/23 at 5:33 PM, the Administrator revealed he was unaware a pharmacy recommendation dated 10/20/22 had not been addressed for Resident #32. The Administrator stated he was aware there was a problem in general with pharmacy recommendations and had reached out to the Consultant Pharmacist so they could meet with the MD to discuss a plan to ensure pharmacy recommendations were addressed.	F 756	the DON and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 5. Date when corrective action will be completed. 3/26/23	

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2. Resident #27 was admitted to the facility 10/06/22 with diagnoses including hyperlipidemia (high cholesterol) and depression.

Review of Resident #27's active Physician orders dated 10/06/22 for Citalopram (an antidepressant medication) 40 milligrams (mg) one time a day, Fenofibrate (a medication for cholesterol) 160 mg once a day, and Pravastatin Sodium (a medication for cholesterol) 40 mg one time a day.

Review of a "Consultation Report" dated 10/21/22 read, "Resident #27 receives a statin (cholesterol medication), Pravastatin Sodium, and a fibric acid derivative (cholesterol medication), Fenofibrate. Please consider discontinuing Fenofibrate if risks outweigh the benefits of combined therapy. If Fenofibrate is discontinued, please monitor a fasting lipid panel (a blood test that monitors cholesterol) in 4 weeks and every 12 months thereafter." A "Consultation Report" also dated 10/21/22 read, "Resident #27 is receiving Citalopram 40 mg one time a day for depression, which exceeds the maximum recommended daily dose of 20 mg in those over 60 years of age. Please decrease Citalopram to 20 mg daily or consider alternative therapy. Rationale (reason) for recommendation: Due to the risk of QT prolongation (a disturbance in how the heart's bottom chambers send signals), the maximum recommended dose of Citalopram is 20 mg daily for individuals who are over 60 years of age." The bottom of the forms where the provider would accept or decline the recommendation and sign were blank.

The quarterly Minimum Data Set (MDS) dated 01/12/23 revealed Resident #27 was cognitively intact and received antidepressant medication 7

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out of 7 days during the look-back period.

Review of Resident #27's Medication Administration Record (MAR) for October 2022, November 2022, December 2022, January 2023, and February 2023 revealed Resident #27 received Citalopram, Fenofibrate, and Pravastatin Sodium as ordered.

During a telephone interview with the Consultant Pharmacist on 02/10/23 at 11:46 AM he explained he usually made notes when completing his monthly medication reviews and followed up on any outstanding recommendations verbally during the exit call with the Director of Nursing (DON). The Consultant Pharmacist confirmed he submitted recommendations for Resident #27 for Citalopram, Fenofibrate, and Pravastatin Sodium on 10/21/22 but did not recall the date he followed up with facility staff on the recommendations. He stated the recommendations for Resident #27 dated 10/21/22 were still open and should have already been addressed by the provider.

During a telephone interview with the Medical Director (MD) on 02/10/23 at 01:28 PM he explained due to turnover with facility staff there had been some confusion as to where the pharmacy recommendations were going after being received from the Consultant Pharmacist. He stated usually the DON placed pharmacy recommendations in the physician communication book to be addressed and he did not recall seeing the recommendations for Resident #27's Citalopram, Fenofibrate, and Pravastatin Sodium. The Medical Director stated if he had seen the pharmacy recommendations he would have discontinued Fenofibrate,

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F 756	Continued From page 31 assessed Resident #27 to see if she was appropriate for a gradual dose reduction (GDR), and would have considered obtaining an electrocardiogram (a test to evaluate electrical signals in the heart). An interview with the Regional Director of Clinical Services (RDCS) on 02/10/23 at 04:20 PM revealed the DON was the person responsible for ensuring the physician received pharmacy recommendations from the Consultant Pharmacist. She explained the DON made a copy of the recommendation, placed the original in the physician communication book to be addressed and when the recommendations were returned by the physician, the DON discarded the copy and followed up on any recommendations not addressed. The RDCS could not explain why the pharmacy recommendations for Resident #27 dated 10/21/22 were not addressed and stated she felt the process had fallen apart when the DON left employment in October 2022. An interview with the Administrator on 02/10/23 at 05:33 PM revealed he was unaware pharmacy recommendations dated 10/21/22 had not been addressed for Resident #27. He stated he was aware there was a problem in general with pharmacy recommendations and had reached out to the Consultant Pharmacist so they could meet with the Medical Director to discuss a plan to ensure pharmacy recommendations were addressed.	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		3/26/23

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F 812	Continued From page 32 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure foods were dated after opened and failed to ensure thickened liquids were discarded prior to the use by date after being opened. These failures occurred in 1 of 1 walk-in refrigerator and 1 of 2 nourishment room refrigerators (500/600 Hall). The findings included: 1. A tour of kitchen was conducted on 02/06/23 from 9:02 AM through 9:36 AM with the Dietary Manager (DM). Observation of the walk-in refrigerator in the kitchen revealed opened containers included mayonnaise dated 01/27, Tuscan dressing dated 11/08, teriyaki marinade dated 05/17, chunky salsa dated 10/31, and a large block of cream cheese half used dated 01/03.	F 812	Identified Concern/Issue: The facility failed to ensure foods were dated after opened and failed to ensure thickened liquids were discarded prior to the use by date after being opened. These failures occurred in 1 of 1 walk-in refrigerator and 1 of 2 nourishment rooms refrigerators (500/600 Hall). 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/9/23, the Dietary Manager discarded all opened containers in the walk-in refrigerator that did not have an open date or a used by date. On 2/9/23, the Dietary Manager discarded	

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F 812	Continued From page 33 During an interview on 02/06/23 at 9:02 AM the DM explained the dates on the open containers in the walk-in refrigerator indicated the date the items were delivered not the date the items were opened or the use by date. The DM revealed the open containers in the walk-in refrigerator were kept in use until the expiration date on the container. It was pointed out to the DM the chunky salsa had an expiration date of 02/15/24. The DM stated it would be used before then. A second tour of the kitchen and interview were conducted on 02/09/23 at 11:10 AM with the DM. The DM revealed it was her responsibility to check and ensure open containers were labeled with the date it was opened. The DM revealed the open containers in the walk-in refrigerator were stored on the top shelf and it was an oversight she didn't check the dates on the containers. The DM revealed food should be labeled with the date it was open by the person who opened the item, and she used a guide to determine when those items should be discarded. 2. An observation and interview of the nourishment room refrigerators were conducted on 02/09/23 at 12:04 PM with the DM. The nourishment room refrigerator located on the 500/600 hall revealed a 46 fluid ounce container of nectar-thick sweet tea was opened and dated 1/30 and a 46 fluid ounce container of honey-thick water was opened and dated 1/17. The DM revealed dietary staff stocked the nourishment room refrigerators, but the nursing staff were responsible for labeling an open date on the container and discard after 7 days in use. An interview was conducted on 02/09/23 at 12:22 PM with Nurse Aide (NA) #5. NA #5 revealed it	F 812	the nectar-thick sweet tea and the honey-thick water found in the nourishment room refrigerator. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/13/23, the Dietary Manager audited the walk-in refrigerator to ensure all items were labeled and stored appropriately. On 2/13/23, the Dietary Manager audited both nourishment room refrigerators to ensure all items were labeled and stored appropriately. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Executive Director (ED) will provide education to the Dietary Manager (DM) on the facility “Food Safety” policy to ensure foods are dated after opened and thickened liquids are discarded prior to the use by date after being opened. Education will be completed by 3/26/23. The DM will provide education to the Dietary department on the facility “Food Safety” policy to ensure foods are dated after opened and thickened liquids are discarded prior to the use by date after being opened. Education will be completed by 3/26/23. The Director of Nursing (DON), and/or the licensed will provide education to the	

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F 812	Continued From page 34 the responsibility of the person who opened the container it to write the date it was opened. NA #5 revealed thickened liquids were okay to use for 7 days after opened and it was the responsibility of the nursing staff to check the dates and discard if necessary.	F 812	licensed nurses and Certified Nurse Assistant (CNA)s on the facility “Food Safety” policy to ensure foods are dated after opened and thickened liquids are discarded prior to the use by date after being opened. Education will be completed by 3/26/23. Any associate who has not completed education by 3/26/23. Will not be allowed to provide direct resident care until education is completed. The ED, DON, DM and/or a licensed nurse will provide education to Dietary associates, licensed nurses, and CNAs upon hire, annually, and as needed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DM will audit the walk-in refrigerator in the dietary department to ensure proper labeling and storage, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The DM will audit the two nourishment room refrigerators to ensure proper labeling and storage, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The ED, DON, DM, and or licensed nurse will implement the POC and will provide education for any incidents of non-compliance.	

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F 812	Continued From page 35	F 812	Results of the audits will be reported by the DON and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 5. Date when corrective action will be completed. 3/26/23	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to dispose of trash and keep the area surrounding the dumpster free of debris for 1 of 2 dumpsters reviewed. The findings included: An observation was made on 02/06/23 at 9:36 AM of the dumpster area. The dumpster doors were closed. Three clear plastic bags of garbage were laying on the ground below the closed doors of dumpster. The garbage bags contained what appeared as soiled briefs and personal protective equipment including disposable gloves and gowns. On the side of the dumpster 2 personal protective (PPE) gowns were laying directly on	F 814	Identified Concern/Issue: The facility failed to dispose of trash and keep the area surrounding the dumpster free of debris for 1 of 2 dumpsters reviewed. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/6/23, the Maintenance Director and the Director of Environmental Services cleaned the dumpster area and properly disposed of all debris and will be responsible for ensuring the dumpster area is clean.	3/26/23

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F 814	Continued From page 36 the ground. An interview was conducted on 02/06/23 at 9:36 AM with the Dietary Manager (DM). The DM explained the garbage thrown on ground was from nursing staff and they were responsible for ensuring the trash was placed inside the dumpster. An interview was conducted on 02/09/23 at 4:30 PM with Assistant Director of Nursing (ADON). The ADON explained housekeeping staff disposed of the trash for nursing until 5:00 PM but after that the Nurse Aides (NA) were responsible for it. The ADON stated the NA staff should ensure the garbage area was kept clean when they threw away trash. During an interview on 02/10/23 at 5:38 PM the Administrator revealed the garbage was picked up on 02/06/23 in the morning and maintenance was responsible for cleaning around the dumpster. The Administrator revealed he thought the trash bags fell from the dumpster when lifted and dumped during pickup and maintenance didn't have time to clean it up before the surveyor observed the dumpster area.	F 814	2. How the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/6/23, the Maintenance Director and the Director of Environmental Services cleaned the dumpster area and properly disposed of all debris and will be responsible for ensuring the dumpster area is clean. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Executive Director (ED), Director of Nursing (DON), licensed Nurse, and/or Dietary Manager (DM) will implement the POC and will provide education to all associates on the facility “Disposal of Garbage and Refuse” policy to ensure all waste is properly contained in the dumpsters or compactor and are covered appropriately. Education will be completed by 3/26/23. Any associate who has not completed education by 3/26/23. Will not be allowed to provide direct resident care until education is completed. The ED, DON, licensed nurse will provide education to all associates upon hire, annually, and as needed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The ED and/or Maintenance associate will	

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F 814	Continued From page 37	F 814	audit dumpster area to ensure all waste is properly contained in the dumpsters or compactor and are covered appropriately, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The ED will provide education for any incidents of non-compliance. Results of the audits will be reported by the DON and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 5. Date when corrective action will be completed. 3/26/23	
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	F 880		3/26/23

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F 880	Continued From page 38	F 880		

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

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

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

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F 880	Continued From page 39 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement their policy for Personal Protective Equipment (PPE) when 2 of 2 staff members (Health Information Manager and Nurse Aide #7) failed to don N95 masks and goggles or faceshield before entering and change facemasks upon exiting 2 of 2 resident rooms who were positive for COVID-19. Findings included: The facility's policy, Transmission-based Precautions and Isolation Procedures, last revised 08/22/22, read in part, "For a resident with known or suspected COVID-19, associates should wear gloves, isolation gown, eye protection, and a N95 or higher-level respirator if available." An observation of the 500 Hall on 02/06/23 at 11:00 AM revealed rooms 503 and 505 were on	F 880	Identified Concern/Issue: The facility failed to implement their policy for Personal Protective Equipment (PPE) when 2 of 2 staff members (Health Information Manager and Nurse Aide #7) failed to don N95 masks an goggles or face shield before entering and change facemasks upon exiting 2 of 2 resident rooms who were positive for COVID-19. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Director of Nursing (DON), and or license nurse provided education on 03/06/23 to the Health Information Manager on facility “Transmission-based Precautions and Isolation Procedures” policy to ensure associate don N95 masks	

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F 880	Continued From page 40 droplet/contact precautions and both residents were positive for COVID-19. 1. During an observation on 02/06/23 at 11:08 AM, the Health Information Manager went into room 503 to answer the call light. The Health Information Manger wore a surgical face mask, donned a gown and gloves, and entered the resident's room. Prior to exiting the room, the Health Information Manager doffed her gown and gloves, sanitized her hands, and proceeded down the hall toward the nurses' station. During an interview on 02/06/23 at 11:14 AM, the Health Information Manager confirmed she donned a gown and gloves but did not put on a N95 mask or eye protection when entering room 503 and did not change her face mask upon exiting the room. The Health Information Manager stated she did not read the posted signage and did not know that she was supposed to wear a N95 mask and goggles or faceshield when entering a resident's room who was COVID-19 positive. The Health Information Manager could not recall what she was trained to do regarding donning/doffing PPE and stated, "I should have asked." During a follow-up interview on 02/06/23 at 3:29 PM, the Health Information Manager stated she spoke with the Assistant Director of Nursing who confirmed she should have donned a gown, gloves, N95 mask and goggles or faceshield prior to entering a COVID-19 positive room and she would make sure to do that next time she entered a resident's room on isolation precautions for COVID-19. During an interview on 02/08/23 at 9:48 AM, the	F 880	and goggles or faceshield before entering and change facemasks upon exiting resident rooms who were positive for COVID-19. Education will be completed by 3/26/23. The DON, and or license nurse provided education on 03/06/23 to the Nurse Aide #7 on facility “Transmission-based Precautions and Isolation Procedures” policy to ensure associate don N95 masks and goggles or faceshield before entering and change facemasks upon exiting resident rooms who were positive for COVID-19. Education will be completed by 3/26/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. No current residents in facility on Transmission-based precautions with COVID-19. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Executive Director (ED), Director of Nursing (DON), Infection Preventionist (IP), Staff Development Coordinator (SDC), and/or licensed nurse will provide education to all associates on the following: • Personal Protective Equipment (PPE) policy • PPE Donning (Putting On) Checklist	

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F 880	Continued From page 41 Regional Director of Clinical Services revealed prior to the Staff Development Coordinator leaving employment in November 2022, staff had received frequent training on COVID-19 policies and procedures which included donning/doffing the appropriate PPE when entering and exiting resident rooms on droplet/contact precautions for COVID-19. The Regional Director of Clinical Services stated the Health Information Manager should have donned a N95 mask and goggles or faceshield from the PPE bin outside room 503 prior to entering and change her facemask upon exiting the room. During an interview on 02/10/23 at 5:33 PM, the Administrator explained staff had been trained repeatedly on COVID precautions and should be donning/doffing the appropriate PPE when entering/exiting COVID positive rooms. 2. During an observation on 02/06/23 at 12:10 PM, Nurse Aide (NA) #7 went into room 505 to deliver the resident's lunch tray. NA #7 wore a surgical face mask, donned a gown and gloves, and entered room 505. NA #7 placed the food items on the resident's overbed table, went into the bathroom to wet a towel, cleaned the overbed table and moved the overbed table closer to the resident. NA #7 then doffed his PPE, sanitized his hands upon exiting the room and went back to the meal cart in the hallway to retrieve another meal tray. During an interview on 02/06/23 at 12:15 PM, NA #7 revealed he was trained to don eye protection and a N95 mask when entering and changing his face mask upon exiting COVID positive rooms. NA #7 stated he was focused on delivering the meal tray to the resident and just forgot to	F 880	• PPE Doffing (taking off) Checklist • Transmission-based Precautions and Isolation Procedures policy • Updated signage for COVID-19 precautions. Any associate who has not completed training by 3/26/2023 will not be allowed to provide direct resident care until training is completed. All associates will be educated on “Use PPE Correctly” located at https://www.youtube.com/watch?v=YYTATw9yav4 [Per DPoC]. Education will be completed by 3/26/2023. *Any associate who has not completed training by 3/26/2023 will not be allowed to provide direct resident care until training is completed. The Executive Director (ED), Director of Nursing (DON), Staff Development Coordinator (SDC), and/or licensed nurse will provide education to all new associates upon hire during orientation. The Executive Director (ED), Director of Nursing (DON), Staff Development Coordinator (SDC), and/or licensed nurse will provide education to all new associates upon hire during orientation. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. DON, Infection Preventionist (IP), and/or licensed nurse will conduct two (2) PPE/donning & doffing observations/audits every shift. Audits will	

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F 880	Continued From page 42 don/doff the appropriate PPE. During an interview on 02/08/23 at 9:48 AM, the Regional Director of Clinical Services revealed prior to the Staff Development Coordinator leaving employment in November 2022, staff had received frequent training on COVID-19 policies and procedures which included donning/doffing the appropriate PPE when entering and exiting resident rooms on droplet/contact precautions for COVID-19. The Regional Director of Clinical Services stated NA #7 should have donned a N95 mask and goggles or faceshield from the PPE bin outside room 505 prior to entering and change his facemask upon exiting the room. During an interview on 02/10/23 at 5:33 PM, the Administrator explained staff had been trained repeatedly on COVID precautions and should be donning/doffing the appropriate PPE when entering/exiting COVID positive rooms.	F 880	be conducted 5 (five) times a week for 4 (four) weeks, then 3 (three) times a week for 4 (four) weeks, then 1 (one) time a week for 4 four) weeks. The Executive Director (ED) and/or Director of Nursing (DON) will provide education for any incidents of non-compliance. Results of the audits will be reported by the DON, Infection Preventionist (IP), and/or Executive Director (ED) to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 5. Date when corrective action will be completed. 3/26/23	
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not	F 886		3/26/23

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F 886	Continued From page 43	F 886		

limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing

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F 886	Continued From page 44 residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their COVID-19 testing policy and the nationally recognized standard to test residents and staff immediately, but not earlier than 24 hours after the exposure, for 4 of 4 residents (Resident #12, Resident #56, Resident #59, Resident #60) and 5 of 5 staff members who tested positive for COVID-19 (Nurse Aide #2, Nurse Aide #6, Nurse Aide #7, Nurse #3, and Receptionist #1) and were identified through contract tracing as having close contact. Findings included: The facility's "COVID-19 Testing" policy, last revised on 12/01/22, noted testing must be conducted according to nationally recognized guidelines as outlined by the CDC. The facility's resident and staff COVID-19 infection surveillance spreadsheet revealed the facility was currently in a COVID-19 outbreak that started on 01/27/23. Further review revealed the following: Resident #12 was tested for COVID-19 on 01/26/23 due to confusion and increased	F 886	Identified Concern/Issue: The facility failed to follow their COVID-19 testing policy and the nationally recognized standard to test residents and staff immediately, but not earlier than 24 hours after the exposure for 4 of 4 residents (Resident #12, Resident #56, Resident #59, Resident #60, and 5 of 5 staff members who tested positive for COVID-19 (Nurse Aide #2, Nurse Aide #6, Nurse Aide #7, Nurse #3, and Receptionist #1, and were identified through contract tracing as having close contact. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #12 recovered on 2/5/23. Resident #56 recovered on 2/10/23. Resident #59 was not identified on the Sample List from survey team.	

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F 886	Continued From page 45 temperature with negative results. On 01/27/23 she was sent out to the hospital for evaluation and tested positive for COVID-19 on 01/27/23. Contact tracing was completed by the facility with no residents identified as having close contact. Staff identified as having close contact were not tested for COVID-19. Resident #56 was tested for COVID-19 on 01/31/23 due to symptoms of fever and chills and tested positive. Contact tracing was completed by the facility with no residents identified as having close contact. Staff identified as having close contact were not tested for COVID-19. Nurse Aide (NA) #6 was tested for COVID-19 on 02/01/23 due to symptoms of body aches and tested positive. Contact tracing was completed by the facility; however, no residents or staff potentially exposed by NA #6 were tested for COVID-19. Resident #60 was tested for COVID-19 on 02/02/23 due to symptoms of nausea and vomiting and tested positive. Contact tracing was completed by the facility with no residents identified as having close contact. Staff identified as having close contact were not tested for COVID-19. Resident #59 had an episode of loss of consciousness while out of the facility with family on 02/06/23, was taken to the hospital for evaluation and tested positive for COVID-19. Contact tracing was conducted by the facility with no residents identified as having close contact. Staff identified as having close contact were not tested for COVID-19. NA #2 was tested for COVID-19 on 02/06/23 due to symptoms of body aches and tested positive. Contact tracing was completed by the facility; however, no residents or staff potentially exposed by NA #2 were tested for COVID-19.	F 886	Resident #60 recovered on 2/13/23. Nurse Aide #2 returned to work on 2/13/23. Nurse Aide #6 returned to work on 2/7/23. Nurse Aide #7 returned to work on 2/13/23. Nurse #3 returned to work on 2/13/23. Receptionist #1 returned to work on 2/11/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents and associates have the potential to be affected. 3. What measure will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Director of Nursing (DON), Infection Preventionists (IP) nurse, and/or licensed nurse will implement the POC and provided education that includes testing residents and staff identified through contract tracing when potentially exposed to all licensed nurses on the following policies: • Coronavirus (COVID 19) (SARS-CoV-2) • Management of Potential Exposure to COVID-19 • COVID-19 Outbreak Investigation	

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F 886	Continued From page 46 Nurse #3 was tested for COVID-19 on 02/07/23 due to symptoms of cough, fever and body aches and tested positive. Contact tracing was completed by the facility; however, no residents or staff potentially exposed by Nurse #3 were tested for COVID-19. Receptionist #1 was tested for COVID-19 on 02/07/23 due to symptoms of cough and tested positive. Contact tracing was completed by the facility with no residents identified as having close contact and staff identified as having close contact were not tested. NA #7 was tested for COVID-19 on 02/07/23 due to symptoms of body aches and sore throat and tested positive. Contact tracing was completed by the facility; however, no residents or staff potentially exposed by NA #8 were tested for COVID-19. During a joint interview with the Regional Director of Clinical Services and Divisional Vice President (VP) on 02/09/23 at 4:09 PM, the Divisional VP stated when a resident and/or staff member tested positive for COVID-19, their process was to conduct contact tracing in lieu of facility-wide testing as they felt it was less invasive for the residents. The Divisional VP confirmed the facility was currently in a COVID-19 outbreak as of 01/27/23 and stated although it was their policy to test residents and staff according to the Centers for Disease Control (CDC) guidelines, they had not conducted testing on the residents and/or staff identified through contact tracing due to confusion with the definition of close contact/high risk exposure in regard to 15-minute cumulative versus 15-minute constant exposure with someone positive for COVID-19. She added they had also gotten conflicting information from the Health Department and were told that if both	F 886	• Checklist for Suspected Case of COVID-19 or Respiratory Cluster • COVID-19 Mitigation Strategies Based on Transmission Rate • SARS-CoV-2 POC Testing • COVID-19 (SARS-CoV-2) HCP Testing • COVID-19 Test Consent/Declination (non-resident) • COVID-19 (SARS-CoV-2) Resident Testing • Resident COVID-19 Test informed Consent/Declination Education will be completed by 3/26/23. Any associate who has not completed education by 3/26/23 will not be allowed to provide direct resident care until education is completed. The Director of Nursing (DON), Social Service Director (SSD) and/or a licensed nurse will provide education to all licensed nurses upon hire, annually, and as needed. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON, and/or licensed nurse will audit Resident COVID-19 testing on New Admission, Readmission, and left facility greater than 24 hours, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks.	

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F 886	Continued From page 47 parties were wearing masks, it wasn't considered a close contact/high-risk exposure and no testing was needed. The Divisional VP stated they had reached out to the Health Department to discuss their plan going forward. During a follow-up interview on 02/10/23 at 4:31 PM, the Regional Director of Clinical Services stated she felt the breakdown in the facility's infection control processes was due to multiple factors such the Director of Nursing/Infection Preventionist leaving employment in October 2022 and their misunderstanding of what close contact/high risk exposure meant regarding 15-minute constant versus 15-minute cumulative exposure with someone positive for COVID-19.	F 886	The DON, and/or licensed nurse will audit Resident COVID-19 testing in response to COVID-19 signs or symptoms, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The DON, and/or licensed nurse will audit Resident COVID-19 testing in response to a Close Contact, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The DON, and/or licensed nurse will audit Associate COVID-19 testing in response to COVID-19 signs or symptoms, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. The DON, and/or licensed nurse will audit Associate COVID-19 testing in response to a Close Contact, five (5) times a week for four (4) weeks, three (3) times a week for four (4) weeks and one (1) time a week for four (4) weeks. DON and/or licensed nurse will provide education for any incidents of non-compliance. The Executive Director (ED) and/or DON will provide education for any incidents of non-compliance. Results of the audits will be reported by the DON and/or Executive Director (ED) to the Quality Assurance and	

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F 886	Continued From page 48	F 886	Performance Improvement (QAPI) Committee monthly for 3 months or until substantial compliance is met. The QAPI Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. 1. Date when corrective action will be completed. 3/26/23	