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	345258	A. BUILDING _____ B. WING _____	C 08/10/2023

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TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

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E 000	Initial Comments The survey team entered the facility on 7/31/2023 to conduct an unannounced recertification and complaint investigation survey and exited on 8/4/23. Additional information was obtained remotely on 8/5/2023 to 8/9/2023. Onsite validation of immediate jeopardy removal was conducted on 8/10/2023. Therefore, the exit date was changed to 8/10/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 2Q5D11	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 7/31/2023 to conduct a recertification and complaint investigation survey and exited on 8/4/23. Additional information was obtained remotely on 8/5/2023 to 8/9/2023. Onsite validation of immediate jeopardy removal was conducted on 8/10/2023. Therefore, the exit date was changed to 8/10/2023. Event ID# 2Q5D11. The following intakes were investigated: NC00204666 NC00204931 NC00205734 NC00204611 6 of the 11 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F697 at a scope and severity of K. The tag F697 constituted Substandard Quality of Care.	F 000		

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

Electronically Signed | 09/01/2023

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F 000	Continued From page 1 Immediate Jeopardy began on 6/23/2023 an was removed on 8/9/2023. An extended survey was conducted.	F 000		
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff	F 561	F 561 1. Residents #46 and #31 were	9/7/23

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interviews, and record reviews, the facility failed to allow residents who were assessed to be safe smokers the ability to smoke independently per their individual preference for 2 of 4 residents (Resident #46 and #31) reviewed for smoking. Resident #46 verbalized this practice resulted in his feelings of being treated like a child and a prisoner.

The findings included:

1. Resident #46 was admitted to the facility on 9/7/18.

A review of Resident #46's electronic medical record included a Smoking Evaluation dated 2/22/23. The smoking evaluation indicated Resident #46 smoked. The last section on the Smoking Evaluation indicated the resident was determined to be a "Safe Smoker."

Upon request, a copy of Resident #46's Smoking Evaluation was provided by the facility. The printed Smoking Evaluation had an Effective Date of 5/26/23 (Signed on 8/1/23). The Summary of Evaluation concluded the resident was determined to be a "Safe Smoker." The supervision needed while smoking was "None."

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 7/18/23. The MDS revealed Resident #46 had intact cognition and was independent with eating and locomotion on/off the unit.

Resident #46's care plan (dated as last reviewed on 7/25/23) included an area of focus which indicated he was a smoker. The goal for this area of focus read: "The resident will not suffer

allowed to smoke at any times of their choosing as of 8/03/2023, as they are deemed safe smokers.
2. A quality review of smoking residents was complete on 8/17/2023 and 3 out 4 residents were deemed to be safe smokers. Residents identified as safe smokers are continued to allow to smoke at any times of their choosing. An Ad hoc Quality Assurance Performance Improvement Committee was held on 08/03/2023 to inform staff that any safe smokers may smoke at times of their choosing.
3. Education will be provided to nursing staff beginning on 08/31/2023 – 09/06/2023 that safe smokers are able to smoke at times of their choosing. Staff will be educated that smoking materials will continue to be kept locked up. Executive Director and Social Services held a meeting with all smokers on 08/25/2023 to review smoking policy and procedure. Residents verbalized understanding. This education will be provided to newly hired nursing staff in orientation.
4. Social Services or designee will conduct Quality Review of safe smokers weekly for six weeks to ensure they feel their right to choose when they smoke is met. Social Services staff will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.

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injury from unsafe smoking practices through the review date." The planned interventions included: instruct resident about smoking risks and hazards and about smoking cessation aids that are available; the resident is able to light own cigarette; the resident's smoking supplies are stored at the nursing station.

An interview was conducted with Resident #46 on 8/1/23 at 9:15 AM. During the interview, the resident stated the facility's smoking policy changed when the new Administrator started a few months ago. Since that time, he has only been allowed to smoke while supervised at designated smoking times. The resident stated, "I'm [age] years old and I don't need to be treated like a child." The resident was asked if the designated smoking times were okay with him. He emphatically stated, "No" and added that he felt like he was "a prisoner." When asked how much time he was given to smoke during the designated smoking times, the resident reported he could only smoke for 1/2 hour. Resident #46 stated he was "allowed" to stay outside after the smoking times but could no longer smoke. The resident did not express any problem with the facility storing his cigarettes and lighter for him in between the smoking breaks.

On 8/1/23 at 9:30 AM, a sign was observed hung on the door leading to the designated smoking area. The sign read:
"Smoking Times
9:30-10:00
11:30 - 12:00
1:30 - 2:00
3:30 - 4:00
7:00 - 7:30
9:30 - 10:00"

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An observation was conducted on 8/1/23 at 9:37 AM as the facility's Director of Nursing (DON) was accompanied by two residents in wheelchairs to the outdoor area designated for smoking. On 8/1/23 at 9:38 AM, two more residents, including Resident #46, were observed to go out to the smoking area. The residents were provided with their cigarette (or pipe) and lighters. On 8/1/23 at 9:40 AM, the Business Office Manager went outside to the smoking area and the DON went indoors. The Business Office Manager was observed as he stood outside and watched the residents as they smoked.

On 8/1/23 at 9:50 AM, an interview was conducted with the Business Office Manager as he was outside in the smoking area. Upon inquiry, the manager reported all four of the smokers were "grandfathered in" for smoking. The manager stated that all four residents were "pretty much independent," but he added that "we supervise them."

An interview was conducted on 8/2/23 at 12:22 PM with the Administrator and Regional Director of Nursing regarding the facility's smoking policy. During the interview, the Administrator reported that the facility was now a "Smoke-free facility." However, the Administrator also reported, "We have a few smokers here that were grand-fathered in." She reported the designated smoking times with supervision did include the safe smokers. The Administrator also stated all smoking materials for the smokers were kept in a locked box and brought out for the smokers at the designated smoking times. When asked why a safe smoker needed to adhere to designated smoking times for supervision, the Regional

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Director of Nursing only responded by saying the facility could remedy this practice for the residents who have been assessed to be safe smokers.
2. Resident #31 was admitted to the facility on 10/24/17 with the diagnosis of nicotine dependence.

The quarterly Minimum Data Set (MDS) dated 4/25/23 documented the resident had an intact cognition and was independent for all his activities of daily living except personal hygiene required limited assistance and bathing was limited to transfer only.

Resident #31's care plan updated 7/25/23 documented the resident smoked. The goal was for no injury and interventions were for the resident to light his own cigarette, supplies stored at the nurses' station, instruct the resident on smoking risks and cessation, and aides available to supervise.

On 08/01/23 at 10:22 an interview was conducted with Resident #31. The resident stated he wanted to smoke at night and was independent. The resident stated he participated in the scheduled smoking during the day, but wanted to smoke after the schedule was over for the day. The facility required the resident smoke supervised on a schedule. The resident stated that it was not necessary for him to be supervised and did not like the restriction. He was able to manage on his own.

Resident #31 was assessed for smoking safety and documented by Social Work as independent on 2/22/23 and 8/1/23.

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F 561	Continued From page 6 Resident #31 was observed on 8/1/23 at 11:30 am smoking with the scheduled resident group. Nursing Assistant (NA) #4 was present. The NA placed a smoking apron and was handed his cigarettes and lighter and expected to independently smoke. The resident lit his cigarette, smoked the cigarette, and extinguished/discarded the cigarette in the appropriate receptacle when done smoking. The resident re-entered the building independently. NA #4 was interviewed on 8/1/23 at 11:30 am. She stated that Resident #31 was independent with smoking, "I just hand him his supplies." On 08/01/23 at 9:50 am an interview was conducted with the Business Office Manager who was outside in the smoking area supervising. He reported all the smokers (4) were "grandfathered in" for smoking. The Business Office Manager further reported all of them were "pretty much independent," but he added that "we supervise them."	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		9/7/23

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F 580	Continued From page 7 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, physician, and staff interviews, the facility failed to notify the physician	F 580	F 580 1. Nurse # 3, Nurse #8 and Nurse #9	

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of blood glucose results greater than 450 (normal range 80-120) for 1 of 1 resident reviewed for notification (Resident #19).

The findings included:

Resident #19 was admitted to the facility 6/27/2023 with diagnoses to include diabetes and heart disease. The admission Minimum Data Set assessment dated 7/3/2023 assessed Resident #19 to be cognitively intact and he had received insulin injections 7 of 7 days during the look-back period.

A review of the medical record revealed a physician order dated 7/20/2023 that read to administer NovoLog (fast-acting insulin) per sliding scale as needed before meals. The sliding scale read:
" administer 3 units (u) if Resident #19's blood glucose was 201-250.
" administer 5 u if blood glucose was 251-300.
" administer 7 u for blood glucose 301-350.
" administer 9 u for blood glucose 351-400.
" administer 11 u for blood glucose 401-450.
" administer 12 u for blood glucose 451-500 and notify the provider.

The medication administration record for July 2023 was reviewed. A blood glucose result of 466 by Nurse #9 was documented on 7/22/2023 at 8:00 AM. It was documented Resident #19 received 12 u of Novolog insulin.

No documentation was in the medical record that indicated a provider had been notified of the blood glucose result.

A blood glucose result of 466 was documented by

were provided education regarding the notification of the residents abnormal blood glucose results by the Divisional Executive Director on 8/31/2023.
2. All residents that have abnormal blood glucose results have the potential to be affected. The Director of Nursing will review all blood glucose results for the last 7 days starting 8/28/2023 and ensure follow up notification has been made to the physician, as needed. The audit revealed four additional residents one of whose is no longer a resident at the facility. The other residents MD were notified.
3. Education will be provided by the Director of Nursing or Designee to licensed nurses on notifying acute / abnormal changes to the physician, per physician orders. This education will be completed by 9/6/2023. Any licensed nurse not inserviced by 9/6/2023 will be inserviced before their next shift. This information will be reviewed with licensed nurses during orientation going forward.
4. The Director of Nursing / Designee will audit three times per week for four weeks then weekly for four weeks to ensure all acute / abnormal changes are communicated to the physician timely. The Director of Nursing will report the results of the quality monitoring to the Monthly QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring updated as indicated

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Nurse #9 on 7/22/2023 at 11:30 AM. It was documented Resident #19 received 12 u of Novolog insulin.

No documentation was in the medical record that indicated a provider had been notified of the blood glucose result.

Nurse #9 was interviewed by phone on 8/3/2023 at 12:35 PM. Nurse #9 reported he did not notify the physician of the blood glucose level of 466 for Resident #19 on 7/22/2023. Nurse #9 reported he did not recall why he had not notified the physician.

A blood glucose result of 457 was documented by Nurse #3 on 7/25/2023 at 8:00 AM. It was documented Resident #19 received 12 u of Novolog insulin.

No documentation was in the medical record that indicated a provider had been notified of the blood glucose result.

Nurse #3 was interviewed on 8/3/2023 at 1:23 PM. Nurse #3 explained that the physician or the nurse practitioner were in the facility frequently and she thought she had verbally notified either the physician or the nurse practitioner of the blood glucose result of 457. Nurse #3 was not certain why she did not document notifying the provider of the elevated blood glucose.

A blood glucose result of 457 was documented by Nurse #8 on 7/26/2023 at 11:30 AM. It was documented Resident #19 received 12 u of Novolog insulin.

No documentation was in the medical record that

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F 580	Continued From page 10 indicated a provider had been notified of the blood glucose result. An interview was conducted with Nurse #8 on 8/3/2023 at 1:31 PM. Nurse #8 reported she notified the physician of the elevated blood glucose, but she was unable to locate the nursing note with that information documented. The physician was interviewed by phone on 8/3/2023 at 4:44 PM. The physician reported he did not recall being notified by any nurse that Resident #19 had a blood glucose result over 450. The physician explained that Resident #19 was non-compliant with his diet and an elevated blood glucose was not unexpected and did not cause Resident #19 harm, however, the nursing staff should have notified him or the nurse practitioner the blood glucose was elevated. The Director of Nursing (DON) was interviewed on 8/4/2023 at 9:55 AM. The DON reported the nursing staff should have notified the physician or the nurse practitioner of the elevated blood glucose for Resident #19 and she did not know why the nurses had not called the physician. The DON reported she expected the nurses to notify the physician of elevated blood glucose and document that notification in the resident medical record.	F 580		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-	F 582		9/7/23

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(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or

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resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) form, CMS-10055 form, to 2 of 3 residents (Resident #193 and Resident #195) reviewed for beneficiary notification.
Findings included:
1. a. Resident #193 admitted to the facility on 6/1/2023 with diagnoses of heart failure and renal disease.

A quarterly Minimum Data Set assessment dated 6/19/2023 indicated Resident #193 was cognitively intact.

During a review of the forms provided to Resident #193 when he was notified his stay may not be covered under Medicare, since he was no longer receiving skilled services, he had not received a CMS-10055 form, Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) form from the facility.

b. Resident #195 admitted to the facility on 7/8/2023 with diagnoses of dementia and cancer. An admission Minimum Data Set assessment dated 7/25/2023 indicated Resident #195 was moderately cognitively impaired.
During a review of the forms Resident #194 was given when he was notified his stay may not be

F582
1. The Business Office Manager and Social Services Director were educated by the Executive Director regarding providing Advanced Beneficiary Notices to current residents when there is a change in payer status that may affect their charges on 08/02/2023.
2. A quality review was conducted on 08/02/2023 by the Executive Director for the past 30 days and there were no other issues. An Ad hoc Quality Assurance Performance Improvement Committee was held on 8/02/2023.
3. The Business Office Manager and the Social Services Director had education provided by the Executive Director regarding providing policy and procedure, including appropriate form for Advanced Beneficiary Notices to residents when there is a change in payer status that may affect their charges on 08/02/2023. This education will be provided to any newly hired Business Office or Social Services staff members during their orientation process.
4 The Executive Director or designee will complete quality monitoring of 2 residents per week with payer changes that remain in the facility for 6 weeks. The Executive

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F 582	Continued From page 13 covered under Medicare, since he was no longer receiving skilled services, he had not received a CMS-10055 from, Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) form from the facility. The Social Worker was interviewed on 8/3/2023 at 2:22 pm and she stated she was responsible for notifying the residents when skilled services may not be covered under Medicare Services and Residents #193 and #195 had not been given the correct form. She stated she was not aware she should be using the CMS-10055 Form, Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage. The Social Worker stated she had obtained the correct form for future notification of residents. On 8/4/2023 at 11:16 am an interview was conducted with the Administrator by phone. She stated she was made aware by the Social Worker the facility had not issued the Advanced Beneficiary Notice of Non-coverage (SNF ABN) form, CMS-10055 form. The Administrator stated the Social Worker should have used the correct form and the facility was already correcting the issue.	F 582	Director will report on the results of the quality monitoring to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring updated as indicated	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		9/7/23

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F 625	Continued From page 14 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide written notification to the resident's responsible party regarding bed hold when the resident was hospitalized for 2 of 2 residents reviewed for hospitalization (Resident #76 and Resident #89). Findings included: 1. A review of the medical record revealed Resident #76 was admitted to the facility on 6/16/2023 with diagnoses to include hypertension and atrial fibrillation. The discharge return anticipated Minimum Data Set (MDS) assessment dated 6/21/2023 documented Resident #76 was discharged to the	F 625	F625 – Notice of Bed Hold Policy Before/Upon Transfer: 1. Resident #76 was readmitted to facility on 6/26/2023. Resident #89 went home with hospice from the hospital. 2. All residents who were discharged to the hospital have the potential to be affected by this practice. An ADHOC Quality Assurance Performance Improvement Committee was held on 08/03/2023. 3. The Executive Director educated the Social Services and Licensed nurses on notice of bed hold policy requirements beginning on 8/28/2023 and ending on 9/01/2023. The Social Services Department will be responsible for written	

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F 625	Continued From page 15 hospital. The admission MDS assessment dated 6/28/2023 documented Resident #76 was readmitted from the hospital on 6/26/2023. The admission MDS assessed Resident #76 to be moderately cognitively impaired. A nursing note dated 6/21/2023 documented Resident #76 was discharged to the hospital for hematuria (blood in the urine). A review of the medical record for Resident #76 revealed no bed hold was scanned into the electronic medical record. There were no unscanned bed hold policies for Resident #76 waiting to be scanned. An interview was conducted with the Admission Coordinator on 8/2/2023 at 2:24 PM. The Admission Coordinator reported that a resident received a bed hold policy on admission and if they are admitted to the hospital for longer than 2 days, the business office manager would call the resident to discuss the bed hold policy. The Admission Coordinator reported she was not aware that a copy of the bed hold policy was not scanned into Resident #76's medical record. Nurse #11 was interviewed on 8/2/2023 at 3:36 PM and she reported she sent the bed hold policy with a resident when they were discharged to the hospital. An interview was conducted with Nurse #13 at 12:43 PM. Nurse #13 reported he sent a copy of the bed hold policy with a resident when they were discharged to the hospital. Nurse #12 was interviewed on 8/3/2023 at 1:08 PM and she reported she discussed the bed hold	F 625	notification to responsible party and the bed hold will be sent with the resident upon discharge by the discharging nurse. The nurse will document that bed hold was provided at time of discharge on SNF/NH to Hospital Transfer Form. 4. The Executive Director will conduct random Quality reviews of facility based transfers 2 times a week for 8 weeks to ensure notification of bed hold complete. The Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 625	Continued From page 16	F 625		

policy with a resident prior to them leaving the facility for the hospital and would get the bed hold signed before they left. Nurse #12 reported the bed hold policy was then placed in a basket for medical records to scan into the medical records. Nurse #12 was unable to recall if she had discussed the bed hold policy with Resident #76.

The Administrator was interviewed on 8/3/2023 at 12:30 PM. The Administrator reported that she believed the nurses were sending the bed hold policy to the hospital with the resident, but no one was getting a signature on the bed hold policy.

2. Resident #89 was admitted to the facility on 3/28/2023 with diagnoses to include diabetes and hypertension. The admission Minimum Data Set (MDS) assessment dated 4/3/23 assessed Resident #89 to be cognitively intact.

The discharge return not anticipated Minimum Data Set assessment dated 6/22/2023 documented Resident #89 was discharged to the hospital.

A change of condition nursing note dated 6/22/2023 documented Resident #89 was sent to the hospital after a change in condition with abnormal lab results, and a change in his behavior.

Resident #89 was not readmitted to the facility. A review of the medical record for Resident #89 revealed no bed hold was scanned into the electronic medical record. There were no unscanned bed hold policies for Resident #89 waiting to be scanned.

An interview was conducted with the Admission

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F 625	Continued From page 17 Coordinator on 8/2/2023 at 2:24 PM. The Admission Coordinator reported that a resident received a bed hold policy on admission and if they are admitted to the hospital for longer than 2 days, the business office manager would call the resident to discuss the bed hold policy. The Admission Coordinator reported she was not aware that a copy of the bed hold policy was not scanned into Resident #89's medical record. Nurse #11 was interviewed on 8/2/2023 at 3:36 PM and she reported she sent the bed hold policy with a resident when they were discharged to the hospital. An interview was conducted with Nurse #13 at 12:43 PM. Nurse #13 reported he sent a copy of the bed hold policy with a resident when they were discharged to the hospital. Nurse #12 was interviewed on 8/3/2023 at 1:08 PM and she reported she discussed the bed hold policy with a resident prior to them leaving the facility for the hospital and would get the bed hold signed before they left. Nurse #12 reported the bed hold policy was then placed in a basket for medical records to scan into the medical records. Nurse #12 was unable to recall if she had discussed the bed hold policy with Resident #89. The Administrator was interviewed on 8/3/2023 at 12:30 PM. The Administrator reported that she believed the nurses were sending the bed hold policy to the hospital with the resident, but no one was getting a signature on the bed hold policy.	F 625		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		9/7/23

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F 677	Continued From page 18 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide 4 dependent residents nail care (Residents #9, #11, #52, and #70) and to provide 3 residents hair washing (Residents #11, #52, and #70) for 4 of 6 residents reviewed for activities of daily living. Findings included: 1. Resident #9 was admitted to the facility with the diagnosis of progressive neurological disease. Resident #9 had a care plan dated 6/24/23. The resident had an activity of daily living (ADL) deficit that required total care for bathing of 2 staff and personal hygiene of 1 staff. The quarterly Minimum Data Set dated 6/24/23 documented the resident had an intact cognition. The resident was totally dependent for bathing and required assistance for personal care. The resident's diagnoses were progressive neurological disease and chronic pain. On 07/31/23 at 10:28 am Resident #9 was observed to have all clean, long nails (1/4) inch) and long facial hair (1/2 inch). On 8/1/23 at 9:40 am Resident #9 was observed to have received a shave and was okay with it (hair remaining). Resident #9's nails remained	F 677	F677 1. Care has been proved to residents #9, #11, #52, and #70. 2. A quality review was completed by the Department Heads and Nurse Managers on current residents on Activities of Daily Living (ADL) care specific to nail care and hair washing on 08/28/2023. Identified residents were provided nail care to include cleaning and trimming at that time, as well as hair care. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 08/31/2023 to review the plan of correction for this deficient practice. 3. The Director of Nursing or designee re-educated all Nursing Staff regarding ADL care by 09/06/2023. Nail and hair care will be monitored on shower list sheet to ensure care offered and completed. Staff will not be allowed to return to work until education is complete after 09/06/23. Moving forward, all newly hired nursing staff will receive this education during orientation. 4. The Nurse Manager will conduct random Quality Reviews of residents to ensure residents are provided nail and hair care with Activities of Daily Living (ADL) care on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit)	

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F 677	Continued From page 19 long, and during concurrent interview he stated he wanted them cut and staff had not provided nail care with his shave when requested. The resident had limited dexterity to his hands/fingers, and he appeared to have generalized edema to his body, including his hands. Resident #9's ADL documentation for July 2023 revealed a shower every 3 days and occasional bed bath in between. Nail cut was not documented. On 8/2/23 at 11:30 am an interview was conducted with Nurse #5. The Nurse stated that Nursing Assistants (NA) were to cut fingernails. If the NA was unable to cut a resident's nails due to diabetes or refusal, they were to report to the nurse. The Nurse stated NAs have reported in the past when there was refusal of care. Nurse #5 stated Resident #9 had not refused care nor had the NA reported he needed his nails cut. On 8/2/23 at 11:45 am an interview was conducted with NA #3. NA #3 stated Resident #9 had not refused care, he was provided choices to participate in care and was cooperative. NA #3 stated she had not noticed his long nails. On 8/2/23 at 10:20 am an interview was conducted with NA #2. The NA stated that if the resident was not a diabetic, she would cut the nails. The nurse would be responsible to cut the nails of diabetic residents. The NA stated she would address Resident #9's long nails and had not noticed his nails this morning during care or last week when scheduled to Resident #9. She further stated the resident had not refused care. On 8/2/23 at 10:40 am an interview was	F 677	and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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conducted with the Interim Director of Nursing (DON). The DON stated that the residents received nail care by the NAs and they were required to report to the assigned nurse if unable.

2. Resident #11 was admitted to the facility on 7/5/21 with the diagnosis of dementia.

Resident #11's care plan dated 6/24/23 documented an activity of daily living (ADL) deficit. The resident required assistance with bathing and was known to have placed her hand in her soiled brief. The intervention was to provide a choice of shower or bed bath.

Resident #11's quarterly Minimum Data Set dated 6/24/23 documented the resident had severely impaired cognition. The resident was totally dependent for bathing and personal care required 1 staff. The resident's diagnoses were diabetes and cirrhosis of the liver.

On 07/31/23 at 8:52 am Resident #11 was observed to have unkempt hair, mildly greasy and sticking up and all nails were long (1/2 inch) and dirty. The nails had brown matter underneath. Concurrent interview with the resident revealed she wanted a shower and hair wash. When asked, the resident observed her nails were long and dirty and stated she wanted her nails cut.

A review of Resident #11's ADL documentation for bathing revealed she received a partial or full bed bath total assistance 3 to 4 times a week and one shower for day shift and 3 showers on evening shift during the month of July 2023. It was noted that showers provided were 17 days apart during the month of July.

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On 8/2/23 at 11:30 am an interview was conducted with Nurse #5. She stated residents' received hair wash in the shower, and if the resident received a bed bath, the hair was to be washed with a pan in the bed. The Nurse stated that Nursing Assistants (NA) were to cut fingernails. If the NA was unable to cut a resident's nails due to diabetes or refusal, they were to report to the nurse. The Nurse stated NAs have reported in the past when there was refusal of care. Resident #11 had not refused care nor had the NA reported the resident needed her nails cut. The resident was known to place her hands in her undergarment when soiled.

On 8/2/23 at 11:45 am an interview was conducted with NA #3. The NA stated Resident #11 had not refused care, she was provided the choice of a bath or shower and was cooperative. The NA was assigned to Resident #11's hall yesterday (8/1/23) and had not remembered if her nails were long.

On 8/2/23 at 10:20 am an interview was conducted with NA #2. The NA stated that if the resident was not a diabetic, she would cut the nails. The nurse would be responsible to cut the nails of diabetic residents. The NA stated she had given Resident #11 a shower as part of her assignment and washed her hair when assigned last week (7/28/23). The NA stated she would address the long, dirty nails and had not noticed the nails this morning during care. She further stated the resident had not refused care.

8/2/23 at 10:40 am an interview was conducted with the Interim Director of Nursing (DON). The DON stated that NAs were responsible for nail

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care of dependent residents. If the NA was unable to provide care, they were required to inform the nurse.

3. Resident #52 was admitted to the facility on 4/29/21 with the diagnosis of progressive neurological disease.

Resident #52's quarterly Minimum Data Set dated 7/16/23 documented the resident had an intact cognition. The resident required 1-person for personal care and was dependent for bathing. The resident's diagnosis was progressive neurological disease.

The care plan dated 7/16/23 for Resident #52 documented she had an activities of daily living deficit. The intervention included bathing required assistance from staff. The resident had no refusal of care, she was weak and to provide care as tolerated.

Resident #52's bathing documentation for June 2023 revealed she had a shower on 7/4/23 and the next shower was 7/21/23 (17 days). The days in between showers, the resident had a bed bath. There was no documentation of hair wash on bed bath days.

On 07/31/23 at 11:24 the Resident #52 was observed to have long dirty nails (1/4 inch long with brown matter underneath) that needed to be cut and her hair was uncombed and sticking up in the center. Concurrent interview revealed the resident stated she wanted her hair washed more often. She also stated she was sometimes too weak for a shower but had not been offered hair wash in the bed and was not offered nail care.

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On 8/2/23 at 10:20 am an interview was conducted with Nursing Assistant (NA) #2. The NA stated that if the resident was not a diabetic, she would cut the nails. The nurse would be responsible to cut the nails of diabetic residents. The NA stated she gave Resident #52 a shower last Friday (7/28/23, 5 days ago) with assistance of a family member and washed her hair. The NA stated she would wash the resident's hair again today. The NA stated she would address the long, dirty nails and had not noticed the nails this morning during morning care or last Friday. She further stated the resident had not refused care; the resident was weak.

On 8/2/23 at 11:45 am an interview was conducted with NA #3. The NA stated residents had their hair washed in the shower or by the beautician. The NA stated she had not washed hair in the bed with a pan.

On 8/2/23 at 10:40 am an interview was conducted with the Interim Director of Nursing (DON). The DON stated that the residents received hair wash during a shower. We do not wash hair in the bed. The DON further stated the residents would have their hair washed at the beauty shop. There was no beautician at present to wash hair, the facility was looking for another beautician. DON also stated if the resident was bed bound a dry shampoo could be used or a pan would then need to be used in the bed.

The beauty shop schedule/list of residents that received hair wash for June and first half of July 2023 had no documentation that Resident #52 received hair care from the beautician.

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4. Resident #70 was admitted to the facility on 5/13/22 with the diagnoses of dementia and peripheral vascular disease.

Resident #70's care plan dated 6/21/23 documented he had an activity of daily living self-care deficit. The intervention was personal hygiene required total staff assistance.

The annual Minimum Data Set dated 6/21/23 for Resident #70 documented he had a severely impaired cognition, no behaviors, and no refusal of care. The resident required assistance of 1 person for personal hygiene and was dependent for bathing. The resident's diagnoses were dementia and anxiety.

On 7/31/23 at 8:40 am an observation was done of Resident #70. He was lying in his bed in a hospital gown. Concurrent interview, Resident #70 stated he preferred to stay in bed. His nails were long and dirty on both hands. The right hand, second fingernail was jagged. His hair appeared greasy together in segments and had not been combed.

A review of the July 2023 bathing documentation for Resident #70 revealed the resident mostly received a bed bath on day shift and an occasional shower on evening shift. The last shower was on 7/29/23. There was no documentation of hair wash. The resident had no shower between the dates 7/6/23 to 7/19/23 (13 days). There was no documentation of hair wash.

On 8/1/23 at 4:00 pm Resident #70 remained with

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long, dirty nails and greasy hair.

On 8/2/23 at 9:15 am an observation was done. Resident #70 was found to have the same long, dirty nails. He commented that he does not like to get out of bed. He could not remember the last time he had a shower, and the staff had not washed his hair in the bed. His hair was uncombed and greasy looking.

On 8/2/23 at 11:30 am an interview was conducted with Nurse #5. She stated residents' received hair wash in the shower, and if the resident received a bed bath, the hair was to be washed with a pan in the bed. The Nurse stated that Nursing Assistants (NA) were to cut fingernails. If the NA was unable to cut a resident's nails due to diabetes or refusal, they were to report to the nurse. The Nurse stated NAs have reported in the past when there was refusal of care and nursing would be responsible. Resident #70 had not refused care nor had the NA reported he needed his nails cut. Nurse #5 was not aware NAs were not washing bed bound residents' hair in the bed.

On 8/2/23 at 11:45 am an interview was conducted with NA #3. The NA stated residents had their hair washed in the shower or by the beautician. The NA stated she had not washed hair in the bed with a pan. Resident #70 had not refused care, he was provided choices to participate in care and was cooperative. He preferred a bed bath and was provided one. NA #3 was unsure when Resident #70 last had his hair washed. When the resident received a shower, the hair was usually washed but there was no place to document hair wash. NA #3 had

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F 677	Continued From page 26 no comment about the long nails. On 8/2/23 at 10:20 am an interview was conducted with NA #2. The NA stated that if the resident was not a diabetic, she would cut the nails. The nurse would be responsible to cut the nails of diabetic residents and would be informed. The NA stated she would address Resident #70's long, dirty nails and had not noticed the nails this morning during incontinence care. She further stated the resident had not refused care but preferred to stay in his bed. On 8/2/23 at 10:40 am an interview was conducted with the Interim Director of Nursing (DON). The DON stated that the residents received hair wash during a shower. We do not wash hair in the bed. The DON further stated the residents would have their hair washed at the beauty shop. There was no beautician at present to wash hair, the facility was looking for another beautician. DON also stated "if the resident was bed bound a dry shampoo could be used or a pan would then be needed to be used in the bed." The beauty shop schedule/list of residents that received hair wash for June and first half of July 2023 had no documentation that Resident #70 received hair care from the beautician.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		9/7/23

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F 686	Continued From page 27 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide pressure relief as ordered to prevent pressure ulcer of both heels (Resident #70) for 1 of 2 residents reviewed for pressure ulcer. Findings included: Resident #70 was admitted to the facility on 5/13/22 with the diagnoses of dementia and peripheral vascular disease. There was a Physician order to offload the heels while in bed dated 6/22/22 for Resident #70. The annual Minimum Data Set dated 6/21/23 for Resident #70 documented he had a severely impaired cognition, no behaviors, and no refusal of care. The resident required assistance of 1 person for personal hygiene and was dependent for bathing. Skin was intact. Resident #70's care plan dated 6/21/23 documented he had a potential for skin breakdown. Intervention was an air pressure reduction Mattress. Record review revealed Resident #70 had an order for a podiatry appointment dated 6/21/23 as	F 686	F686 1. Order to offload bilateral heels while in bed was discontinued for resident #70 on 08/07/2023. 2. On 08/28/2023, the Divisional Executive Director conducted Quality Review of current residents' with orders with pressure relief interventions. Any issues identified were addressed. 3. Licensed Nurses will be educated on following physician orders by 09/06/2023. Those not educated will receive education prior to working their next shift. All newly hire Licensed Nurses will receive education during orientation process. 4. The Director of Nursing or designee will complete quality monitoring of 3 residents weekly for 12 weeks with pressure relief interventions to ensure physician orders are being followed. The Director of Nursing or designee will report on the results of the quality monitoring and report to the Quality Assurance Performance Improvement committee. Findings will be reviewed by Quality Assurance Performance Improvement committee monthly and Quality monitoring updated as indicated.	

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needed. The last podiatry appointment was in facility on 2/28/23. The podiatrist recommended follow up care in six months. There were no wounds or lesions.

On 07/31/23 at 9:52 AM an observation was done of Resident #70 in his bed with his feet up against the foot board and heels lying directly on the mattress. The resident's heels were not offloaded while in bed. Concurrent interview with the resident stated he preferred to stay in bed. He further stated there was no extra pillow for his feet.

On 8/1/23 at 2:00 PM Resident #70 was observed to be in bed and his heels were not offloaded.

On 8/1/23 at 4:10 PM an observation of Resident #70 in his room while in bed and concurrent interview was conducted with Nurse #5. The resident was observed to have his heels on the bed mattress and feet against the footrest. The resident was tall and reached the head of the bed and the footrest. His heels were not offloaded, and Nurse #5 stated she was not aware there was an order to off load the resident's heels for pressure reduction. Nurse #5 was observed to look for a pillow and there was no pillow or heel booties to elevate the heels and reduce pressure in the resident's room. The Nurse left the room to obtain a bed pillow and elevated the resident's heels. The Nurse stated that the resident received skin prep to his heels and moisturizer to his feet each day. The resident commented "that felt better" (to have his heels elevated). The resident was observed to be on an air mattress that alternates to prevent pressure ulcer and had proper settings. The resident commented he

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F 686	Continued From page 29 preferred to remain in his bed. On 8/2/23 at PM an interview was conducted with the Administrator. The Administrator stated she was not aware nursing staff had not followed Resident #70's physician order to offload his heel to prevent pressure ulcers and would investigate.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to prevent 1 of 5 residents (Resident #11) from leaving the facility and found in front of the building without staff supervision. Findings included: Resident #11 was admitted to the facility on 8/2/19 with diagnoses of dementia. A quarterly Minimum Data Set (MDS) assessment dated 5/15/2023 indicated Resident #11 was severely cognitively impaired and required total assistance with transfers. The assessment did not indicate Resident #11 had behaviors.	F 689	Past noncompliance: no plan of correction required.	

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Review of Resident #11's medical record revealed she was discharged to the hospital on 5/16/2023 and readmitted to the facility on 5/27/2023.

An Incident Investigation dated 5/28/2023 stated a family member reported to Nurse #4 that Resident #11 was in the circle drive just outside the front door of the facility at 1:28 pm. The Incident Investigation stated Resident #11 was on the side of the circle drive closest to the facility. Nurse #4 returned Resident #11 to the facility and assessed her for injuries, and none were found. The Incident Investigation also stated Resident #11 was observed at the nurse's station 18 minutes before she was found outside the facility.

During an interview with Nurse #4 on 8/2/2023 at 3:14 pm she stated a family member was leaving the facility on 5/28/2023 when they saw Resident #11 outside the building in the circle drive. The family member came back into the building to get Nurse #4. Nurse #4 stated when she went outside Resident #11 was sitting in the circle drive, on the side closest to the door, and under the overhang. Nurse #4 stated Resident #11 told her she was going to see her mother. Nurse #4 stated Resident #11 did not have a wandering alert bracelet on. She stated she assessed the resident for injuries, and she did not have any injuries. The Nurse stated Resident #11 was at the nurse's station approximately 15 to 18 minutes before she was found outside the facility.

An interview was conducted with the Director of Nursing (DON) on 8/2/2023 at 2:05 pm. The DON stated Resident #11 had a wandering alert bracelet on when she went out to the hospital on 5/16/2023 and when she returned to the facility

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on 5/27/2023 the admitting nurse failed to put the wander alert bracelet back on. The DON stated Resident #11 was not harmed and a wander alert bracelet was applied, and other interventions put into place at that time.

The Administrator was interviewed on 8/4/2023 at 11:16 am and she stated the facility completed a root cause analysis when Resident #11 was found in the circle drive of the facility on 5/28/2023. She stated they had concluded the nurse who re-admitted Resident #11 to the facility after her last hospitalization had failed to complete the Elopement Risk Evaluation correctly and had not place a wander alert bracelet on her. The Administrator stated they had come up with interventions to prevent any further incidents of a resident leaving the building; they had educated all of the staff regarding how to do the Elopement Risk Evaluation and other interventions correctly; they had monitored the residents to ensure the Elopement Risk Evaluation was done correctly; and they had monitored their progress in the facility's Quality Assurance Performance Improvement meetings and continued to monitor their progress.

The facility began a Plan of Correction on 5/28/2023:
An Elopement Risk Evaluation dated 5/28/2023 at 7:18 pm, which was after Resident was found outside the facility at 1:28 pm, indicated Resident #11 was at risk of elopement and a care plan should be implemented immediately to ensure her safety.

A root cause analysis was conducted on 5/28/2023 by the facility when Resident #11 was found outside the front of the building in the circle

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drive at the front of the building and the facility concluded the resident's wander alert bracelet was not put on resident when she was re-admitted from the hospital on 5/27/2023 and the admitting nurse did not complete the Elopement Risk Evaluation correctly.

Resident #11 was assisted back inside the facility and assessed for any injuries which she did not have. An Elopement Risk Evaluation was completed, and a wander alert bracelet was place on Resident #11. An updated picture of Resident #11 was uploaded into the facility's electronic charting.
All other resident's location was verified when Resident #11 was brought back into the building on 5/28/2023. An updated Elopement Risk Evaluation was completed for all residents to ensure those at risk are properly identified and interventions were in place as appropriate on 5/28/2023. All of the facility's doors were checked to ensure they functioned properly, and the alarms sounded properly on 5/28/2023. An elopement risk book, Kardex and care plans were updated to ensure appropriate interventions were included for any at risk residents.

All nursing staff were re-educated on the elopement policy, appropriate completion of the elopement risk evaluation, the appropriate function and placement of the wander alert bracelet, and documentation of the wander alert bracelet on the Medication Administration Record.
The Business Office Manager educated the receptionist that the front door will be locked, and staff will open the door for visitors when notified by the doorbell when the receptionist is not on duty.

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Monitoring will be completed on ten residents' Elopement Risk Evaluation per week for 12 weeks and ten residents monthly on-going to ensure assessment is complete and accurate. The Administrator will complete quality monitoring on the front door security to ensure the receptionist is present daily until 7:00 pm or the door is locked with use of keypad for visitor entry and staff three times a week for 12 weeks.

The results of the quality monitoring will be discussed in the monthly QAPI meeting, and any further concerns will be addressed with further IDT recommendations.

Compliance date 6/15/2023

The Plan of Correction was verified, and the corrective action plan was completed by 6/15/2023. The facility assessed all residents for risk of elopement and put interventions into place to ensure the safety of Resident #11 and all at risk residents. The facility nursing staff were educated on how to complete the Elopement Risk Assessment correctly, the appropriate function and placement of the wander alert bracelet, documentation of the wander alert bracelet on the residents Medication Administration Record, and the elopement policy. The facility completed Elopement Risk Assessments on all residents and put interventions into place. The facility's doors were checked for proper functioning and the alarm sounding. The facility also completed the monitoring they put into place and continued to monitor as of the date of the survey. The facility also brought monitoring to the Quality Assurance Performance Improvement meeting for review.

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F 697 SS=K	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident observation, record review, and interviews with the nursing staff, Nurse Practitioner (NP), and Medical Director, the facility failed to administer pain medication prior to completing 50 wound dressing changes during the previous 34 days for a resident with a Stage 4 pressure ulcer and severe cognitive impairment. This occurred for 1 of 2 residents (Resident #16) reviewed for pressure ulcers. Resident #16's Stage 4 pressure ulcer on her left heel required scheduled wound dressing changes; the frequency of these dressing changes increased from once daily to twice a day on 6/22/23. At that time, Resident #16 had an order for an opioid pain medication to be administered twice daily. However, the frequency of this pain medication (med) was reduced with instructions to administer only one dose of the opioid pain medication every 24 hours as needed for heel/leg pain (Start Date 6/23/23). The order also included a notation to give the pain medication 60 minutes prior to dressing changes. Staff interviews revealed Resident #16 would frequently "holler out and kick" during wound dressing changes and she would sometimes yell so loudly during wound care that she could be heard out in the hallway (even with the door closed). Nursing staff described the resident's level of pain during	F 697	F 697 1. Resident #16 has been assessed by the Wound Care nurse on 08/03/23 and pain medication was administered. Regional Director of Clinical Services, along with Executive Director notified medical director regarding pain management and new orders received for additional pain medication and hospice consult, and transcribed to the Medication Administration Record, Resident #16’s responsible party was notified of new orders to include medication changes. Resident #16’s Plan of Care has been updated on 08/03/2023 by the Minimum Data Set Nurse to reflect resident’s problem, goal, and interventions. 2. Current Residents with wounds (12) had Pain Assessments completed by a Licensed Nurse on 8/08/23 using a Pain Assessment to determine those that are at risk for pain. Current residents with wounds (12) were reviewed to ensure current orders included pain management. These Residents had interventions put into place by a Licensed	9/7/23

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dressing changes as, "off the scale and severe."

Immediate Jeopardy began on 6/23/23 when Resident #16's medication orders were reduced to once daily dosing and no longer coincided with the frequency of the resident's wound dressing changes provided twice a day. Immediate Jeopardy was removed as of 8/9/2023 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level "E" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective.

The findings included:

Resident #16 was admitted to the facility on 12/9/14. Her cumulative diagnoses included diabetes, peripheral vascular disease, hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following unspecified cerebrovascular disease, a history of gout, chronic pain syndrome, Alzheimer's disease, and dementia.

The resident's physician's orders included the following, in part:
--325 mg acetaminophen to be given as two tablets by mouth every 6 hours as needed for pain (Start Date 5/25/23).
--Left heel: Clean with ¼ strength Dakins (a solution used to prevent and treat skin and tissue infections), pack with gauze soaked with Dakins, covered by a dry dressing every day and evening shift (Start Date 6/22/23).
--50 milligrams (mg) tramadol (an opioid pain

Nurse and their Plans of care were updated on 08/08/23.

· 3. Current Certified Wound Physician and Wound Care Nurse were re-educated by Regional Director of Clinical Services on 08/08/2023 related to assessing pain before, during and after wound care is provided. Physician will be included in updating resident's plan of care to include pharmacological and non-pharmacological pain interventions are being offered prior to wound care management. Resident's that have dementia or other cognitive impairment will be medicated per nonverbal pain cues and assessment. Regional Director of Clinical Services also educated Wound Care Nurse on 08/08/2023, to provide a copy of the Certified Wound Physician notes and orders to the primary care provider (Nurse Practitioner or Medical Director) weekly. On 08/08/2023, the Director of Nursing conducted education with the Nurse Manager/Wound Care Nurse to ensure the following Licensed Nursing Staff will assess pain before, during and after wound care is provided, to verify that pharmacological pain interventions are offered prior to wound care management, will communicate with wound care provider of any pain management changes, pain medications are to be administered as per physician orders for residents with documentation in the medical record, according to the plan of care. Wound care education will be provided by the Nurse Manager during orientation for newly hired nurses and

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medication) to be given as one tablet by mouth every 24 hours as needed for heel/leg pain. Give 60 minutes prior to dressing changes (Start Date 6/23/23). Tramadol is a controlled substance medication.

A review of Resident #16's electronic medical record (EMR) included a progress note dated 6/28/23 and authored by the Nurse Practitioner (NP) who helped to care for the resident. The History of Present Illness noted, " ...She has a left heel unstageable pressure ulcer under treatment. The wound MD is closely following it for treatment interventions and the wound nurse is following it for daily drsg [dressing] changes ..."

Resident #16's most recent Minimum Data Set (MDS) was a significant change assessment dated 7/4/23. The MDS reported the resident had severely impaired cognition. Resident #16 required extensive assistance for bed mobility, transfers, dressing, toileting, and personal hygiene. She was totally dependent on staff for eating. The resident was reported to be incontinent of bladder and bowel. The MDS indicated Resident #16 had one unhealed Stage 4 pressure ulcer. The assessment reported the resident received as needed (PRN) medication for pain, which included an opioid pain medication on 1 out of 7 days during the look back period.

A Wound Evaluation and Management Summary dated 7/6/23 revealed Resident #16 was seen for follow-up by the facility's Wound Care Physician #1 for an assessment and evaluation. The resident was reported to have a Stage 4 pressure wound (full thickness) of the left heel of greater than 88 days duration. The size of the wound was measured as 6.4 centimeters (cm) length by

ongoing. On 08/08/2023, the Director of Nursing and/or Nurse Manager conducted re-education with Licensed Nursing Staff to ensure the following:

a. Licensed Nursing Staff – assess pain before, during and after wound care is provided.

b. Licensed Nursing Staff- education provided on how to anticipate needs and assess pain for residents that are cognitively impaired.

c. Licensed Nursing staff – education provided to verify that pharmacological pain interventions are offered prior to wound care management.

d. Licensed Nursing staff – will communicate with resident's primary care provider to notify of any signs and symptoms of pain and to request any pain medication.

e. Licensed Nursing staff – will communicate with wound care provider of any pain management changes. Wound care education will be provided by the Nurse Manager during orientation for newly hired nurses and ongoing

f. Licensed Nursing Staff- pain medications are to be administered as per physician orders for residents with documentation in the medical record, according to the plan of care.

g. Starting on 08/08/2023 Nurse Aides

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5.8 cm width by 1.8 cm depth. The wound was reported to have deteriorated due to the generalized decline of the patient.

Resident #16 was also followed by Wound Care Physician #1 on 7/13/23 and 7/20/23. The Wound Evaluation and Management Summary from the 7/20/23 visit indicated the size of resident's Stage 4 pressure wound (full thickness) of the left heel was measured as 7.4 cm in length by 5.7 cm width by 1.7 cm depth. The wound progress was reported as "Exacerbated due to generalized decline of patient." The Additional Wound Detail note read: "progressive necrosis of plantar foot wound noted. Do not think that this wound will heal, and if it does, it will mean over 2 years of dressing changes and pain from wound. Will check with family to see if they would consider a below knee amputation to give healed wound, less pain over time and decrease need for daily dressing changes for the foreseeable future."

The resident's most recent care plan (last date of review completed on 7/20/23) included the following areas of focus:
--Resident has Activities of Daily Living (ADL) self-care performance deficits related (in part) to weakness, debility, and residual left hemiparesis for old cerebrovascular accident (CVA or stroke), Alzheimer's disease, and dementia. A notation within this area of focus (dated 7/4/23) reported the resident had a significant change in condition with deterioration of a pressure wound to her left heel.
--Resident has actual skin breakdown/cellulitis with potential for further impaired skin integrity related to incontinence, a history of diabetes, and impaired mobility. An undated notation within this

were provided education related to reporting pain to the nurse based on the request or observation of the patient according to the plan of care.

h. Staff not educated prior to 08/08/2023 will be educated prior to working their next shift. The Executive Director will validate the staff education was completed prior to the staff member working their next shift

i. Certified Wound Physician received education by the Regional Director of Clinical Services on 08/08/2023 related to assessing pain before, during and after wound care is provided according to the plan of care.

j. Newly hired nursing staff will be educated by the Nurse Manager during the orientation period going forward.

4. The Director of Nursing or Nurse Manager will complete quality review audits to ensure Wound Nurse provides Primary Care Provider with weekly wound recommendations weekly for 12 weeks. The results of the audits will be submitted to the QAPI Committee by the Director of Clinical Services for review by the IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed. The Director of Nursing or Nurse Manager will complete quality review audits to ensure effective pain management is in place for residents receiving wound care for 10 residents weekly for 12 weeks. The results of the audits will be submitted to

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F 697	Continued From page 38 area of focus documented, "medication for pain prior [to] dressing changes as ordered and deterioration." The planned interventions included providing treatment(s) to the resident's left heel as ordered and continuing treatment via the wound physician. The resident's physician's orders included the following, in part: --Left heel: Clean with ¼ strength Dakins, pack with gauze soaked with Dakins, covered by an ABD pad (a highly absorbent, non-woven material that wicks moisture away from the wound) with dry dressing every day and evening shift (Start Date 7/25/23). --250 mg cephalexin (an antibiotic) to be given as 1 tablet by mouth every 12 hours for left heel cellulitis times 14 days (Start Date 7/26/23). Resident #16 continued to be followed by Wound Care Physician #1 on 7/27/23. The Wound Evaluation and Management Summary from the 7/27/23 visit indicated the size of resident's Stage 4 pressure wound (full thickness) of the left heel was measured as 7.6 cm in length by 5.6 cm width by 1.9 cm depth. The wound progress was reported as "not improved." On 8/2/23, Resident #16 was seen by Wound Care Physician #2 (a provider covering for Wound Care Physician #1). The Wound Evaluation and Management Summary from the 8/2/23 visit indicated the size of resident's Stage 4 pressure wound (full thickness) of the left heel was measured as 9.2 cm in length by 6.7 cm width by 1.9 cm depth. The wound progress was again reported as "not improved." Wound Care Physician #1 was not available for	F 697	the QAPI Committee by the Director of Clinical Services for review by the IDT members each month for 3 months.	

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an interview.

An observation of Resident #16's wound care was scheduled with the facility's Wound Care Nurse for the morning of 8/3/23. On 8/3/23 at 7:45 AM, the Wound Care Nurse cautioned that although Resident #16 would frequently "holler out and kick" during the wound dressing changes, she would have to continue to complete her wound care. The nurse stated she typically needed to have another staff member in the room to help hold the resident during the wound dressing change. The Wound Care Nurse confirmed Resident #16 had been premedicated for pain. On 8/3/23 at 7:57 AM, Nurse Aide (NA) #1 and the Wound Care Nurse were accompanied to Resident #16's room for her wound dressing change. Both the nurse and NA were observed as they washed their hands and donned clean gloves. The Wound Care Nurse explained to Resident #16 what they were planning to do. The resident gave permission for the wound dressing change and observation of the wound care at that time. Resident #16 was repositioned onto her right side; the NA supported her with one hand while gently holding her other hand. As the Wound Care Nurse removed the wound's outer dressing and gauze packing the wound, the resident moaned and called out in pain. She also appeared to try and move her leg away as the wound was re-packed and dressed; the Wound Care Nurse requested the NA attempt to hold her foot and leg still. As the resident exhibited these obvious signs of pain, NA #1 was observed as he rubbed the resident's back and leg to help soothe her. At the conclusion of the wound care, both NA #1 and the Wound Care Nurse agreed the resident did relatively well during this dressing change. NA #1 explained

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that sometimes he could hear the resident yell so loudly during wound care that she could be heard out in the hallway (even with her door closed).

A review of the resident's EMR included her July 2023 and August 2023 Treatment Administration Records (TARs). The TARs from 7/1/23 to 8/3/23 indicated the resident's wound dressing was scheduled to be changed every day and every evening shift (twice daily).

A review of Resident #16's Controlled Medication Utilization Record (a declining inventory sheet) revealed from 7/1/23 to the morning of 8/3/23, only 17 doses of tramadol had been withdrawn from the inventory dispensed for this resident. One dose of tramadol was withdrawn from Resident #16's inventory on each of the following dates:
--7/2/23 at 12:19 PM
--7/3/23 at 10:00 AM
--7/5/23 at 10:00 PM
--7/9/23 at 9:00 PM
--7/12/23 at 9:00 PM
--7/13/23 at 10:00 AM
--7/14/23 at 10:00 AM
--7/17/23 at 11:00 AM
--7/22/23 at 10:00 AM
--7/23/23 at 11:00 AM
--7/24/23 at 10:00 AM
--7/25/23 at 11:05 AM
--7/26/23 at 12:06 PM
--7/27/23 at 9:00 AM
--7/28/23 at 10:00 AM
--7/31/23 at 10:30 AM
--8/3/23 at 6:07 AM

A review of the resident's Medication Administration Record (MAR) from July 2023 and

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August 2023 revealed from 7/1/23 to the morning of 8/3/23, only 4 doses (two tablets) of 325 mg PRN acetaminophen was administered to Resident #16 on the following dates:
--7/3/23 at 10:08 PM
--7/6/23 at 10:42 AM
--7/19/23 at 5:52 AM
--7/20/23 at 5:49 AM

An interview was conducted with the Wound Care Nurse on 8/3/23 at 2:00 PM. Upon inquiry, the Wound Care Nurse reported she completed the facility's wound dressing changes on Monday through Friday's day shift while the hall nurses completed the wound care during the evening shifts and on weekends. When asked about the pre-medication for Resident #16, the nurse stated she always checked with the hall nurse to be sure the resident had received her pain medication prior to doing her dressing change. When the results of Resident #16's Controlled Medication Utilization Record were shared, the Wound Care Nurse stated from now on she would need to "verify" the resident had been pre-medicated before proceeding with a dressing change instead of just asking the nurse about it. At that time, the nurse confirmed the resident's orders for tramadol included only one dose every 24 hours. The Wound Care Nurse reported Resident #16's pain meds had been reduced by the NP some time ago because twice daily dosing sedated her too much. The nurse reported Resident #16 did very well with the dressing change today and NA #1 had even commented to her about it. She reported the resident usually exhibited three (3) times the behaviors related to pain during dressing changes that were observed earlier that morning (on 8/3/23). When repeating what NA #1 said about the resident sometimes yelling out so

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loud in pain that she could be heard out in the hallway, the nurse acknowledged this statement was true.

A telephone interview was conducted on 8/7/23 at 2:22 PM with Nurse #8. Nurse #8 was identified by her initials on Resident #16's July 2023 TAR as having completed the resident's evening wound dressing changes on 7/2/23, 7/5/23, and 7/12/23. Nurse #8 was also identified as having withdrawn one dose of tramadol for Resident #16 on 7/5/22 at 10:00 PM and on 7/12/22 at 9:00 PM. When asked if she could recall whether the tramadol was given to the resident as pre-medication prior to the dressing changes on those evenings, the nurse thought they likely were because she typically completed dressing changes after her medication pass was done. When asked about the resident's level of pain during the evening dressing changes, the nurse stated, "for sure, she had discomfort with the dressing changes." The nurse stated she had not worked with the resident in the last 3 weeks or so but when she did, Resident #16 would occasionally cry out in pain when she completed the dressing changes.

A telephone interview was conducted on 8/7/23 at 2:37 PM with Nurse #4. Nurse #4 was identified by her initials on Resident #16's July 2023 TAR as having completed evening wound dressing changes for the resident on 7/9/23, 7/17/23, and 7/23/23. The nurse recalled that the resident initially received her pain medication (tramadol) twice daily to help cover her pain with the twice daily dressing changes. However, the pain medication was later reduced to once daily. The nurse reported it was difficult to know what to do because the order for pain medication indicated it

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was to be given one hour before a dressing change, but the dressing changes were done twice daily. The nurse stated she would give the resident her pain medication in the morning and acetaminophen later as well. When asked about the resident's level of pain experienced during the evening dressing changes, Nurse #4 stated, "It was off the scale." The nurse described her pain as "severe" and reported Resident #16 would "holler out" and try to move her feet away. Nurse #4 reported she would always give the resident chewing gum after her dressing change as a reward because she knew the resident enjoyed it.

A telephone interview was conducted on 8/7/23 at 3:59 PM with Nurse #9. Nurse #9 was identified by her initials on Resident #16's July 2023 TAR as having completed evening wound dressing changes for the resident on 7/3/23, 7/8/23, 7/10/23, 7/13/23, 7/14/23, 7/22/23 7/27/23, and 7/31/23. Upon inquiry, Nurse #9 was asked how Resident #16 tolerated her dressing changes. The nurse stated, "Most of the time, she doesn't like it. She flinches." Nurse #9 added that the resident might call out "Ow" at times and would also try to move her leg some. When asked if she could estimate the resident's level of pain exhibited, the nurse stated it varied but was probably a "5" (on a scale of 0 to 10, with 0 indicative of no pain). She stated, "I try to do it [the dressing change] as easy as I can." Upon further inquiry, the nurse reported removing and replacing the packing from Resident #16's wound tended to be the most painful part of the dressing change for her. Nurse #9 stated she has given the resident PRN acetaminophen quite a few times in the past to help with the pain. When asked why she did not give the acetaminophen to the resident every time she had to do a dressing

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change, the nurse stated it would have been because someone else had probably given it to her.

An interview was conducted on 8/3/23 at 3:55 PM with the facility's Director of Nursing (DON). During the interview, the DON was shown Resident #16's TARs (which documented dressing changes were scheduled to be completed twice daily), along with her order for 50 mg tramadol to be given as one tablet by mouth every 24 hours as needed for heel/leg pain to be given 60 minutes prior to dressing changes. When asked about the discrepancy in the frequency of the wound care and pre-medication orders, the DON recalled that at some point in time Resident #16's pain medication had been reduced due to sedation. The DON reported the order for the pain medication should have been written differently and added to the resident's TAR to ensure the resident was always pre-medicated prior to her dressing changes.

A telephone interview was conducted on 8/4/23 at 9:27 AM with the facility's Administrator, DON, and Wound Care Nurse. During the interview, the Wound Care Nurse reported she had received a verbal order from Wound Care Physician #1 some time ago for the frequency of the dressing changes for Resident #16 to be completed twice daily (instead of once a day). Upon review of the resident's medical record, the Wound Care Nurse reported the verbal order for twice daily dressing changes was received on 6/22/23 due to the large amount of drainage the resident had from her wound. The DON reported Resident #16's pain management was addressed last evening (8/3/23) with new orders written by the facility's Medical Director.

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A telephone interview was conducted on 8/4/23 at 8:00 AM with the resident's NP and her Clinical Services Manager. During the interview, the NP was informed that Resident #16's wound dressing change for the Stage 4 pressure ulcer on her left heel was observed on the morning of 8/3/23. Although the Wound Care Nurse and NA both reported the resident was less vocal and less resistant to the wound care than usual, the resident was observed to exhibit obvious signs of pain even after being pre-medicated. When the NP was asked if she was aware of the resident having pain with the dressing changes, the NP stated Resident #16 was at a point where she needed to have a portion of her limb amputated. She stated until then, the resident would have pain there. She added, "no amount of pain med will take care of that pain." When asked if the NP intended for Resident #16 to be pre-medicated with a dose of tramadol prior to each dressing change, the NP replied, "Correct....that's for the first wound [first dressing change]." The NP reported at one point, she tried to schedule an opioid pain medication twice daily but that was too much for this resident. The NP stated, "She was truly lethargic with twice a day dosing." Upon further inquiry, the NP reported she did not know until yesterday (8/3/23) that the resident was getting a dressing change twice a day. She stated, "My intentions were daily if they were doing it [dressing changes] daily and [that she be] pre-medicated before [the wound care]." When asked if the NP was aware the resident was not always being pre-medicated for dressing changes, she responded by saying, "No, I wanted her to be pre-medicated before the dressing changes daily." The NP stated Resident #16 did have medication orders for PRN acetaminophen

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and the NP would encourage administration of it in addition to the tramadol to help with the pain.

An interview was conducted on 8/2/23 at 2:14 PM with the facility's Medical Director (who is also a Medical Doctor or MD). During the interview, the MD reported Resident #16's wound would not heal at this point due to the lack of circulation to her limb. He stated a surgical consult was requested and amputation of her lower leg was recommended. He reported Resident #16's family needed to decide as to whether the amputation would be done.

A follow-up telephone interview was conducted on 8/4/23 at 9:40 AM with the facility's Medical Director. During the interview, the MD reported although the resident was under another provider's service, he was the physician for all residents in the building. The observation of Resident #16's wound dressing change on 8/3/23 and staff interviews were discussed, along with the resident's medication records which revealed she was not routinely pre-medicated for the dressing changes scheduled each day. When asked, the MD reported twice daily dressing changes would not deter a wound from healing and would only help. The MD recalled Resident #16's NP had shared that the resident's pain medication was previously cut back due to oversedation. However, the MD reported that yesterday (8/3/23), he went ahead and changed her medication regimen. The MD stated he trusted the changes would help the resident's level of comfort going forward and he would follow-up with her as needed.

The Administrator was notified of immediate jeopardy on 8/8/2023.

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F 697	Continued From page 47 The facility provided the following immediate jeopardy removal plan: Credible Allegation of Immediate Jeopardy Removal F-697 o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and Based on observations, record reviews, and State Surveyor and staff interviews, the facility failed to provide pain management for a resident with severe cognitive impairment, who had a Stage 4 pressure ulcer of her heel (Resident #16). " Resident #16 has been assessed by the Wound Care nurse on 08/03/23 and pain medication was administered. Regional Director of Clinical Services, along with Executive Director notified medical director regarding pain management and new orders received for additional pain medication and hospice consult, and transcribed to the Medication Administration Record, Resident #16's responsible party was notified of new orders to include medication changes. Resident #16's Plan of Care has been updated on 08/03/2023 by the Minimum Data Set Nurse to reflect resident's problem, goal, and interventions. " Current Facility Residents with wounds have the potential to be affected. a. Current Residents with wounds (12) had Pain Assessments completed by a Licensed Nurse on 8/08/23 using a Pain Assessment to determine those that are at risk for pain. a.i. Current residents with wounds (12) were reviewed to ensure current orders included pain management. These Residents had interventions put into place by a Licensed Nurse and their Plans of care were updated on 08/08/23. b. Current Residents with wounds (12) had	F 697		

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orders for pain management received for wound care prior to treatment. Pain Evaluations were performed by a Licensed Nurse on 08/08/23 to ensure that pain management has been addressed for residents with wounds and appropriate interventions are in place.
b.i. These affected Residents had interventions put into place by a Licensed Nurse and their Plans of care were updated, accordingly on 8/08/23. The residents and/or Responsible Party was notified of changes made with current orders to include pain medications and plan of care.
The Facility has a contract with a Certified Wound Company with Physicians who makes rounds weekly for consultation, assessment, and treatment orders. The Certified Wound Physician is available by phone and via telehealth for consultation, assessment and treatment orders.
Current Certified Wound Physician and Wound Care Nurse will be re-educated by Regional Director of Clinical Services on 08/08/2023 related to assessing pain before, during and after wound care is provided. Physician will be included in updating resident's plan of care to include pharmacological and non-pharmacological pain interventions are being offered prior to wound care management. Resident's that have dementia or other cognitive impairment will be medicated per nonverbal pain cues and assessment.
Regional Director of Clinical Services also educated Wound Care Nurse on 08/08/2023, to provide a copy of the Certified Wound Physician notes and orders to the primary care provider (Nurse Practitioner or Medical Director) weekly.
o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
" On 08/08/2023, the Director of Nursing

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F 697	Continued From page 49 conducted education with the Nurse Manager/Wound Care Nurse to ensure the following Licensed Nursing Staff will assess pain before, during and after wound care is provided, to verify that pharmacological pain interventions are offered prior to wound care management, will communicate with wound care provider of any pain management changes, pain medications are to be administered as per physician orders for residents with documentation in the medical record, according to the plan of care. Wound care education will be provided by the Nurse Manager during orientation for newly hired nurses and ongoing. " On 08/08/2023, the Director of Nursing conducted education with the Nurse Manager/Wound Care Nurse to ensure the Nurse Aides were provided education related to reporting pain to the nurse based on the request or observation of the patient according to the plan of care. " Current Certified Wound Physician and Wound Care Nurse will be re-educated by Regional Director of Clinical Services on 08/08/2023 related to assessing pain before, during and after wound care is provided. Physician will be included in updating resident's plan of care to include pharmacological and non-pharmacological pain interventions are being offered prior to wound care management. Regional Director of Clinical Services also educated Wound Care Nurse to provide a copy of the Certified Wound Physician notes and orders to the primary care provider (Nurse Practitioner or Medical Director). " On 08/08/2023, the Director of Nursing	F 697		

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and/or Nurse Manager conducted re-education with Licensed Nursing Staff to ensure the following:
a. Licensed Nursing Staff - assess pain before, during and after wound care is provided.
b. Licensed Nursing Staff- education provided on how to anticipate needs and assess pain for residents that are cognitively impaired.
c. Licensed Nursing staff - education provided to verify that pharmacological pain interventions are offered prior to wound care management.
d. Licensed Nursing staff - will communicate with resident's primary care provider to notify of any signs and symptoms of pain and to request any pain medication.
e. Licensed Nursing staff - will communicate with wound care provider of any pain management changes. Wound care education will be provided by the Nurse Manager during orientation for newly hired nurses and ongoing
f. Licensed Nursing Staff- pain medications are to be administered as per physician orders for residents with documentation in the medical record, according to the plan of care.
g. Starting on 08/08/2023 Nurse Aides were provided education related to reporting pain to the nurse based on the request or observation of the patient according to the plan of care.
h. Staff not educated prior to 08/08/2023 will be educated prior to working their next shift. The Executive Director will validate the staff education was completed prior to the staff member working their next shift
i. Certified Wound Physician received education by the Regional Director of Clinical Services on 08/08/2023 related to assessing pain before, during and after wound care is provided according to the plan of care.
j. Newly hired nursing staff will be educated by

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the Nurse Manager during the orientation period going forward.

The Executive Director is responsible for the implementation of this credible allegation F-697 Abatement Plan for removal of Immediate Jeopardy Transitional Health Services of Kannapolis (8/09/2023)

Dated alleged Immediate Jeopardy removal: 08/09/23.
The validation of the credible allegation conducted on 08/10/23 included licensed and certified nurse staff completed in-service education related to pain assessment of verbal and nonverbal residents prior to wound care, during wound care and post wound care. Random nurse staff were interviewed and explained the policy related identification of signs and symptoms of pain and proper reporting to the physician and Responsible Party of pain medication effectiveness. The nurse management staff began audits to monitor pain assessments for residents residing in the facility on 08/08/23. Resident care plans were reviewed and updated on 08/08/23 to reflect current pain management goals and interventions related to pain management during wound care. Resident #16 was observed asleep in bed. The wound care nurse revealed that she had performed wound care as ordered the morning of 08/10/23 and Resident #16 had received her scheduled pain medication as ordered 30 minutes prior to her wound care and Resident #16 tolerated her wound care with no verbal or nonverbal signs or symptoms of pain. Interviews were conducted with alert and oriented residents that received wound care and pain management provided during wound care with no concerns identified.

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F 697	Continued From page 52 Immediate Jeopardy removal date effective 08/09/23.	F 697		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732		9/7/23

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F 732	Continued From page 53 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to post accurate staffing information for licensed and unlicensed nursing staff for 8 of 10 posted daily staffing forms reviewed (2/24/2023, 3/20/2023, 3/21/2023,4/5/2023, 4/6/2023, 5/20/2023, 5/21/2023, and 6/26/2023) and failed to post the daily nursing staffing sheet daily for 2 of 4 days observed (7/31/2023 and 8/3/2023). The findings included: 1. Daily posted nursing staffing sheets for the following dates were reviewed: 2/24/2023, 2/25/2023, 2/26/2023, 3/20/2023, 3/21/2023,4/5/2023, 4/6/2023, 5/20/2023, 5/21/2023, and 6/26/2023. a. The nursing schedule for 2/24/2023 indicated that 6 nursing assistants (NA) were scheduled to work the evening shift (3:00 PM to 11:00 PM). The daily posted nursing staffing sheet documented that 7 NAs were working that date. b. The nursing schedule for 3/20/2023 indicated no Registered Nurse (RN) was scheduled to work the day shift (7:00 AM and 3:00 PM). The daily posted nursing staffing sheet documented that 1 RN was working that date. c. The nursing schedule for 3/21/2023 indicated no RN was scheduled to work the day shift. The daily posted nursing staffing sheet documented that 1 RN was working that date.	F 732	F732 1. The staffing sheet is posted and updated daily by staffing coordinator on weekdays. Designated nurse posts and updates staffing sheet on weekends. 2. A quality review was completed by the Assistant Director of Nursing of the last 7 days of staffing sheets and sheets were posted and staffing hours were correct and reflected changes in schedule. An ADHOC Quality Assurance Performance Improvement Committee will be held on 8/31/2023 to review plan of correction. 3. The Executive Director educated the staffing scheduler on posting daily staffing sheet and how to complete and update the staffing sheet with ongoing census and staffing hours on 8/31/2023. The Executive Director educated the Nurse Managers as to how to complete and update the staffing sheet with ongoing census and staffing hours and changes on 09/06/2023. The Nurse Manager will educate Nurses on how to complete, post, and update staffing sheet by 09/06/2023. Newly hired nurses will receive education during orientation. 4. The Executive Director will conduct random Quality reviews of staffing sheets to ensure accurately posted with nursing hours 2 times a week for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to	

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F 732	Continued From page 54 d. The nursing schedule for 4/5/2023 indicated that 8 NAs were scheduled to work the day shift, 1 RN was schedule to work the evening shift, and 5 NA were scheduled to work the evening shift. The daily posted nursing staffing sheet documented that 8 NAs worked the day shift, no RN worked the evening shift, and 7 NAs on the evening shift were working that date. e. The nursing schedule for 4/6/2023 indicated that 9 NAs were scheduled for the day shift, 1 RN was scheduled to work 4 hours on the evening shift, and 8 NAs were scheduled to work the evening shift. The daily nursing staffing sheet documented that no RN worked the evening shift, and 7 NAs were working that date. f. The nursing schedule for 5/20/2023 9 NAs were scheduled to work the day shift, and 8 NAs were scheduled to work the evening shift. The daily posted nursing staffing sheet documented that 8 NAs provided 60 hours of care on the day shift and 7 NAs were working that date. g. The nursing schedule for 5/21/2023 indicated that 9 NAs were scheduled to work the day shift. The daily posted nursing staffing sheet documented that 8 NAs were working that date. h. The nursing schedule for 6/26/2023 indicated that 9 NAs were scheduled to work the day shift, 1 RN was scheduled to work the evening shift, with another RN arriving at 6:00 PM to work a partial shift, and 7 NAs were scheduled to work the evening shift. The daily posted nursing staffing sheet documented that 7 NAs worked the day shift, 1 RN worked the evening shift, and 6 NAs were working that date.	F 732	the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 732	Continued From page 55 The Director of Nursing (DON) was interviewed on 8/4/2023 at 9:55 AM. The DON reported she had been managing the schedule and the daily posted nursing staffing sheets had not been corrected for the staff who worked. 2. a. The posted nursing staffing sheet was observed on 7/31/2023 at 6:25 AM and dated 7/28/2023. b. The posted nursing staffing sheet was observed on 8/3/2023 at 10:26 AM dated 8/2/2023. The Director of Nursing (DON) was interviewed on 8/4/2023 at 9:55 AM. The DON reported the facility had not had a scheduler for the past 3 weeks and she had been managing the schedule and the daily posted nursing staffing sheets. The DON reported she worked Monday through Friday, and the posted nursing staffing sheet was not changed on 7/31/2023 because she had not been in the facility since 7/28/2023. The DON explained that the daily posted staffing sheet did not get posted over the weekends. The DON reported the daily posted nursing staffing sheet was not changed on 8/3/2023 because she had been busy when she arrived on 8/3/2023.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		9/7/23

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F 755	Continued From page 56 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews, the facility failed to provide routine medications for 1 of 8 residents reviewed for medication administration (Resident #19). The findings included: Resident #19 was admitted to the facility on 6/27/2023 with diagnoses to include heart failure and diabetes. Resident #19's admission Minimum Data Set assessment dated 7/3/2023 assessed him to be cognitively intact.	F 755	F755 1. Resident #19 is receiving medications per MD order. Licensed Nurses will be re-educated by the Director of Clinical Services on pharmacy procedures for ordering medications from pharmacy timely, to include ordering them STAT if needed, by 09/06/2023. Licenses Nurses were also re-educated by the Director of Clinical Services on proper documentation of	

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F 755	Continued From page 57 A physician order dated 6/27/2023 with a start date of 6/28/2023 ordered Sacubitril/Valsartan 49/51 milligrams (mg) to be administered twice per day for congestive heart failure. The medication administration record for July 2023 was reviewed and documented on 7/13/2023 the evening dose of Sacubitril/Valsartan was not administered, and the nurse documented "9" (see nursing notes). A nursing note dated 7/13/2023 documented the evening dose of Sacubitril/Valsartan was not available and the physician had been notified. A physician order dated 7/13/2023 documented to hold the evening dose of Sacubitril/Valsartan until it was available. A nursing note dated 7/14/2023 written by Nurse #14 documented Resident #19 had gotten upset because the Sacubitril/Valsartan evening dose was not available, and he had called emergency medical services (EMS) for transport to the emergency room for evaluation. The note documented Resident #19 was transferred to the emergency room by EMS. Hospital emergency room notes dated 7/14/2023 documented Resident #19 came to the hospital because he was having chest pain and his defibrillator fired 4 times and he missed a dose of Sacubitril/Valsartan. The note dated 7/14/2023 documented EMS gave Resident #19 an aspirin 324 mg. Then note documented that Resident #19 reported he was having sharp, left-sided chest pain and felt like his defibrillator (an implanted device that delivers an electrical shock	F 755	medication administration. 2. Quality review was completed on 8/29/2023 of current residents' medication administration records to ensure all meds are available. The audit reveals 10 residents that medication needed to be ordered. Any medications not available were ordered. 3. The Director of Clinical Services/Assistant Director of Nursing and/or Unit Manager will re-educate nurses on pharmacy procedures for ordering of medications, calling of pharmacy to validate receiving of new admission orders and time of arrival of medications, use of back up medications and back up narcotics by 09/06/2023. The Director of Clinical Services or Nurse Manager will re-educate nurses on proper documentation of medication administration by 09/06/2023. This education will be provided to newly hired nursing staff in orientation. 4. The Director of Clinical Services/ Assistant Director of Clinical Services and or Unit Manager will complete quality monitoring on 10 residents' medication administration records weekly for 6 weeks to ensure medications given timely with no holes, circling or medications without explanation or medication unavailable. Opportunities will be corrected by the Director of Clinical Services/Assistant Director of Clinical Services and or Unit Manager as identified during these	

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F 755	Continued From page 58 to the heart if an abnormal heart rhythm is detected) was "zapping him, but not fully firing." The note documented Resident #19 had a chest x-ray completed and it was normal. An EKG (electrocardiogram that shows the rhythm of the heart) showed a normal sinus rhythm. The cardiac defibrillator inquiry revealed that the defibrillator had normal device function and had not fired. Lab work obtained during the emergency room visit was normal. Resident #19 was interviewed on 7/31/2023 at 12:02 PM. Resident #19 reported that he took the Sacubitril/Valsartan for heart failure, and he had been taking it "for a while". Resident #19 reported the Sacubitril/Valsartan was not available for him to take on 7/13/2023 in the evening and when the medication was delivered after midnight on 7/14/2023, Nurse #14 refused to administer it to him. Resident #19 reported he was having chest pain and was feeling uncomfortable, and he wanted to go to the hospital for evaluation. Nurse #14 was interviewed by phone on 8/3/2023 at 6:01 PM. Nurse #14 explained she was assigned to Resident #19 on 7/13/2023 for the night shift from 11:00 PM until 7:00 AM. Nurse #14 recalled that the evening shift (3:00 PM to 11:00 PM) reported to her the Sacubitril/Valsartan was not available, and that nurse had gotten an order to hold the medication until it was delivered. Nurse #14 indicated that the medication was delivered about 1:40 AM on 7/14/2023 when she was in the middle of patient care. Nurse #14 explained she returned to her medication cart "about 10 minutes after the medication was delivered" and Resident #19 was very angry and told her that he had called EMS to be transported	F 755	reviews. The results of these quality reviews will be submitted to the Quality Assurance and Performance Improvement Committee (QAPI) by the Director of Clinical Services for review by the Interdisciplinary members each month. The QAPI committee will evaluate the effectiveness and amend as needed.	

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F 755	Continued From page 59	F 755		

to the emergency room. Nurse #14 reported EMS arrived and took him to the emergency room. When asked if she attempted to administer the Sacubitril/Valsartan, Nurse #14 reported that Resident #19 was very upset and did not give her the opportunity to administer the medication before he left for the hospital.

Nurse #11 was interviewed on 8/2/2023 at 3:36 PM. Nurse #11 reported that medications were reordered when there were 3 or 4 doses left so that the resident did not run out of medications. Nurse #11 explained she had administered Sacubitril/Valsartan morning dose on 7/13/2023 and noted that it was the last dose. Nurse #11 reported she attempted to reorder the Sacubitril/Valsartan for Resident #19, but when she put in the request, it showed that the medication was already on-order. Nurse #11 indicated the medication was not delivered on 7/12/2023 before the end of her shift at 3:00 PM.

During an interview with Nurse #15 (unit manager), she reported the Sacubitril/Valsartan was not delivered on 7/13/2023 in time for the evening dose and the on-call provider was contacted by the nurse and an order was obtained to hold the medication until the Sacubitril/Valsartan was delivered. Nurse #15 explained that when the medication was delivered, Resident #19 decided to go to the emergency room because he said he was having chest pain. Nurse #15 reported that pharmacy delivery times are not accurate unless a medication is ordered STAT (for immediate delivery).

An interview was conducted with the Director of Nursing (DON) on 8/3/2023 at 3:51 PM. The DON

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F 755	Continued From page 60 reported the Sacubitril/Valsartan had been ordered on 7/13/2023 at 10:00 AM by Nurse #11 and it had been delivered to the facility after 11:00 PM on 7/13/2023. The DON reported the Sacubitril/Valsartan should have been ordered STAT if it was ordered the day the medication ran out to ensure delivery in time to administer the medication. The DON reported nurses should not wait until the last dose of any medication to reorder refills to prevent a resident from missing a dose of any medication. The DON was interviewed again on 8/4/2023 at 9:55 AM. The DON reported she was not certain why the Sacubitril/Valsartan was not ordered before 7/13/2023 and all medications should be ordered with 4-5 days left to ensure the resident does not miss any doses. The facility physician (MD) was interviewed on 8/2/2023 at 2:41 PM. The MD explained that missing one dose of Sacubitril/Valsartan would not have negatively impacted Resident #19. The MD reported that the Sacubitril/Valsartan was delivered prior to Resident #19 leaving for the emergency room for evaluation.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a	F 759	F 759 1. Residents #9 and #66 receive	9/7/23

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F 759	Continued From page 61 medication error rate of less than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.4% for 2 of 7 residents (Resident #9 and Resident #66) observed during the medication administration observation. The findings included: 1. Resident #9 was admitted to the facility on 11/17/14. His cumulative diagnoses included constipation. On 7/31/23 at 8:15 AM, Nurse #1 was observed as she prepared 14 oral medications for administration to Resident #9. The oral medications included polyethylene glycol 3350 powder (a medication used to manage constipation). Nurse #1 was observed as she poured the powder into a medication (med) cup with imprinted markings for ounces and drams (a fluid dram equals 1/8 of a fluid ounce) intended to measure liquid medications. She then poured the powder from the med cup into a drinking cup containing 6-8 ounces of water and mixed the solution. The nurse was observed as she administered Resident #9's medications. A review of Resident #9's current physician's orders obtained from the electronic medical record revealed his medications included: polyethylene glycol 3350 powder to be given as 17 grams by mouth two times a day for constipation in 8 ounces of water (Start Date 1/6/22). The medication was scheduled for administration to Resident #9 at 9:00 AM and 5:00 PM daily. The manufacturer's instructions for polyethylene	F 759	medications as ordered by physician. A medication variance was completed for residents and resident #66 had insulin ordered clarified. Nurse #1 no longer works at facility. Nurse #2 will receive individualized re-education on 6 rights of medication administration and preventing medication errors by 09/06/2023. 2. All Nurses and Medication Aides will be observed during medication pass utilizing medication pass worksheet to ensure accuracy with medication pass by 09/06/2023 by the DON / Nurse Managers. 3. Licensed Nurses and Certified Medication Aides will be re-educated on 6 rights of medication administration and preventing medication errors by 09/06/2023 by the DON / Nurse Managers. Any nurse that has not received the education will be educated prior to working their next shift and newly hired nurses will be educated during orientation by the Assistant Director of Nursing / Nurse Manager. 4. The Director of Nursing or Nurse Manager will complete random medication pass observations of 3 nurses 3 times weekly for 4 weeks, then 3 nurses weekly for 4 weeks, then monthly for 2 months on various shifts to include weekends. The results of the medication pass observations and physician order to cart audits will be submitted to the QAPI Committee by the Director of Clinical Services for review by the IDT members each month for 6 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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glycol 3350 powder indicated the 17-gram dosage of the powder should be measured with the measuring cap (bottle top) provided by the manufacturer.

An interview was conducted with Nurse #1 on 7/31/23 at 12:40 AM. During the interview, the nurse was asked how she usually measured out the polyethylene glycol 3350 powder to ensure an accurate dose of 17 grams was administered. The nurse stated she typically used the lid of the manufacturer's container to measure the dose. However, Nurse #1 stated she thought perhaps she should use the medication cup to measure the powder during the med pass observation. At that time, Nurse #1 removed the container of polyethylene glycol 3350 powder from the med cart, poured 17 grams into the measuring cap (bottle top) provided by the manufacturer, then poured it into the med cup to compare the two measurements. As she did so, the nurse stated she thought the imprinted markings on the med cup said "grams" (not drams). After comparing what she recalled measuring out in the med cup earlier that morning to the more accurate measurement obtained from the manufacturer's measuring cap, Nurse #1 reported she likely gave the resident "slightly less" than the 17-gram dose ordered for Resident #9.

An interview was conducted on 8/2/23 at 9:39 AM with the facility's Director of Nursing (DON). During the interview, the DON reported she would have expected the nurse to measure a dose of polyethylene glycol 3350 powder using the marked cap from the manufacturer's bottle to ensure accuracy of the dose provided.

2. Resident #66 was admitted to the facility on

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11/17/14. Her cumulative diagnoses included diabetes.

On 8/1/23 at 8:47 AM, Nurse #2 was observed as she prepared to check Resident #66's blood glucose level and to administer insulin to Resident #66. She prepared a Lantus SoloStar pen (containing a long-acting insulin) to administer a dose of 65 units. After entering the resident's room, Nurse #2 checked Resident #66's blood glucose level (which was 191), then administered the Lantus insulin in the resident's left arm. The nurse returned to the medication cart, then prepared Resident #66's insulin lispro pen (containing a rapid-acting insulin) to deliver a total of 4 units (2 units for the scheduled insulin lispro and 2 units for the sliding scale coverage from the insulin lispro). Nurse #2 was observed as she injected the insulin lispro into the resident's right arm on 8/1/23 at 8:52 AM. Nurse #2 neither administered Novolog insulin to Resident #66 nor did she clarify the active order for the Novolog insulin scheduled for administration at that time.

A review of Resident #66's current physician orders obtained from the electronic medical record revealed her insulin orders included the following, in part:
--65 units of Lantus SoloStar (insulin glargine) to be injected subcutaneously in the morning for diabetes mellitus (Start Date 4/1/23);
--2 units of insulin lispro to be injected subcutaneously before meals for diabetes mellitus (Start Date 7/28/23);
--Insulin lispro to be injected subcutaneously before meals and at bedtime for diabetes mellitus per sliding scale (where the dose of insulin was dependent on the resident's current blood

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glucose level). For a blood glucose level of 150-200, give 2 units of insulin lispro (Start Date 4/21/23);
--2 units Novolog insulin Flexpen (containing a rapid-acting insulin) to be injected subcutaneously with meals related to diabetes mellitus (Start Date 7/27/23).

An interview was conducted on 8/1/23 at 1:30 PM with Nurse #2 regarding Resident #66's current order for Novolog insulin. During the interview, the nurse confirmed she only administered Resident #66's Lantus insulin and insulin lispro during the morning medication observation. The nurse stated she did miss the Novolog insulin listed on the resident's Medication Administration Record (MAR) which indicated 2 units of Novolog insulin should have also been administered during the morning medication observation. When asked what her thoughts were about two rapid-acting insulins being ordered for administration at the same time, she stated, "I've never seen that before."

The facility's Director of Nursing (DON) joined Nurse #2 at the med cart and an interview was conducted on 8/1/23 at 1:45 PM with both the DON and Nurse #2. At that time, the nurse asked the DON about the possible duplication of the order for rapid acting insulin. The DON stated she did not think both insulins should not have been ordered. The DON stated the order would need to be clarified.

An interview was conducted on 8/2/23 at 9:39 AM with the DON to discuss the results of the medication administration observation. During the interview, the DON reported Resident #66's the physician discontinued the order for Novolog

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F 759	Continued From page 65 when the request for clarification was made. Upon further inquiry, the DON stated she would have expected Nurse #2 to have clarified the order for Novolog during the morning med administration observation on 8/1/23. The DON explained that even though the two rapid-acting insulins were interchangeable, they were two separate orders. She stated when a nurse ran across something like that, they needed to clarify it. The DON agreed this mistake was a medication error because the Novolog was scheduled for administration the morning of 8/1/23, but the Novolog insulin was neither given nor was the order clarified.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff and Medical Director interviews, and record reviews, the facility failed to identify the need to clarify a physician's medication order for the administration of two rapid-acting insulins to be given within 30 minutes of each other at mealtime three times daily. This duplication resulted in both rapid-acting insulins being administered on 17 occasions to 1 of 5 residents (Resident #66) reviewed for unnecessary medications. The findings included: Resident #66 was admitted to the facility on 11/17/14. Her cumulative diagnoses included diabetes.	F 760	F 760 1. Resident #66 received medications as ordered by physician. A medication variance was completed for resident #66 and insulin ordered clarified. Nurses #4, #7, and #2 will receive individualized re-education on 6 rights of medication administration and preventing medication errors by 09/06/2023. 2. All Nurses and Medication Aides will be observed during medication pass for random residents utilizing the medication pass worksheet to ensure accuracy with medication pass by 09/06/2023 by the Director of Nursing / Nurse Managers. 3. All Licensed Nurses and Certified	9/7/23

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F 760	Continued From page 66 The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 7/14/23. Resident #66 was assessed to have intact cognition. She was independent with eating, required extensive staff assistance for bed mobility, and was totally dependent on staff for the remainder of her Activities of Daily Living (ADLs). The MDS assessment reported the resident received insulin injection(s) on 7 out of 7 days during the lookback period. Resident #66's care plan (last reviewed on 7/31/23) included the following area of focus, in part: --The resident has a diagnosis of diabetes mellitus with neuropathy. The planned interventions included: Administer medication as ordered. A review of Resident #66's current physician orders in her electronic medical record (EMR) revealed the resident's insulin orders included the following, in part: --65 units of Lantus SoloStar (a long-acting insulin) to be injected subcutaneously in the morning for diabetes mellitus (Start Date 4/1/23). The Lantus insulin order was scheduled for administration at 8:00 AM daily. --Insulin lispro (a rapid-acting insulin) to be injected subcutaneously before meals and at bedtime for diabetes mellitus per sliding scale (where the dose of insulin administered was dependent on the resident's current blood glucose level). The sliding scale indicated: For a blood glucose level of 150-200, inject 2 units of insulin lispro For a blood glucose level of 201-250, inject 4 units of insulin lispro	F 760	Medication Aide staff will be re-educated on 6 rights of medication administration and preventing medication errors by 09/06/2023 by the Director of Nursing / Nurse Manager. Any nurse that has not received the education will be educated prior to working their next shift and newly hired nurses will be educated during orientation. 4. The Director of Nursing or Nurse Manager will complete random medication pass observations of 3 nurses 3 times weekly for 4 weeks, then 3 nurses weekly for 4 weeks, then monthly for 2 months on various shifts to include weekends. The results of the medication pass observations and physician order to cart audits will be submitted to the QAPI Committee by the Director of Clinical Services for review by the IDT members each month for 6 months. The QAPI Committee will evaluate the effectiveness and amend as needed	

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For a blood glucose level of 251-300, inject 6 units of insulin lispro
For a blood glucose level of 301-350, inject 8 units of insulin lispro
For a blood glucose level of 351-400, inject 10 units of insulin lispro. Additional instructions were provided to page the Medical Doctor (MD) / Nurse Practitioner (NP) for a blood glucose level above 400; notify the provider if the blood glucose was less than 60 or greater than 400 (Start date 4/21/23). The sliding scale insulin order was scheduled for administration at 8:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM daily.
--2 units Novolog insulin Flexpen (a rapid-acting insulin) to be injected subcutaneously with meals related to diabetes mellitus (Start Date 7/27/23). The Novolog insulin order was scheduled for administration at 8:00 AM, 11:00 AM and 4:00 PM daily.
--2 units of insulin lispro to be injected subcutaneously before meals for diabetes mellitus (Start Date 7/28/23). The insulin lispro order was scheduled for administration at 8:00 AM, 11:30 AM, and 4:30 PM daily.

Further review of Resident #66's EMR included her July 2023 and August 2023 Medication Administration Records (MARs). The MARs documented that both Novolog and insulin lispro were documented as administered to the resident on each of the following dates/times:
--7/27/23 at 8:00 AM
--7/27/23 at 11:00 AM - 11:30 AM
--7/27/23 at 4:00 PM - 4:30 PM
--7/28/23 at 8:00 AM
--7/28/23 at 11:00 AM - 11:30 AM
--7/28/23 at 4:00 PM - 4:30 PM
--7/29/23 at 8:00 AM
--7/29/23 at 11:00 AM - 11:30 AM

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--7/29/23 at 4:00 PM - 4:30 PM
--7/30/23 at 8:00 AM
--7/30/23 at 11:00 AM - 11:30 AM
--7/30/23 at 4:00 PM - 4:30 PM
--7/31/23 at 8:00 AM
--7/31/23 at 11:00 AM - 11:30 AM
--7/31/23 at 4:00 PM - 4:30 PM
--8/1/23 at 8:00 AM (observed as not having been administered)
--8/1/23 at 11:00 AM - 11:30 AM
--8/1/23 at 4:00 PM

A review of the resident's blood glucose levels recorded in the Vital Signs of the EMR also revealed Resident #66 did not experience low blood glucose levels (hypoglycemia) as a result of both rapid-acting insulins (Novolog and insulin lispro) having been being administered.
--On 7/27/23, her blood glucose levels ranged from 87 to 148 milligram/deciliter (mg/dL)
--On 7/28/23, her blood glucose levels ranged from 188 - 262 mg/dL
--On 7/29/23, her blood glucose levels ranged from at 140 - 238 mg/dL
--On 7/30/23, her blood glucose levels ranged from 172 - 274 mg/dL
--On 7/31/23, her blood glucose levels ranged from 112 - 308 mg/dL
--On 8/1/23, her blood glucose levels ranged from 191 - 270 mg/dL

A telephone interview was conducted on 8/2/23 at 3:21 PM with Nurse #4. Nurse #4 was identified by her initials on Resident #66's July 2023 MAR as having administered both Novolog insulin and insulin lispro on 9 occasions between 7/27/23 - 8/1/23 (7/27/23 at 8:00 AM; 7/27/23 at 11:00 AM, 7/27/23 at 4:00 PM; 7/28/23 at 8:00 AM; 7/28/23 at 11:00 AM, 7/28/23 at 4:00 PM; 7/31/23 at 8:00

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AM; 7/31/23 at 11:00 AM, and 7/31/23 at 4:00 PM). When asked about the duplication of the rapid-acting insulins, the nurse described the orders for both Novolog and insulin lispro as "weird." However, she reported she did go ahead and administer both insulins as indicated on the MAR.

Neither Nurse #6 nor Nurse #7 could be reached for a telephone interview. Nurse #6 was identified by her initials on Resident #66's July 2023 MAR as having documented that she administered both Novolog insulin and insulin lispro on two occasions (7/29/23 at 8:00 AM and 7/29/23 at 11:00 AM). Nurse #7 was also identified as having documented the administration of both Novolog insulin and insulin lispro to Resident #66 on two occasions (on 7/29/23 at 4:00 PM and 7/30/23 at 4:00 PM).

An interview was conducted with Nurse #3 on 8/2/23 at 10:30 AM. Nurse #3 was identified by her initials on Resident #66's July 2023 MAR as having administered both Novolog insulin and insulin lispro on two occasions (7/30/23 at 8:00 AM and 7/30/23 at 11:00 AM). During the interview, the nurse was shown the July 2023 MAR and an inquiry was made as to what the checkmark and her initials on the MAR indicated. The nurse confirmed the documentation on the MAR indicated she administered both the scheduled Novolog and the scheduled insulin lispro to Resident #66. When asked if she had questioned the orders for two rapid-acting insulins to be given, she stated she did not because she knew the resident had been on multiple high doses of insulin in the past.

On 8/1/23 at 8:47 AM, a medication

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administration observation was conducted as Nurse #2 administered 65 units of Lantus insulin and 4 units of insulin lispro (2 units for the scheduled insulin lispro and 2 units for the sliding scale coverage due to a blood glucose level of 191) to Resident #66. The resident did not have any questions nor express any concerns regarding the type of insulin or the dosage administered to her. Nurse #2 neither administered Novolog insulin to Resident #66 nor did she clarify the active order for the Novolog insulin scheduled for administration at that time.

An interview was conducted on 8/1/23 at 1:30 PM with Nurse #2 regarding Resident #66's current order for Novolog insulin. During the interview, the nurse confirmed she only administered Resident #66's Lantus insulin and insulin lispro during the morning medication observation. The nurse stated she missed the Novolog insulin listed on the resident's Medication Administration Record (MAR) which indicated 2 units of Novolog insulin should have also been administered during the morning medication observation. However, Nurse #2 reported she gave the resident both the Novolog (2 units) and insulin lispro (2 units) to the resident at lunchtime. When asked what her thoughts were about two rapid-acting insulins being ordered for administration at approximately the same time, she stated, "I've never seen that before."

The facility's Director of Nursing (DON) joined Nurse #2 at the med cart and an interview was conducted on 8/1/23 at 1:45 PM with both the DON and Nurse #2. At that time, the nurse asked the DON about the possible duplication of the order for rapid acting insulin. The DON stated she did not think both insulins should have been

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ordered. The DON stated the order needed to be clarified. A follow-up interview was conducted with the DON on 8/1/23 at 4:00 PM. During the interview, the DON was asked if the order for Resident # 66's potential duplication of rapid-acting insulins had been clarified by the Medical Doctor (MD). She stated it had not yet been addressed.

A telephone interview was conducted on 8/2/23 at 10:51 AM with Nurse #5. Nurse #5 was identified by her initials on Resident #66's August 2023 MAR as having documented that both Novolog insulin and insulin lispro had been administered to the resident on 8/1/23 at 4:00 PM. During the interview, the nurse confirmed she administered both the scheduled Novolog and insulin lispro to the resident on 8/1/23 for the 4:00 PM dose. The nurse stated she questioned giving the two insulins because this was unusual for Resident #66. However, she acknowledged she did administer both types of insulin as the MAR indicated.

An interview was conducted on 8/2/23 at 9:39 AM with the DON to discuss Resident #66's duplicate orders for rapid-acting insulins. During the interview, the DON reported Resident #66's MD discontinued the order for Novolog insulin when the request for clarification was made on 8/1/23. Upon further inquiry, the DON stated that even though the two rapid-acting insulins were interchangeable, they were two separate orders. She stated when a nurse ran across something like that, they needed to clarify it. The DON reported she realized insulin was a "high risk" medication and accurate dosing was important for this medication.

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F 760	Continued From page 72 An interview was conducted on 8/2/23 at 2:14 PM with the resident's MD (who also assumed responsibilities as the facility's Medical Director). During the interview, the MD recalled the duplicate orders written for Resident #66's rapid-acting insulins was clarified and resolved yesterday (8/1/23). He reported the Novolog insulin order scheduled to be given three times daily at mealtime was discontinued. When asked, the MD stated he had not intended for the resident to receive both the mealtime Novolog insulin and insulin lispro.	F 760		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		9/7/23

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 74 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete daily skilled nursing assessment for 3 of 3 residents reviewed for documentation (Resident #19, #76, and #142). The findings included: 1. Resident #19 was admitted to the facility on 6/27/22023 with diagnosis to include heart failure and diabetes. A physician order dated 6/27/2023 ordered a skilled note to be completed every shift. This order was discontinued on 7/24/2023. A review of the skilled notes from 6/27/2023 to 7/24/2023 for Resident #19 revealed that out of 81 opportunities for shift documentation, the documentation was completed 10 times. The skilled notes were completed for the following dates: - 6/28/2023 day shift (7:00 AM to 3:00 PM) - 6/30/2023 day shift - 7/30/2023 day shift - 7/9/2023 day shift and evening shift (3:00 PM to 11:00 PM) - 7/11/2023 day shift - 7/18/2023 day shift - 7/21/2023 night shift (11:00 PM to 7:00 AM) - 7/22/2023 night shift - 7/23/2023 day shift An interview was conducted with Nurse #3 on 8/2/2023 at 11:09 AM. Nurse #3 reported a skilled note was supposed to be completed every	F 842	F 842 1. Residents #142 and #76 are no longer at the facility. Resident #19 no longer requires a daily skilled nursing assessment. 2. A Quality Review was done on current residents requiring daily skilled nursing assessment on 8/29/2023 to ensure compliance.The audit revealed inconsistencies with documentation daily. Education has begun. 3. Licensed Nurses will be re-educated on completing daily skilled nursing assessments as required for skilled residents by 09/06/2023. Nurses not re-educated by this date will be re-educated prior to working their next shift. Newly hired nurses will be educated during orientation. 4. The Director of Nursing or Nurse Manager will complete quality review audits to ensure completion of daily skilled nursing assessments on 5 residents per week for 6 weeks. The Director of Nursing or designee will report on the results of the quality monitoring and report to the Quality Assurance Performance Improvement committee. Findings will be reviewed by Quality Assurance Performance Improvement committee monthly and Quality monitoring updated as indicated.	

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shift for each new admission for 2 weeks and she tried to complete the assessment each shift, but sometimes she was not able to do it.

During an interview with Nurse #12 on 8/3/2023 at 1:08 PM, she reported that a skilled note was ordered to be completed each shift for new admission residents. Nurse #12 explained that she attempted to write a skilled note for each resident.

Nurse #15, the unit manager, was interviewed on 8/3/2023 at 1:37 PM. Nurse #15 reported she was not aware the daily skilled notes were not being completed every shift.

The Director of Nursing (DON) was interviewed on 8/4/2023 at 9:55 AM. The DON explained the hall was very busy with new admissions and resident care. The DON reported that attempts had been made to audit charting to ensure that the documentation was completed. The DON explained that the documentation was not required to be completed 3 times per day, but they had hoped that assigning the assessment to each shift would get it completed once daily.

The Administrator was interviewed on 8/4/2023 at 10:59 AM and she reported she was not aware the skilled notes were not completed for Resident #19.

2. Resident #76 was admitted to the facility on 6/16/2023 and readmitted on 6/26/2023 with diagnoses to include lung disease and hypertension.

A physician order dated 6/27/2023 ordered a skilled note to be completed every shift.

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A review of the skilled notes from 6/27/2023 to 7/20/2023 revealed out of 69 opportunities for shift documentation, the documentation was completed 9 times. The skilled notes were completed for the following dates:
- 7/3/2023 day shift (7:00 AM to 3:00 PM)
- 7/8/2023 day shift, evening shift (3:00 PM to 11:00 PM, and night shift (11:00 PM to 7:00 AM)
- 7/9/2023 evening shift
- 7/11/2023 day shift
- 7/14/2023 day shift
- 7/18/2023 day shift
- 7/20/2023 day shift

An interview was conducted with Nurse #3 on 8/2/2023 at 11:09 AM. Nurse #3 reported a skilled note was supposed to be completed every shift for each new admission for 2 weeks and she tried to complete the assessment each shift, but sometimes she was not able to do it.

During an interview with Nurse #12 on 8/3/2023 at 1:08 PM, she reported that a skilled note was ordered to be completed each shift for new admission residents. Nurse #12 explained that she attempted to write a skilled note for each resident.

Nurse #15, the unit manager, was interviewed on 8/3/2023 at 1:37 PM. Nurse #15 reported she was not aware the daily skilled notes were not being completed every shift.

The Director of Nursing (DON) was interviewed on 8/4/2023 at 9:55 AM. The DON explained the hall was very busy with new admissions and resident care. The DON reported that attempts had been made to audit charting to ensure that

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the documentation was completed. The DON explained that the documentation was not required to be completed 3 times per day, but they had hoped that assigning the assessment to each shift would get it completed once daily.

The Administrator was interviewed on 8/4/2023 at 10:59 AM and she reported she was not aware the skilled notes were not completed for Resident #76.

3. Resident #142 was admitted to the facility on 7/24/2023 with diagnoses to include atrial fibrillation.

A physician order dated 7/24/2023 ordered a skilled note to be completed every shift.

A review of the skilled notes from 7/24/2023 to 7/31/2023 revealed 19 opportunities for shift documentation. A review of the medical record revealed no daily skilled note had been completed for Resident #142.

An interview was conducted with Nurse #3 on 8/2/2023 at 11:09 AM. Nurse #3 reported a skilled note was supposed to be completed every shift for each new admission for 2 weeks and she tried to complete the assessment each shift, but sometimes she was not able to do it.

During an interview with Nurse #12 on 8/3/2023 at 1:08 PM, she reported that a skilled note was ordered to be completed each shift for new admission residents. Nurse #12 explained that she attempted to write a skilled note for each resident.

Nurse #15, the unit manager, was interviewed on

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F 842	Continued From page 78 8/3/2023 at 1:37 PM. Nurse #15 reported she was not aware the daily skilled notes were not being completed every shift. The Director of Nursing (DON) was interviewed on 8/4/2023 at 9:55 AM. The DON explained the hall was very busy with new admissions and resident care. The DON reported that attempts had been made to audit charting to ensure that the documentation was completed. The DON explained that the documentation was not required to be completed 3 times per day, but they had hoped that assigning the assessment to each shift would get it completed once daily. The Administrator was interviewed on 8/4/2023 at 10:59 AM and she reported she was not aware the skilled notes were not completed for Resident #142.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		9/7/23

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F 867	Continued From page 79 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems	F 867		

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level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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F 867	Continued From page 81 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions put into place following the 3/17/2022 recertification and complaint investigation survey. The facility had deficiencies previously cited in the areas of activities of daily living provided to dependent residents (F677), pharmacy services (F755), and infection prevention and control (F880). These deficiencies were cited again during the facility's current recertification and complaint investigation survey of 8/10/2023. The continued failure of the facility during the previous federal survey of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F677-Based on observations, a resident	F 867	F867 1. The Executive Director held a Quality Assurance Performance Improvement meeting on 8/31/2023 with the Interdisciplinary Team including the Director of Nursing, Dietary Manager, Admissions Coordinator, Social Services Director, Medical Records Director and Business Office Manager focusing on the areas of Cleaning of Glucometers at F880, ADL care related to nail and hair care at F677, and F755 Pharmacy Service related to medication storage and disposal. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. 2. During the Quality Assurance Performance Improvement on 08/30/2023	

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F 867	Continued From page 82 interview, staff interviews, and record review, the facility failed to shave a resident dependent on staff for assistance with activities of daily living (ADL) for 1 of 3 residents sampled for ADL dependence. During the recertification and complaint investigation survey completed on 3/17/22 the facility failed to shave a resident dependent on staff for assistance with activities of daily living (ADL) for 1 of 3 residents sampled for ADL dependence. F755-Based on observations, staff interviews, and record reviews, the facility failed to: 1) Identify unused controlled substance medications for disposition (the process of returning and/or destroying unused medications) for 1 of 1 discharged resident whose medications were observed to remain in 1 of 2 medication carts (400 Hall med cart); and 2) Implement facility ' s procedures to replace the emergency supply of narcotics available in the automated dispensing system with the controlled substances observed on 1 of 2 medication carts (400-500-600 Hall med cart) labeled for the Emergency Narcotic Kit. During the recertification and complaint investigation survey completed on 3/17/22 the facility failed to: 1) Identify unused controlled substance medications for disposition (the process of returning and/or destroying unused medications) for 1 of 1 discharged resident (Resident #76) whose medications were observed to remain in 1 of 2 medication carts (400 Hall med cart); and 2) Implement facility ' s procedures to replace the emergency supply of narcotics available in the automated dispensing system with the controlled substances observed	F 867	the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. 3. The Regional Director of Clinical Services will attend the facility Quality Assurance Performance Improvement Committee meeting at a minimum of quarterly to evaluate the effectiveness of the program, the compliance of ongoing monitoring and the revision to the plan of correction for citations as appropriate to maintain compliance. 4. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month for three months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 867	Continued From page 83	F 867		

on 1 of 2 medication carts (400-500-600 Hall med cart) labeled for the Emergency Narcotic Kit.

F-880-Based on observations, staff interviews and record reviews, the facility failed to: 1) Post the appropriate signage to implement transmission based precautions (TBP) as recommended by the Center for Disease Control and Prevention (CDC) and as directed by the facility's policy for 1 of 2 newly admitted residents who was unvaccinated against COVID-19 (Resident #526); 2) Follow the CDC guidelines for personal protective equipment (PPE) when a nurse was observed entering a quarantined resident's room without wearing gloves and a gown as instructed by the TBP signage for 1 of 2 newly admitted residents (Resident #526); and, 3) Implement measures specified by the CDC when dietary staff member(s) were observed on multiple occasions as they failed to wear a facemask while they worked in the facility. These failures occurred during a COVID-19 pandemic.

During the recertification and complaint investigation survey completed on 3/17/22 the facility failed to: 1) Post the appropriate signage to implement transmission based precautions (TBP) as recommended by the Center for Disease Control and Prevention (CDC) and as directed by the facility's policy for 1 of 2 newly admitted residents who was unvaccinated against COVID-19; 2) Follow the CDC guidelines for personal protective equipment (PPE) when a nurse was observed entering a quarantined resident's room without wearing gloves and a gown as instructed by the TBP signage for 1 of 2 newly admitted residents; and, 3) Implement measures specified by the CDC when dietary staff member(s) were observed on multiple

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F 867	Continued From page 84 occasions as they failed to wear a facemask while they worked in the facility. These failures occurred during a COVID-19 pandemic. On 8/4/2023 at 11:18 am an interview was conducted with the Administrator and she stated their QAA committee meets monthly and their Medical Director and Pharmacist attend the meeting at least quarterly. She stated the facility would address the areas of concern, activities of daily living for dependent residents, pharmacy services and infection control, in there Quality Assurance and Performance Improvement (QAPI) meetings. The Administrator stated she was not employed at the facility during the last survey of record and could not speak to why the facility's QAPI plans did not work, but the facility will address the issues found in the current survey, audit our progress, and monitor our progress in our QAPI meetings.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		9/7/23

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F 880	Continued From page 85	F 880		

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 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

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F 880	Continued From page 86 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility staff failed to clean and disinfect a blood glucose meter (glucometer) dedicated for individual-resident use in accordance with the manufacturer of the disinfectant wipes and as indicated by the facility's policy to protect against cross-contamination from contact with other meters or equipment. This was observed for 2 out of 3 residents (Resident #66 and Resident #48) who were observed to have a blood glucose (sugar) check performed by one of two hall nurses (Nurse #2). The findings included: A review of the facility policy entitled "Blood Glucose Monitoring & Disinfecting" (Effective Date: 11/30/14; Revision Date: 4/20/22) included the following Procedures related to the disinfection of the glucometer: "--Clean and disinfect the meter with disinfecting wipes (per manufacture guidelines) --Place meter in resident specific bag for storage." The manufacturer instructions for the disinfectant	F 880	F880 Infection Prevention and Control 1. Residents #66 and #48 did not suffer any adverse effects by nurse failing to disinfect glucometers according to manufacturer guide of the disinfectant wipes and facility policy. Nurse #2 was re-educated on infection prevention and control related to glucometer cleaning and disinfecting by 08/01/2023. 2. Nurses and Medication Aides will be observed while checking blood glucose levels to ensure proper cleaning and disinfecting of glucometers by 09/06/2023 by the Director of Nurses / Nurse Manager.All nurses and medication aides will return demonstration using Skilled Competency Assessment by the Director of Nursing or Nurse Manager by 9/6/23. 3. The Director of Clinical Services or Nurse Manager will provide re-education for all Licensed Nurses and Medication Aides on glucometer cleaning and disinfecting by 09/06/2023. Nurses that have not received education by this date will receive it prior to working their next shift. Newly hired nurses will receive education during orientation.	

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F 880	Continued From page 87 wipes observed to be used by the facility to clean and disinfect the individual-resident use glucometers read as follows: "To disinfect nonfood contact surfaces only; Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for two (2) minutes. Let air dry. For heavily soiled surface, use a wipe to pre-clean prior to disinfecting." A medication (med) administration observation was attempted on 8/1/23 at 8:42 PM with Nurse #2. Upon approaching the med cart, the nurse reported she had just finished checking Resident #34's blood glucose level. The nurse was observed as she placed the glucometer in a vinyl and fabric pouch labeled for Resident #34. The pouch containing the meter was then placed in the bottom drawer of the medication (med) cart. On 8/1/23 at 8:47 AM, Nurse #2 was observed as she prepared to check Resident #66's blood glucose level. She pulled the resident's glucometer stored in a vinyl/fabric pouch from the med cart. Both the meter and the pouch were labeled with Resident #66's name. She removed the meter from the pouch, inserted a strip, pulled two packets of alcohol wipes a disposable lancet from the cart, and entered the resident's room. The nurse proceeded to check the resident's blood glucose level. After the nurse administered two insulin injections to the resident, she returned to the med cart, placed the meter back into the resident's pouch, and put it back into the bottom drawer of the med cart. On 8/1/23 at 8:55 AM, Nurse #2 pulled a glucometer stored in a vinyl/fabric pouch from the med cart for Resident #48 to begin a blood glucose check for this resident. Both the meter	F 880	4. The Director of Clinical Services or Nurse Manager will complete a quality review by observation of Licensed Nurses to ensure glucometers are properly cleaned and disinfected. The Director of Clinical Services or designee will complete quality monitoring using the glucometer skills competency checklist on two staff members two times weekly for eight weeks, then weekly for four weeks. Opportunities will be corrected by the Director of Clinical Services or designee as identified during these quality monitoring sessions. The Director of Clinical Services will report on the results of the quality monitoring and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring updated as indicated.	

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F 880	Continued From page 88	F 880		

and the pouch were labeled with Resident #48's name. At that time, the nurse was asked what the facility's policy was regarding the disinfection of the resident-specific blood glucometers. The nurse stated, "I made a mistake with the last one." She further explained by saying she should have disinfected the last glucometer (used for Resident #66) before putting the meter back in its pouch.

As the observation continued on 8/1/23 at 8:56 AM, Nurse #2 removed Resident #48's glucometer from the pouch, inserted a glucometer strip, obtained a pair of gloves, alcohol wipes and a lancet from the med cart for a blood glucose check. She entered Resident #48's room and completed the blood glucose check. Nurse #2 then went to the med cart and placed the used glucometer on top of the med cart. While wearing gloves, the nurse wiped the glucometer with a disinfectant wipe for 8-10 seconds, then placed it on top of its vinyl/fabric pouch on the med cart to "let it air dry a little bit." The glucometer was not visibly wet when placed on the pouch. The nurse then placed this glucometer back in its pouch on 8/1/23 at 8:57 AM and returned it to the bottom drawer of the med cart.

An interview was conducted on 8/1/23 at 12:10 PM with the facility's Administrator, the Regional Director of Nursing (DON), and a DON from a sister facility. During the interview, the glucometer disinfection concerns observed earlier that morning were discussed. The Regional DON reported nursing staff education would need to be initiated on the appropriate disinfection of the resident-specific glucometers to ensure the disinfection was done appropriately.

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F 880	Continued From page 89 An interview was conducted on 8/1/23 at 1:30 PM with Nurse #2. During the interview, the concerns regarding the glucometer disinfection were discussed. Upon request, the nurse reviewed the manufacturer labeling of the disinfectant wipes used to clean and disinfect the glucometers. The labeling on the wipes indicated a wet contact time of two (2) minutes was required for disinfection. The nurse asked if it would be appropriate to wrap the glucometer in a disinfectant wipe to keep it wet for the two-minute contact time. It was recommended Nurse #2 discuss the facility's policy for disinfection with the DON for further guidance. An interview was conducted on 8/2/23 at 9:49 AM with the facility's DON. During the interview, the DON reported she had initiated glucometer disinfection education for staff. When asked what the education involved, she reported the nurses were educated that resident-specific glucometers were to be disinfected both before and after use. The staff was also reminded that the glucometers needed to be wet for the entire wait time (determined by the disinfectant product used) before putting the glucometer back into the resident's pouch.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		9/7/23

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F 883	Continued From page 90 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

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F 883	Continued From page 91 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, , the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the Influenza and Pneumococcal immunization, and if residents received the Influenza or Pneumococcal immunization or did not receive the Influenza Pneumococcal immunization due to medical contraindication or refusal for 4 of 5 residents reviewed for infection control (Resident #66, #19, #143, and #142). The findings included: 1. a. Resident #66 was admitted to the facility on 12/17/2021. A review of the medical record revealed no documentation related to influenza or pneumonia immunization status. No documentation related to the Vaccine Information Statement were found in the electronic medical record. The quarterly Minimum Data Set (MDS) assessment dated 7/14/2023 documented Resident #66 received the influenza vaccine on 9/22/2022 and did not receive a pneumococcal vaccine. b. Resident #19 was admitted to the facility on 6/27/2023. A review of the medical record revealed no documentation related to influenza or	F 883	F883 1. Resident #142 no longer resides in facility. Residents' #19, #66, and #143 records have been reviewed. Residents #19, #66, and #143 have all been offered the Influenza and pneumococcal vaccination. Resident's #19, #66, and #143 have been educated on benefits and side effects of both the influenza and pneumococcal vaccines. For those have guardians, Power of Attorneys, and appointed person" have all been educated on the benefits and side effects of both the influenza and pneumococcal. Residents #19, #66, and #143 chose/declined the influenza and pneumococcal vaccine Residents #19, #66, and #143 medical record was documented to indicate administration and/or refusal. 2. All current and newly admitted residents have the potential to be effected. An audit of current residents' records has been completed to ensure both the pneumococcal vaccination and influenza vaccination have been offered. The audit revealed lack of documentation in the resident records therefore the facility obtained consents from all current Responsible Parties / Residents	

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F 883	Continued From page 92 pneumonia immunization status. No documentation related to the Vaccine Information Statement were found in the electronic medical record. The admission MDS documented Resident #19 did not receive the influenza or pneumococcal vaccine. c. Resident #143 was admitted to the facility on 7/14/2023. A review of the medical record revealed no documentation related to influenza or pneumonia immunization status. No documentation related to the Vaccine Information Statement was found in the electronic medical record. The admission MDS dated 7/20/2023 documented Resident #143 did not receive the influenza or pneumococcal vaccine. d. Resident #142 was admitted to the facility on 7/24/2023. A review of the medical record revealed no documentation related to influenza or pneumonia immunization status. No documentation related to the Vaccine Information Statement was found in the electronic medical record. The admission MDS was incomplete at the time of review without information related to influenza or pneumococcal vaccines. The Director of Nursing (DON) was interviewed on 8/3/2023 at 11:20 AM. The DON reported she was the facility Infection Preventionist and was responsible for immunizations. The DON explained that the admissions department had been getting the consents for influenza and	F 883	(depending on BIMS) Any consents needed were obtained by 09/06/2023. 3. On 08/31/2023 the Divisional Executive Director educated Nurse Managers and Admissions team to offer current residents and newly admitted residents both the influenza and pneumococcal vaccinations and providing residents with education on the benefits and side effects of these vaccinations. All licensed nurses were also educated to document the in resident's medical record that education on these vaccinations has been provided and their decision to accept or decline. This education will be provided to newly hired nursing staff in orientation. 4. To monitor, all new admission packets will be audited by the Administrator or designee to ensure residents have been offed the vaccinations and education has been provided on the benefits and side effects of these vaccinations. The Director of Nursing or designee will audit all new resident medical records to ensure licensed staff have offered the influenza and pneumococcal vaccinations and the medical record has been documented to reflect education on the benefits and side effects has been provided, and the resident's decision to accept or decline. Audits by the Administrator and Director of Nursing or their designees will be conducted three times weekly for twelve weeks. Findings will be reported to the facility QAPI Committee monthly for three months.	

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F 883	Continued From page 93 pneumococcal immunization signed on admission and had been providing the residents with the Vaccine Information Statement. The DON reported that the admissions department stopped providing the consents and Vaccine Information Statement "a few months ago" and she was not certain why they stopped. The DON reported that every resident should have immunization records in their electronic medical record and should be provided with the Vaccine Information Statement. The DON reported she did not know why the immunization status was not documented in the electronic medical record.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those	F 887		9/7/23

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F 887	Continued From page 94 additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential risks associated with the COVID-19 immunization, documentation each	F 887	F 887 Resident #142 no longer resides at the facility. Residents #19, and #143 records have been reviewed and updated to reflect their current Covid 19 immunization	

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F 887	Continued From page 95 dose of the COVID-19 vaccine admininstered, and if residents did or did not receive the COVID-19 immunization due to medical contraindication or refusal for 3 of 5 residents reviewed for infection control (Resident #19, #143, and #142). The findings included: 1.a. Resident #19 was admitted to the facility on 6/27/2023. A review of the medical record revealed no documentation related to COVID-19 immunization status. No documentation related to the Vaccine Information Statement were found in the electronic medical record. b. Resident #143 was admitted to the facility on 7/14/2023. A review of the medical record revealed no documentation related to COVID-19 immunization status. No documentation related to the Vaccine Information Statement was found in the electronic medical record. c. Resident #142 was admitted to the facility on 7/24/2023. A review of the medical record revealed no documentation related to COVID-19 immunization status. No documentation related to the Vaccine Information Statement was found in the electronic medical record. The Director of Nursing (DON) was interviewed on 8/3/2023 at 11:20 AM. The DON reported she was the facility Infection Preventionist and was responsible for immunizations. The DON explained that the admissions department had been getting the consents for COVID-19 immunization signed on admission and had been providing the residents with the Vaccine Information Statement. The DON reported that	F 887	status, offered immunization based on status and provided education to reflect education regarding the potential benefits and risk associated with the Covid 19 immunization had been given. 2. All current and newly admitted residents have the potential to be effected. An audit of current residents records has been completed to ensure the Covid vaccination have been offered. The audit revealed that 14 residents are in need of being offered that booster and 2 residents are in need of vaccine. Any consents needed were obtained by 09/06/2023. 3. By 09/06/23 the Divisional Executive Director will educate Nurse Managers and the Admissions team to offer Covid 19 immunization to residents based on their immunization status, provide education regarding the potential benefits and risk associated with the Covid 19. Licensed staff were also educated to document the residents medical record based that education had been provided and the decision to accept or decline. This education will be provided to newly hired nursing staff in orientation. 4. To monitor, all new admission packets will be audited by the Administrator or designee to ensure residents have been offered Covid 19 immunization and education has been provided regarding the potential benefits and risks associated with the Covid 19. The Director of Nursing or designee will audit all new resident medical records to ensure licensed staff have offered Covid 19 education regarding the potential benefits and risks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 887	Continued From page 96 the admissions department stopped providing the consents and Vaccine Information Statement "a few months ago" and she was not certain why they stopped. The DON reported that every resident should have immunization records in their electronic medical record and should be provided with the Vaccine Information Statement. The DON reported she did not know why the immunization status was not documented in the electronic medical record.	F 887	associated with the Covid 19, and the resident□s decision to accept or decline. Audits by the Administrator and Director of Nursing or their designees will be conducted three times weekly for twelve weeks. Findings will be reported to the facility QAPI Committee monthly for three months.	