STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

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E 000	Initial Comments An unannouced recertification and complaint survey was conducted 6/1/21 through 6/11/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event # INT411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/01/21 through 06/11/21. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (K) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/19/20 for Resident #74 and was removed on 06/05/21. Immediate Jeopardy began on 03/26/21 for Resident #80 and was removed on 06/05/21. An extended survey was conducted. 22 of the 42 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		7/2/21

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

Electronically Signed | 06/28/2021

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F 558	Continued From page 1 Based on observations, staff, responsible party (RP) interviews and record review, the facility failed to accommodate a resident's needs and implement an effective method of communication for Spanish speaking resident (Resident #72) who could not understand written Spanish and written or spoken English. This was for 1 (Resident #72) of 1 residents reviewed for accommodation of needs. The findings included: Resident #72 was admitted on 5/7/21 with cumulative diagnoses of a fractured tibia, developmental delay, mixed receptive and expressive language disorder. Resident #72's admission Minimum Data Set (MDS) dated 5/17/21 indicated severe cognitive impairment and she exhibited no behaviors. The communication section of the MDS read her speech was unclear and sometimes was she understood. This MDS assessment was completed with the assistance of her RP. Resident #72 was care planned on 5/10/21 for difficulty in communicating related to speaking Spanish and her developmental delay since childhood. Interventions included simple, direct communication, provide a quiet environment when discussing important issues, allow plenty of time to respond and provide an interpreter/Spanish speaking staff. Review of Resident #72's speech evaluation dated 5/10/21 read Speech Therapist (ST) recommended providing a communication board to maximize communication efficiency to break down the barrier in order for Resident #72 to communicate her wants/needs to unfamiliar listeners.	F 558	F558 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #72 was provided with an accurate Spanish comprehensive communication board to effectively communicate with staff as well as an Availability of Translator Services communication sheet, by the Social worker on 6. 2.2021 How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility Administrator and Social Services Director completed an audit of all current Spanish speaking resident to ensure they were provided accurate communication board on 6/7/21. Any new admission who is identified in need of an alternative form of communication would be assessed by the Speech Therapy to ensure an appropriate means of communication.	

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F 558	Continued From page 2 Review of the ST progress notes from 5/10/21 to 6/2/21 revealed there was no further evaluation of the effectiveness of the use of a communication board for this resident. In a telephone interview on 6/2/21 at 1:38 PM, the RP stated Resident #72 had been unable to talk since birth. She stated Resident #72 could understand spoken Spanish and could point to a picture but she was unable to understand written Spanish and did not understand spoken or written English. The RP stated if she were shown pictures, she could communicate by pointing to what she needed or wanted. The RP stated when Resident #72 was admitted, she asked the facility about an interpreter. She stated the facility never gave her a straight answer about whether they had a access to an interpreter or not. In an observation on 6/1/21 at 10:25 AM, Resident #19 was sitting in a wheelchair in her room. Facial grimacing was noted. On her bedside table were two clear plastic sheet protectors containing 7 pictures. The pictures represented the following: good, bad, go to the bathroom, sit in chair, get the nurse, food and water. Five of the 7 pictures cards were illegible due water damage. In another observation on 6/1/21 at 1:13 PM, Resident #72 was sitting in her wheelchair with a grimace on her face. In another interview on 6/1/21 at 1:27 PM, Nurse #6 stated she had given Resident #72 Tylenol approximately 15 minutes ago after staff reported that she was in pain. She stated Resident #72 could not speak English and she was unsure if	F 558	Director of Nursing, unit managers, and/or designee will review new admissions to ensure resident has the accurate communication board for Spanish speaking residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Admissions Director and/or Social Services Director does have an interpreter service that can be utilized for any communication needs for residents who primary language is not English. This service is available at time of admission to ensure residents are able to communicate their needs. The Director of Nursing and Administrator provided training with all facility staff, including nursing (licensed/unlicensed), contract staff, dietary, leadership) on the ability to use the interpreter services. This training was completed by July 2, 2021. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Social Services and Admissions Director will complete observation audits with those residents who need an alternative method of communication is present and being used by the resident and staff. These audits will occur 3 x/week x 4 weeks, then monthly for 3 months. The Admissions Director and/or Social	

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F 558	Continued From page 3 she could read Spanish. She stated the therapy department copied some pictures and wrote in English and Spanish but it was not useful. She stated her method of communication with Resident #72 was through gestures. Nurse #6 stated if she needed help, she could find a Spanish speaking staff member to translate or use the interpreter line. In an observation on 6/3/21 at 9:02 AM, Resident #72 was sitting up in bed eating breakfast. She appeared comfortable. Upon greeting her in Spanish, she replied in Spanish. In an interview on 6/3/21 at 9:15 AM, Nursing Assistant (NA) #4 stated she used the sheets in her room for her to point to what she needed. She stated if she couldn't understand what Resident #72 wanted, she would find a staff member who spoke Spanish to translate. NA #4 stated she did not know if there was a staff member to translate on all days, weekends or shifts but on first shift, it wasn't difficult finding an interpreter. She stated she was not aware if the facility utilized an interpreter phone line but she knew there were applications that could be downloaded to a smart phone to translate. In an interview on 6/3/21 at 3:55 PM, Nursing Assistant (NA) #6 stated she communicated with Resident #72 by her pointing to what she wanted or needed. She stated if she didn't understand what Resident #72 was trying to convey, she would get a co-worker who spoke Spanish. NA #6 stated she seldom used communication sheets because they had gotten wet causing the marker to smear on the pictures. In an interview on 6/3/21 at 9:18 AM, Unit	F 558	Services Director will complete a summary of the audit results and present at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. Completion date: July 2, 2021	

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F 558	Continued From page 4	F 558		

Manager (UM) #2 stated therapy provided Resident #72 communication sheets with pictures for her to point to what she needed. When asked if there was another communication board other than the 2 sheets in her room, she stated not that she was aware of. She stated at the nurses station, there was a folder with stapled packets of nothing but pictures that could be used to communicate. UM #2 stated the facility also utilized Spanish speaking staff and the facility had an interpreter line. She stated there was not always a Spanish speaking staff member available to translate. When asked how the staff knew Resident #72 was in pain, UM #2 stated Resident #72 was known to grimace when she was in pain and she was unaware that the communication pictures in her room did not include a anything about pain.

In an observation on 6/3/21 at 9:20 AM, UM #2 pulled 2 packets, each stapled with nothing but photocopied images. She stated the sheets at the nurses station were the ones normally used for any resident with communication limitations. UM #2 stated the one in Resident #72's room at present was made by the ST and she did not think she was allowed to change it.

In an interview on 6/3/21 at 9:45 AM, the ST stated she made the communication sheets that were currently in Resident #72's room. She stated she wrote the words in English and Spanish on each picture in the plastic sleeves. She stated she was not aware that there was no picture representing pain but she stated she thought there were more pictures in her room. The ST also stated she was not aware that Resident #72 could not read English or Spanish. She stated Resident #72 was still on ST caseload and she

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F 558	Continued From page 5 was working to improve the method of communication. The ST stated she could understand Resident #72's needs by using gestures, body language (facial grimacing) and pointing to what she wants. The ST also stated she utilized the Spanish speaking staff members In another interview on 6/4/21 at 4:57 PM, the ST stated she made a new notebook and expanded the pictures to include more images of what Resident #72 could possibly need or want. She also stated she sealed the pictures in plastic to avoid water damage to the pictures. In another observation on 6/4/21 at 5:15 PM, Resident #72 was sitting in her wheelchair in her room. On the bedside table was a notebook. Inside the notebook were pictures with words written in Spanish. The pictures included one for pain and all the pictures were sealed in plastic to prevent water damage. In an interview on 6/4/21 at 5:20 PM, the Director of Nursing (DON) stated it was her expectation there be an effective method of communication with Resident #72 to meet her needs.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		7/2/21

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F 561	Continued From page 6 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 observation and staff and resident interviews, the facility failed to provide a facial shave as requested (Resident #29) for 1 of 2 dependent residents reviewed. Findings included: Resident #29 was admitted to the facility on 1/4/21 with the diagnoses of stroke and hemiplegia. A review of the resident ' s quarterly Minimum Data Set dated 1/4/2021 revealed the resident was cognitively intact. Activities of daily living (ADL)s documented dependent for bathing and dressing. The resident ' s care plan was started upon	F 561	F561 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be	

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F 561	Continued From page 7	F 561		

admission and updated on 3/16/2021. The resident required assistance for mobility, dressing, grooming, and bathing.

On 06/01/21 at 10:10 AM an observation was done of the resident in his room in the bed. Nursing Assistant (NA) #9 was present and informed the resident she would return for am care and to get him up to the wheelchair. The resident complained that he would like to have a shave. Facial hair was noted to be 1/2 inch long.

On 06/01/21 at 11:44 am an observation was done of the resident in his room. The resident was dressed in a hospital gown sitting in his wheelchair. The resident was not shaved.

An interview was conducted on 6/1/21 at 11:44 am with the resident. He stated that he would like to be shaved but NA #9 had not offered. It had been several days since his shave and the hair was long. The resident commented he had not received am care and his shave yet and was waiting for the NA to come back as promised.

On 6/1/2021 at 12:00 pm Nurse #4 was interviewed and informed of Resident #29's request for a shave and the nurse stated he would inform the NA assigned (NA #9).

An observation was done of the resident on 6/1/21 at 4 pm. He remained in the same soiled hospital gown and facial hair remained unchanged. NA #9 was done with day shift and gone for the day.

On 6/3/2021 at 9:30 am the resident was observed that he received a shave. The resident was interviewed, and he stated he received a

accomplished for those residents found to have been affected by the deficient practice:
The facility failed to provide a facial shave as requested by Resident #29 on the day of request.
Resident #29 facial hair was removed on 6/2/2021 by certified nursing assistant. All residents' have the potential to be affected.

How the facility will identify other residents having the potential to be affected by the same deficient practice:
Effective 6/4/2021, Director of Nursing and/or designee audit current residents to ensure residents were shaved. 3 Residents that were identified during the audit on 6/4/2021 were shaved on 6/4/2021 by certified nursing assistants.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 6/4/2021, the Director of Nursing and/or designee will in-service all nursing staff on shaving residents upon request and to identify residents that are in need of shaving. In-service will continue with orientation. In-service will be in-person or via phone. Any nursing staff that does not receive the in-service by midnight of 6/9/2021 will be unable to work until so. Education to be completed by DON or designee.

Indicate how the facility plans to monitor

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F 561	Continued From page 8 shave yesterday 6/2/2021. On 6/3/2021 at 7:00 pm an interview was conducted with NA #9. The NA stated that the facility was short staffed, and she was not able to complete all her assignments. The NA commented that she did not have enough time on her shift to complete Resident #29 ' s shave and was aware that the resident wanted a shave (6/1/2021). The NA stated that she was aware the resident ' s facial hair was long. Incontinence care and feeding took priority and then shaving was completed if time allowed. On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated she was not aware of the resident ' s request for a shave. The staff was expected to provide personal care to residents as needed and upon request or to inform nursing to address.	F 561	its performance to make sure that solutions are sustained: To monitor and maintain ongoing compliance, the DON or designee will observe a random sample of 10 residents weekly for 30 days; then every other week for 30 days; then monthly for 3 months. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. Completion date: July 2, 2021	
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's	F 563		7/2/21

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F 563	Continued From page 9 right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and guidance from the Centers for Medicare and Medicaid Services (QSO-20-39-NH), the facility enforced a protocol requiring visitors to be rapid tested for COVID-19 prior to entering the facility resulting in the community mobile crisis provider declining an emergent crisis assessment of Resident #80. This was for 1 of 1 residents (Resident #80) reviewed for visitation. The findings included: CMS (Centers for Medicare and Medicaid Services) guidance from "QSO-20-39-NH" with a revision date of 4/27/21 indicated that while visitor testing can help prevent the spread of COVID-19 that visitors should not be required to be tested as a condition of visitation. Resident #80 was admitted to the facility on 3/3/21 with diagnoses that included Traumatic Brain Injury (TBI) and dementia.	F 563	F563 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How corrective action will be accomplished for those residents found to have been affected by the same deficient practice: Resident #80 was not seen by the	

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F 563	Continued From page 10 The quarterly Minimum Data Set (MDS) assessment dated 3/10/21 indicated Resident #80 ' s cognition was severely impaired. Social Worker (SW) notes dated 3/30/21 indicated that Resident #80 had a history of sexual behaviors and aggression towards others. She wrote that Resident #80 exhibited the following behavioral symptoms: - 3/15/21 agitation, holding another resident's wrist, and swinging and combative toward staff - 3/18/21 agitation with staff and attempting to enter another resident ' s room - 3/25/21 combative with staff and attempting to go in another resident's room - 3/26/21 grabbed another female resident's genital area and was rubbing her legs - 3/30/21 entered another female resident's room and was holding her legs and combative toward staff This SW note revealed that she made a referral for a mobile crisis assessment on 3/30/21, but mobile crisis staff declined to assess resident via face to face due to nursing home protocols for rapid COVID-19 testing. An interview was conducted with the SW on 6/3/21 at 12:54 PM. The SW confirmed that on 3/30/21 she contacted the community ' s mobile crisis team by phone for an emergency assessment of Resident #80. She indicated that the facility had a protocol in place that required visitors to be rapid tested for COVID-19 prior to entering the facility and when the mobile crisis staff were informed of this requirement they refused the testing and were unable to complete the assessment for Resident #80.	F 563	community mobile crisis provider due to the facility requiring them to tested prior to entering the facility. Resident #80 discharged to hospital on 3/31/2021 from Universal Healthcare of Ramseur. No other residents were affected. Resident #80 no longer resides at the facility. How corrective action will be accomplished for those residents with potential to be affected by the same deficient practice: All residents have the potential to be affected when visitors (including mobile crisis personnel) are required to have a COVID test as a condition for visitation. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 6/3/2021 the Administrator, Director of Nursing, Social Worker and Receptionist were in-serviced by the Regional Nurse Consultant that visitors (including the community mobile crisis provider) should not be required to have a COVID test as a condition of visitation (including to perform emergent crisis assessments) in the facility. How facility plans to monitor its performance to make sure that solutions are sustained:	

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F 563	Continued From page 11 During a phone interview with Former Administrator #1 on 6/4/21 at 8:30 AM he confirmed the SW ' s interview that the facility protocol required visitors to have a rapid test for COVID-19 prior to entering the building. He indicated that this applied to external providers including the community mobile crisis provider. He indicated that this was a corporate protocol and that he was not sure if it was actually written in the facility ' s policy. An interview was conducted with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 6/4/21 at 5:35 PM. The RDCS stated that Former Administrator #1 misinterpreted the corporate protocol and that it was not policy for rapid testing for COVID-19 to be completed prior to entering the facility for external providers or other visitors. The DON stated that she expected CMS guidance and the regulations related to visitation to be followed.	F 563	Beginning 6/3/2021 the Charge Nurse, Receptionist, and/or designee will complete monitoring for use of the community mobile crisis provider to ensure COVID testing is not a condition for entry in the facility to perform emergent crisis assessments. This monitoring schedule will be performed daily Sunday through Saturday weekly x 6 weeks, if the community mobile crisis team is needed and Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Completion date: July 2, 2021	
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 clinical complications); (C) A need to alter treatment significantly (that is,	F 580		7/2/21

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F 580	Continued From page 12 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 review and interviews with family, staff, and Medical Director, the facility failed to consult with the physician and to notify the Responsible Party (RP) prior to making a	F 580	F580 The statements included are not an admission and do not constitute agreement with the alleged deficiencies	

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F 580	Continued From page 13 significant alteration in the treatment plan of Resident #74. An Involuntary Commitment (IVC) was filed for Resident #74 without the knowledge of her physician or RP. This was for 1 of 1 residents reviewed for notification of change. The findings included: Resident #74 was admitted to the facility on 1/19/19 with multiple diagnoses that included dementia with behavioral disturbance. A significant change Minimum Data Set (MDS) assessment dated 7/6/20 indicated Resident #74's cognition was severely impaired. She had no behavioral symptoms, but she had rejected care and wandered on 1 to 3 days during the MDS review period. A nursing note for Resident #74 completed by Nurse #5 dated 8/19/20 at 12:02 PM indicated that at 10:30 AM Resident #74 "attacked" another resident. The other resident was visiting with family at the end of the hallway at the door (window visit by way of exterior door with glass) when Resident #74 approached Resident #17 from behind and began striking her in the right arm. The other resident ' s family banged on the door when this was observed in order to alert Nurse #5. Nurse #5 wrote that when he was alerted he ran and separated them. He indicated that the incident was about 5 to 10 seconds. There were no injuries to either resident. The Physician ' s Assistant (PA) was notified of the incident and he ordered a one-time dose of Ativan (antianxiety medication) 1 milligram (mg) Intramuscular (IM). Nurse #5 indicated the Ativan was effective and the resident had calmed.	F 580	herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Facility staff failed to notify the attending physician or patient representative with a significant change in residents mental, or psychosocial status. Resident #74 no longer resides in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: To identify other residents who have the potential to be affected, on 6/4/2021, all the nursing staff was educated on proper notification of the attending physician and the patient representative if a resident has a significant change in their physical, mental, or psychosocial status by the Director of Nursing and/or designee. In person and/or via phone. Address what measures will be put into	

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F 580	Continued From page 14 Resident was placed on 1 on 1 (1:1) observation with staff. A hospital Emergency Department (ED) report dated 8/19/20 indicated Resident #74 was seen by the provider at 4:25 PM. The note stated that Resident #74 was brought in by the police from the facility with Involuntary Commitment (IVC) papers. She was noted to be on a secured unit and was sent to the ED because she got into an altercation with another resident. The note indicated that the facility also sent her there to have medication adjustments even though they had their own physician that completed this task. Resident #74 was assessed with no aggressive behaviors and no psychiatric symptoms and she was to be sent back to the facility to follow up with her primary care physician for treatment of behavioral disturbances. A nursing note dated 8/20/20 at 12:05 AM indicated Resident #74 returned from the hospital at 9:00 PM. A "Transfer to Hospital Audit ([Quality Assurance Tool])" form dated 8/20/20 was completed in relation to a hospital transfer for Resident #74 that occurred on 8/19/20 at 3:10 PM. The form revealed that no physician had authorized the transfer as IVC papers were filed by the Administrator (Former Administrator #2) for Resident #74. A physician's note dated 8/20/20 completed by the Medical Director (late entry note entered on 8/26/20 at 7:21 PM) indicated that he saw Resident #74 at the request of the facility Administrator for a recent episode of agitation with a resident to resident altercation. He wrote	F 580	place or systemic changes made to ensure that the deficient practice will not recur: Effective 6/1/2021, Director of Nursing and unit managers reviewed 30 days of residents that were discharged to another facility for treatment and current residents that had a significant change to ensure the responsible party and MD were notified. A review of clinical notes for the Audit revealed that all responsible parties and the MD of residents that were discharged to another facility for treatment and current residents that had a changed in condition were notified. Progress notes will be reviewed Daily in Clinical meetings by the Director of Nursing, Assistance Director of Nursing, Unit managers, and Social Worker to ensure the responsible party was notified of a significant change. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON and/or designee will monitor all discharge reports and Nurses Notes daily in clinical meeting to ensure that the Responsible Party and Attending Physician is notified of any significant changes in conditions daily x 1-month, weekly x 1 month, and monthly for 1 month. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X3 for further problem resolution if needed.	

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F 580	Continued From page 15 that he personally was unaware of the details after the incident, but that apparently Resident #74 was transported to the hospital emergency room under an IVC order. Resident #74 was evaluated at the hospital with no acute medical conditions and she was transferred back to the facility. A physician's note dated 8/23/20 completed the Medical Director (late entry not entered on 8/26/20 at 7:34 PM) indicated he spoke with Resident #74 ' s RP related to her concerns over the incident from the previous week when Resident #74 was sent to the hospital without her consent or prior knowledge. She stated that she was not made aware of this hospital transfer until after the IVC had been filed, approved, and Resident #74 was in route to the hospital. She explained that the Administrator (Former Administrator #2) contacted her by phone in the afternoon on 8/19/20 and informed her that Resident #74 was already on the way to the hospital for medication reconciliation and psychiatric evaluation. The Medical Director revealed that he shared with the RP that he also was not made aware of the decision to file for an IVC. He explained that he was only made aware by a concerned nurse who reached out to him to notify him of what was occurring at that time which had not allowed for him to make any changes in these plans to send Resident #74 out to the hospital as it became a legal matter at that point because the IVC had already been filed. The Medical Director wrote that he spoke with Former Administrator #2 by phone in the evening of 8/19/20 after it was determined Resident #74 was being sent back to the facility. A phone interview was conducted with Resident	F 580	Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Completion date: July 2, 2021	

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F 580	Continued From page 16	F 580		

74's RP on 6/4/21 at 1:10 PM. She stated that on 8/19/20 around 12:00 PM she was contacted by the Social Worker (SW) and informed Resident #74 had been in a resident to resident altercation. She reported that the facility requested the RP ' s consent to have Resident #74 seen for psychiatric evaluation. The RP stated that at that point in time she agreed to a psychiatric evaluation at the facility and indicated the consent form would be signed the following date (8/20/20) in person. She indicated that later that same afternoon (8/19/20) Former Administrator #2 or the SW (unable to recall with certainty) contacted her and informed her that Resident #74 was being transferred to the hospital for a psychiatric evaluation. She indicated that she told the staff that she had not consented to this transfer and she had not wanted Resident #74 to go to the hospital. The staff member reportedly informed the RP that Resident #74 was already in route to the hospital. The RP stated that she later found out from one of the nurses (unable to recall their name) that Resident #74 had been taken by the police to the hospital under an IVC.

During a phone interview with Former Administrator #2 on 6/4/21 at 11:00 AM she stated that she completed the IVC on 8/19/20 because Resident #74 was a danger to Resident #17. She explained that right after the 8/19/20 incident, Resident #74 continued to "target" Resident #17 by following her around the secured memory care unit after they had been separated. Former Administrator #2 stated that there were no further altercations between the residents on 8/19/20 as Resident #74 was placed on 1:1. She revealed that at the time of the IVC filing, there was no immediate danger, but rather she was concerned of future behaviors or resident to

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resident altercations. She was unable to explain why the Medical Director or other covering physician who was involved with Resident #74's care was not consulted and involved in the treatment plan. When asked if Resident #74's RP was notified of the significant alteration in treatment for Resident #74 she indicated that she was not notified prior to filing for the IVC, but she thought she had been notified prior to the hospital transfer.

A phone interview was conducted with the Medical Director on 6/4/21 at 4:20 PM. He verified that he had not been consulted nor informed of the decision to file for an IVC for Resident #74 on 8/19/20 until after the paperwork had already been filed. He explained that since the paperwork had already been filed he was unable to make any decisions or changes to the treatment plan at that time as it had already become a legal matter. He indicated that his expectation was to be notified of any significant changes and to be consulted prior to hospital transfers or IVC filings unless there was an imminent danger that prevented this from happening. The Medical Director stated that in this instance, he should have been contacted prior to the filing of the IVC paperwork on 8/19/20 as there was no imminent danger which was supported by the ED evaluation. He confirmed he spoke with Resident #74's RP by phone on 8/23/20 and she expressed her concerns with not being notified of the decision to IVC or the hospital transfer until after resident #74 was on the way to the hospital.

During an interview with the current Director of Nursing (DON) on 6/4/21 at 5:35 PM she stated that she was not employed at the facility at the

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F 580	Continued From page 18 time of the 8/19/20 IVC for Resident #74, but her expectation was to notify the physician and RP of any significant changes and to consult with the physician prior to making any significant alterations to a resident's treatment.	F 580		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		7/2/21

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F 609	Continued From page 19 Based on record review and interviews with staff and Physician ' s Assistant, the facility failed to report allegations of resident to resident abuse to the State agency for 2 of 3 allegations of abuse reviewed (Residents #80 and #17). The findings included: 1. Resident #80 was admitted to the facility on 3/3/21 with diagnoses that included Traumatic Brain Injury (TBI) and dementia. The facility's Abuse Policy, titled "Abuse Prevention, Intervention, Reporting, and Investigation", dated July 2018 and revised on February 2021, stated that all alleged violations involving abuse were reported per Federal and State Law. The quarterly Minimum Data Set (MDS) assessment dated 3/10/21 indicated Resident #80 ' s cognition was severely impaired. A nursing note for Resident #80 for 3/29/21 (entered as a late entry note on 3/30/21 at 1:58 PM) completed by Nurse #3 indicated she was called to the memory care unit by Nursing Assistant (NA) #1 at 7:00 PM. Resident #80 had been found in the doorway of Resident #8 ' s room. Resident #80 was bleeding and Resident #8 was on the floor out of bed with her shirt ripped and her left arm out of shirt. Resident #80 stated to NA #1 "this [b***h] scratched me and bit my finger". Resident #80 was assessed and had skin tears to his right forearm which were treated. Nurse #3 wrote that when asking Resident #80 if he pulled Resident #8 out of bed he stated, "I may have done that". The Director of Nursing (DON) was contacted immediately and notified of	F 609	F609 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 4/20/2021 Resident #17 struck resident #61 on the arm when resident #41 approached resident #17 while she was in bed. NA #13 assisted resident #61 back to bed and no further incidences were reported that shift. NA #13 failed to report this incidence to DON on 4/20/2021. The Facility Administrator completed 24 hour and 5-day reportable and submitted to the state agency on 4/27/2021. This is evident of receipt of fax confirmation from the state agency. On 3/29/2021 resident #80 allegedly pulled the resident # 8 out of the bed. Resident #80 noted to obtain a skin tear. Resident #80 was removed for the room. Resident #8 was found in the floor. Resident #8 was assessed and placed	

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F 609	Continued From page 20 incident. (Resident #8 ' s 3/3/21 MDS indicated she had severe cognitive impairment and no behavioral symptoms.) A nursing note for Resident #8 for 3/29/21 (entered as a late entry note on 3/30/21 at 1:58 PM) completed by Nurse #3 indicated she was called to Resident #8 ' s room by NA #1 and Resident #8 was on the floor beside her roommate ' s bed with her head at the foot of the roommate ' s bed. Another resident (Resident #80) was in Resident #8 ' s doorway. Resident #8 ' s shirt was ripped and her left arm was noted to be out of the shirt. Resident #8 was assessed with no injuries. Nurse #3 indicated that she immediately contacted the DON to make aware of incident and the physician and RP were notified. A hard copy typed statement signed by the DON and dated 3/30/21 indicated that she spoke with Resident #80 and Resident #8 due to the incident that occurred on 3/29/21. Resident #80 stated that he had not remembered any incident that happened on 3/29/21. Resident #8 was not oriented enough to answer if something had happened on 3/29/21. The DON wrote that she interviewed staff to see if the 3/29/21 incident with Resident #80 and #8 was witnessed and staff stated that it was not witnessed, but was an assumption due to Resident #80 sitting in his wheelchair in Resident #8 ' s doorway. Review of the facility ' s 24-hour reports and 5 day investigation reports on 6/3/21 revealed no reports were filed regarding the incident with Resident #80 and Resident #8 on 3/29/21. During an interview with Nurse #3 on 6/3/21 at	F 609	back in bed. Resident #8 obtained no injuries. The facility administrator completed 24 hour and 5-day reportable and submitted to the state agency on 6/10/21. This is evident of receipt of fax confirmation from the state agency. How the facility will identify other residents having the potential to be affected by the same deficient practice: Effective 6/3/2021 the Regional Nurse Consultant will review resident all electronic nursing notes for the months of April and May 2021 any other negative interactions, injuries of unknown origin or indications of abuse. This will be completed by 6/4/2021. Effective 6/4/2021, the Regional Nurse Consultant will review all incident reports for the months of April and May 2021 to identify any other negative interactions, injuries of unknown origin or indications of abuse. This will be completed by 6/4/2021. 100% audit was completed by the Administrator for all allegation of abuse and/or neglect submitted in the months of April and May to determine if all 24- & 5-days reports were completed and submitted to the state agency as required by regulation and Elder Justice Act in a timely manner. This audit was completed on 6/4/2021 with no other concerns. Address what measures will be put into place or systemic changes made to	

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F 609	Continued From page 21 1:30 PM she explained that she had not witnessed Resident #80 pull Resident #8 out of bed on 3/29/21 as she was administering medications on a different hall at the time of the incident, but when she was called over by NA #1 it seemed obvious that Resident #80 pulled Resident #8 out of bed and ripped her shirt as the shirt was previously intact. She added that Resident #8 had scratched Resident #80 in what appeared to be self-defense. Nurse #3 stated that she reported this information to the DON and Former Administrator #1. During an interview with NA #1 on 6/3/21 at 4:18 PM she confirmed she was working on 3/29/21 during the 2nd shift at the time of the resident to resident incident between Resident #80 and Resident #8. She indicated that during that shift she heard Resident #8 yelling out. She stated that this was a normal behavior for Resident #8 so initially she had not reacted. She indicated that Resident #8 kept yelling and that at some point the yelling sounding "different" indicating that it sounded like she was in distress so that ' s when she went over to her room and found Resident #8 laying on the floor with Resident #80 seated in his wheelchair in the doorway. Resident #80 said to her, "I got her, I got her" and he held out his arm and showed her the scratches he had on his arm. She reported that Resident #8 stopped yelling as soon as she saw her come to the room. She stated that Resident #8 ' s shirt was ripped and one arm was out of the sleeve to the shirt and it was bunched up to her neck. NA #1 reiterated Nurse #3 ' s statement that although she had not witnessed the incident, it seemed obvious that Resident #80 pulled Resident #8 out of bed and ripped her shirt in the process. She stated that she reported this	F 609	ensure that the deficient practice will not recur: Effective 6/4/2021 a member of the Corporate Leadership Team will review the Daily Morning Stand-up, Clinical Meeting daily Monday thru Friday for four weeks. Incident reports along with the 24 nursing notes/logs will be reviewed daily for two weeks then daily Monday thru Friday to ensure any concerns are addressed that are reportable to state agencies via email. The Regional Nursing Consultant educated the Facility Leadership Team on the Abuse Policy and reporting requirements. They will also be in-serviced on reporting to the Regional Director of Operations and Regional Nursing Consultant for supervision with each reportable who will ensure that the allegation was completely investigated. This education will be completed by 6/4/2021. Effective 6/4/2021, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to ED, Regional Nursing Consultant, and the Regional Director of Operation’s, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the	

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F 609	Continued From page 22 information to the DON and Former Administrator #1. A phone interview with the Physician ' s Assistant (PA) on 6/3/21 at 2:42 PM indicated he was aware of the resident to resident incident that occurred with Residents #80 and #8 on 3/29/21. He stated that he evaluated Resident #80 on 3/31/21 and when asked about this incident the resident denied it. The PA revealed that in his opinion, Resident #80 was cognitive enough to be aware of his actions and that he also was aware enough to deny his actions. He indicated that his expectation was for the facility to follow their normal protocol for reporting allegations of abuse. During a phone interview with Former Administrator #1 on 6/4/21 at 8:30 AM he stated that the facility ' s abuse policy was for all alleged violations of abuse to be reported to the state authority. He revealed that the 3/29/21 resident to resident incident between Resident #80 and #8 was not reported to the state authority. He explained that after the incident he spoke with the corporate office and he was advised that since the incident was not witnessed that it was not to be reported. Former Administrator #1 further explained that it was not known with 100% certainty what happened between Residents #80 and #8 since it was not observed by staff. He acknowledged that the staff members who were working at the time of the incident, Nurse #3 and NA #1, expressed that they believed Resident #80 had pulled Resident #8 from her bed onto the floor ripping her shirt in the process despite their not having had actually witnessed the incident. Former Administrator #1 stated that looking back on the incident, it should have been reported in accordance with their abuse policy as an	F 609	administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Effective 6/4/2021, 24 hours and 5 days investigation reports were completed and reviewed by the Administrator before submitted to the state agency and other officials as required by regulation and/or Elder Justice Act per regulatory requirement. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the Director of Nursing, SDC and/or Nurse Supervisor. A review of the months of April and May of the grievances by the Regional Nursing Consultant was completed on 6/4/2021 to ensure all areas of concern that could be a possible reportable was done so in the appropriate time frames. No areas of concern were identified. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 6/4/2021, Administrator and the Regional Director of Operations will review all alleged violation to ensure a thorough investigation is completed and reported to the state agency and other officials as required by regulation and/or	

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F 609	Continued From page 23 allegation of abuse with Resident #80 as the perpetrator and Resident #8 as the victim. An interview was conducted with the DON on 6/4/21 at 5:35 PM. She indicated that she expected the facility ' s abuse policy to be followed and for all alleged violations to be reported to the state authority. 2. Resident #17 was admitted to the facility on 3/22/2019 with diagnoses that included dementia with behaviors. The most recent quarterly Minimum Data Set (MDS), dated 4/1/2021, indicated Resident #17 was severely cognitively impaired and exhibited behaviors of inattention and disorganized thinking that were fluctuating in nature. Resident #17's most recent comprehensive care plan dated 3/17/2021, included a focus for episodes of disruptive behavior and aggression toward staff during activities of daily living (ADLs). Interventions included placing resident in areas where frequent observation is possible, remove from public areas when behavior is not appropriate, and monitor/document target behaviors. The facility's Policy, titled Abuse prevention, intervention, reporting, and investigation, dated July 2018 with revision date of February 2021, stated physical abuse was defined as non-accidental use of physical force that resulted in bodily injury, physical pain, or impairment. Examples included but were not limited to hitting, slapping, pinching, and kicking. The policy also stated the facility will ensure abuse allegations	F 609	Elder Justice Act. Any issues identified during this monitoring process will be addressed promptly. The Facility Administrator and Social Worker will be reviewing clinical notes, incident reports and grievance during daily stand- up meeting to identify and potential allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property that would require a 24 hour and 5-day reportable sent to the state agency. This review will be daily Monday- Friday. Effective 6/4/2021, Administrator, Social Worker and/or designee will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Completed Date: July 2, 2021	

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F 609	Continued From page 24	F 609		

are reported immediately, but not later than 2 hours after the allegation is made, to the administrator of the facility and to other officials (including the State Survey Agency and Adult Protective Services) in accordance with federal requirements and state law.

Review of an incident report dated 4/22/2021 3:28pm revealed NA #13 heard yelling coming from Resident #17's room around 8:00pm on 4/19/2021. NA#13 reported when she entered the room, Resident #61 was standing next to the resident's bed and Resident #17 struck her on the arm. The report stated NA#13 assisted Resident #61 back to bed and no further incidences were reported that shift.

Review of an incident report dated 4/22/2021 3:27pm revealed NA#13 witnessed Resident #17 self-propel her wheelchair over to Resident #41 and strike him on the back of the head with her hand. NA#13 intervened by separating the residents. The report indicated Resident #41 yelled out when struck by Resident #17 but did not suffer any physical injuries.

On 6/01/21 at 1:36pm Resident #17 was observed in her wheelchair using her legs to self-propel down the 200 hall. An attempt to interview Resident #17 was unsuccessful due to the resident's level of cognitive impairment.

On 6/1/2021 at 1:45pm an interview with Resident #61 was attempted but was unsuccessful due to the resident's level of cognitive impairment.

On 6/1/2021 at 2:05pm an interview was conducted with Resident #41. When asked if he had ever been hit by another resident, he replied

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F 609	Continued From page 25	F 609		

no. When asked if he had ever been hit by Resident #17, he replied no.

NA#13 was no longer employed by the facility and attempts to contact by phone were unsuccessful.

6/04/21 at 9:45am an interview was conducted with the Director of Nursing (DON). She stated the delay in reporting the altercation between Resident #17 and Resident #61 was due to NA #13 not reporting the incident until after the second altercation involving Resident #17 on 4/21/2021. When NA#13 reported the altercation between Resident #17 and Resident #41, she also reported the altercation between Resident #17 and Resident #61 that occurred two days prior. The two incidents were reported to the DON on 4/21/2021. The DON stated she immediately put Resident #17 on every 15 minute checks and moved Resident #61 out of the room into another room. Additionally, she contacted the Resident's responsible party (RP) regarding the behaviors. She further stated the RP did not consent to the resident being seen by behavioral services out of fear the resident would be placed on medications that would alter her level of consciousness. The DON stated the facility's physician placed the resident on hydroxyzine (antihistamine that can be used to treat anxiety). The DON reported the incident reports for both altercations were faxed to the Health Care Personnel Registry on the afternoon of 4/22/2021. The DON reported there had been no additional occurrences of Resident #17 being physical with other residents and it was not a behavior she displayed prior to these two incidents. When asked why NA#13 did not report the first incident that occurred on 4/19/2021, the DON stated it did not occur to the NA that the incident needed to be reported. The entire staff

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F 609	Continued From page 26 was provided education regarding mandatory reporting of abuse and neglect on 4/28/2021 at 3:00pm by the DON. On 6/4/2021 at 5:20pm and interview was conducted with the DON. She stated it was her expectation that physical altercations between residents be reported immediately.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) accurately in the areas of prognosis (Resident #20), range of motion (Resident #19) and Preadmission Screening Resident Review (PASRR) level 2 (Resident #35). This was for 3 of the 19 MDS's reviewed for accuracy. The finding included: 1. Resident #20 was admitted on 12/12/20 with Atrial Fibrillation, tachycardia and shortness of breath. Resident #20's significant change in status MDS dated 4/1/21 indicated she received hospice services but did not indicate she had a life expectancy of less than six months. In a telephone interview on 6/7/21 at 6:02 PM, the MDS Nurse stated she was trained to only code hospice when services had been received. She stated she must have written documentation by	F 641	F641 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How corrective action will be accomplished for those residents found to have been affected by the same deficient practice: The facility failed to accurately code	7/2/21

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F 641	Continued From page 27 the Physician indicating Resident #20 had a prognosis for less than six months to code the prognosis on the MDS assessment. 2. Resident #19 was admitted on 3/25/21 with cumulative diagnoses of an intracranial hemorrhage and respiratory failure. Review of Resident #19's hospital discharge summary dated 3/25/21 indicated she had bilateral hand contractures at the time she was discharged to the facility. Resident #19's significant change Minimum Data Set (MDS) dated 5/26/21 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for a functional limitation in range of motion (ROM) to one upper extremity. Review of an OT Discharge Summary dated 4/19/21 read Resident #19 was to wear right and left hand resting splints on with finger separators for up to 8 hours daily. In an observation on 6/1/21 at 11:10 AM, Resident #19 was lying in bed. Both hands were contracted with her fingers clinched covering the palms of her hands. In a telephone interview on 6/7/21 at 6:02 PM, the MDS Nurse stated she coded Resident #19's MDS dated 5/26/21 inaccurately in the area of ROM. She stated Resident #19 should have been coded for functional limitations in ROM to both upper extremities.	F 641	resident #20 areas of prognosis on MDS "minimum data set" 4/1/2021 significant change, resident #19 range of motion on MDS 5/26/2021 significant change, and resident #35 PASRR "Pre- Admission Screening and Resident Review" level II on MDS 4/14/2021 annual. Resident #20 MDS was modified to reflect areas of prognosis transmitted on by 6/10/2021 MDS coordinator. Resident #19 MDS was modified to reflect range of motion transmitted on 6/10/2021 by MDS coordinator. Resident #35 was modified to reflect PASRR level II on transmitted on 6/28/2021 by MDS consultant. How the facility will identify other residents having the potential to be affected by the same deficient practice: Director of Nursing will audit 100% of residents that are Hospice to verify to have MDS review coding. July 2, 2021. Director of Nursing will audit 100% of residents to verify contractures by July 2, 2021, to have MDS review coding. Social worker will audit 100% of residents to ensure accuracy of PASRRs by July 2, 2021, to have MDS review coding. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: MDS consultant will verify accuracy of areas of prognosis documentation, range of motion documentation, and PASRR	

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F 641	Continued From page 28 In as interview on 6/7/21 at 5:20 PM, the Director of Nursing stated it was her expectation that Resident #19's significant change MDS was coded accuracy for her functional limitation in ROM to both upper extremities. 3. Resident #35 was admitted to the facility on 7/13/18 with diagnoses that included bipolar disorder. A review of Resident #35 ' s Preadmission Screening and Resident Review (PASRR) determination notification indicated she had a PASRR Level II with no expiration date in place since admission to the facility. The annual Minimum Data Set (MDS) assessment dated 4/14/21 indicated Resident #35 had no PASRR Level II. She was assessed with severe cognitive impairment. A phone interview was conducted with the MDS Nurse on 6/4/21 at 6:01 PM. Resident #35 ' s 4/14/21 annual MDS assessment that indicated she had no PASRR Level II was reviewed with the MDS Nurse. Resident #35 ' s Level II PASRR with no expiration date was reviewed with the MDS Nurse. She stated that she had not known Resident #35 had a Level II PASRR. She indicated she should have verified this information prior to coding the 4/14/21 annual MDS. During an interview with the Director of Nursing (DON) on 6/4/21 at 5:35 PM she stated that she expected the MDS to be coded accurately.	F 641	level II documentation prior to completing MDS assessment. MDS Consultant will educate MDS nurse on coding areas of prognosis documentation, range of motion documentation, and PASRR level II documentation prior to completing MDS assessment accurately. Completed on 6/28/2021. How facility plans to monitor its performance to make sure that solutions are sustained: MDS Consultant will audit list of current residents on Hospice, contractures, and with level II PASRRs to ensure most current MDS has been coded accurately by July 2, 2021. MDS will audit 5 MDS on Hospice to ensure MDS is coded correctly for review 1 week for a total of 4 weeks, twice monthly for 1 month, then 1 time a month for one month. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. MDS will audit 5 MDS with contractures to ensure MDS is coded correctly for review 1 week for a total of 4 weeks, twice monthly for 1 month, then 1 time a month for one month. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. MDS will audit 5 MDS with level II	

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F 641	Continued From page 29	F 641	PASRRs to ensure MDS is coded correctly for review 1 week for a total of 4 weeks, twice monthly for 1 month, then 1 time a month for one month. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed. Completion date: July 2, 2021	
F 658 SS=B	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview, the facility failed to obtain a physician order since admission (5/27/2021) for the required intravenous line flush before and after antibiotic administration (Resident #223) for 1 of 1 reviewed. Findings included: Resident #223 was admitted to the facility on 5/27/21 with the diagnoses of osteomyelitis of the foot and sepsis. On 6/1/2021 at 9:20 am an observation of the resident was done. He had a picc line (intravenous line) in the right forearm that was intact. The pressurized antibiotic bag was attached and had infused. An interview was conducted with the resident on 6/1/21 at 9:20 am. He stated that he had been	F 658	F658 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	7/2/21

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F 658	Continued From page 30 receiving intravenous (IV) antibiotic medication since admission. An interview was conducted on 6/3/2021 at 9:40 am with Nurse #7 responsible for the resident. The nurse stated the IV antibiotic was started by the night shift around 6 am and that she (the nurse) was responsible to discontinue the IV and flush the picc line with saline and place heparin (SASH=saline, antibiotic, saline, heparin through the IV). Nurses' note dated 6/3/2021 documented by Nurse #9 wrote that she discontinued the IV antibiotic and flushed the IV picc line with SASH flush. A review of the resident ' s physician orders and medication administration record for the entire facility stay revealed that there was not an order for IV SASH flush. On 6/3/3031 at 10:30 am an interview was conducted with Nurse #9 who stated that there was no order for SASH flush in error and that she would obtain one. A review of the resident ' s physician order dated 6/3/2021 revealed to flush the picc line with SASH protocol. (Flush picc line using SASH method: 10 ML normal saline, antibiotic, 10 ML normal saline, 5 ML Heparin). On 6/4/2021 at 5:31 pm an interview was conducted with Director of Nursing who stated that an order for SASH IV flush was required to be written before administration.	F 658	Resident #223 orders were obtained for required intravenous line (PICC Line) flush before and after antibiotic administration. Orders were then entered into resident electronic medical record by the unit manager 6/1/2021. Resident #223's intravenous line (PICC Line) is now being flushed before and after antibiotic administration as of 6/1/2021 How the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident with a intravenous line (PICC) could have been affected by this alleged deficient practice. Unit Managers completed a medical review of current residents with an intravenous line (PICC) to ensure they had a physician order to flush before and after antibiotic administration. This audit included a review of physician orders to ensure they were entered into the resident's electronic medical record. This review was completed by the facility Unit Managers by 7/2/21 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: To prevent this from recurring, beginning on 6/9/2021, the Director of Nursing and Unit Managers started education with all	

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F 658	Continued From page 31	F 658	licensed nurses on the intent of F658, including obtaining an order for any resident with a intravenous line (PICC) to flush before and after antibiotic administration. This education will be completed by 7/2/21. This training will be a part of new orientation for new licensed nurses. The Director of Nursing and/or Unit Managers will review any new orders for intravenous placement at the morning clinical meeting to ensure physician orders are present and entered into resident medical record for all flush orders, daily x 3 weeks, weekly x 4 weeks and monthly x 3 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will complete a summary of audit results and present at the facility Quarterly Quality Assurance Meeting X 4 for further problem resolution if needed. Director of Nursing is responsible for ensuring continued compliance. Completion date: July 2, 2021	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		7/2/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 32 by: Based on observation, record review, and staff and resident interviews, the facility failed to provide scheduled showers (Resident #29), baths (Residents #65, #75, #76, and #223), nail care (Resident #19), and facial shaving (Resident #41) for 7 of 8 activity of daily living (ADL) dependent residents reviewed. Findings included: 1. Resident #29 was admitted to the facility on 1/4/21 with the diagnoses of stroke and hemiplegia. A review of the resident ' s quarterly Minimum Data Set (MDS) dated 1/4/2021 revealed the resident was cognitively intact. Activities of daily living (ADL)s documented dependent for bathing and dressing. The active diagnoses were stroke, hemiplegia, and dysarthria (pain of the joints). The resident ' s care plan was started upon admission and updated on 3/16/2021. The resident required assistance for mobility, transfers, dressing, grooming, and bathing. The resident ' s shower sheets documentation from 4/27/2021 through 6/2/201 was reviewed, the resident received 7 showers for a total of 6 weeks. There was documentation that the resident was scheduled for showers twice a week and no documentation that he refused. On 06/01/21 at 10:10 AM an observation was done of the resident in his room. Nursing Assistant (NA) #9 was present and informed the resident she would return for morning care and to get him up to the wheelchair. The resident complained that he only received 1 shower per	F 677	F677 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #75 and #76 no longer reside in the facility. 1) #29 and #41 facial hair has been removed, on 6/2/2021 by Certified Nursing Aide. 2) #19 nails have been cut, 0n 6/1/2021 by Certified Nursing Aide. 3) #223 shower has been completed, on 6/1/2021 Certified Nursing Aide. 4) #65 bath has been completed (Resident per MD order not allowed showers), on 6/1/2021 Certified Nursing aide How the facility will identify other residents having the potential to be affected by the same deficient practice: On 6/03/2021, the Unit Managers conducted an observation round of	

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F 677	Continued From page 33 week and would like to have more. His hair was unkempt, appeared dirty and facial hair was noted to be 1/2 inch long. On 06/01/21 at 11:44 am an observation was done of the resident in his room. The resident was dressed in a hospital gown sitting in his wheelchair. The gown was noted to have food on the front and his hair appeared greasy. The resident was not shaved. An interview was conducted on 6/1/21 at 11:44 am with the resident. He stated that he would like to be shaved but the nursing assistant (NA #9) had not offered. It had been several days since his shave. The resident also stated that a shower once a week was not enough and a bed bath or at the sink wash was not enough. "I was supposed to get 2 showers a week." The resident commented he had not received morning care yet and was waiting for the NA to come back as promised. On 6/1/2021 at 4:00 pm the resident was observed to remain in a hospital gown and facial hair was unchanged. It appeared the resident had not been provided a shower and shave. NA #9 was scheduled for day shift and had gone for the day. On 6/3/2021 at 9:10 am an interview was conducted with Nurse #7. The nurse was assigned to the resident on 6/1/2021 and stated she was not informed by NA #9 that the resident requested a shower and shave. On 6/3/2021 at 9:30 am the resident was observed to have received a shave, he stated the shave was received yesterday with a shower.	F 677	current residents to ensure that no resident needed grooming or showers. Any resident identified with a need for any grooming needs, including showers, nail care and/or shaving received care by their assigned Certified Nursing Assistant by 6/4/21. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: New shower sheet in place and staff educated by DON on 6/5/21. This sheet will be used to ensure nursing staff is aware of each resident's shower schedule. This sheet will be updated at he daily clinical meeting, M-F based on new admissions, discharges, and resident preferences by the facility Unit Managers and/or the Activities Director. The Activities Director will monitor the completion of daily shower sheets to ensure documentation is completed appropriately and schedules are maintained. On 6/3/2021, Director of Nursing, and Unit Managers started In-servicing licensed nurses, medication aides, Certified Nursing Aides, and contract nursing staff, on the need to ensure all residents receive grooming, nail care and showers as part of their Activities of Daily Living (ADL's) and plan of care services. Education will be completed on or before 6/09/2021. New hires will receive training at orientation Indicate how the facility plans to monitor its performance to make sure that	

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F 677	Continued From page 34 On 6/3/2021 at 7:00 pm an interview was conducted with NA #9. The NA stated that the facility was short staffed, and she was not able to complete all her assignments (including on 6/1/2021). The NA commented that she did not have enough time on her shift to complete Resident #29 ' s shave as requested. Incontinence care and feeding took priority and then bathing, showers, and shaving were completed if time allowed. On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated that residents are required to receive their bath, shower and/or shave as scheduled and as needed/requested. 2. Resident #65 was admitted to the facility on 5/4/21 with the diagnoses of spinal stenosis with laminectomy. The resident ' s care plan dated 5/5/2021 documented toileting and bathing assistance dependent. A review of the resident ' s admission Minimum Data Set (MDS) dated 5/11/2021 revealed cognition was intact, and the resident was dependent for showers/bathing and assistance for dressing and am care. The active diagnoses were orthopedic condition, surgical after care, spinal stenosis, and lower back pain. A review of the resident ' s shower/bath sheets documented 5/4/2021 through 6/1/2021 revealed the resident had a bath on 5/11, 5/13, 5/18, 5/20, 5/22, 5/23, 5/25, 5/28. (none on 5/29 - 6/1 [4 days]).	F 677	solutions are sustained: The DON and/or Unit Managers will observe a random sample of 10 residents weekly for 30 days; then every other week for 30 days; then monthly for 3 months, to ensure that residents are receiving showers per their preference, including shaving, nail care and other grooming needs. The Director of Nursing will complete a summary of the audits and present audit results at the facility Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. Completion date: July 2, 2021	

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On 6/1/2021 at 12:15 pm an interview was conducted with the resident. The resident stated she was not getting her baths (showers were postponed until the surgical wound was closed). The resident stated that she asked Nursing Assistant (NA) #9 this morning for a bath. Observation during interview at 12:20 pm revealed NA #9 entered the resident ' s room to answer the call light and stated that lunch trays were coming, and she would need to assist with bathing after lunch or the resident would miss lunch. The resident commented to the NA "I thought you said you were going to come back for the bath."

The resident stated on 6/1/2021 at 3:20 pm during interview that she did not receive assistance with a bath from NA #9.

On 6/1/2021 at 4:10 pm resident interview revealed that she did not receive assistance for bathing today.

On 6/3/2021 at 9:40 am an interview was conducted with Nurse #7. The nurse was regularly assigned to the resident and the resident had complained that she had not received her bath. The Director of Nursing (DON) was informed and completed a grievance. Nurse #7 stated she had reminded NA #9 of the resident's requests.

On 6/3/2021 at 7:00 pm an interview was conducted with NA #9. The NA stated that the facility was short staffed, and she was not able to complete all her assignments. Incontinence care and feeding took priority and then bathing, showers, and shaving were completed if time

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allowed. The NA stated that she had not returned to the resident to provide a bath on 6/1/2021.

On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated that residents are required to receive their bath, shower and/or shave as scheduled and as needed/requested.

3. Resident #75 was no longer at the facility

Resident #75 was admitted to the facility on 5/12/15 with the diagnoses of hemiplegia, muscle wasting, and dementia.

The resident ' s care plan dated 7/6/20 revealed the resident was dependent for all ADLs (Activities of Daily Living).

A review of the resident ' s significant change Minimum Data Set (MDS) dated 6/26/2021 documented severe cognitive deficit. The active diagnoses were Alzheimer's dementia and hemiplegia secondary to stroke.

The resident ' s care plan dated 5/27/20 documented left sided hemiplegia, muscle wasting, and dependent with all ADLs.

On 6/3/2021 at 2:10 pm an interview was conducted Nursing Assiatnt (NA) #10. The NA stated that the resident had not received her full bed bath as scheduled. The care was not getting done because there was not enough staff. NA #10 believed that the lack of showers were covered up. The NA stated she brought the issues to corporate but were not addressed.

On 6/4/2021 at 10:40 am an interview was

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conducted with NA #11. The NA stated that when the resident was residing in the facility, August 2020, there was a significant lack of staffing, and showers and bathing were not done. The lack of staff happened on all shifts and affected the ability for staff to provide ADL assistance. NA #11 stated her concerns were shared with the Administrator but were not addressed.

On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated that residents are required to receive their bath, shower and/or shave as scheduled and as needed/requested.

4. Resident #76 was admitted to the facility on 3/16/21 with the diagnosis of fracture with cast.

The resident is no longer at the facility.

A review of the resident ' s discharge Minimum Data Set (MDS) dated 5/6/21 documented she was comatose and fully ADL dependent. The active diagnoses were malnutrition, muscle wasting, and weakness.

The resident ' s care plan dated 3/16/21 revealed impaired mobility with assistance for all ADLs (Activities of Daily Living).

The resident ' s shower/bath sheets for April 2021 documented 4 baths for the month (4/9/2021, 4/13/2021, 4/16/2021, and 4/20/2021).

On 6/3/2021 at 7:00 pm an interview was conducted with Nursing Assistant (NA) #9. The NA stated that the facility was short staffed, and she was not able to complete all her

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assignments. The NA commented that she did not have enough time on her shift to complete Resident #29 ' s shave. Incontinence care and feeding took priority and then bathing, showers, and shaving were completed if time allowed.

On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated that residents are required to receive their bath, shower and/or shave as scheduled and as needed/requested.

5. Resident #223 was admitted to the facility on 5/27/21 with the diagnoses of osteomyelitis of the foot and partial foot amputation.

Admission nurses ' note dated 5/27/21 documented resident had right sided weakness and required assistance with ADLs. He was non-ambulatory with right foot dressing secondary to partial amputation resulting from osteomyelitis. The resident was alert and oriented and able to make his needs known.

The preliminary nursing care plan on admission (5/27/21) included assistance required with ADLs (including bathing).

On 06/01/21 at 2:46 an interview was conducted with the resident. He stated that he had not had a bath since admission, for 4 days. The resident stated he had not refused a bath. Observation of the resident ' s hair appeared shiny/greasy.

On 6/3/2021 at 9:00 am an interview was conducted with the resident. The resident stated that he was bathed this morning. Resident looked clean in his body. His hair was greasy but

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combed.

An interview was conducted on 6/3/2021 at 9:40 am with Nurse #7 who was assigned to the resident. The nurse stated she was not aware that the resident had not received a bath since admission.

On 6/3/2021 at 7:00 pm an interview was conducted with Nursing Assistant (NA) #9. The NA stated that the facility was short staffed, and she was not able to complete all her assignments. The NA commented that she did not have enough time on her shift to complete Resident #29 ' s shave. Incontinence care and feeding took priority and then bathing, showers, and shaving were completed if time allowed. The NA stated that she had not provided the resident a bath.

On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated that residents are required to receive their bath, shower and/or shave as scheduled and as needed/requested.

6. Resident #41 was admitted to the facility on 1/17/15 with the diagnoses of seizure disorder and cerebral palsy at birth.

The resident ' s care plan updated on 3/18/20 documented the resident needed help with hygiene.

A review of the resident ' s quarterly Minimum Data Set (MDS) dated 4/19/21 revealed the resident understood/understands with clear speech and had a moderately impaired cognition

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with no behaviors (no refusal of care). For ADLs, the resident required 1 staff assist for personal care and bathing. Active diagnoses were seizure disorder and weakness.

On 6/1/2021 at 10:40 am an observation of the resident was done while in his wheelchair on the hall. The resident asked Nursing Assistant (NA) #9 for a shave, and she responded later today. The resident's facial hair was observed to be approximately 1/2 inch long.

On 6/1/21 at 2:25 pm another observation of the resident was done. He asked NA #9 for a shave, and she replied, "not now."

Repeat observation on 6/1/2021 of the resident at 4:45 pm revealed the resident had not received a shave and NA #9 was scheduled for day shift and had left the facility. The resident commented that he had been asking for a shave and "no one helped me."

6/3/2021 at 9:10 am Nurse #7 who was assigned to Resident #41 on 6/1/2021 stated she was not informed by NA #9 that the resident requested a shave and one should have been provided.

On 6/3/2021 at 9:15 am the resident was observed to have been shaved.

On 6/3/2021 at 7:00 pm an interview was conducted with NA #9. The NA stated that the facility was short staffed, and she was not able to complete all her assignments. The NA commented that she did not have enough time on her shift to complete Resident #41 ' s shave. Incontinence care and feeding took priority and then bathing, showers, and shaving were

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F 677	Continued From page 41 completed if time allowed. The NA stated that she did not provide the resident a shave when requested on 6/1/2021. On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated that residents are required to receive their bath, shower and/or shave as scheduled and as needed/requested. 7. Resident #19 was admitted on 3/25/21 with cumulative diagnoses of an intracranial hemorrhage, hand contractures and respiratory failure. Resident #19's significant change Minimum Data Set (MDS) dated 5/26/21 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for total assistance with personal hygiene. Resident #19's care plan revised 4/4/21 read she required staff assistance with the personal hygiene and grooming. Resident #19's undated aide Daily Care Guide did not mention of nail care. In an observation on 6/1/21 at 11:10 AM, Resident #19 was lying in bed. Both hands and all	F 677		

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fingers were contracted and her fingernails were very long, jagged and dirty. It was apparent that Resident #19 had acrylic nails at one time. Her fingernails had grown out to the point that the remaining acrylic could be cut off if her nails were trimmed.

In an observation on 6/1/21 at 3:01 PM, Resident #19 was lying in bed. Her fingernails were very long, jagged and dirty.

In an observation on 6/3/21 at 9:05 AM, Resident #19 was lying in bed. Her fingernails were very long, jagged and dirty.

In an interview on 6/3/21 at 9:15 AM, Nursing Assistant (NA) #4 stated Resident #19 was totally dependent on staff for her activities of daily living (ADLs). She stated it was the responsibility of the nurses to cut all resident's fingernails.

In an interview on 6/3/21 at 9:18 AM, Unit Coordinator (UC) #2 stated it was the responsibility of the aides to provide nail care. She stated the aides were allowed to trim diabetic residents fingernails but not toenails.

In an observation on 6/3/21 at 11:04 AM, Resident #19 was lying in bed. Her fingernails were very long, jagged and dirty.

In an interview on 6/3/21 at 12:05 PM, Nurse #6 stated the nurses were responsible for nail care.

In an interview on 6/3/21 at 12:50 PM, NA #5 stated she was unsure who was responsible for nail care.

In an observation on 6/3/21 at 3:40 PM, Resident

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F 677	Continued From page 43 #19 was lying in bed. Her fingernails were very long, jagged and dirty. In an interview on 6/3/21 at 3:55 PM, NA #6 stated it was the responsibility of the nurses to provide nail care. In an observation on 6/4/21 at 9:02 AM, Resident #19 was lying in bed. Her fingernails were very long, jagged and dirty. In an observation with the Director of Nursing (DON) on 6/4/21 at 9:10 AM, she stated she was not aware that Resident #19's nail care had not been completed recently. She stated it was the responsibility of the aides to provide nail care unless the resident was diabetic. The DON stated the staff tried to cut Resident #19's acrylic nails once but they would not come off. In an interview on 6/4/21 at 10:05 AM, NA #2 stated it was the responsible of the aides to provide nail care. In an interview on 6/4/21 at 5:20 PM, the DON stated it was her expectation that Resident #19's nail care be completed by the aides as needed.	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 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		7/2/21

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F 686	Continued From page 44 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 staff and resident interview, the facility failed to turn a resident as ordered to promote healing and to prevent further skin breakdown for 1 of 4 reviewed for position and mobility (Resident #30). Findings included: Resident #30 was admitted to the facility on 11/18/13 with the diagnoses of osteoarthritis and cardiac disease. A review of the resident ' s significant change Minimum Data Set dated 4/2/2021 documented a moderately impaired cognition. The resident was dependent for all activities of daily living. Active Diagnosis were stroke, arthritis, malnutrition. The resident had a stage 4 pressure ulcer that was present on admission from the hospital. The resident ' s care plan updated on 4/2/21 revealed pressure ulcer stage 4 and interventions to prevent further skin breakdown of pressure reduction, activities of daily living dependent, and palliative care (no plan to turn every 2 hours). The resident had a physician order dated 4/30/2021 to turn every 2 hours while awake. The resident ' s nurses ' notes review documented from 5/4/21 to 6/4/21 a sacral pressure ulcer was present on admission from the hospital. Palliative care was being provided	F 686	F686 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #30 no longer resides at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident has the potential to be affected by this alleged deficient practice. Unit Managers completed an audit of current resident's medical record to identify other residents who had orders for	

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F 686	Continued From page 45 for the resident. The resident was malnourished with long standing decreased appetite. One entry on 5/27/2021 and one on 5/17/2021 documented the resident was turned every 2 hours on day shift. One entry the resident was on her left side on 5/5/2021 turned every 2 hours. The resident ' s medication administration record (MAR) for 6/1/2021 was reviewed and signed by Nurse #7 that the resident was turned. The entire month of May MAR was signed as being turned. On 6/1/2021 consecutive observations of the resident in her bed were as follows: · 9:20 am lying on her right side · 10:10 am lying on her right side easily aroused · 11:32 am lying on her right side easily aroused and stated "do not feel well" · 12:05 pm lying on her right side. Nursing Assistant (NA) #9 entered the room at 12:10 pm but did not turn the resident. The resident informed the NA that she was not feeling well. · 12:25 sitting up for lunch in the bed · 1:45 pm lying on her right side awake · 2:55 pm lying on her right side awake · 3:35 pm lying on her right side asleep · 4:00 pm lying on her right side easily aroused. On 06/01/21 at 12:44 pm an interview was conducted with Nursing Assistant (NA) #9 who was assigned to Resident #30 on 6/1/2021. The NA stated that if a resident had an order to turn in the bed every 2 hours the nurse would inform the NA or complete the turning themselves. NA #9 stated she was not aware or informed she was to turn Resident #30. NA #9 commented that	F 686	turning & repositioning. Residents identified with an order for turning & repositioning every 2 hours were placed on resident care guide, so the certified nursing assistants and licensed nurses are aware of this expectation. Audits were completed on 6/3/2021. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Current residents who have an order for turning & repositioning very 2 hours will be placed on resident care guide by the facility DON and/or Unit Managers as of 7/2/2021. New admissions will be reviewed during the morning clinical meeting and any resident identified in need of turning and repositioning will be added to the resident care guide by the DON and/or Unit Manager, to alert the certified nursing assistants of the care expectation for that specific resident. Current licensed and unlicensed nursing staff including contract staff have received re-education by the Director of Nursing on location of care guides, care expectations, related to turning and repositioning residents every 2 hours while in bed, and required documentation. This re-education was completed on 7/2/2021. All newly hired licensed, unlicensed and contract nursing staff will receive this training at orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

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F 686	Continued From page 46 bed-bound residents were usually turned. On 6/1/2021 at 12:57 pm an interview was conducted with Nurse # 7. The nurse was assigned to the resident regularly. The nurse stated that there was a NA huddle sheet communication at shift change (NAs were responsible for) which documented turning and was housed at the nurses' station. The assigned nurse and NA would be responsible for a resident that was ordered for turn every 2 hours. The information would be placed on the huddle sheet and the NA care plan. Nurse #7 stated that she did not turn the resident on day shift 6/1/2021. A review of the NA huddle sheet dated 6/1/2021 documented reminder to turn bedbound residents. There was no documentation that Resident #30 had an order to turn every 2 hours. On 6/3/2021 9:10 am an observation was done of the resident in her bed lying on her right side awake On 6/3/2021 10:05 am an observation was done of the resident in her bed lying on her right side awake On 6/3/2021 at 11:05 am observations were done of the resident in her bed lying on her left side. At 12:30 pm was sitting up for her meal. At 2:00 pm the resident was lying on her left side. An interview on 6/3/2021 at 11:10 am was conducted with the Director of Nursing (DON) who stated that the NA would have any ordered turning on their NA care plan (kiosk documentation) and the assigned nurse would have the turn every 2 hours on the Medication	F 686	To monitor and maintain ongoing compliance, the DON and/or Unit Managers will conduct random observations during varies shifts and weekends of bed bound residents, to ensure they are being turned every 2 hours when in bed daily x 3 weeks, then 3x a week x 3 weeks, then weekly x 2 months. The Director of Nursing will prepare a summary of audit results and present at the facility Quarterly QAPI x 2 for further problem resolution if needed. Director of Nursing is responsible for ensuring continued compliance. Completion Date: July 2, 2021	

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F 686	Continued From page 47 Administration Record (MAR). All NAs were provided education upon hire and annually that all bed-bound residents were to be turned every 2 hours whether there was an order. On 6/3/2021 at 2:50 pm an interview was conducted with NA #12. The NA opened the resident's NA care plan at the kiosk and stated that there were no turn every 2 hours assigned task. The NA stated that education upon hire and annually included bed-bound residents were required to be turned every 2 hours (whether there was an order). On 6/3/2021 at 7:10 pm an interview was conducted by telephone with NA #9. The NA stated that she was assigned to the resident on 6/1/2021 for day shift and had not turned the resident. The NA also stated that she was not informed by the assigned nurse (Nurse #7) to turn the resident.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		7/2/21

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F 688	Continued From page 48 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to have an method of communication between the therapy staff and the nursing staff resulting in the failure to apply bilateral hand splints and bilateral palmer guards and failed to ensure bilateral hand splints fit Resident #19 properly resulting in a sore to her right hand. This deficient practice was for 2 (Resident #19 and Resident #6) of 3 residents reviewed for range of motion (ROM). The findings included: 1. Resident #19 was admitted on 3/25/21 with cumulative diagnoses of an intracranial hemorrhage and respiratory failure. Review of Resident #19's hospital discharge summary dated 3/25/21 indicated she had bilateral hand contractures at the time she was discharged to the facility. Review of an OT Discharge Summary dated 4/19/21 read as follows: *Resident #19 will safely wear a right and left hand resting splints on with finger separators for up to 8 hours with minimal signs and symptoms of redness, swelling, discomfort or pain. This goal was met on 4/19/21. *The Discharge Recommendations read OT established a splint and brace program. The Restorative Aide (RA) was trained in the application of bilateral upper extremity resting hands splints.	F 688	F688 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #19 and Resident #6 were reviewed for proper splints and application by the Therapy Department on 6/07/2021. Resident #19 and Resident #6 now have their splints in place as of 6/7/2021. How the facility will identify other residents having the potential to be affected by the same deficient practice: On, 6/1/2021 an audit of current residents was completed by the Director of nursing to identify those residents with current	

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F 688	Continued From page 49 Resident #19's care plan revised 4/4/21 did not include a focus for her contractures or splints. Resident #19's undated, electronic aide Daily Care Guide did not mention the use of any splints or hand contractures. Resident #19's significant change Minimum Data Set (MDS) dated 5/26/21 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded for limited ROM in one upper and one lower extremity. In an observation on 6/1/21 at 11:10 AM, Resident #19 was lying in bed. Both hands were contracted with her fingers clinched covering the palms of her hands. There were no splints in use. In an observation on 6/1/21 at 3:01 PM, Resident #19 was lying in bed. There were no splints on her hands. In an observation on 6/3/21 at 9:05 AM, Resident #19 was lying in bed. There were no splints on her hands. In an interview on 6/3/21 at 9:15 AM, Nursing Assistant (NA) #4 stated Resident #19 was totally dependent on staff for her activities of daily living (ADLs). She stated she was not aware of any splints for Resident #19's hands. NA #4 stated the therapy department had a restorative aide (RA) and was responsible for the splints. In an interview on 6/3/21 at 9:18 AM, Unit Coordinator (UC) #2 stated it was normally the responsibility of the RA but when she wasn't working, it was the responsibility of the aides. UC	F 688	orders for splints and palmar guards. Those residents who were identified as having a need for a splint or palmar guard have been added to their care guide. The current certified nursing assistants, licensed nurses, medication aides and contract nursing staff have received re-training on the location of the resident care guide and the care expectation for those residents identified with a need for a splint or care guide. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A new communication sheet that outlines the proper way to apply splints was developed as a tool to educate certified nursing aides on proper application of splints. A return demonstration sign off sheet for the certified nursing aide to sign was provided by the Therapy Department. Occupational Therapy will continue to train certified nursing aides to apply splints and palmer guards, for all new admissions and new orders for splints for current residents that reside in the facility L On, 6/21/2021 certified nursing aides were educated on applying splints and palmer guards per schedule and documenting instances of resident non-compliance, by the Occupational Therapist. Any new certified nursing assistant will receive this education during orientation.	

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F 688	Continued From page 50 #2 stated for residents who wore splints, the instructions would appear of the aides electronic Daily Care Guide. In an interview on 6/3/21 at 9:45 AM, the OT stated the therapy department had an RA whose responsibility was to see recently discharged residents from therapy for 2 weeks or 10 visits prior to being turned over to the floor aides. He stated he also educated the aides on the established splinting plan for Resident #19. The OT stated therapy did not write physician orders for splinting but rather the nurse wrote the orders after therapy completed a communication form with specific directions. He stated the nurses also had access to the OT discharge summary in the electronic medical record. He was unable to find any documented evidence of a communication form for nursing staff regarding Resident #19's splints. He stated he was not aware of any communication forms between nursing and therapy until today. He stated he received a communication form today from the nursing department regarding the need for a re-evaluation by OT because her splints no longer fit her properly. In an interview on 6/3/21 at 10:00 AM, the Rehabilitation Manager (RM) stated the RA worked with newly discharged residents to transition them over to the nursing staff. She stated it was the responsibility of the therapist to educate the nursing staff. She stated nursing staff would also ask someone in the rehabilitation department for directions. The RM stated she was unsure who was responsible for writing Physician orders for splints once the residents was discharged from therapy services. She stated it was her understanding that the therapist	F 688	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and/or Therapy Services will conduct observation rounds to monitor splints that are applied every other day x 3 weeks, weekly x 3 weeks and monthly x 2 months. The Director of Nursing and/or Unit Managers will complete a summary of audit results and present at Quarterly Quality Assurance Meeting X3 for further problem resolution if needed. Director of Nursing is responsible for ensuring continued compliance. Completion date: July 2, 2021	

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F 688	Continued From page 51	F 688		

wrote a communication form for the nursing staff with a copy of the form also going to the Director of Nursing (DON) and the Administrator.

In an observation on 6/3/21 at 11:04 AM, Resident #19 was lying in bed. There were no splints on her hands.

In an interview on 6/3/21 at 11:50 AM, The Therapy Regional Director stated therapy was not responsible for writing Physician orders for splinting. She stated the therapist would give recommendations to the DON and she would update the resident's care plan. Once the DON updated the care plan, the splinting recommendations would appear of the aide's electronic Daily Care Guide for them to perform. She stated the nursing staff received training for specific things like splinting prior to the resident's discharge.

In an interview on 6/3/21 at 12:05 PM, Nurse #6 stated the therapy department applied all splints and wrote their own orders for splints.

In an interview on 6/3/21 at 12:50 PM, NA #5 stated therapy educated aides on applying splints and they had to sign a form stating they received the instruction. She stated for residents with splints, instructions would pop up on the Daily Care Guide. NA #5 stated she was not aware that Resident #19 had bilateral hand splints. She stated there was nothing on her Daily Care Guide about splints.

In an observation on 6/3/21 at 3:40 PM, Resident #19 was lying in bed. There were no splints on her hands.

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In an interview on 6/3/21 at 3:55 PM, NA #6 stated she was not aware that Resident #19 was supposed to wear bilateral hand splints. She stated there was nothing on the Daily Care Guide regarding splinting.

In an interview on 6/4/21 at 8:10 AM, the Director of Nursing (DON) stated she was not aware that Resident #19's splints were not being applied. She stated she did not receive a communication form from OT on 4/19/21 about Resident #19 splinting program. The DON stated if she did not receive a communication form she would not know to update the care plan which updated the Daily Care Guide. The DON confirmed that the facility practice was not to obtain Physician orders for splinting. She stated if there was and order, it would have likely improve communication between the therapy department and the nursing department.

In another interview on 6/4/21 at 8:50 AM, the RM stated Resident #19 was to be picked up by OT for splinting because it was discovered on 6/3/21 that her bilateral hand splints no longer fit on her hands. The RM confirmed that a worsening of Resident #19's hand contractures likely occurred because there was some confusion and a breakdown in communication regarding her established splinting program.

In an observation on 6/4/21 at 9:02 AM, Resident #19 was lying in bed. There were no splints on her hands.

In an interview on 6/4/21 at 10:05 AM, NA #2 stated it was the responsibility of the aides to apply splints on residents with hand contractures. She stated the therapy department taught the

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F 688	Continued From page 53	F 688		

nursing staff how to apply splints and for how long a splint should be worn. NA #2 stated she recalled Resident #19 being admitted with hand splints but she was unsure what happened to her splints.

A would care observation was completed on 6/4/21 at 10:50 AM with Nurse #3. She stated Resident #19's bilateral hand splints were located yesterday and were on the dresser. She stated staff attempted to apply the splints but the splints did not fit her anymore. The splints were made of a hard fresh colored plastic with no padding.

In another interview on 6/4/21 at 4:57 PM, the RM stated she nor the OT had assessed Resident #19's old splints. She stated the DON told her that the splints no longer fit. She stated the earliest OT could re-evaluate Resident #19 until Monday 6/7/21.

In another interview on 6/4/21 at 5:20 PM, the DON stated she a few weeks ago, it was brought to her attention that Resident #19's splints did not fit her properly. The DON stated she was under the impression that therapy was aware. The DON stated it appeared as if Resident #19's splints had not been addressed yet by therapy. The DON stated the hand splints were again tried on Resident #19's hands yesterday and again the splints did not fit her hands properly. The DON stated it was her expectation that Resident #19's hand splints fit properly and be applied according to the established splinting instructions developed by therapy. She further stated it was her expectation that communication between the nursing staff and the therapy staff be consistent and complete. The DON stated she did not expect there to be any written Physician orders

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for splints.

2. Resident #6 was admitted to the facility on 12/9/2020 with diagnoses that included quadriplegia secondary to spinal stenosis and cerebral vascular accident.

Resident #6's most recent quarterly Minimum Data Set (MDS), dated 5/28/2021, indicated the resident was cognitively intact, had no behaviors, and was total dependent in activities of daily living (ADLs) including mobility, transfers, eating, bathing, toileting, and personal hygiene. The MDS also indicated the resident had contractures of the right and left hands. The MDS indicted the resident received Occupational Therapy (OT) services 5 days a week. OT therapy start date was 5/20/2021 and end date was ongoing. Resident #6's MDS also indicated she did not receive splint or brace assistance during the assessment period.

A comprehensive care plan for Resident #6, dated 3/17/2021, indicated the resident required assistance for all activities of daily living (ADLs) due to quadriplegia and bilateral upper arm weakness. The care plan did not include a focus for the resident's bilateral hand contractures or palm guards.

A review of the Occupational Therapy (OT) discharge summary dated 6/1/2021 read as follows:
Resident #6 will wear a palm guard on right hand and left hand for up to 6 hours with minimal signs of redness, swelling, discomfort, or pain. The summary of skilled services indicated Resident #6 exceeded goals for palm guard tolerance.

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F 688	Continued From page 55	F 688		

On 6/1/21 at 11:55am Resident #6 was observed to have bilateral hand contractures. She was not wearing any type of splinting device but palm guards were observed in the room on a table near her bed. The resident's active orders for June 2021 did not reveal an order for palm guards.

On 6/3/2021 at 8:30am Resident #6 was observed without palm guards. The devices were again observed in the resident's room.

On 6/03/21 at 9:05am an interview was conducted with NA #7 who was assigned to the resident on that day. She stated Resident #6 did have palm guards for contractures but therapy was responsible for placing them on the resident. The resident was observed at that time and did not have devices in use.

At 11:27am on 6/3/2021 Resident #6 was observed again lying supine in bed without palm guards.

On 6/03/21 at 12:02pm an interview was conducted with NA #8 who stated she was familiar with Resident #6 and worked with her often. NA #8 stated the resident did have palm guards for bilateral hand contractures, they were sitting on the bedside table in the resident's room. She stated she was not told to apply splints. She believed they were applied by therapy. NA#8 further stated the resident's daily care guide did not indicated the resident needed devices applied. NA#8 then demonstrated by pulling up the electronic daily care guide for Resident #6 which listed only wheelchair, and pressure reducing devices under the safety devices and appliances column.

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F 688	Continued From page 56	F 688		

In an interview on 6/3/2021 at 9:45am the OT stated the therapy department had a restorative aide (RA) who followed residents for two weeks or 10 visits after discharge from therapy. The RA is responsible for training the NAs on application, duration, and frequency of recommended devices.

An interview was conducted with the Rehabilitation Manger on 6/03/21 at 10:02am. She stated she began working at the facility in March. She further stated she trained the day shift NA on how to place Resident #6's palm guards prior to the resident being discharged from therapy. She stated she instructed the NA to place the palm guards on during the day as tolerated and remove them at night. When asked where these instructions were documented for other NAs to access, she stated she did not know.

In an interview on 6/3/2021 at 11:50am the Therapy Regional Director stated therapy did not write Physician orders for splinting devices. She stated the therapist gave recommendations via nursing communication form to the DON and she would update the resident's care plan. Once the care plan was updated, the splinting recommendations would automatically populate in the resident's electronic daily care guide as a task for NAs to perform.

On 6/4/2021 at 5:20pm the DON stated she was not aware Resident #6 's palm guards were not being applied. She did not recall getting a nursing communication form regarding the application, duration, and frequency for the palm guards

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F 688	Continued From page 57 therefore she did not update the care plan. She further stated it was her expectation communication between nursing staff and therapy staff be consistent and complete.	F 688		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Medical Director, and Physician's Assistant, the facility failed to provide supervision to 2 residents (Residents #80 and #74) with known behavioral symptoms to prevent the physical assault, unwanted physical contact, and/or unwanted advancements into the personal space of cognitively impaired residents (Residents #8, #17, #35, #37, #41, #64, #81, and #82). This was for 2 of 3 residents reviewed for resident to resident altercations. Immediate Jeopardy began for Resident #74 on 8/19/20 when she approached Resident #17 from behind and "attacked" her by striking her multiple times in the arm. Immediate Jeopardy began for Resident #80 on 3/26/21 when he attempted to grab Resident #37's genital area. Immediate Jeopardy for Residents #74 and #80 was removed on 6/5/21 when the facility provided and implemented an acceptable credible allegation of	F 689	F689 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #80 and Resident #74 with	7/2/21

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F 689	Continued From page 58 Immediate Jeopardy Removal. The facility will remain out of compliance at a lower scope and severity level E (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to correct the deficient practice and to ensure that the education and the systems put in place to remove the Immediate Jeopardy are effective. The findings included: 1. Resident #80 was admitted to the facility on 3/3/21 with diagnoses that included Traumatic Brain Injury (TBI) and dementia. The facility's status listing indicated Resident #80 resided on the secured memory care unit (400 hall) at the time of admission. On 3/3/21 a care plan was initiated for "Wandering: unsafe situations". The goal was for wandering not to contribute to injury. The following interventions were initiated on 3/3/21: - Place resident in area where frequent observation is possible - Provide diversional activities - Place monitoring device on resident that sounds alarms when resident leaves building - Note which exits resident favors for elopement from facility and alert staff working near those areas - Monitor and document target behaviors - Implement facility protocol for locating an eloped resident - If wandering away from unit, instruct staff to stay with resident, converse and gently persuade to walk back to designated area with them - Approach wandering resident in a positive, calm, and accepting manner	F 689	known behavioral symptoms to prevent the physical assault, unwanted physical contact, and/or unwanted advancements into the personal space of cognitively impaired residents. (Residents #8, #35, #37, #41, #64, #81, and #82) Resident #80 no longer resides in the facility. Resident #74 no longer resides in the facility. Resident #81 no longer resides in the facility. Resident #82 no longer resides in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: Because all residents are at risk when the facility fails to supervise residents with behaviors, the following plan has been formulated to address this issue: Effective 6/4/2021, all staff was educated by the Director of Nursing on managing resident behaviors and prevention of resident-to-resident altercations. This will include identifying contributing factors such as situationally, physical environment, staff, and organizational factors. An emphasis will be placed upon ensuring supervision of residents to aid in preventing physical assault, unwanted physical contact, and unwanted advancements into the personal space of cognitively impaired residents. On 6/4/2021, the facility reviewed the behavioral management policy to ensure it included strategies to manage residents' behaviors toward others. Also, crisis	

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F 689	Continued From page 59 - Alert staff to wandering behavior The quarterly Minimum Data Set (MDS) assessment dated 3/10/21 indicated Resident #80 ' s cognition was severely impaired. He was assessed with no behaviors, no rejection of care, and no wandering. Resident #80 required extensive assistance of 2 or more for bed mobility and transfers and the extensive assistance of 1 for locomotion on/off the unit. He utilized a wheelchair and had impairment with range of motion on 1 side of his upper and lower extremities. Resident #80 was administered no psychotropic medications. The Medication Administration Record (MAR) indicated Resident #80 refused routine medications on 3/15/21. A nursing note dated 3/15/21 at 1:56 PM by Nurse #1 indicated Resident #80 grabbed Resident #64 by the wrist. When staff attempted to remove Resident #80's hand from Resident #64 he became combative and started swinging at staff member and trying to get back to the resident who had been moved away. The Physician's Assistant (PA) advised to give as needed (PRN) Ativan (antianxiety medication) and continue to monitor. Nurse #1 wrote that she spoke with Resident #80 ' s Responsible Party (RP) and she was advised that Resident #80 had a history of elopement and exit seeking. He also had a history of sexual behaviors and aggression toward others. The RP was made aware of the incident with Resident #64. (Resident #64's 2/9/21 MDS indicated she had severe cognitive impairment and no behavioral symptoms.) A physician's order for Resident #80 dated	F 689	management resources were discussed to include tele-health services with facility provider, mobile crisis response team, , local inpatient and outpatient psychiatric support services and contacting local ombudsman for further guidance with resources. The education will be communicated verbally and telephonically by the Executive Director, Director of Nursing and Assistant Director of Nursing/Staff Development coordinator. Written education will be available for review prior to the staff member working their assigned shift. Assistant Director of Nursing will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. Education will also be included during orientation for newly hired staff. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 6/4/2021, the Senior Clinical Consultant will provide the Admissions Director, Administrator, and Director of Nursing on the facility Memory Care/ Secured Unit Admission/Discharge policy including staffing unit based upon guidance outlined in the facility Alzheimer's/Dementia Care Unit Guidelines. This education was completed on 6/4/2021. Effective 6/4/2021, the Senior Clinical Consultant educated the facility Social Worker, Director of Nursing and Administrator of process to follow when a resident needs psych services but unable related to insurance denial and/o	

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F 689	Continued From page 60 3/15/21 indicated a PRN order for Ativan Intramuscular (IM) 2 milligrams (mg)/milliliter (ml) vial administer 0.25 ml (0.5 mg) IM every 6 hours PRN for agitation. This order had a discontinue date of 3/16/21. Review of the MAR indicated that was administered 1 time on 3/15/21 and was noted to be effective. During a phone interview with Nurse #1 on 6/3/21 at 3:30 PM she revealed Resident #80 resided on the secured memory care unit (400 hall) and that on 3/15/21 he grabbed Resident #64 by the wrist and was holding really tight. She stated that this was inappropriate contact and was unwanted by the other resident. When attempting to redirect Resident #80 and asking him to let go of Resident #64 he became violent, agitated, and combative. Nurse #1 revealed that Resident #80 then visibly held Resident #64 ' s wrist tighter. Nurse #1 stated that she was able to redirect Resident #80 eventually and she contacted the PA and received an order for PRN Ativan. She indicated she also spoke with his RP and the Director of Nursing (DON) to inform of this incident. Nurse #1 stated Resident #80 frequently wandered in other resident rooms by self-propelling his wheelchair. She reported that he moved quickly in his wheelchair throughout the unit. Nurse #1 revealed that prior to this incident she was informed by other nursing staff, unable to recall whom, of Resident #80's inappropriate physical contact with female residents such as rubbing female residents' thighs and holding their hands. On 3/15/21 a care plan was initiated for Resident #80 related to socially inappropriate, disruptive behavior, combative, grabbing staff, grabbing residents, and a history of sexual behaviors. The goal was for Resident #80 to have no more than	F 689	family refusal. If a resident needs psychiatric services and insurance denies, the facility should request the psych provider to bill the facility for services rendered. Additionally, if a resident and/or responsible party refused psych services after orders by the physician, the facility will coordinate a care plan meeting with the local ombudsman office to mediate. If the resident is displaying aggressive behaviors towards others, the resident will be monitored closely which will include 1 to 1 observation if the resident continues to have behaviors. If the resident continues to have aggressive behaviors despite interventions, the facility will issue an immediate notice of discharge. Effective 6/4/2021, the facility Social Worker and Director of Nursing will review clinical notes for the past 30 days for current memory care residents to identify any further residents with documented physical and sexual behaviors to ensure behavioral interventions including psych service referral (as applicable) and non-pharmacological interventions. This review was completed on 6/4/2021. Effective 6/5/2021, the facility has allocated full-time employee (activity assistant) designated to the memory care unit in order to increase activities for memory care residents to mediate any behaviors (as applicable). Effective 6/5/2021, the facility Interdisciplinary team will monitor residents with behaviors in daily clinical	

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F 689	Continued From page 61 1 episode of inappropriate and/or combative behaviors through the next review period (6/20/21). The interventions, all initiated on 3/15/21, read: - Talk in calm voice when behavior is disruptive - Refer to Social Services for evaluation - Remove from public area when behavior is disruptive and unacceptable - Do not argue with resident - Administer behavior medications as ordered by physician - Provide diversional activities A care plan was also initiated for Resident #80 on 3/15/21 related to physically aggressive behaviors. The goal was for episodes of physically aggressive behaviors to decrease by 50% within specified timeframe (6/25/21). The interventions, all initiated on 3/15/21, read: - Do not argue with resident - Talk in calm voice when behavior is disruptive - Refer to Social Services for evaluation - Reinforce unacceptability of verbal abuse - Remove from public area when behavior is disruptive and unacceptable - Praise for demonstrating desired behavior - Monitor and document target behaviors - Identify causes for behavior and reduce factors that may provoke aggressive behaviors - Discuss options for appropriate channeling of anger - Assist in selection of appropriate coping mechanisms - Administer behavior medications as ordered by physician - Provide diversional activities A nursing note dated 3/18/21 at 1:46 PM	F 689	meeting. Targeted behaviors and interventions will be discussed with input from the physician and resident responsible party. Care plan will be reviewed, and interventions modified (as applicable). On 6/4/2021, the facility reviewed the behavioral management policy to ensure it included strategies to manage residents' behaviors toward others. Also, crisis management resources were discussed to include tele-health services with facility provider, mobile crisis response team, local inpatient and outpatient psychiatric support services and contacting local ombudsman for further guidance with resources. The education will be communicated verbally and telephonically by the Executive Director, Director of Nursing. Written education will be available for review prior to the staff member working their assigned shift. DON or designee will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. Education will also be included during orientation for newly hired staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 6/5/2021, the facility Administrator, Director of Nursing, Social Worker and Charge Nurse will perform facility tours (including off shifts and weekends) throughout the facility to observe for any residents with behaviors	

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F 689	Continued From page 62 completed by Unit Manager (UM) #1 indicated Resident #80 became agitated with the Nursing Assistant (NA) when he was attempting to go into another resident's room. Resident #80 began yelling and she (UM #1) intervened and determined the resident wanted to lay down in his bed. He was noted to be easily redirected. The MAR indicated Resident #80 refused routine medications on 3/18/21, 3/19/21, 3/20/21, 3/21/21, 3/22/21, and 3/23/21. A nursing note for Resident #80 for 3/23/21 (entered as a late entry note on 3/25/21 at 4:44 AM) completed by Nurse #2 indicated that Resident #80 was extremely combative, uncooperative, verbally aggressive, and was refusing medication. The physician on call was notified and made aware of behaviors and new orders were received. A physician's order dated 3/24/21 for Resident #80 indicated Ativan IM 2 mg/ml vial 1 mg IM once. The MAR indicated that this was administered 1 time on 3/24/21 at 2:11 AM and was noted to be effective. The MAR indicated Resident #80 refused routine medications on 3/24/21. A nursing note dated 3/25/21 at 4:51 AM by Nurse #2 indicated Resident #80 continued to have episodes of extreme combativeness, was refusing medications, and would not allow staff to assist him. He had to constantly be redirected out of other residents ' rooms and when staff attempted to remove him he began to swing at staff. Nurse #2 wrote that staff would continue to attempt to redirect Resident #80 and continue to	F 689	which would need additional interventions. Additionally, the Administrator and Director of Nursing will monitor staffing levels in the facility to ensure adequate staff to provide supervision to residents to prevent physical assault, unwanted physical contact, and unwanted advancements into the personal space of cognitively impaired residents. The Facility Administrator, Director of Nursing and/or Social Worker will complete a summary of result and present the results of these observations at Monthly Quality Assurance Meeting x3 for further problem resolution if needed. Completion Date: July 2, 2021	

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monitor behaviors.

The MAR indicated Resident #80 refused routine medications on 3/25/21 and 3/26/21.

A nursing note dated 3/26/21 at 10:10 PM completed by UM #1 read, "Resident [#80] noted with inappropriate sexual behaviors - Resident observed in another residents room, resident pulled the blanket off of a resident that was resting in her bed and attempted to grab her genital area ...". UM #1 wrote that staff intervened and removed Resident #80 from the other resident (Resident #37) and he was assisted to common area. UM #1 further wrote that Resident #80 soon left common area and began going in and out of other resident rooms again. She indicated that staff attempted to monitor frequently and keep Resident #80 away from female residents as he was "often observed rubbing others legs and other unwanted physical contact." (Resident #37 ' s 1/14/21 MDS indicated she had severe cognitive impairment and no behavioral symptoms.)

An interview was conducted with UM #1 on 6/3/21 at 2:00 PM. UM #1 revealed that on 3/26/21 she observed Resident #80 in Resident #37's room. She indicated Resident #37 was sleeping and Resident #80 had pulled down her covers and his hand was about 6 inches away from her brief and she believed he was reaching down to touch her in the genital area, but she was able to intervene in time to prevent this. UM #1 stated that after this incident she and the two NAs, unable to recall names, who were working kept a close eye on him the rest of the shift. She stated that she was aware Resident #80 had previously exhibited combative behaviors and sexually inappropriate

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F 689	Continued From page 64	F 689		

behaviors that included rubbing females ' thighs and holding their hands. She stated that to her recollection these behaviors began occurring within a week of his admission (3/3/21).

The MAR indicated Resident #80 refused routine medications on 3/27/21, 3/28/21, and 3/29/21.

A physician's order dated 3/29/21 indicated Ativan 2 mg/ml administer 0.25 ml (0.5 mg) 3 times daily 9:00 AM, 5:00 PM, 9:00 PM). The first scheduled administration on the MAR was 3/29/21 at 5:00 PM. The MAR revealed that Resident #80 refused IM Ativan on 3/29/21.

A nursing note for Resident #80 for 3/29/21 (entered as a late entry note on 3/30/21 at 1:58 PM) completed by Nurse #3 indicated she was called to the memory care unit by NA #1 at 7:00 PM. Resident #80 had been found in the doorway of Resident #8's room. Resident #80 was bleeding and Resident #8 was on the floor out of bed with her shirt ripped and her left arm out of shirt. Resident #80 stated to NA #1 "this [b***h] scratched me and bit my finger". Resident #80 was assessed and had skin tears to his right forearm which were treated. Nurse #3 wrote that when asking Resident #80 if he pulled Resident #8 out of bed he stated, "I may have done that". The DON was contacted immediately and notified of incident. Resident #80 was later noted in another resident ' s room by NA #1. NA #1 reported Resident #80 had a female resident (Resident #35) by the leg and when she attempted to redirect him he threw a trash can at her. Nurse #3 indicated that later that day when she returned to the secured unit Resident #80 was in another female resident ' s room (Resident #81) and he was again redirected. Resident #80

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was placed with a one to one (1:1) sitter for the 3rd shift. Physician and RP were made aware. (Resident #8's 3/3/21 MDS indicated she had severe cognitive impairment and no behavioral symptoms. Resident #35 ' s 2/2/21 MDS indicated she had severe cognitive impairment and no behavioral symptoms. Resident #81's 4/4/21 MDS indicated she had severe cognitive impairment and no behavioral symptoms.)

A nursing note for Resident #8 for 3/29/21 (entered as a late entry note on 3/30/21 at 1:58 PM) completed by Nurse #3 indicated she was called to Resident #8's room by NA #1 and Resident #8 was on the floor beside her roommate ' s bed with her head at the foot of the roommate's bed. Another resident (Resident #80) was in Resident #8's doorway. Resident #8's shirt was ripped and her left arm was noted to be out of the shirt. Resident #8 was assessed with no injuries. Nurse #3 indicated that she immediately contacted the DON to make aware of incident and the physician and RP were notified.

A facility fall report completed by Nurse #3 indicated on 3/29/21 at 7:00 PM Resident #8 was noted on the floor beside the bed. Another resident (Resident #80) was noted pulling on Resident #8's arm. Resident #8 scratched Resident #80's arm.

The following hard copy statements were completed in relation to incidents with Resident #80 that occurred on 3/29/21:

- A hard copy typed statement signed by the DON and dated 3/30/21 indicated that she spoke with Resident #80 and Resident #8 due to the incident

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report on 3/29/21. Resident #80 stated that he had not remembered any incident that happened on 3/29/21. Resident #8 was not oriented enough to answer if something had happened on 3/29/21. The DON wrote that she interviewed staff to see if the 3/29/21 incident with Resident #80 and #8 was witnessed and staff stated that it was not witnessed, but was an assumption due to Resident #80 sitting in his wheelchair in Resident #8 ' s doorway.

- A hard copy typed statement signed by NA #1 (undated) indicated she was working on the memory care unit (400 hall) on the night of 3/29/21 when she heard Resident #35 screaming. NA #1 wrote that she went to Resident #35's room and saw him holding her legs and starting to pull her out of bed. When Resident #80 was redirected from Resident #35 he threw a trash can at NA #1 and then attempted to hit her with his fists. NA #1 revealed, "[Resident #80] is very combative and dangerous to the women in this facility. He is constantly in and out of female resident rooms".
- A hard copy written statement signed by Nurse #3 on 3/29/21 indicated NA #1 observed Resident #80 in Resident #35 's room pulling on her leg. Resident #80 was later noted in another female resident ' s room, Resident #81. Resident #80 was removed from Resident #81's room. Nurse #3 wrote that all information was reported to the DON and Resident #80 was put with a 1:1 sitter on the 3rd shift.
- A hard copy typed statement signed by the SW and dated 3/30/21 indicated that on 3/30/21 she received information from the DON and Administrator of the incidents that occurred with perpetrator Resident #80 and victims Resident #8 and #35. Resident #80 reported no memory of the incidents and the victims, Resident #8 and

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#35, were unable to provide any information on the incident. SW interviewed NA #1, the NA who was working at the time of the incidents, and she reported that Resident #80 was seen coming out of Resident #8's room saying, "that b***h scratched me". NA #1 stated that Resident #8 was found on the floor with head positioned by roommate's bed. Resident #8 had no visible injuries or signs of pain per NA #1. Resident #80 had sustained a scratch on his forearm. The SW wrote that later that day Resident #80 was found in Resident #35's room pulling on her ankles and Resident #35 was stating, "get that man out of my room". The SW indicated that she was instructed by the Administrator to initiate an IVC on Resident #80 as he was a threat to other residents. The IVC order was denied by the county Magistrate's Office and a referral was then given to mobile crisis. SW contacted mobile crisis, but staff declined to proceed with mental health evaluation due to COVID-19 testing protocols at the facility. The DON contacted the Medical Director and Resident #80 was moved from the memory care unit (400 hall) to another unit in the facility (200 hall).

During an interview with Nurse #3 on 6/3/21 at 1:30 PM she confirmed the information in her documentation and hard copy statement. She indicated that there were 2 NAs working in the secured unit on the 2nd shift on 3/29/21 and she was working a split hall with the secured unit (400 hall) and the 300 hall. She explained that when she was on the 300 hall she was not able to see into the hallway of the secured unit as it was around the corner from the 300 hall. Nurse #3 further explained that she had not witnessed Resident #80 pull Resident #8 out of bed as she was administering medications on the 300 hall at

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the time of the incident, but when she was called over by NA #1 it seemed obvious that Resident #80 pulled Resident #8 out of bed and ripped her shirt as the shirt was previously intact. She added that Resident #8 had scratched Resident #80 in what appeared to be self-defense. Nurse #3 stated that on 3/29/21 after the incident with Resident #8, Resident #80 was placed on 15 minute observations. She indicated that sometime after that, unsure of the time, Resident #80 was found in Resident #35's room holding her leg, and then again later that shift he was found in Resident #81's room. She was asked why Resident #80 was not placed on 1:1 during the second shift she stated that there was not enough staff to assign someone to Resident #80 for 1:1 until the 3rd shift.

During an interview with NA #1 on 6/3/21 at 4:18 PM she stated that she regularly worked with Resident #80 when he was at the facility and that it was known by all staff who worked on the secured unit that he regularly wandered in and out of other resident rooms and frequently was seen with his hands rubbing female residents' legs or holding their hands. She reported that they tried to redirect him the best they could. She confirmed she was working on 3/29/21 during the 2nd shift. She stated that she was working with one other NA (unable to recall the NA) and Nurse #3 was split with the secured memory care unit (400) and the 300 hall. She indicated that during that shift she heard Resident #8 yelling out. She stated that this was a normal behavior for Resident #8 so initially she had not reacted. She indicated that Resident #8 kept yelling and that at some point the yelling sounding "different" indicating that it sounded like she was in distress so that's when she went over to her room and

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found Resident #8 laying on the floor with Resident #80 seated in his wheelchair in the doorway. Resident #80 said to her, "I got her, I got her" and he held out his arm and showed her the scratches he had on his arm. She indicated that Resident #8 stopped yelling as soon as she saw her come to the room. She stated that Resident #8's shirt was ripped and one arm was out of the sleeve to the shirt and it was bunched up to her neck. NA #1 indicated that she had not known how long Resident #80 was in the room with Resident #8 because she was providing care to another resident and initially had not responded to the yelling because this was her baseline behavior. She reported that the other NA was in a different resident ' s room. She stated the other NA had not even come to Resident #8's room when she was yelling as she was in the middle of care. She confirmed Resident #80 had another incident that same night in which she found him in Resident #35's room grabbing her leg and holding it out off of the bed. She had not recalled Resident #80 being found in Resident #81 ' s room on 3/29/21 as was indicated by Nurse #3's interview and nursing note. NA #1 reported that Resident #80 was placed on 15 minute observations for the remainder of the 2nd shift and was then on 1:1 during the 3rd shift. She stated that there was not enough staff to assign someone for 1:1 during the 2nd shift. She revealed that there were times during the shift that she and the other NA were both in rooms with other residents providing care and Nurse #3 was on the 300 hall and no one was supervising Resident #80.

The Resident Status History List indicated that Resident #80 was moved off the memory care unit (400 hall) on 3/30/21.

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The MAR indicated Resident #80 refused routine medications on 3/30/21. These medications included routine IM Ativan.

A note dated 3/30/21 at 10:10 PM completed by the Social Worker (SW) read, "On 3/15/21 [Resident #80] is agitated and threw cup of water at staff, holding another resident's wrist, swinging and combative at staff. On 3/18/21 [Resident #80] is agitated with staff. Resident has [history] of sexual behaviors and aggression towards others. On 03/18/21 [Resident #80] is agitated with staff, attempting to enter another resident's room. On 03/25/21 [Resident #80] is combative with staff and attempting to go in another resident's room.

A note dated 3/30/21 at 10:54 PM completed by the SW indicated that on 3/26/21 Resident #80 grabbed another female resident's genital area and was rubbing her legs and on 3/30/21 Resident #80 entered another female resident's room and was holding her legs. Staff intervened and Resident #80 threw a trash can at staff. The SW wrote that she made a prior psychiatry referral with nursing facility ' s psychiatric provider, but Resident #80 ' s insurance had not covered this service. SW indicated she made referral for Involuntary Commitment (IVC) at the magistrate ' s office on 3/30/21 for immediate in-patient psychiatry services, but the magistrate ' s office denied IVC. SW then made referral for mobile crisis assessment, but mobile crisis staff declined to follow up with resident via face to face due to nursing home protocols for rapid COVID testing and they also declined virtual assessment due to their lack of virtual service capabilities. SW consulted with DON and administrator regarding care plan for psychiatry follow up. DON contacted

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on call facility physician and resident was transferred to another hall with behavioral monitoring.

An interview was conducted with the SW on 6/3/21 at 12:54 PM. She stated that the information in her 3/30/21 notes came from nursing notes and staff report and that she had not observed any of these behaviors. She indicated that she was aware Resident #80 had physical behaviors and verbal behaviors directed toward staff, but she had not been aware of his inappropriate sexual behaviors until 3/29/21. She explained that on Monday 3/29/21 she learned about the incident that occurred on Friday 3/26/21 in which Resident #80 was observed attempting to touch Resident #37 ' s genital area. The SW stated that on 3/30/21 she was informed of the incidents that occurred with perpetrator Resident #80 and victims Resident #8 and Resident #35 on 3/29/21. The SW indicated that she tried to get Resident #80 psychiatric services with the facility ' s provider, but they denied him services due to insurance reasons. She stated that she was instructed by the Administrator and DON to make a referral for an IVC, but that this was denied by the magistrate (3/30/21). She indicated that she then contacted mobile crisis to see if they would complete an emergency assessment, but they declined to come to the facility for a face to face visit as the facility was requiring all persons who came into the facility to be rapid tested for COVID-19 prior to entrance. She reported that mobile crisis also refused to complete a virtual visit stating that they had not had the capabilities to do this. The SW stated that mobile crisis suggested that she speak with the facility ' s physician and have them file for an IVC. She reported that this was when she spoke with the

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PA and he agreed to file for an IVC for Resident #80.

A PA note dated 3/31/21 indicated an acute visit was conducted with Resident #80 (entered as a late entry note on 4/5/21 at 3:06 PM). The PA wrote that Resident #80 had "assaulted several staff and residents" at the facility and he was signing for an IVC to a more secure setting. The PA indicated that he was notified by the nursing staff that Resident #80 had, over the past five days, been combative and uncooperative and was not taking his medications. He's also been "going into other residents' rooms, females and groping them in a sexual manner. This has been going on for several days." The PA revealed that on this date, 3/31/21, staff told him that on the third shift, he went into a female resident ' s room, pulled her out of her bed, was groping her genital area, and rubbing her legs. When this behavior was discovered and Resident #80 was confronted by the staff he threw a trash can at the staff. The PA indicated that efforts were made to have a psychiatric evaluation but unfortunately his insurance had not covered that type of consultation. He indicated that an involuntary commitment request was made at the Magistrate's Office and they refused to issue the involuntary commitment. He further wrote that on his examination of Resident #80 on this date (3/31/21) the resident was sitting in his room eating his lunch. When asked about these recent behaviors he denied any of these incidents / behaviors. Resident #80 had been moved out of the secured memory care unit and into another hallway for "fear of any further harm to the memory care patients". He indicated that Resident #80 had been refusing to take his medications over the last 5 days and along with

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the above mentioned behaviors, there were other reported incidents including cursing and slurs at the staff, swinging, and attempting to assault the staff members and other residents. Resident #80 was noted to be confined to a wheelchair and hemiplegic (weakness of one side of the body) on his non-dominant side, but he had full range of motion with his dominant upper extremity and was able to propel himself in his wheelchair. The PA indicated that he was a large male and his general strength was fairly well preserved in his upper body and lower body on his dominant side. He further indicated that Resident #80 had been "causing issues with the other older, weaker and demented patients in the memory care unit". He wrote that an attempt of trial Ativan IM was to be conducted to see if this would help with his behaviors, but that the DON asked that an involuntary commitment form be completed on Resident #80 to transfer him out of this facility.

A phone interview with the PA on 6/3/21 at 2:42 PM confirmed the information in the above note. He stated that the behavioral information was reported to him by nursing staff. He indicated that he also spoke with the DON. The PA revealed that in his opinion, Resident #80 was cognitive enough to be aware of his actions and that he also was aware enough to deny it. He acknowledged that Resident #80 physically assaulted Resident #8 and that he made unwanted sexual advances towards multiple female residents. The PA was asked if he was aware Resident #80 had 2 more incidents of being found in female resident rooms on the same night as of incident with Resident #8 (3/29/21). He indicated he was not aware there were multiple incidents on the same night. He was asked if expected staff to provide the

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supervision necessary to prevent repeat incidents for residents with known behaviors and to keep other residents safe and free of physical assault, unwanted advancements, and inappropriate sexual behaviors he indicated that this was his expectation. He stated that Resident #80 was "abusing the residents" and throwing things and swinging at staff and that they could not have him "hurting people" at the facility so Resident #80 had to be sent out in order to receive a psychiatric evaluation. The PA explained that he wanted Resident #80 to have a psychiatric evaluation as this was their area of expertise. He stated that he was told by facility staff that due to insurance reasons Resident #80 was unable to see the facility ' s psychiatric provider. The PA reported that these reasons as well as the DON ' s request was the reason he filed for an IVC of Resident #80.

During a phone interview with Former Administrator #1 on 6/4/21 at 8:30 AM he stated that during Resident #80 ' s time at the facility he was regularly wandering in and out of residents ' rooms and was "taking liberties" with female residents as evidenced by trying to "put his hands on the women" on the memory care unit. He indicated that Resident #80 required 1:1 care to prevent reoccurrences of behavioral issues and that the facility was limited with staffing and were not able to provide 1:1 staffing all the time. Former Administrator #1 indicated that this was why an IVC was completed by the PA for Resident #80. He stated that the hospital notified the facility when Resident #80 was stable and they wanted to discharge him back to the facility, but he was not accepted back as he felt they were unable to provide the 1:1 care that would have been necessary to protect the other

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residents at the facility.

During an interview with the DON on 6/3/21 at 3:30 PM she stated that when Resident #80 was admitted to the facility (3/3/21) she was aware that he had a TBI, was diagnosed with dementia, and had wandering behaviors. She indicated that prior to his admission she was hesitant to accept him as a resident at the facility as resident ' s who suffered a TBI could be unpredictable and volatile. She reported that ultimately it was a corporate decision for Resident #80 to be admitted. She stated that she became aware of Resident #80 ' s combative behaviors after the 3/16/21 incident in which he was holding Resident #64 by the wrist, but she had not been aware of his inappropriate sexual behaviors until 3/29/21. She explained that on Monday 3/29/21 she learned about the incident that occurred on Friday 3/26/21 in which Resident #80 was observed attempting to touch Resident #37 ' s genital area. She further explained that staff had not reported to her Resident #80 ' s behavior of frequently rubbing females ' thighs and hand holding. The DON reported that had she known of this frequent behavior she would ' ve considered moving him off of the secured memory care unit and into a private room on a less populated hall to prevent any further inappropriate physical contact/sexual behaviors being enacted by Resident #80 on cognitively impaired female residents. She indicated that on 3/29/21 after the incident with Resident #8 being found on the floor with Resident #80 in her room, Resident #80 was placed on 15 minute observations. She reported that on the 3rd shift he was placed on 1:1 and on the following day he was moved to the 200 hall and an IVC by the SW was attempted and was refused. When asked why he had not

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been placed on 1:1 during the second shift after the incident with Resident #8 on 3/29/21 she revealed that there was not enough staff to put him 1:1 for the remainder of that shift. She acknowledged that the necessary supervision had not been provided to prevent Resident #80 from enacting any further physical and/or sexual advances from occurring. She verified Resident #80 was IVC by the PA on 3/31/21. She revealed that the hospital Resident #80 was sent to on 3/31/21 contacted them when he was stabilized as they wanted to send him back to the facility, but the facility refused to take him back.

A phone interview was conducted with the Medical Director on 6/4/21 at 4:20 PM. He stated that he was not very familiar with Resident #80 as he only had 1 visit with him. He indicate that his expectation was for residents at the facility to be protected from harm, from unwanted advancements into their personal space, and from sexually inappropriate behaviors. He further indicated that the facility needed to be able to provide the necessary care and the level of supervision required to meet the needs of all residents who were admitted.

2. Resident #74 was admitted to the facility on 1/19/19 with multiple diagnoses that included dementia with behavioral disturbance.

A significant change Minimum Data Set (MDS) assessment dated 7/6/20 indicated Resident #74 ' s cognition was severely impaired. She had no behavioral symptoms, but she had rejected care and wandered on 1 to 3 days during the MDS

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review period. She required the extensive assistance of 2 or more with bed mobility and was dependent on 2 or more with transfers. Resident #74 required limited assistance of 1 for walking in room and locomotion on the unit. She utilized a wheelchair and had no impairment with range of motion. Resident #74 was administered antipsychotic medication and antidepressant medication on 7 of 7 days.

A nursing note dated 7/9/20 at 8:48 PM completed by Nurse #3 indicated the Nursing Assistant (NA) reported at 7:10 PM that she witnessed Resident #74 hit another resident (resident not named) in the upper arm four times in the hallway of the secured memory care unit. Residents were separated and assessed with no injuries noted. The Administrator was made aware and new orders were received from the Physician ' s Assistant (PA) to obtain a Urine Analysis Culture and Sensitivity (UA C&S). Resident #74 was placed on every (q) 15 minute checks for 72 hours.

During an interview with Nurse #3 on 6/4/21 at 10:23 AM the 7/9/20 note she completed was reviewed. Nurse #3 stated she was unable to recall who the other resident was from the 7/9/20 incident with Resident #74. She also was unable to recall who the NA was that reported it to her. She stated that she had not recalled Resident #74 having had any physical altercations with other residents prior to this incident. She indicated that Resident #74 regularly self-propelled herself by wheelchair throughout the secured memory care unit (400 hall). Nurse #3 stated that she believed Resident #74 hit the other resident to get them out of her way on 7/9/20. She explained that Resident #74 was

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primarily non-verbal and she talked with her hands a lot.

A Social Worker (SW) note dated 7/10/20 at 12:07 PM indicated she assessed Resident #74 ' s behavior and mood after altercation with another resident that occurred on 7/9/20. Resident #74 was noted to be doing well with no signs or symptoms of distress or further behavioral concerns. She was not interviewable due to confusion and inability to provide appropriate responses to questions. Her Responsible Party (RP) continued to decline psychiatry services and wished for the facility physician to provide care and monitor behaviors due to her diagnosis of dementia. SW reviewed and updated resident's care plan. No further concerns presented.

On 7/10/20 a care plan was initiated for Resident #74 related to physically aggressive behaviors. The goal was for episodes of physically aggressive behaviors to decrease by 50% within specified timeframe (10/10/20). The interventions initiated on 7/10/20 were as follows:
- Do not argue with resident
- Talk in calm voice when behavior is disruptive
- Refer to Social Services for evaluation
- Reinforce unacceptability of verbal abuse
- Remove from public area when behavior is disruptive and unacceptable
- Praise for demonstrating desired behavior
- Monitor and document target behaviors
- Identify causes for behavior and reduce factors that may provoke aggressive behaviors
- Discuss options for appropriate channeling of anger
- Assist in selection of appropriate coping mechanisms

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F 689	Continued From page 79 - Administer behavior medications as ordered by physician - Provide diversional activities - Urine analysis - Medication evaluation A nursing note dated 7/10/20 at 9:40 PM completed by Nurse #3 indicated Resident #74 was on 15 minute checks. Her UA C&S returned and was negative. The PA ordered Depakote (anticonvulsant with an off label use for impulsivity and aggression). Resident #74 remained on q15 minute checks. Physician ' s orders dated 7/10/20 for Resident #74 indicated Depakote 125 milligrams (mg) twice daily and as needed (PRN) Ativan (antianxiety medication) 0.5 mg once every 6 hours. A nursing note dated 7/11/20 at 7:07 PM by Nurse #3 indicated Resident #74 voiced wanting to see her "people". Nurse #3 indicated she contacted her RP and a family member came to the facility for a window visit. Resident #74 was noted with an increase in behaviors and exit seeking, but her mood was noticeably improved after seeing family. The Medication Administration Record (MAR) indicated PRN Ativan was administered to Resident #74 on 7/12/20 related to the behavior of disruptive sounds. A nursing note dated 7/12/20 at 2:10 PM indicated Resident #74 was administered PRN Ativan early that morning as she appeared agitated, but this had since resolved.	F 689		

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The MAR indicated PRN Ativan was administered to Resident #74 on 7/13/20 for the behavior of grabbing and 7/14/20
for the behaviors of hitting and screaming.

A nursing note dated 7/14/20 indicated Resident #74 was heard yelling and crying and upon seeing the nurse Resident #74 began reaching out. The nurse indicated positive reassurance was provided. She wrote that the NA reported that Resident #74 was easily agitated that morning, crying, or hitting at them when they were trying to do care. PRN Ativan was noted to be administered.

An Interdisciplinary Team (IDT) note dated 7/14/20 indicated the 7/9/20 resident to resident altercation in which Resident #74 was observed striking another resident 4 times in the upper arm was reviewed. There were no injuries as a result of the incident. A UA was obtained which was negative and a medical evaluation was completed by the PA with new orders for Depakote and PRN Ativan.

A review of nursing notes indicated q15 minute checks continued for Resident #74 through 7/14/20.

A facility investigation dated 7/15/20 of the 7/9/20 incident with Resident #74 ' s physical altercation with another resident was completed by Former Administrator #2. This investigation indicated that Resident #74 had been experiencing an exacerbation of her mental health issues over the last several weeks related to a COVID-19 diagnosis. She was noted with fluctuations in mood and at times was difficult to redirect or

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console. She was moved to several different rooms recently related to COVID-19 room changes and she had since returned to the secured memory care unit and was still adjusting to the change in environment. Resident #74 ' s medications were noted to be adjusted after the incident.

A nursing note dated 7/16/20 indicated Resident #74 was noted with increased anxiety and PRN Ativan was administered and noted to be effective.

A nursing note dated 7/19/20 indicated Resident #74 was noted to be calling out and tearful earlier that shift and PRN Ativan was given an was effective.

On 7/23/20 Resident #74 ' s PRN Ativan physician ' s order from 7/10/20 was discontinued. A new physician ' s order indicated PRN Ativan 0.5 mg every 6 hours PRN.

A PA note for a monthly visit conducted 7/23/20 at 8:50 AM (entered as a late entry note on 8/2/20) indicated that during the exam Resident #74 became slightly agitated. Nursing staff reported she had some mild agitation which was easily calmed.

The MAR indicated PRN Ativan was administered to Resident #74 on 8/3/20 at 8:01 PM for the behavior of rummaging and it was effective.

The MAR indicated PRN Ativan was administered to Resident #74 on 8/8/20 at 3:05 PM for the behavior of grabbing and screaming and it was effective.

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Resident #74 ' s behavior monitoring on the MAR indicated the following behaviors:
- 8/8/20 at 7:21 PM: grabbing, pacing, rummaging, and disruptive sounds
- 8/14/20 at 7:42 PM: grabbing
- 8/15/20 at 8:20 PM: grabbing

An IDT note dated 8/19/20 at 10:22 AM indicated staff were instructed to allow Resident #74 to self-propel herself on the unit when agitated while ensuring the safety of others.

A nursing note for Resident #74 completed by Nurse #5 dated 8/19/20 at 12:02 PM indicated that at 10:30 AM Resident #74 "attacked" Resident #17. Resident #17 was visiting with family at the end of the hallway at the door (window visit by way of exterior door with glass) when Resident #74 approached Resident #17 from behind and began striking her in the right arm. Resident #17 ' s family banged on the door when this was observed in order to alert Nurse #5. Nurse #5 wrote that when he was alerted he ran and separated them. He indicated that the incident was about 5 to 10 seconds. There were no injuries to either resident. The PA was notified of the incident and he ordered a one-time dose of Ativan 1 mg. Nurse #5 indicated the Ativan was effective and the resident had calmed. Resident was placed on 1 on 1 (1:1) observation with staff. (Resident #17 ' s 4/1/21 MDS indicated her cognition was severely impaired and she had no behavioral symptoms.)

A physician ' s order dated 8/19/20 indicated Ativan 2 mg/milliliter (ml) inject 1 mg Intramuscular (IM) one time for agitation. The MAR indicated this medication was administered as ordered.

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Nurse #5 was interviewed by phone on 6/4/21 at 10:36 AM and he confirmed the information in his 8/19/20 note. He stated that prior to incident he had noticed Resident #74 and #17 tended to "target" one another. He explained that there had been other times that he saw Resident #74 and #17 get close to each other and he intervened and redirected them as he was afraid of an altercation. He added that Resident #74 was unpredictable and her behaviors/mood could change quickly. He reported that he had not documented these instances that he separated the residents because nothing had occurred as he was able to intervene to prevent an altercation.

A hard copy typed statement dated 8/19/20 completed by the SW indicated that she spoke with Resident #17 ' s family member that had witnessed the resident to resident altercation. The family member stated that Resident #74 approached Resident #17 and started pulling her arm and began hitting her. She reported that Resident #17 had not been hurt, but she was scared. The family member wanted to know how the facility was going to protect Resident #17. The SW explained the process of reporting incidents to the state, separation, monitoring, and behavioral health evaluations. The family member requested that the SW speak to Resident #17 to ensure she was not anxious about the incident. The SW wrote that she spoke with Resident #17 and she was noted to be doing fine with no pain issues identified.

A hospital Emergency Department (ED) report dated 8/19/20 indicated Resident #74 was seen by the provider at 4:25 PM. The note stated that Resident #74 was brought in by the police from

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the facility with Involuntary Commitment (IVC) papers. She was noted to be on a secured unit and was sent to the ED because she got into an altercation with another resident. The note indicated that the facility also sent her there to have medication adjustments. Resident #74 was assessed with no aggressive behaviors and no psychiatric symptoms and she was to be sent back to the facility to follow up with her primary care physician for treatment of behavioral disturbances.

On 8/19/20 an intervention was added to Resident #74 ' s care plan related to the focus area of physically aggressive behaviors that read: "Referral to psych services due to resident's physical aggression towards another resident. Family declined psych services and requested for [primary care physician] to assess and monitor resident."

A nursing note dated 8/20/20 at 12:05 AM indicated Resident #74 returned from the hospital at 9:00 PM. She was placed on 1:1. The facility ' s status listing indicated Resident #74 was moved to the 300 hall upon return to the hospital related to quarantine for COVID-19.

A facility investigation, undated, of the 8/19/20 incident with Resident #74 ' s physical altercation with Resident #17 was completed by Former Administrator #2. This investigation indicated Resident #74 was self-propelling in the hallway as Resident #17 was participating in a window visit with family when Resident #74 struck her in the arm. Resident #74 was referred for a psychiatric consultation, but the RP refused psychiatric services. The facility then obtained an IVC referral for Resident #74 to have a psychiatric

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evaluation at the hospital. Resident #74 was evaluated at the hospital and was released back to the facility where she was placed on 1:1.

During a phone interview with Former Administrator #2 on 6/4/21 at 11:00 AM she stated that she completed the IVC on 8/19/20 because Resident #74 was a danger to Resident #17. She explained that prior to the incident she was experiencing behaviors that included "hitting other residents" and that she also seemed to be "fixated" on Resident #17. She further explained that right after the 8/19/20 incident, Resident #74 continued to "target" Resident #17 by following her around the secured memory care unit after they had been separated. Former Administrator #2 stated that there were no further altercations between the residents on 8/19/20 as they had increased the supervision and monitoring of Resident #74, but she felt that it was necessary for the safety of the facility residents to have Resident #74 evaluated by psychiatric services as they could not control her behaviors at the facility.

An interview was conducted with NA #2 on 6/4/21 at 3:40 PM. She stated that she was familiar with Resident #74 and she previously worked with her on the secured memory care unit. She indicated that Resident #74 had behaviors that included screaming, grabbing at staff, and shaking staff. She stated that there were times that there was nothing that could be done to console her or calm her down. NA #2 stated that it wasn ' t until July 2020 when her behaviors increased and she started to act out more. She indicated that she thought this was because other families were visiting by window and Resident #74 was missing her family and this made her mad or jealous. She explained that Resident #74 ' s family had

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visited regularly prior to the COVID-19 visitation restrictions and that they had not made regular window visits since the restrictions were in place. NA #2 spoke about the 8/19/20 incident in which Resident #74 hit Resident #17. She made similar statements as Nurse #5 and Former Administrator #2 stating that it had seemed like Resident #74 had been targeting Resident #17 and that it seemed like there was "something" between the 2 residents prior to the incident.

A physician ' s note dated 8/20/20 completed by the Medical Director (late entry note entered on 8/26/20 at 7:21 PM). The Medical Director indicated that he saw Resident #74 at the request of the facility Administrator for a recent episode of agitation with resident to resident altercation. He wrote that he personally was unaware of the details after the incident, but that apparently Resident #74 was transported to the hospital emergency room under an IVC order. Resident #74 was evaluated at the hospital with no acute medical conditions and she was transferred back to the facility. The Medical Director indicated Resident #74 was arousable from sleep, in no distress, and displaying no agitation. She had a 1:1 sitter. He reported that he was hesitant to give PRN medication due to the sedative effects of the PRN IM Ativan administered on 8/19/20 as well as the fact that PRN Ativan could have a counter effect of increasing agitation. He indicated he would not continue the PRN orders for Ativan and he instructed the nursing staff to notify him of any episodes of agitation. He wrote that he would then consider starting a new medication such as Seroquel for mood stabilization.

A physician ' s order dated 8/20/20 indicated a

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discontinuation of PRN Ativan for Resident #74.

Resident #74 ' s behavior monitoring on the MAR indicated she had the behavior of screaming on 8/23/20 at 8:30 AM.

A nursing note dated 8/23/20 at 12:19 PM indicated Resident #74 sat up on the side her bed yelling out and swinging her arms. The 1:1 sitter attempted to calm resident down without much success. Nurse went in to see what Resident #74 needed and she swung at nurse trying to hit in the face. Nurse contacted the Medical Director and received new orders for Seroquel (antipsychotic medication).

A physician ' s order dated 8/23/20 for Resident #74 indicated Seroquel (antipsychotic medication) 25 mg start date 8/23/20 and stop date 8/23/20. The MAR indicated Seroquel 25 mg was administered to Resident #74 one time on 8/23/20 at 9:00 PM.

A Medical Director note dated 8/23/20 (entered as a late entry note on 8/26/20) indicated he was informed by nursing staff that morning of Resident #74 ' s behaviors/agitation and he initiated a medication for limited timeframe in an effort to stabilize her mood. He indicated he would taper the medication upwards to avoid over sedation.

A care plan was initiated for Resident #73 on 8/23/20 related to socially inappropriate/disruptive behavior. The goal was for episodes of inappropriate and/or disruptive behaviors to decrease by 50% within specified timeframe (11/23/2020). The interventions, all initiated on 8/23/20, included the following:

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F 689	Continued From page 88 - Talk in calm voice when behavior is disruptive - Refer to Social Services for evaluation - Remove from public area when behavior is disruptive and unacceptable - Praise for demonstrating desired behavior - Monitor and document target behaviors - Elicit family input for best approach(es) to resident - Do not argue with resident - Discuss options for appropriate channeling of anger - Administer behavior medications as ordered by physician - Provide diversional activities A physician ' s order dated 8/24/20 for Resident #74 indicated Seroquel 50 mg in the morning and evening for 1 day. On 8/25/20 a new physician ' s order for Seroquel for Resident #74 indicated 50 mg twice daily for 14 days (stop date 9/8/20). A nursing note for Resident #74 for 8/28/20 (entered as a late entry not on 9/1/20 at 12:33 AM) indicated Resident #74 was changed from 1:1 to q15 minute checks. Resident #74 ' s behavior monitoring on the MAR indicated the following behaviors: - 8/29/20 at 8:08 AM: screaming - 8/31/20 at 6:16 PM: grabbing and disruptive sounds The facility ' s status listing indicated Resident #74 was moved back to the secured memory care unit (400 hall) on 9/2/20 as her quarantine period had ended.	F 689		

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Resident #74 ' s behavior monitoring on the MAR indicated the following behaviors:
- 9/5/20 at 8:06 A: grabbing
- 9/6/20 at 6:15 PM: grabbing

On 9/8/20 Resident #74 ' s 14 day Seroquel order from 8/25/20 was discontinued.

A nursing noted 9/9/20 at 3:42 AM indicated Resident #74 was yelling out multiple times during the beginning of the shift.

A nursing note dated 9/9/20 at 11:58 AM completed by Nurse #5 indicated that the NA reported at 11:40 AM that Resident #74 "rolled up behind another resident, [Resident #82], who was visiting with family at the door at the end of the hall, and began hitting her in top of the head." Nurse #5 indicated he was told it was random and unprovoked. No injuries were observed. (Resident #82 ' s 10/20/20 MDS indicated her cognition was severely impaired and she had no behavioral symptoms.)

On 9/9/20 an intervention was added to Resident #74 ' s care plan related to the focus area of physically aggressive behavioral care plan that read: "Provide activities to resident while other family members are visiting other residents".

A nursing note dated 9/9/20 at 2:58 PM indicated Resident #74 was placed on 1:1 for inappropriate behaviors.

An IDT note dated 9/9/20 at 4:02 PM indicated Resident #74 became excited and happy when she saw family visiting and she tended to approach the resident being visited. Resident #74 ' s speech was not understood most of the

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time and therefore she communicated with non-verbal gestures. The resident was noted with dementia and she had not known that the families visiting were not her family. Resident #74 enjoyed visitation with her family and she was noted to miss her family since they had not visited often. In this incident on 9/9/20 Resident #74 was very excited to see family visiting and wanted to approach them as she potentially thought it was her family.

A phone interview was conducted with NA #3 on 6/4/21 at 4:01 PM. She stated that she regularly worked with Resident #74 on the secured memory care unit. She indicated that when the COVID-19 visitation restrictions went into effect it seemed as if she became "sad" and "depressed" and she thought this was because she missed her family. She reported that her behaviors increased during this time and these behaviors included hitting and swinging at staff and at times she was physically aggressive toward other residents. NA #3 stated that she recalled the 8/19/20 incident when Resident #74 hit Resident #17 and the 9/9/20 incident when Resident #74 hit Resident #82. She indicated that she believed these incidents were situations where Resident #74 had wanted attention and both of these residents (Resident #17 and Resident #82) had been visiting with family at the time of the incidents.

Resident #74 ' s behavior monitoring on the MAR indicated the following behaviors:
- 9/12/20 at 8:30 AM: grabbing
- 9/13/20 at 8:37 AM: grabbing and screaming

A nursing note dated 9/13/20 at 11:21 AM indicated Resident #74 was noted yelling and

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shaking her hands in the air at staff. The resident was encouraged to calm down and use her words to communicate and Resident #74 was then able to state, "I am scared". The nurse wrote that Resident #74 was consoled and was then taken to the bathroom and laid down for a nap by the NA.

A nursing note dated 9/13/20 at 12:30 PM indicated Resident #74 ' s behaviors had improved while on the trial dose of Seroquel that was stopped on 9/8/20. Resident #74 ' s behaviors worsened since the medication was stopped and after discussing with the Medical Director and family the Seroquel was going to be restarted.

A physician ' s order dated 9/13/20 for Resident #74 indicated Seroquel 50 mg twice daily.

A nursing note dated 9/14/20 at 4:04 AM indicated Resident #74 was hollering out the beginning of the shift. She was gotten up and into wheelchair with staff ' s assistance. Resident #74 was then rolling up and down the hallway hollering out. She sat at the nurse ' s station and hollered out with no words spoken, just noises such as "ahhhhhh". Resident #74 later stated, "I wanna go to bed". She was assisted back to bed with no further issues.

Resident #74 ' s behavior monitoring on the MAR indicated the following behaviors:
- 9/19/20 at 8:46 AM: screaming
- 9/20/20 at 5:46 PM: hitting and grabbing
- 10/4/20 at 9:38 AM: disruptive sounds and screaming
- 10/10/20 at 1:01 PM: disruptive sounds and screaming

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- 10/10/20 at 6:16 PM: grabbing, disruptive sounds, and screaming
- 10/11/20 at 8:47 AM: screaming
- 10/11/20 at 9:08 PM: disruptive sounds and screaming

The nursing notes indicated Resident #74 remained on q15 minute checks through 10/12/20.

The facility ' s status listing indicated Resident #74 was moved off of the secured memory care unit to the 300 hall on 10/12/20.

During a phone interview with Former Administrator #2 on 6/4/21 at 11:00 AM she stated that Resident #74 was moved off of the secured memory care unit to decrease her stimulation and to avoid any further resident to resident altercations. She explained that there were a lot of window visits being held on this unit and because it had been identified that the potential for incident was greater when window visits were occurring that it was decided to move her off of the secured memory care unit to protect the residents who resided on the unit as well as protecting Resident #74.

A nursing note dated 10/13/20 at 3:40 AM indicated Resident #74 was awake most of the shift with some agitation noted, but was able to be redirected.

The facility ' s status listing indicated Resident #74 was moved from the 300 hall to the 200 hall on 10/14/20.

Resident #74 ' s behavior monitoring on the MAR indicated the following behaviors:

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F 689	Continued From page 93 - 10/15/20 at 5:41 PM: hitting and disruptive sounds - 10/16/20 at 10:34 AM hitting and disruptive sounds - 10/19/20 at 9:45 AM: pacing - 10/19/20 at 4:19 PM: grabbing, pacing, and disruptive sounds A nursing note dated 10/19/20 at 8:52 PM indicated Resident #74 had behavioral issues and yelled out at intervals. Resident #74 ' s behavior monitoring on the MAR indicated the following behaviors: - 10/20/20 at 9:23 AM: disruptive sounds - 10/20/20 at 4:01 PM: screaming - 10/21/20 at 9:39 AM: screaming, pacing, and disruptive sounds - 10/21/20 at 4:50 PM: hitting, grabbing, screaming, pacing, and disruptive sounds On 10/21/20 a care plan was initiated for Resident #74 related to wandering behaviors that led to unsafe situations. The goal was for wandering not to contribute to injury (target date 1/21/2021). The interventions, all initiated on 10/21/20, included the following: - Place resident in area where frequent observation is possible - Provide diversional activities - Redirect when wandering into other resident's rooms - Note which exits resident favors for elopement from facility. Alert staff working near those areas - Monitor and document target behaviors - Instruct visitors to inform staff when they are leaving the designated area with the resident - Implement facility protocol for locating an eloped	F 689		

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resident
- If wandering away from unit, instruct staff to stay with resident, converse and gently persuade to walk back to designated area with them
- Designate staff to account for resident whereabouts throughout the day
- Approach wandering resident in a positive, calm, and accepting manner
- Alert staff to wandering behavior

On 10/21/20 a care plan was also initiated for Resident #74 related to wandering behaviors that intruded on the privacy of other residents. This care plan had an identical goal and interventions as the above wandering care plan (unsafe situations) with the addition of the intervention: Redirect when wandering into other resident ' s rooms (initiated on 10/21/20).

Resident #74 ' s behavior monitoring on the MAR indicated the following behavioral symptoms:
- 10/22/20 at 10:38 AM: grabbing
- 10/23/20 at 10:56 AM: disruptive sounds
- 10/23/20 at 6:49 PM: grabbing and disruptive sounds
- 10/24/20 at 4:49 PM: disruptive sounds
- 10/25/20 at 8:35 AM: disruptive sounds
- 10/26/20 at 6:23 PM: disruptive sounds
- 10/29/20 at 1:35 PM: disruptive sounds
- 11/1/20 at 9:22 AM: disruptive sounds
- 11/7/20 at 8:59 AM: disruptive sounds
- 11/7/20 at 6:25 PM: disruptive sounds

A PA note indicated he had an acute visit with Resident #74 on 11/9/20 (entered as a late entry note on 11/29/20). Resident #74 was noted with recent aggressive behaviors and her family member complained of a change in behavior. The resident was noted to be calm, alert, and

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cooperative during the exam and no acute issues were identified.

Resident #74 ' s behavior monitoring on the MAR indicated she had the following behaviors:
- 11/10/20 at 8:05 AM: disruptive sounds and screaming
- 11/13/20 at 10:07 AM: disruptive sounds and screaming

A nursing note dated 11/13/20 at 12:47 PM by Nurse #4 indicated Resident #74 had an altercation with another resident. The other resident reported that Resident #74 entered his room and when she was told to leave she scratched his forehead. The residents were separated.

A hard copy typed statement completed by Nurse #4 indicated that prior to the 11/13/20 resident to resident altercation Resident #74 had been observed in the hall yelling and reaching out.

A facility investigation dated 11/19/20 of the 11/13/20 incident with Resident #74 ' s physical altercation with another resident (identified as Resident #41) was completed by Former Administrator #2. This investigation indicated that Resident #74 had fluctuations in mood and at times was difficult to redirect or console. She was experiencing an exacerbation of her mental health issues over the last several weeks due to several different room changes that occurred recently due to COVID-19 room changes. These changes were noted to increase her confusion. On 11/13/20 Resident #74 inadvertently self-propelled into Resident #41 ' s room, Resident #41 yelled at her to get out of his room, and Resident #74 raised her hands as she was

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known to do when she was excited or agitated and she incidentally "nicked" Resident #41 ' s forehead. Residents were separated by staff and assessed by the nurse who reported no injuries other than the scratch to Resident #41 ' s forehead. (Resident #41 ' s 10/19/20 MDS indicated his cognition was moderately impaired and he had no behavioral symptoms.)

During an interview with Nurse #4 on 6/4/21 at 9:21 AM he confirmed the information written in his 11/13/20 note and typed statement. He stated that Resident #74 scratched a male resident ' s (Resident #41) forehead. Nurse #4 stated that he was aware Resident #74 had been on the secured memory care unit previously and because of this he tried to keep a "close watch on her". He indicated he was unable to recall if she had any previous physical altercations with residents.

A nursing note dated 11/19/20 indicated Resident #74 had a change in condition and was transferred to the hospital.

During an interview with former Administrator #2 by phone on 6/4/21 at 11:00 AM she confirmed she was the Administrator during the incidents dated 7/9/20, 8/19/20, 9/9/20, and 11/13/20 in which Resident #74 had physical altercations with other residents. She stated that her expectation was for staff to provide the necessary supervision to prevent physical altercations between residents.

During an interview with the current Director of Nursing (DON) on 6/4/21 at 11:30 AM she stated that she was only employed at the facility for the 11/13/20 incident and she stated that she had not

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believed Resident #74 was being malicious or intentional when she scratched Resident #41. The DON indicated that she could not speak to the other incidents of resident to resident altercations with Resident #74 as she was not familiar with the details.

A phone interview was conducted with the Medical Director on 6/4/21 at 4:20 PM. He stated that he was very familiar with Resident #74 revealing that she had multiple incidents of physical altercations with other residents and physical behaviors toward the staff. He indicated that her family had refused psychiatric services so he was very involved with her medications and made multiple adjustments in an effort to manage her behaviors and stabilize her. The Medical Director explained that there was a fine line between prescribing medication that decreased behaviors and avoiding medications that would have sedated her. The staff interviews that indicated Resident #74 had an increase in behavioral symptoms when visitation restrictions were implemented related to COVID-19 as well as the incidents on 8/19/20 and 9/9/20 that occurred during family window visits for other residents were reviewed with the Medical Director. He reported that if staff identified a trigger for these physical altercations they should have implemented interventions such as increased supervision during the timeframe of window visits to prevent any further incidents with Resident #74. The Medical Director acknowledged that the facility needed to be able to provide the necessary care and the level of supervision required to meet the needs of all residents at the facility.

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The Administrator and DON were notified of the Immediate Jeopardy on 6/4/21 at 1:37 PM.

On 6/4/21 at 8:21 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

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

Charge nurse #1 noted resident #80 grabbed Resident #64 by the wrist. The nurse attempted to remove the residents hand off resident #64 wrist. Resident became combative and started swinging at staff member and trying to get back to the resident who had been moved away. The MD was called, and Nurse #1 received an order for Ativan IM 0.5 mg every 6 hours PRN. Resident received the medication on 3/15/2021 at 3:13 PM. On 3/15/21 a care plan was initiated to prevent further socially inappropriate physical behaviors. No injuries noted and no mental anguish noted on either resident. On 3/23/2021it was noted that resident #80 extremely combative, uncooperative, verbally aggressive, and was refusing medication. MD was called and new order was received to give Ativan IM 1mg x 1 on 3/24/2021. The medication was given on 3/24/2021 at 2:11AM. No injuries noted and no mental anguish noted for resident. On 3/26/2021 resident #80 pulled the blanket off of resident#37that was resting in her bed and attempted to grab resident #37 genital area. Resident #80 was removed from the room and placed in a common area. Resident #80 left the common area and started going in and out of the residents ' room. Staff increase the rounds on the resident to keep him from going in and out

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of the residents ' room. No injuries noted and no mental anguish noted on either resident. On 3/29/2021 resident #80 allegedly pulled the resident # 8 out of the bed. Resident #80 noted to obtain a skin tear. Resident #80 was removed for the room. Resident #8 was found in the floor. Resident #8 was assessed and placed back in bed. Resident #8 obtained no injuries. On 3/29/2021 resident #80 was noted to have resident #35 by the leg. Resident #80 was removed from the room and given Ativan IM 0.5mg. No injuries noted and no mental anguish noted on resident #35 and #8. Resident #80 was placed with a one to one (1:1) sitter for the 3rd shift. On 3/30/2021 resident was removed out of the 400 unit and placed on 200 unit. On 3/30/2021 social worker went to the magistrate office to obtain Involuntary Commitment. She was informed to have the Crisis Team to come out and assess resident. Crisis Team refused to come due to needing to be test for COVID19. Social worker offered to do Tele-visit and/or outside visit. Crisis Team refused both. On 3/31/2021 resident #80 was Involuntary Commitment (IVC) and he was sent to the hospital. Resident did not return to the facility.

On 7/9/2020 resident #74 was witnessed hitting another resident in the upper arm 4 times in the hallway. Residents were immediately separated and assessed. No injuries noted and no mental anguish noted on either resident. MD called and received new orders to obtain UA/C&S. It was noted to be negative. On 7/10/2020 residents ' #74 care plan was updated to prevent further physically aggressive behaviors. Resident #74 was placed on 15-minute checks and was carried out to 7/14/2020. On 8/19/2020 resident #74 hit resident #17 on the right arm. Resident #74

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received Ativan 1mg. Resident #74 was also placed on 1-1. Resident was Involuntary Commitment and sent to the ER for further evaluation. Resident care plan was updated for the resident to receive psych services and family declined. No injuries noted and no mental anguish noted on either resident. On 9/9/2020 resident rolled up behind resident #82 and began hitting her on the top of the head. Resident was removed from the hallway and placed on 15-minute checks. Residents care plan was updated to provide activities to resident while other family members are visiting other residents. No injuries noted and no mental anguish noted on either resident. On 11/13/2020 resident #74 entered residents #41 room and was asked to leave the room. Upon asking to leave the room resident #74 scratched resident #41 on the forehead. The residents were separated immediately. No mental anguish noted on either resident.

The facility did not provide necessary supervision of behavioral residents in the facility memory care unit. Therefore, all residents on the memory care unit are at risk for physical assault, unwanted physical, contact, and unwanted advancements into the personal space of cognitively impaired reside

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:

Resident #80 was discharged from the facility on 3/31/2021 and has not returned. Resident #74 was discharged from the facility on 11/18/2020 and has not returned.

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Because all residents are at risk when the facility fails to supervise residents with behaviors, the following plan has been formulated to address this issue: Effective 6/4/2021, all staff was educated by the Director of Nursing on managing resident behaviors and prevention of resident-to-resident altercations. This will include identifying contributing factors such as situationally, physical environment, staff, and organizational factors. An emphasis will be placed upon ensuring supervision of residents to aid in preventing physical assault, unwanted physical contact, and unwanted advancements into the personal space of cognitively impaired residents. On 6/4/2021, the facility reviewed the behavioral management policy to ensure it included strategies to manage residents ' behaviors toward others. Also, crisis management resources were discussed to include tele-health services with facility provider, mobile crisis response team, , local inpatient and outpatient psychiatric support services and contacting local ombudsman for further guidance with resources. The education will be communicated verbally and telephonically by the Executive Director, Director of Nursing and Assistant Director of Nursing/Staff Development coordinator. Written education will be available for review prior to the staff member working their assigned shift. Assistant Director of Nursing will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

Effective 6/4/2021, the Senior Clinical Consultant will provide the Admissions Director, Administrator, and Director of Nursing on the

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facility Memory Care/ Secured Unit Admission/Discharge policy including staffing unit based upon guidance outlined in the facility Alzheimer ' s/Dementia Care Unit Guidelines. This education was completed on 6/4/2021.

Effective 6/4/2021, the Senior Clinical Consultant educated the facility Social Worker, Director of Nursing and Administrator of process to follow when a resident needs psych services but unable related to insurance denial and/o family refusal. If a resident needs psychiatric services and insurance denies, the facility should request the psych provider to bill the facility for services rendered. Additionally, if a resident and/or responsible party refused psych services after orders by the physician, the facility will coordinate a care plan meeting with the local ombudsman office to mediate. If the resident is displaying aggressive behaviors towards others, the resident will be monitored closely which will include 1 to 1 observation if the resident continues to have behaviors. If the resident continues to have aggressive behaviors despite interventions, the facility will issue an immediate notice of discharge.

Effective 6/4/2021, the facility Social Worker and Director of Nursing will review clinical notes for the past 30 days for current memory care residents to identify any further residents with documented physical and sexual behaviors to ensure behavioral interventions including psych service referral (as applicable) and non-pharmacological interventions. This review was completed on 6/4/2021.

Effective 6/5/2021, the facility has allocated full-time employee (activity assistant) designated

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to the memory care unit in order to increase activities for memory care residents to mediate any behaviors (as applicable).

Effective 6/5/2021, the facility Administrator, Director of Nursing, Social Worker and Charge Nurse will perform facility tours (including off shifts and weekends) daily throughout the memory unit to observe for any residents with behaviors which would need additional interventions. Additionally, the Administrator and Director of Nursing will monitor staffing levels on the memory care unit to ensure adequate staff to provide supervision to residents to prevent physical assault, unwanted physical contact, and unwanted advancements into the personal space of cognitively impaired residents.

Effective 6/5/2021, the facility Interdisciplinary team will monitor residents with behaviors in daily clinical meeting. Targeted behaviors and interventions will be discussed with input from the physician and resident responsible party. Care plan will be reviewed, and interventions modified (as applicable).
Effective 6/4/2021, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.
Compliance Date: 6/5/2021

The facility alleges the removal of Immediate Jeopardy on 6/5/21.

The credible allegation of Immediate Jeopardy Removal was validated by onsite verification on 6/11/21 as evidenced by interviews with staff on the memory care unit and the social worker.

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F 689	Continued From page 104 Nursing staff had been educated on the prevention of resident to resident altercations. Staff were also educated on the facility behavioral management policy and Alzheimer's /Dementia guidelines. Facility staff began reviewing clinical notes and monitoring behaviors in their daily clinical meeting. Interviews with staff on the memory care unit confirmed that they had not experienced any resident to resident altercations since prior to the survey date. The facility's Immediate Jeopardy removal date of 6/5/21 was validated.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to change the oxygen tubing and humidification weekly for a resident dependent on continuous oxygen. This was for 1 (Resident #20) of 2 residents reviewed for respiratory care. The findings included: Resident #20 was admitted on 12/12/20 with cumulative diagnoses of atrial fibrillation and shortness of breath (SOB).	F 695	F695 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's	7/2/21

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F 695	Continued From page 105 Resident #20's June 2021 Physician orders read as follows but did not include a frequency: *Oxygen at 2 liters via nasal cannula (NC) continuous for comfort care. *Change oxygen tubing/humidifier bottle and label each one with the date. Resident #20's significant change Minimum Data Set (MDS) dated 4/1/21 indicated she had moderate cognitive impairment. She was coded for the use of oxygen. Review of Resident #20's respiratory care plan revised 4/1/21 read she required continuous oxygen via NC. Interventions included replacing the oxygen tubing and replacing the humidification bottle on the concentrator. The care plan did not indicate how frequently the oxygen tubing and humification was to be changed. Review of Resident #20's May 2021 Treatment Administration Record (TAR) revealed documentation that the last time her oxygen tubing and humification bottle were changed was on 5/28/21 and was completed by Medication Aide (MA) #1. In an observation on 6/1/21 at 1:30 PM, Resident #20 was lying in bed wearing her oxygen. The oxygen tubing and the humification bottle were both undated. In an observation on 6/3/21 at 9:00 AM, Resident #20 was lying in bed wearing her oxygen. The oxygen tubing and the humification bottle were both undated.	F 695	allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #20 oxygen tubing and humidification was changed 6/1/2021. How the facility will identify other residents having the potential to be affected by the same deficient practice: Director of Nursing, Unit Managers and Supply Person completed an audit of current residents who have an order for continuous or as needed oxygen to ensure, that O2 tubing and humidification bottles were changed and dated, this happened on 6/4/2021. This audit included ensuring that current residents on continuous or as needed oxygen had a physician order in their medical record. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A list of all residents on oxygen was created using the audit form by the Director of Nursing on 6/4/2021. The Unit Managers and/or Supply Person will be completing weekly room rounds for the residents who are currently on oxygen, changing and dating oxygen tubing, humidification bottles.	

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F 695	Continued From page 106 In an interview on 6/3/21 at 12:05 PM, Nurse #6 stated all oxygen tubing and humification were to be changed every Thursday on third shift. In another observation on 6/3/21 at 3:45 PM, Resident #20 was lying in bed wearing her oxygen. The oxygen tubing and the humification bottle were both undated. In an observation on 6/4/21 at 9:05 AM, the oxygen tubing and the humification bottle had both been changed and dated 6/3/21. In an interview on 6/4/21 at 11:30 AM, MA #1 stated oxygen tubing and humidification bottles were to be changed weekly on Thursday nights. She stated Resident #20's Treatment Administration Record (TAR) in the computer notified staff to change the tubing and bottle every Thursdays on third shift. MA #1 acknowledged she documented on 5/28/21 that she changed Resident #20's oxygen tubing and humidification bottle but she stated she did not actually do it. MA #1 stated she made a mistake when she initialed the TAR and stated she must have gotten side tracked. In an interview on 6/4/21 at 5:20 PM, the Director of Nursing (DON) stated there was Physician order to change Resident #20's oxygen tubing and humidification every Thursday on third shift. The DON stated it was her expectation that the staff follow the Physician's order to change the oxygen tubing and humidification bottle every Thursday on third shift.	F 695	The DON and/or Unit Managers educated all certified nursing assistants, licensed nurses, medication aides, and contract nursing staff about ensuring the oxygen tubing and humidification bottles area changed out weekly and dated. This was completed on 6/3/2021. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing, Administrative Nurses and/or Supply Person will audit weekly Oxygen Tubing and Humidification bottles for the next x 12 weeks to ensure that Oxygen Tubing and Humidification bottles are changed per Physician's order. The Director of Nursing will complete a summary of the results of these audits and will present at the facility Quality Assurance Meeting x 3 months to ensure continued compliance. Completion date: July 2, 2021	
F 697 SS=G	Pain Management CFR(s): 483.25(k)	F 697		7/2/21

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F 697	Continued From page 107 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interview, the facility failed to administer pain medication as ordered due to unavailability of medication resulting in acute pain (level of 10 pain for 1 to 10 with 10 being the worst) for 1 of 2 reviewed for pain (Resident #65). Findings included: Resident #65 was admitted to the facility on 5/4/21 with the diagnoses of spinal stenosis with laminectomy (spinal bone fusion). The resident ' s physician order dated 5/4/21 documented Oxycodone/APAP 10-325 milligrams (mg) every 4 hours as needed for pain. The resident ' s care plan dated 5/5/2021 had problems and interventions for surgical wound and pain. A review of Resident #65 ' s medication administration record (MAR) revealed pain assessment score 1 to 10 with 10 being the worst pain documentation when medication was requested: 5/5/21 9:11 am Pain score 8 start documentation 1:28 pm Pain score 9 5:30 pm Pain score 9 11:44 pm Pain score 10	F 697	F697 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #65 medication was obtained from the electronic mediation dispensing machine, located at the facility on 5/10/21 by the Licensed Nurse. Resident #65 received his medication from Medication Aide #2 on 5/10/21 at 11:54am and a new prescription was obtained from the resident's attending physician on 5/10/21 at 2:09 pm	

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F 697	Continued From page 108 5/6/21 5:51 am Pain score 10 10:08 am Pain score 8 2:22 pm Pain score 9 7:29 pm Pain score 8 11:28 pm Pain score 7 5/7/21 5:19 am Pain score 7 9:24 am Pain score 9 2:02 pm Pain score 8 6:07 pm Pain score 8 11:33 pm Pain score 8 5/8/21 9:04 am Pain score 5 4:02 pm Pain score 6 5/9/21 12:31 am Pain score 8 4:45 am Pain score 8 5/10/2110:21 pm Pain score 8 (ran out of medication) 5/11/21 2:09 pm Pain score 8 (obtained medication) 10:47 pm Pain score 8 5/12/21 3:03 am Pain score 8 The resident ' s admission Minimum Data Set (MDS) dated 5/11/2021 review revealed her cognition was intact. The resident was dependent for most of her activities of daily living. Active diagnoses were orthopedic condition, surgical after care, spinal stenosis, and lower back pain. The resident had frequent moderate pain, spinal surgery, and surgical wound with dressing. The resident's Narcotic controlled drug record for Oxycodone/APA 10-325 mg every 4 hours as needed for pain documented on 5/10/21 at 1 pm last dose administered, and amount left was "0". Next dose administered was 5/11/2021 at 1:48 pm left was "30" (new order). A review of the narcotic record form revealed the resident was requesting as needed pain medication 6 doses	F 697	How the facility will identify other residents having the potential to be affected by the same deficient practice: DON and/or Unit Managers completed an audit of current resident Medication Administration Records to ensure that residents did receive their pain medication timely. This was completed on 6/5/21. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: When medications are not available the Charge Nurse should call pharmacy and inquire about the status of the medication. The nurse should ask for an emergency/stat Medication delivery and the medication is then rescheduled by the resident's attending physician to be given as soon as medication is received. The facility also has an emergency electronic medication dispensing machine that can be used for alternative order for the attending physician to prescribe until medication is received from back up pharmacy. On 6/9/2021, the DON and Unit Managers began education with all Licensed Nurses, Medication Aides, and contract nurse staff, this training included the process for re-order of medications from the pharmacy, use of the electronic medication dispensing machine, notification of resident attending physician to ask for an alternative order until medications can be obtained. This	

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F 697	Continued From page 109 per day (24-hour period) for post orthopedic surgical pain since admission when the medication was available. On 5/10/2021 the resident received 4 doses (last dose 1 pm). On 5/11/2021 the resident received 3 doses (first dose at 1:48 pm). Medication administration documentation: 5/5/21 4:35 am, 9:11am, 1:27 pm, 5:27 pm, 11:44 pm 5/6/21 5:51 am, 10:08 am, 2:22 pm, 7:20 pm, 11:18 pm 5/7/21 4:40 am, 9:24 am, 2:02 pm, 6:02 pm, 11:35 pm 5/8/21 4:38 am, 9:00 am, 1:00 pm, 4:00 pm, 8:00 pm 5/9/21 12:00 am, 9:00 am, 1:00 pm, 4:00 pm, 8:00 pm 5/10/21 12:00 am, 4:30 am, 9:00 am, 1:00 pm (no medication available) 5/11/21 (medication obtained) 1:48 pm, 5:54 pm, 10:42 pm Nurses ' notes from 5/5/2021 to 5/11/2021 documented in 3 notes that the resident ' s pain medication gave her pain relief (was satisfied). Documentation from the stock medication revealed that one dose of Oxycodone was retrieved from the medication stock supply for Resident #65 on 5/11/2021 at 8:49 am. There was no medical record documentation that it was administered to the resident. Resident agreed this pain medication dose was provided. Grievance form dated 5/11/21 for Resident #65 documented that she had not received her pain medication as ordered/needed on 5/10/21 and 5/11/21 and complained of severe (after	F 697	training will be provided during orientation for a new licensed nurse, medication aides, and contract nurse staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON or Nurse Management will Audit all pain medications to make sure they are available 3 x per week for 3 weeks, then weekly x 3 weeks, then monthly x 2 months. The Director of Nursing will complete a summary of audit of results and present at the at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. Completion date: July 2, 2021	

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F 697	Continued From page 110	F 697		

orthopedic surgery). There was no pain medication available because the script was not faxed to the pharmacy. A stat (immediate) order from the physician assistant (he was notified) was requested as a substitute until the pain medication was received from the pharmacy. The documented resolution determined that there were problems with the faxing of the resident ' s narcotic script (identified when the medication was out). The Unit Coordinator called the physician assistant for another script to be electronically sent to the pharmacy and a stat (immediate) order for a stock pain medication replacement (Oxycodone from stock) was ordered (1 dose) until the narcotic medication order was received (on 5/11/2021 at approximately 1:30 pm 30 tablets).

On 6/1/21 at 11:20 am the resident participated in an interview. The Resident stated that the facility ran out of her pain medication oxycodone on 5/10/21, and she did not receive any pain medication for 20 hours (documented 10 hours over night without medication and stock dose was used in the morning). The resident also commented that she was not receiving her medication regularly on 5/8/21 so the staff started to place her on a schedule (every 4 hours) until the medication ran out. The resident stated she had orthopedic surgery, a laminectomy and has pain daily and requires pain medication. The pain medication lowers the pain to relief about a score of 3, but I need another dose of medication after 4 hours. The resident also stated that her spinal nerves were crushed and caused her pain. The pain was sharp in her lower back and caused decreased use of her legs. The resident stated that when she did not have her pain medication she could hardly move in her bed, and no other

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F 697	Continued From page 111 alternate pain medication was offered when her medication was out (1 stock dose of pain medication was used). The resident was able to participate in her bed bath, eat all her meals and communicate with family on her cell phone. An interview was conducted on 6/3/2021 at 11:30 am with Nurse #7. The nurse stated she was assigned to Resident #65 and commented that there were narcotic count sheets to ascertain when the medication was ordered, used, ran out and reordered. The nurse was aware that the resident ' s pain medication had ran out because the resident complained of acute pain and filed a grievance. The nurse was unsure how long the resident was without her pain medication. The resident ' s assessment of pain was evaluated to be a 10 at times. (Score of 1 to 10, with 10 being the worst pain.) Nurse #7 assessed the resident after pain medication administration and the resident would score her pain about a "3" documented in the nurses ' notes. On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). Medication was required to be reordered before it was completed. The DON commented that she was aware of the resident ' s grievance regarding her pain medication not available and that the resident was in acute pain (up to level 10). The pain medication was reordered before it ran out, but there was a fax error where the script was not received by pharmacy to refill. This error was not identified until the medication ran out.	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		7/2/21

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F 725	Continued From page 112 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to have sufficient nursing staff to provide Activity of Daily Living (ADL) assistance to residents who required total care for bathing, showers, facial shaving, and/or nail care. This affected 7 of 8 residents reviewed for ADL care (Residents #19, #29, #41, #65, #75, #76, and #223) and the members of the Resident Council.	F 725	F725 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following	

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F 725	Continued From page 113 The findings included: This tag is cross-referred to: F677: Based on observation, record review, and staff and resident interviews, the facility failed to provide scheduled showers (Resident #29), baths (Residents #65, #75, #76, and #223), nail care (Resident #19), and facial shaving (Resident #41) for 7 of 8 activity of daily living (ADL) dependent residents reviewed. A review of Resident Council minutes dated 3/30/21 and 5/28/21 indicated the residents stated that there was not enough staff to assist with care. On 6/4/21 at 11:30 AM a meeting was conducted with 7 members of the Resident Council. The residents reported that they felt the facility was not sufficiently staffed to meet the needs of the residents at the facility. They explained that Activity of Daily Living (ADL) care such as showers and baths were not always completed as scheduled. The residents collectively reported that when the Nursing Assistants (no specific names mentioned) were not able to provide assistance with their ADL needs they stated it was because they were short staffed and had not had time to provide this care. The Resident Council members indicated that the facility had been working on this staffing issue and that it had improved since a year ago, but that it still had not been resolved completely. An interview was conducted with the Director of Nursing (DON) on 6/4/21 at 5:35 PM. She indicated that it was her expectation that the facility have a sufficient number of nursing staff to	F 725	plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident name was identified. DON and Staffing Coordinator reviewed staffing schedule to ensure staffing was adequate for resident census. This was completed 6.3.2021 How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit was completed by DON and Staffing Coordinator of the current schedule for the last 30 days to ensure that proper staffing coverage was maintained based current facility census on 6/3/2021. DON and Staffing Coordinator were educated by Administrator on requirement for proper staff coverage current on facility census. Completed on Date 6/9/2021. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning on 6/3/2021 DON, ADON, Unit Manager, and/or designee started In-servicing licensed nurses and Certified Nursing Aides on the need to ensure all	

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F 725	Continued From page 114 meet the needs of the residents. She reported that this included having enough staff to provide assistance with all ADL care to include showers, baths, nail care, and facial shaving.	F 725	residents receive grooming, nail care and showers as part of their Activities of Daily Living (ADL's) and plan of care services.-F677 Administrator and/or Director of Nursing will audit daily schedules 5 days per week x 12 weeks to ensure proper staff coverage is maintained. The Facility Administrator, Don and/or Staffing Coordinator will conduct daily labor meeting, this Daily Monday-Friday as a part of morning stand up meeting for x 2 weeks to ensure the facility has proper staffing coverage based facility census and resident care needs. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Facility Administrator, DON and/or Staff Coordinator will complete a summary of the audit to present to monthly QA meeting. Results of these audits will be reviewed at Monthly Quality Assurance Meeting X2 for further problem resolution if needed. Completion date: July 2, 2021	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727		7/2/21

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F 727	Continued From page 115 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours per day 7 days a week for 15 of 31 days reviewed. The findings included: A review of the posted daily Nurse Staffing forms from 5/1/21 through 5/31/21 revealed the facility had not had the required Registered Nurse (RN) coverage (at least 8 consecutive hours per day 7 days a week) on the following dates: 5/1/21, 5/2/21, 5/3/21, 5/8/21, 5/13/21, 5/14/21, 5/16/21, 5/20/21, 5/21/21, 5/22/21, 5/23/21, 5/26/21, 5/27/21, 5/29/21, and 5/30/21. On each of these dates the census was between 70 and 76 residents. During an interview with the Director Nursing (DON) on 6/3/21 at 10:55 AM she revealed that one of their full-time RNs quit in the end of April 2021 and since that time they had been having difficulty ensuring RN coverage was met. She stated that they had been trying to hire a new RN, but they had been unsuccessful with finding a qualified applicant thus far. She further stated that the facility was utilizing agency staff, but that agency RNs were also difficult to find. The DON indicated that she expected RN coverage to be	F 727	F727 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was named in this deficient practice. Staff schedules were adjusted immediately to ensure proper Register Nurse (RN) coverage is in place, by Director of Nursing and Scheduler on 6/1/2021. How the facility will identify other residents	

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F 727	Continued From page 116 met in accordance with the regulations and she hoped to find a new RN soon to fill their vacancy.	F 727	having the potential to be affected by the same deficient practice: An audit was completed by Director of Nursing and Staffing Coordinator of the current working schedule for the upcoming 30 days to ensure that proper Register Nurse coverage was maintained. Completed on 6/1/2021 On 6/1/2021 Administrative Nurses, Staffing Coordinator, and Director of Nursing were educated by Nursing Consultant on requirement for consecutive 8 hour registered nurse, this included ensuring that current work schedule reflect proper Register Nurse coverage. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Facility Administrator, Don and/or Staffing Coordinator will conduct daily labor meeting, this Daily Monday-Friday as a part of morning stand up meeting for x 2 weeks to ensure the facility has proper staffing coverage based on facility census and resident care needs. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Facility Administrator, DON and/or Staff Coordinator will complete a summary of the audit to present to monthly QA meeting. Results of these audits will be reviewed at Monthly Quality Assurance Meeting X2 for	

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F 727	Continued From page 117	F 727	further problem resolution if needed Completion date: July 2, 2021	
F 732 SS=C	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	F 732		7/2/21

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F 732	Continued From page 118 requirements. The facility must maintain the 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 review of the facility's required posted daily Nurse Staffing forms and staff interviews, the facility failed to accurately complete the posting on 31 of 31 days reviewed (5/01/21 through 5/31/21). The findings included: Review of the posted daily Nurse Staffing forms from 5/01/21 through 5/31/21 revealed identical information was typed on each form for the total number and actual hours worked of Registered Nurses (RNs), Licensed Practical Nurses (LPN), and Nursing Assistants (NAs). The only typed information that changed on the form from day to day was the census and the date. Handwritten on the forms were crossed off numbers and replacement numbers in the areas of total number and actual hours worked for the following dates, shifts, and staff positions: - 5/01/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift NAs - 5/02/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift NAs - 5/03/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift NAs - 5/04/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift RNs, LPNs, and NAs - 5/05/21: Day shift RNs, LPNs, and NAs;	F 732	F732 Staff Posting The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: There was no Resident identified to be affected by this alleged deficient practice. The facility scheduler corrected the current staff posting to ensure the accurate daily censes and staffing numbers on 6/3/2021. The facility's staff posting is being posted accurately daily as of 7/2/21. How the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 732	Continued From page 119 Evening shift RNs, LPNs, and NAs; Night shift RNs, LPNs, and NAs - 5/06/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift RNs and LPNs - 5/07/21: Day shift RNs, LPNs, and NAs; Evening shift RNs and NAs; Night shift NAs - 5/08/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift NAs - 5/09/21: Day shift LPNs and NAs; Evening shift LPNs and NAs; Night shift NAs - 5/10/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift RNs, LPNs, and NAs - 5/11/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift RNs, LPNs, and NAs - 5/12/21: Day shift RNs, LPNs, and NAs; Evening shift RNs and NAs; Night shift RNs and LPNs - 5/13/21: Day shift RNs, LPNs, and NAs; Evening shift RNs and NAs; Night shift NAs - 5/14/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift RNs, LPNs, and NAs - 5/15/21: Day shift RNs, LPNs, and NAs; Evening shift LPNs and NAs; Night shift RNs and LPNs - 5/16/21: Day shift RNs and LPNs; Evening shift RNs, LPNs, and NAs - 5/17/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift RNs and NAs - 5/18/21: Day shift RNs, LPNs, and NAs; Evening shift LPNs and NAs; Night shift RNs and NAs - 5/19/21: Day shift RNs, LPNs, and NAs; Evening shift RNS, LPNs and NAs; Night shift	F 732	Any resident could have been affected by this alleged deficient practice. The Facility Administrator and DON completed an audit of current facility staffing sheets for the last 30 days to ensure accuracy of the census and staffing numbers, this was completed on 6/4/2021. Any facility staffing sheets that were noted to have inaccurate census or staffing numbers were corrected by the DON and/or Facility Administrator on 6/4/2021 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility scheduler will maintain the Daily Staffing Sheets daily to include daily census and accurate staffing numbers. The Daily Staffing sheets will be updated throughout the workday of any census or staffing numbers as needed by the facility scheduler and/or receptionist. The facility Administrator and/or Manager on Duty will review these staffing sheets daily to ensure accuracy of census and staffing numbers. These audits will be completed daily for 5 days for 2 weeks, then weekly for 3 months, to ensure continued compliance. Facility Administrator completed training with the facility scheduler, receptionist and manager on duty on 6/1/21, on the content of F732, including but not limited	

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F 732	Continued From page 120 RNs and NAs - 5/20/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift LPNs and NAs - 5/21/21: Day shift RNs, LPNs, and NAs; Evening shift LPNs and NAs; Night shift NAs - 5/22/21: Day shift RNs, LPNs, and NAs; Evening shift LPNs and NAs; Night shift NAs - 5/23/21: Day shift RNs, LPNs, and NAs; Evening shift LPNs and NAs - 5/24/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs; Night shift RNs, LPNs, and NAs - 5/25/21: Day shift RNs, LPNs, and NAs; Evening shift LPNs and NAs; Night shift RNs, LPNs, and NAs - 5/26/21: Day shift RNs, LPNs, and NAs; Evening shift RNs and NAs; Night shift NAs - 5/27/21: Day shift NAs; Evening shift RNs and NAs; Night shift NAs - 5/28/21: Day shift RNs, LPNs, and NAs; Evening shift LPNs; Night shift RNs and NAs - 5/29/21: Day shift RNs, LPNs, and NAs; Evening shift RNs, LPNs, and NAs - 5/30/21: Day shift RNs and LPNs; Evening shift RNs, LPNs, and NAs; Night shift NAs - 5/31/21: Day shift RNs, LPNs, and NAs; Evening shift RNs and LPNs; Night shift RNs, LPNs, and NAs An interview was conducted on 6/04/21 at 11:11 AM with the Scheduler. She revealed that on 6/02/21 it was discovered that the posted daily Nurse Staffing forms had identical information for the total number and actual hours worked of RNs, LPNs, and NAs and that no one had updated the forms with accurate information on each date.	F 732	to, timely posting, documenting accurate census/staffing numbers (licensed & unlicensed staff) and updating of the staffing sheet as needed when changes occur throughout the workday Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Scheduler will complete a summary of audit results and present monthly at the Quarterly QAPI committee to ensure continued compliance. Completion Date: July 2, 2021.	

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F 732	Continued From page 121 The Scheduler explained that prior to providing the posted daily Nurse Staffing forms to the survey team on 6/02/21 the Administrator and Director of Nursing (DON) reviewed the forms and realized this error. She further explained that on 6/02/21 she went through the posted daily Nurse Staffing forms and compared them to the schedules and the timesheets and then handwrote on the forms the corrections. She revealed that every form from 5/01/21 through 05/31/21 had inaccurate information in multiple areas. The Scheduler stated that as of 6/02/21 she was given access to the facility ' s computer system that was utilized for the completion of the posted daily Nurse Staffing forms and she was now responsible for ensuring the forms were posted with accurate information. She reported that prior to 6/02/21 she had not had access to this computer system. During an interview with the DON on 6/04/21 at 5:35 PM she confirmed the Scheduler ' s interview that indicated it was discovered on 6/02/21 that no one had been updating the posted daily Nurse Staffing forms with accurate information. She reported that she had not realized this prior to 6/02/21. The DON stated she thought the Scheduler had been completing this task and she had not known the Scheduler had no access to the computer system utilized for completion of the forms. She indicated that as of 6/02/21 the Scheduler was given access to the computer system and that moving forward this responsibility was assigned to the Scheduler. She indicated that she expected the posted daily Nurse Staffing forms to be completed accurately and in accordance with the regulations.	F 732		
F 742 SS=E	Treatment/Srvcs Mental/Psychoscial Concerns	F 742		7/2/21

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F 742	Continued From page 122 CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with staff and Medical Director, the facility failed to provide behavioral healthcare services to a resident with diagnosed mental health disorders and behavioral symptoms for 1 of 2 residents (Resident #8) reviewed for behavioral and emotional needs. The findings included: Resident #8 was admitted to the facility on 4/23/18 with multiple diagnoses that included mood disorder, major depressive disorder, anxiety disorder, and dementia with behavioral disturbance. The quarterly Minimum Data Set (MDS) assessment dated 3/3/21 indicated Resident #8 ' s cognition was severely impaired. She was assessed with no psychosis, behavioral symptoms, or rejection of care. Resident #8 was administered antipsychotic medication and antidepressant medication on 7 of 7 days.	F 742	F742 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Facility failed to ensure that resident #8 received adequate Behavioral Health Services. Resident #8 will be followed by facilities new Behavioral Health Team.	

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F 742	Continued From page 123 Resident #8 ' s active care plan included the focus area of physically aggressive behaviors. This area was initiated on 7/15/20 and included the following interventions (all initiated on 7/15/20): - Do not argue with resident - Talk in calm voice when behavior is disruptive - Refer to Social Services for evaluation - Reinforce unacceptability of verbal abuse - Praise for demonstrating desired behavior - Monitor and document target behaviors - Identify causes for behavior and reduce factors that may provoke aggressive behaviors - Discuss options for appropriate channeling of anger - Assist in selection of appropriate coping mechanisms - Administer behavior medications as ordered by physician. - Provide diversional activities Resident #8 ' s active care plan also included a focus area of exhibiting aggressive behavior with Activities of Daily Living (ADL) care. This area was initiated on 10/16/20 and included the following interventions (all initiated on 10/16/20): - Place resident in area where frequent observation is possible - Talk in calm voice when behavior is disruptive - Refer to Social Services for evaluation - Remove from public area when behavior is disruptive and unacceptable - Praise for demonstrating desired behavior - Monitor and document target behaviors - Elicit family input for best approach(es) to resident - Do not argue with resident - Discuss options for appropriate channeling of anger	F 742	Resident #8 was seen by BHT on 6/20/2021. How the facility will identify other residents having the potential to be affected by the same deficient practice: Current residents, who had an order for mental health services were seen by the facilities new Behavioral Health Service provider on 6/20/2021. The facility Social Worker and Director of Nursing will ensure that any resident with behaviors in need of Behavioral Health Services will be referred upon identification of behaviors . Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All recommendations received from the facility Behavioral Health Services Provider will be discussed at the facility Clinical Meeting to ensure that recommendation is reviewed by the attending physician, orders obtained, and interventions implemented timely. This review will be completed by the facility IDT team weekly x 12 weeks, then monthly. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Social Worker will complete a summary of these audits and present at the monthly QAPI meeting to ensure	

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F 742	Continued From page 124 - Approach wandering resident in a positive, calm, and accepting manner - Allow opportunity to make choices and participate in care - Administer behavior medications as ordered by physician - Provide diversional activities A review of Resident #8 ' s medical record from 1/1/21 through 6/1/21 revealed no psychiatric services or other behavioral health care services were provided to the resident. A review of Resident #8 ' s behavioral documentation from 4/1/21 through 6/1/21 revealed the following: - 4/1/21: hitting/grabbing - 4/6/21: refused all medications - 4/13/21: disruptive sounds - 4/14/21: cursing - 4/17/21: disruptive sounds and cursing - 4/20/21: screaming - 4/26/21: disruptive sounds and screaming - 4/27/21: disruptive sounds - 4/30/21: disruptive sounds and screaming - 5/2/21: disruptive sounds - 5/10/21: disruptive sounds - 5/13/21: disruptive sounds - 5/14/21: hitting and disruptive sounds - 5/17/21: disruptive sounds - 5/18/21: disruptive sounds - 5/19/21: disruptive sounds and cursing - 5/20/21: disruptive sounds - 5/21/21: threatening and screaming - 5/22/21: hitting and kicking - 5/28/21: screaming and cursing - 5/29/21: hitting, kicking, screaming, cursing, refused medications	F 742	continued compliance. Completion date: 7/2/2021, then on-going	

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F 742	Continued From page 125 - 5/30/21 cursing - 5/31/21 disruptive sounds - 6/1/21: screaming Resident #8 ' s active physician ' s orders as of 6/1/21 included the following psychotropic medications - Seroquel (antipsychotic medication) 200 milligrams (mg) once daily (start date 9/25/19) - Lexapro (antidepressant medication) 15 mg once daily (start date 12/14/19) - Depakote (prescribed for treatment of mood disorder) 125 mg three times daily (start date 9/21/20) An observation was conducted of Resident #8 on 6/1/21 at 1:00 PM. No behavioral issues were observed. During an interview with Nursing Assistant (NA) #1 on 6/3/21 at 4:18 PM she stated that she regularly worked with Resident #8. She indicated that Resident #8 had some behavioral symptoms that included yelling out and making disruptive sounds. She reported that sometimes Resident #8 had physical behaviors toward the staff during ADL care. On 6/4/21 at 4:45 PM the facility ' s Social Worker (SW) provided the following documentation: - An email from the facility ' s psychiatric provider to the facility ' s SW dated 6/3/21 indicated Resident #8 ' s insurance provider they had been billing was terminated on 11/20/19 and she had not been seen for psychiatric services since 11/15/19. The 11/15/19 psychiatry note was indicated to be attached to the email.	F 742		

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F 742	Continued From page 126	F 742		

- A psychiatry follow up note dated 11/15/19 indicated Resident #8 was seen for a follow up psychiatric evaluation for medical management of psychotropic medications and assessment of mood and behavior. Her associated signs/symptoms were noted to include anxiety and delusions. Resident #8 was noted to be receiving antianxiety medication, antipsychotic medication, antidepressant medication, and a mood stabilizer. The psychiatric Physician ' s Assistant indicated Resident #8 ' s dementia with behavioral disturbance with psychosis was stable.

An interview was conducted with the SW on 6/4/21 at 4:45 PM upon receipt of the above documentation. She revealed that she had not realized Resident #8 was not receiving psychiatric services. She explained that each month she received a list from the psychiatric provider of all residents who were "active" indicating they were receiving services. She further explained that it appeared on this list as if Resident #8 was receiving services. The SW stated that Resident #8 was on multiple psychotropic medications and she had some behavioral issues. She indicated that had she known the resident was no longer receiving psychiatric services she would have sought out other alternatives such as other psychiatric providers to ensure Resident #8 had her behavioral health care needs met.

A phone interview was conducted with the Medical Director on 6/4/21 at 4:20 PM. He stated that it was his expectation for facility residents to receive the care and services necessary to meet their behavioral healthcare needs. He indicated that insurance should not be a reason that a resident cannot receive behavioral healthcare services. The Medical Director explained that the

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F 742	Continued From page 127 facility needed to seek out alternative behavioral healthcare resources if their psychiatric provider was unable to treat a resident diagnosed with mental health conditions who exhibited behavioral symptoms. During an interview with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 6/4/21 at 5:35 PM they both indicated they expected residents to receive the care and services necessary to meet their behavioral healthcare needs. The DON revealed she was unaware Resident #8 was not being seen by the psychiatric provider until this week. She indicated that alternative resources or an alternative provider should have been sought out when the facility ' s psychiatric provider declined the provision of further services to Resident #8.	F 742		
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 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	F 755		7/2/21

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F 755	Continued From page 128 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 observation, record review and staff interview, the facility failed to administer medication as ordered for 2 of 2 residents (Residents #65 [two medications] and 9) due to medication not being available. Findings included: 1. Resident #65 was admitted to the facility on 5/4/21 with the diagnoses of spinal stenosis with laminectomy. The resident ' s care plan dated 5/5/2021 had problems and interventions for surgical wound and pain. The resident ' s admission Minimum Data Set (MDS) dated 5/11/2021 review revealed her cognition was intact. The resident was dependent for most of her activities of daily living. Active diagnoses were orthopedic condition, surgical after care, spinal stenosis, and lower back pain. Pain medication was administered 7 of 7 days of the assessment lookback period.	F 755	F755 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #65 medication was pulled from the First Dose the, the emergency medication system, by Director of Nursing on 5/10/2021 at 11:54 AM.	

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F 755	Continued From page 129 1a. Resident #65 ' s physician order dated 5/4/21 documented Oxycodone/APAP (narcotic pain medication) 10-325 milligrams (mg) every 4 hours as needed for pain. The resident's Narcotic controlled drug record for Oxycodone/APAP 10-325 mg every 4 hours as needed for pain documented on 5/10/21 at 1 pm as being the last dose administered, and amount left was "0" (there was no more medication to administer). Grievance form dated 5/11/21 for Resident #65 documented that she had not received her pain medication as ordered/needed on 5/10/21 and 5/11/21. There was no pain medication available because the script was not faxed to the pharmacy. The Director of Nursing obtained a stat (immediate order) from the physician assistant (30 tablets) and one dose was retrieved from the stock medication (no administration documentation). On 6/1/21 at 11:20 am the resident participated in an interview. The resident stated that the facility ran out of her pain medication oxycodone on 5/10/21 and the medication had to be reordered, and she did not receive any pain medication for several hours until the next day. The resident stated she was not offered an alternative and her pain was acute (score 10 of 1 to 10 with 10 being the worst). An interview was conducted on 6/3/2021 at 11:30 am with Nurse #7. The nurse stated she was assigned to Resident #65 and was aware that the resident ' s pain medication had ran out because the resident complained of acute pain and filed a	F 755	Resident #9 medication was reordered on 5/10/2021 and Pharmacy was called for a stat courier order. The PA was notified, along with the residents Responsible Party, 6/1/2021 by Charge Nurse. Medication arrived at 2:21 pm. How the facility will identify other residents having the potential to be affected by the same deficient practice: To identify other residents who have the potential to be affected, on 6/1/2021, the Charge Nurses started a 100% review of all resident’s medication regimes to identify residents at risk. Residents found to be at risk due to the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending Physician will be notified. The Audit revealed 12 residents that did not have medications on the cart for administering. Medications were re-ordered on 6/1/2021 and arrived on 6/1/2021 at 8:30 pm. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Director of Nursing and/or designee educated All licensed Nurses and Med Aides on 6/9/2021 the procedure for medication administration to include medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The In	

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F 755	Continued From page 130 grievance. The nurse was unsure how long the resident was without her pain medication. On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated medication was required to be reordered before it was completed. The DON commented that she was aware of the resident ' s grievance regarding her pain medication not available. The resident ' s script was faxed, but not received at the pharmacy due to mechanical failure. This was not identified until the medication ran out. One dose of pain medication was taken from stock medication. The physician assistant was notified, and a stat script was sent to the pharmacy for 30 tablets. 1b. Nurses ' note dated 5/8/20201 revealed Resident #65 complained of signs and symptoms of a Urinary Tract Infenction (urgency). Urine sample was taken, and Cipro (antibiotic) was ordered. The resident had a physician order dated 5/8/2021 for Cipro 500 milligrams (mg) twice a day for 10 days. A review of the resident ' s medication administration record documentation revealed that Cipro 500 mg twice a day was not administered on 5/10/21 at 9:00 am as ordered. It was documented as not given "N." On 6/1/2021 at 12:15 pm an interview was conducted with the resident. The resident stated she had not received her antibiotic morning dose on 5/10/21 for her UTI because there was no medication available. The resident stated she informed the Director of Nursing (DON), and a	F 755	Service included the steps the nurses should take should a medication not be delivered timely and the steps if a medication is unavailable. Nurses trained/ in-serviced of proper notification and the use of the First Dose dispensing. Residents' physician and Responsible Party notified of any unavailable medications. Education will be provided to all licensed nurses and med aides on how to reorder medication in AHT. All new employees will be educated upon hire. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: To prevent this from recurring, beginning on 6/4/2021, the Director of Nursing and/or designee will audit 10 random residents' medications daily for 3 weeks, then weekly for 2 weeks, then monthly for 1 month. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X3 for further problem resolution if needed. Director of Nursing is responsible for ensuring continued compliance. Completion date: July 2, 2021	

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grievance was filed.

On 6/3/2021 at 9:20 am an interview was conducted with Medication Aide (MA) #2. The MA stated she was without medication for a resident this morning 6/3/2021 because it was not reordered. This has been a problem because the contract nursing staff does not know how to reorder, and reordering medication sometimes gets forgotten or delayed.

On 6/3/2021 at 2:40 pm an interview was conducted with Nurse #9. The nurse stated that she was aware that the resident ' s antibiotic was not available one morning (5/10/2021) because it was not available, and the DON was made aware on 5/10/2021 (contract nursing staff failed to reorder). The DON provided medication reorder education for all contract nursing staff.

On 6/3/2021 at an interview was conducted with the DON. The DON stated that she was made aware that the resident ' s antibiotic medication was not available on one morning (5/10/2021). The nurse assigned (contract nurse was not available) was unaware that the antibiotic was available in medication storage stock but not obtained. The DON expected staff to reorder medication before it is gone so residents can receive their medication as ordered. The DON stated that she provided medication reorder education for all contract nursing staff.

2. Resident #9 was admitted to the facility on 9/2/2020 with the diagnosis of hypertension.

The resident ' s care plan dated 9/2/2020 revealed cardiac diagnoses with medication

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administration and side effects.

A review of the resident ' s quarterly Minimum Data Set (MDS) dated 3/11/21 revealed the resident had an intact cognition. Active diagnosis was hypertension.

The resident had a physician order dated 9/2/2020 for Cardizem (medication for treatment of hypertension)120 milligrams (mg) twice a day.

A review of the June 2021 medication administration record documented that the resident missed one dose of Cardizem 120 mg on 6/1/2021 8:00 am

During medication pass on 6/3/2021 at 9:20 am with Medication Aide (MA) #2 observation revealed that Cardizem 120 mg ordered twice a day was not available for the resident. There was no more medication remaining for administration and none in stock medication. Only Cardizem 240 mg was available in stock medication.

On 6/3/2021 at 9:20 am an interview was conducted with MA #2. She stated that she was without medication (Cardizem 120 mg) for the resident this morning 6/1/2021 because it was not reordered. This (failure to reorder) has been a problem because contract nursing staff does not know how to reorder, and reordering medication sometimes gets forgotten or delayed. MA #2 was aware that medications were not always reordered when needed and that residents had to wait (unknown amount of time) for their medication administration after the reorder and the medication was received. MA #2 stated she will reorder the medication now.

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F 755	Continued From page 133 On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she was made aware that contract nurses do not know how to reorder medication and education was provided. She expected staff to reorder medication before it ran out.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 761	F761	7/2/21

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F 761	Continued From page 134 interview, the facility failed to administer medication after being prepared (poured) and stored the prepared medication in the medication cart and the facility also failed to date 3 multi-dose vials of tuberculin (2) and Ativan (1) after being opened and were stored in the medication storage refrigerator for 2 of 2 medication storage rooms. Findings included: A review of the facility documented "Medication Administration-General Guidelines", undated, read: 4) When medications are administered by mobile cart taken to the resident ' s location (room, dining, area, etc.) medications are administered at the time they are prepared. Medications are not pre-poured either in advance of the med pass or for more than one resident at a time. 7) The person who prepares the dose for administration is the person who administers the dose. 12) Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes ..." 1. On 6/03/21 at 9:20 am an observation was done of medication pass with Medication Aide (MA) #2. The MA poured medication (pills into a cup) for Resident #9. The resident ' s medication of Eliquis 5 milligrams (mg) was in the medication cup when the MA recognized there was no more Cardizem 120 mg due at 9:00 am. The MA placed the cup of medication (not labeled) in the medication cart drawer, locked the cart, and walked away. The MA required assistance to reorder Cardizem 120 mg. The MA returned about 15 minutes later to her assigned medication cart and unlocked the cart to retrieve	F 761	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Facility failed to administer medication after being prepared (poured) by medication aide #2 and stored the prepared medication in the medication cart and the facility also failed to date 3 multi dose vials of tuberculin (2) And Ativan (1) after being opened and were stored in the medication storage refrigerator for 2 of 2 medication storage rooms. Medication Aide #2 was educated 1:1 by the DON on 6/4/2021 on medication prep according to policy. 3 multi dose vials were discarded appropriately and immediately by Nursing Staff on 6/4/2021. How the facility will identify other residents having the potential to be affected by the	

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F 761	Continued From page 135 the medication cup that was not labeled for administration. On 6/3/21 at 9:35 am an interview was conducted with MA #2. The MA stated that leaving a cup of unlabeled medication in the medication cart for later administration was not part of her training and affects the 5-rights of medication administration. On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON agreed that once medication was poured, staff were required to administer the medication and not left unlabeled and/or unattended. 2a. On 6/3/2021 at 3:00 pm an observation of the locked unit ' s medication storage room was completed with Nurse #7. There was 1 Tuberculin multi-use vial opened and not dated. The vial was almost empty and appeared to have been used. There was 1 Ativan multi-use vial stock medication (not resident assigned) opened and not dated. The vial was almost empty. Recommended use after opening was 30 days. On 6/3/2021 at 3:00 pm an interview was conducted with Nurse #7. The nurse stated that all multiuse vials were required to be dated when opened and would discard the 2 undated vials. On 6/4/2021 at 5:31 pm an interview was conducted with the Director of Nursing (DON). The DON stated that opened multi-use vials were required to be dated and kept in use according to the manufacturer ' s recommendation (usually 30 days).	F 761	same deficient practice: To identify other residents who have the potential to be affected, on 6/7/2021, an Audit was 100% completed for review of all medication carts and medication rooms was conducted by the Nurse Management team to ensure medications were Dated/Labeled per manufacturing instructions. Results of audit revealed no other deficiencies on medications for Dates or Labeling. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Licensed Nurses and Med Aides, including agency staff were re-educated by the Director of Nursing on 6/9/2021 dating multi-dose vials and the storage dates of opened Tuberculin and Ativan. Licensed Nurses and Med Aides were also re-educated on the 5-Rights of Medication Administration All Licensed nurses and medication aides, including agency staff will be educated in orientation on dating medication upon opening and storing medication properly. All Licensed Nurses and medication aides, including agency staff will be in serviced on the 5- rights of medication administration. In person or via telephone by the Director of Nursing and/or designee July 2, 2021.	

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F 761	Continued From page 136 2. b. On 6/3/2021 at 2:01pm in the presence of Nurse #4, an observation was conducted of the medication storage room at the top of the 200 hall. The observation revealed two open vials of Tuberculin in a refrigerator. Neither vial was dated. On the side of the box containing the vials the manufacturer recommendations were to discard the vial 30 days after vial was opened. At 2:03pm on 6/3/2021 an interview was conducted with Nurse #4. He stated Tuberculin vials should be dated with the date they were opened because they are only good for 30 days after they are open. He stated neither vial was dated and he removed both vials from the refrigerator and discarded them. On 6/4/2021 at 5:20pm and interview was conducted with the DON. She stated it was her expectation that bottles of Tuberculin be dated when open and then discarded 30 days after the date they were open per manufacturers recommendation.	F 761	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 6/7/2021 Director of Nursing and/or designee will audit 5 medication passes weekly for 12 weeks to ensure License Nurses and Medication aides are administering medications to ensure medications are administered to residents. To prevent this from recurring, beginning on 6/7/2021 the DON and nurse management team began monitoring Medication carts and Medication Rooms via observation, 3 x weekly x 4 weeks then 2 x per week x 4 weeks, then 2 x per month x 3 months to ensure medications are dated/labeled and the medication rooms had no undated/unlabeled open medications. Results of these audits will be reviewed at Monthly QAPI x 3 months. If any issues or trends are identified, it will be addressed by the QAPI Committee, and the plan will be revised to ensure compliance. Completion date: July 2, 2021	
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.	F 880		7/2/21

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F 880	Continued From page 137 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 06/11/2021

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F 880	Continued From page 138 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 observation, record review and staff interviews, the facility failed to use hand hygiene (hand sanitizer or soap and water) and disinfect the pulse oximeter (check oxygen) between resident encounters observed during medication pass (1 of 2 staff) for 2 of 5 residents (Residents in Room #303 bed A and B). Findings included: A review of the undated facility "Medication Administration-General Guidelines" revealed: 2) Handwashing and Hand Sanitization: The person administering medications adhere to good hand hygiene, which includes cleansing hands thoroughly · before beginning a medication pass · prior to handling any medication · after coming into direct contact with a resident	F 880	F880 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 880	Continued From page 139 During medication pass observation on 6/3/2021 at 9:20 am, Medication Aide (MA) #2 was observed entering room #303. MA #2 administered medication to and checked the temperature and oxygen saturation of the resident in bed B. The MA then walked over to the resident in bed A and checked her temperature and oxygen saturation without performing hand hygiene or cleaning the pulse oximeter between residents. MA #2 was interviewed on 6/3/2021 at 9:25 am. MA #2 stated that she forgot to use hand sanitizer in-between resident care for the residents in room #303. On 6/4/2021 at 5:31 pm an interview was conducted with Director of Nursing who stated that hand hygiene was required to be done after each resident contact.	F 880	Ensure to use hand hygiene (hand sanitizer or soap and water) and disinfect the pulse oximeter (check oxygen) between resident encounters by MA #2. The pulse oximeter was immediately cleaned by MA #2. MA #2 immediately sanitized her hands with hand sanitizer after leaving resident room. How the facility will identify other residents having the potential to be affected by the same deficient practice: To identify other residents who have the potential to be affected, on 6/9/2021, all staff was educated on proper Hand Hygiene according to facility Infection Control Policy by DON. The MA #2 who was observed not disinfecting the pulse oximeter and sanitizing her hands between use for residents in the same room was provided 1:1 education by DON on 6/4/2021 on infection control cleaning and disinfecting policy and procedure for non-specific resident equipment. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The DON or designee will do Infection Control observations rounds daily on all 3 shifts to ensure staff compliance with	

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F 880	Continued From page 140	F 880	infection control guidelines. QAPI committee will be meeting weekly to review findings of the Infection Control Rounds and ensure additional education and/or corrective action is being given as needed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON or designee will Audit 3 direct care staff doing vital signs 2 times a week for 1 month, then 1 staff weekly for 3 months to ensure compliance with disinfecting nonspecific resident equipment and sanitizing of hands in between residents immediately after contact with a resident. The results of these Audits will be reviewed at Quarterly QAPI meeting x2 for further problem resolution if needed. Completion Date: July 2, 2021	