STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 000	INITIAL COMMENTS An unannounced, on-site complaint investigation was conducted on 09/08/21 to 09/09/21 with exit from the facility on 09/09/21. Additional information was obtained offsite through 09/20/21. The survey team returned to the facility on 09/20/21 to validate the credible allegation of compliance. Therefore, the exit date was changed to 09/20/21. There were 26 allegations investigated and 8 allegations were substantiated. Event ID# R3LG11. Past non-compliance was identified at: CFR 483.45 at tag F 760 at a scope and severity of K. The tag F 760 constituted Substandard Quailty of Care. An extended survey was conducted.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		10/13/21

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

Electronically Signed | 10/12/2021

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sanitary overbed tables for 8 of 23 overbed tables (Rooms #106, #229, #104, #102, #100, #101, #228, #220), maintain overbed tables in good condition for 1 of 1 overbed table (Room #229), maintain a sanitary dresser in 1 of 1 room (Room #102), they also failed to maintain sanitary wheelchairs for 5 of 7 wheelchairs (Wheelchair #1, #2, #3, #4, and #5) and wheelchair armrests in good condition for 3 of 7 (Wheelchair #2, #4, #5) reviewed for safe, clean, comfortable and homelike environment.	F 584	1. No residents cited. Identified overbed tables were cleaned by staff. Identified wheelchairs were cleaned, armrests repaired and those with rust were discarded. 2. Residents in the facility have the potential to be affected by this alleged deficient practice. The Administrator has reviewed wheelchairs & overbed tables to validate cleanliness & condition as of 10/12/21. All concerns were addressed at time of discovery. 3. The Director of Nursing or Assistant	

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F 584	Continued From page 2 Findings included: 1. a. An observation of Room #106's A-bed overbed table on 09/08/21 at 10:50 AM revealed an area of dried debris to the top of the table and multiple areas of dried debris to the base of the table. An observation of Room #106's A-bed overbed table on 09/09/21 at 07:22 AM revealed the overbed table remained unchanged. b. An observation of the B-bed overbed table in Room #229 on 09/08/21 at 11:18 AM revealed peeling finish to the top of the table and dried stains to the base of the table. The A-bed overbed table was observed to have dried stains to the top of the table. An observation of the A-bed and B-bed overbed tables of Room #229 on 09/09/21 at 12:40 PM revealed the tables were unchanged. c. An observation of the base of the B-bed overbed table in Room #104 on 09/08/21 at 11:29 AM revealed dried debris to the base of the table and dried debris to the base of the A-bed overbed table. An observation of the A-bed and B-bed overbed tables in Room #104 on 09/09/21 at 07:25 AM revealed the tables remained unchanged. d. An observation of the overbed table in Room #102 on 09/08/21 at 11:39 AM revealed dried debris to the top and base of the table and dried streaks to the front of the dresser. An observation of the overbed table and dresser in Room #102 on 09/09/21 at 07:27 AM revealed the table and dresser were unchanged. e. An observation of the overbed table of Room #100 on 09/08/21 at 11:44 AM revealed dried	F 584	Director of Nursing has educated the housekeeping staff on consistently cleaning overbed tables, the nursing assistants on cleaning resident wheelchairs and the maintenance director on discarding resident wheelchairs when rusted. This education was completed by 10/13/21. Any housekeeper or nursing assistant not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire and agency orientation. 4. The Interdisciplinary Team will monitor overbed tables and resident wheelchairs during room rounds 3 times per week for 4 weeks then weekly for 2 months. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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F 584	Continued From page 3	F 584		

debris to the top and base of the table. An observation of the overbed table of Room #100 on 09/09/21 at 07:29 AM revealed the table was unchanged.

f. An observation of the overbed table of Room #101 on 09/08/21 at 11:47 AM revealed dried debris to the base of the table.

g. An observation of the A-bed overbed table of Room #228 on 09/08/21 at 11:59 AM revealed dried material to the top and base of the table. The base of the B-bed overbed table was observed to have dried material to the base of the table. An observation of the A-bed overbed table of Room #228 on 09/09/21 at 12:45 PM revealed dried material to the base of the table.

h. An observation of the A-bed overbed table of Room #220 on 09/08/21 at 12:04 PM revealed dried material to the top and base of the table. An observation of the A-bed overbed table of Room #220 on 09/09/21 at 07:39 AM revealed the table was unchanged.

An interview with the Housekeeping Supervisor on 09/09/21 at 03:37 PM revealed cleaning of resident rooms included cleaning the tops and bases of overbed tables and dressers daily during room rounds. He stated housekeeping should also be monitoring overbed tables to make sure they were in good repair and if not to notify him.

A walking round was conducted with the Administrator, Director of Nursing (DON), and Housekeeping Supervisor on 09/09/21 at 05:12 PM to observe areas of concern regarding overbed tables and the unsanitary dresser. A joint interview with all 3 staff members at the

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F 584	Continued From page 4	F 584		

same date and time revealed overbed tables and dressers were expected to be cleaned daily and there was no excuse for the tables and dresser to be soiled. The Administrator stated the overbed tables should not have peeling finish and the facility would develop a plan to make sure overbed tables were maintained in good repair.

2. a. An observation of Wheelchair #1 on 09/08/21 at 11:44 AM revealed dried debris to the right armrest and both wheels. An observation of Wheelchair #1 on 09/09/21 at 07:29 AM revealed the wheelchair was unchanged.

b. An observation of Wheelchair #2 on 09/08/21 at 11:47 AM revealed dried material to both armrests and unraveling tape to both armrests. An observation of Wheelchair #2 on 09/09/21 at 07:31 AM revealed the wheelchair was unchanged.

c. An observation of Wheelchair #3 on 09/08/21 at 11:51 PM revealed the frame and the left brake were rusty. An observation of Wheelchair #3 on 09/09/21 at 07:33 AM revealed the wheelchair was unchanged.

d. An observation of Wheelchair #4 on 09/08/21 at 11:55 AM revealed the covering of the left armrest was peeling off, the frame was rusty, and there was dried material to the spokes of both wheels. An observation of Wheelchair #4 on 09/09/21 at 12:43PM revealed the wheelchair was unchanged.

e. An observation of Wheelchair #5 on 09/08/21 at 12:04 PM revealed the covering of both armrests was peeling and there was dried material to both wheels. An observation of

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Wheelchair #5 on 09/09/21 at 07:39 AM revealed the wheelchair was unchanged.

An interview with the Housekeeping Supervisor on 09/09/21 at 03:37 PM revealed housekeeping was responsible for wiping down wheelchair armrests and cushions as needed and he was not sure who was responsible for cleaning wheelchair frames and wheels.

An interview with the Maintenance Director on 09/09/21 at 04:35 PM revealed housekeeping was responsible for cleaning wheelchairs and if there were tears in the armrest of wheelchairs he was responsible for fixing them. He explained if the therapy or nursing departments notified of him of a need to fix wheelchair armrests he would fix the armrests. The Maintenance Director stated he was notified of the need for repairs either verbally or through a computer system and he did not perform rounds to check wheelchairs for needing repairs.

An interview with the Director of Nursing on 09/09/21 at 04:57 PM revealed she was not sure who was responsible for cleaning wheelchairs and she would have to check with the Social Worker or the Maintenance Director to see if they knew who was responsible for cleaning wheelchairs.

A walking round was conducted with the Administrator, Director of Nursing (DON), and Housekeeping Supervisor on 09/09/21 at 05:12 PM to observe areas of concern regarding unsanitary wheelchairs and wheelchair armrests in need of repair. A joint interview with all 3 staff members at the same date and time revealed they were not sure who was responsible for

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F 584	Continued From page 6 cleaning wheelchairs but they were going to meet with each other and develop a plan for cleaning the wheelchairs. The Administrator stated maintenance was responsible for repairing wheelchair armrests and wheelchair armrests should be in good condition.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure by not submitting an initial or 5-day investigative report for 1) an injury of unknown origin for a dependent resident with swelling noted to her leg that was subsequently determined to be a fracture (Resident #5) and 2) an allegation of resident-to-resident abuse within 2 hours of being notified (Resident #2) to the Division of Health Service Regulation (DHSR) for 2 of 4 sampled residents reviewed for abuse. Findings included: The facility policy titled, "Abuse, Neglect and	F 607	1. Resident #5 is stable in the facility. Resident #2 no longer resides in the facility. 2. Residents in the facility have the potential to be affected this alleged deficient practice. No issues have been reported since the survey exit of 9/20/21. 3. The Regional Director of Clinical Services has educated the facility management team on reporting requirements, including reporting of injuries of unknown source, and the reporting timeframe requirement of 2 hours pertaining to allegations of abuse and the Director of Nursing has educated	10/13/21

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F 607	Continued From page 7 Exploitation implemented 11/01/20, read in part: "it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. All alleged violations will be reported to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: Immediate, 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." 1. Resident #5 was admitted to the facility on 06/29/19 with multiple diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 08/02/21 assessed Resident #5 with severe impairment in cognition for daily decision making. The MDS noted Resident #5 required extensive staff assistance with bed mobility, total staff assistance with transfers and had impairment on both lower extremities. A nurse progress note for Resident #5 dated 05/31/21 written by Nurse #4 read in part, "Resident complained of Right Lower Extremity (RLE) pain. During assessment resident's RLE had mild swelling and tender to touch. RLE elevated using a pillow and cold compress applied to site. One hour post scheduled pain medication pain lessened. Nurse Practitioner notified via written report to evaluate."	F 607	facility staff on reporting potential abuse or neglect to facility management immediately. This education was completed by 10/13/21. Any staff member not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation and agency orientation. 4. The Administrator will monitor resident injuries and reportable issues to validate reporting requirements are met weekly for 4 weeks then monthly for 2 months. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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The Medical Doctor (MD) progress note for Resident #5 dated 06/03/21 read in part, "acute visit for evaluation of right leg fracture at the request of nursing staff. Resident #5 was noted to have swelling in her right leg yesterday. STAT (urgent) x-ray obtained and demonstrated an acute proximal tibia (long bone on inside of lower leg) fracture with malignment (displacement). I spoke in length with the nursing team including the Director of Nursing. Resident #5 has not had any witnessed falls or recent injuries. I saw Resident #5 in her room, she denies any falls or injury, however, she is a very poor historian. She does have a history of osteoporosis and previous fractures. Assessment: Right tibial fracture. She appears to have sustained a spontaneous fracture. Spontaneous fractures are seen in elderly, debilitated patients. She has multiple risk factors for spontaneous fractures including her advanced age, diabetes, osteoporosis, Vitamin D deficiency and history of previous fractures. I have no suspicion for abuse."

Review of facility documentation revealed no initial or 5-day investigative reports were submitted to the DHSR related to Resident #5's injury of unknown origin.

During an interview on 09/09/21 at 1:40 PM, Nurse #4 confirmed she was assigned to provide care to Resident #5 on 05/30/21 during the hours of 6:30 PM to 6:30 AM. Nurse #4 stated during early morning rounds on 05/31/21, Resident #5 complained of pain in her right lower extremity and upon assessment, she noticed it was swollen but had no discoloration or signs of obvious fracture. Nurse #4 stated when Resident #5 received her scheduled pain medication and ice

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was applied, her pain lessened. Nurse #4 added she did not contact the on-call physician but did give report during shift change and left a communication note for the MD or Nurse Practitioner to evaluate.

Telephone attempts on 09/10/21 at 1:46 PM and 09/13/21 at 12:26 PM to speak with the facility's former MD who evaluated Resident #5 on 06/03/21 were unsuccessful.

The Director of Nursing (DON) and Administrator at the time this incident occurred were no longer employed at the facility and unavailable for an interview.

During an interview on 09/09/21/21 at 5:00 PM, the Regional Clinical Operations Consultant (RCOC) explained Resident #5 was noted to have mild swelling to her leg on 05/31/21 and upon exam an x-ray was ordered by the Nurse Practitioner on 06/02/21 which confirmed a fracture and she was sent to the Emergency Department for evaluation and treatment. The RCOC stated the incident was investigated by the previous DON who noted Resident #5 had no reported falls or other incidents but she did have an outside visit with her family on 05/29/21. When Resident #5 was asked what had happened to her leg, Resident #5 reported she fell getting into the truck; however, her family reported she did not get into a truck to go anywhere during their visit on 05/29/21. The RCOC added they were unable to determine the source of the injury. The RCOC confirmed the previous administrative staff did not report Resident #5's injury of unknown origin as required and stated they should have submitted the initial and investigative reports to DHSR when the injury

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was identified and subsequently investigated.

2. Resident #2 was admitted to the facility on 07/29/20 with multiple diagnoses that included Parkinson's disease and dementia.

The quarterly Minimum Data Set (MDS) dated 07/05/21 assessed Resident #2 with intact cognition.

Review of the initial investigative report submitted by the facility to the Division of Health Service Regulation (DHSR) noted an allegation type of resident abuse involving Resident #2 and a cognitively impaired female resident that occurred on 08/14/21 at 4:00 PM. It was further noted, the initial investigative report was submitted to DHSR on 08/16/21 at 11:37 AM.

During an interview, Nurse #3 revealed she worked on 08/14/21 when Resident #2 was observed touching a female resident inappropriately. Nurse #3 stated the residents were separated and the female resident was assessed with no injury or signs of distress noted. She added she called the Director of Nursing (DON) to inform her of the incident and was instructed to place Resident #2 on 15-minute checks for monitoring.

During an interview on 09/09/21 at 3:00 PM, the DON confirmed she was notified by Nurse #3 of the resident-to-resident incident involving Resident #2. The DON explained she was out of town at the time and instructed Nurse #3 to notify the Assistant Director of Nursing and place Resident #2 on 15-minute checks for monitoring. The DON stated when she arrived back at the facility on 08/16/21, she discussed the incident

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F 607	Continued From page 11 with the Administrator, the initial investigative report was faxed to DHSR, and an investigation was initiated. During an interview on 09/09/21 at 3:28 PM, the Administrator confirmed he was notified the morning of 08/16/21 of the resident-to-resident incident that occurred the afternoon of 08/14/21 involving Resident #2 and an investigation was immediately initiated. The Administrator was aware of the regulatory time frame for reporting abuse allegations and verified the initial report was not submitted to DHSR until 11:37 AM on 08/16/21. He stated staff should have notified him on 08/14/21 when the incident occurred and added all staff had since been re-educated on the abuse policy.	F 607		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a dependent resident assessed by a licensed medical professional when the resident complained of pain and swelling was noted to her leg that was subsequently determined to be a fracture which caused a delay of treatment for 1 of 3 residents	F 684	1. Resident #5 is stable in the facility. 2. Residents experiencing acute onset of edema and pain in their extremities have the potential to be affected by this alleged deficient practice. The Director of Nursing/Assistant Director of Nursing have completed body audits on facility	10/13/21

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reviewed for accidents (Resident #5).

Findings included:

Resident #5 was admitted to the facility on 06/29/19 with multiple diagnoses that included Alzheimer's disease, leg pain, osteoporosis, and history of left femur fracture.

Review of Resident #5's medical record revealed the following physician orders:
11/19/20 read in part, Observation: pain - observe every shift. If pain present, complete pain flow sheet and treat trying non-pharmacologic interventions prior to medicating if appropriate.
11/19/20 read in part, Tramadol (pain medication) 50 mg three times a day for leg pain.
11/24/20 Tylenol (pain medication) 325 milligrams (mg) - give 2 tablets by mouth two times a day for pain.

The quarterly Minimum Data Set (MDS) dated 08/02/21 assessed Resident #5 with severe impairment in cognition for daily decision making. The MDS noted Resident #5 required extensive staff assistance with bed mobility, total staff assistance with transfers and had impairment on both lower extremities.

Review of Resident #5's Medication Administration Record (MAR) for May 2021 revealed her pain level was assessed using a scale of 0 (no pain) to 10 (severe pain) each shift as ordered and recorded as follows:
05/30/21 at 6:30 AM, pain level was documented as a level 0.
05/30/21 at 2:30 PM, pain level was documented as a level 0.
05/31/21 at 6:30 AM, pain level was documented

residents on 10/8/21 to validate no acute onset of edema and pain in extremities is present. No concerns were identified.
3. The Director of Nursing/Assistant Director of Nursing has educated the Licensed Nurses on notifying the provider either in person or via telephone for timely intervention with acute onsets of edema and pain in a resident□s extremity and the Nursing Assistants on escalating issues regarding residents to the Assistant Director of Nursing or Director of Nursing so they may intervene with provider notification should their charge nurse indicate nothing can be done. This education was completed by 10/13/21. Any Licensed Nurse or Nursing Assistant not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire and agency orientation.
4. The Director of Nursing/Assistant Director of Nursing will monitor the 24hr report to validate timely provider notification and corresponding interventions occurred daily in clinical morning meeting, Mon-Fri, for 4 weeks then weekly for 2 months. The Administrator will randomly review monitoring for concerns monthly for 3 months. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Director of Nursing for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery.

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as a level 0.
05/31/21 at 2:30 PM, pain level was documented as a level 5.
05/31/21 at 10:30 PM, pain level was documented as a level 5.

A nurse progress note for Resident #5 dated 05/31/21 written by Nurse #4 read in part, "Resident complained of Right Lower Extremity (RLE) pain. During assessment resident's RLE had mild swelling and tender to touch. RLE elevated using a pillow and cold compress applied to site. One hour post scheduled pain medication pain lessened. Nurse Practitioner notified via written report to evaluate."

The radiology x-ray results dated 06/02/21 revealed in part, "acute proximal (nearer to the center) tibia (larger of the two bones in the lower leg) fracture."

A nurse progress note for Resident #5 dated 06/03/21 written by Nurse #5 stated x-ray results were received and indicated a proximal tibia fracture to the right leg. Nurse #5 documented a physician was contacted and gave orders for Resident #5 to be transferred to the emergency room for treatment. Nurse #5 noted Resident #5 left the facility with emergency medical services at 6:00 AM.

Review of the medical record revealed Resident #5 returned to the facility later that same day with a splint on her right leg.

The Medical Doctor (MD) progress note for Resident #5 dated 06/03/21 read in part, "acute visit for evaluation of right leg fracture at the request of nursing staff. Resident #5 was noted

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to have swelling in her right leg yesterday. STAT (urgent) x-ray obtained and demonstrated an acute proximal tibia (long bone on inside of lower leg) fracture with malignment (displacement). I spoke in length with the nursing team including the Director of Nursing (DON). Resident #5 has not had any witnessed falls or recent injuries. I saw Resident #5 in her room, she denies any falls or injury, however, she is a very poor historian. She does have a history of osteoporosis and previous fractures. Assessment: Right tibial fracture. She appears to have sustained a spontaneous fracture. Spontaneous fractures are seen in elderly, debilitated patients. She has multiple risk factors for spontaneous fractures including her advanced age, diabetes, osteoporosis, Vitamin D deficiency and history of previous fractures. I have no suspicion for abuse. Pain Management: still with some pain. Will increase Tramadol to 50 mg every 6 hours scheduled with Tylenol 650 mg. every 6 hours as scheduled. Continue to monitor."

During an interview on 09/13/21 at 3:34 PM, Nurse Aide (NA) #2 confirmed she was assigned to provide care to Resident #5 during the hours of 6:30 AM to 2:30 PM on 05/31/21. NA #2 recalled being told during shift report Resident #5's leg was swollen and they had applied ice. She stated during the shift, Resident #5 complained of some pain but nothing abnormal for her. NA #2 stated Resident #5's leg was swollen but she did not grimace or voice any complaints of pain when care was provided during the shift.

During an interview on 09/13/21 at 10:03 AM, NA #3 confirmed she was assigned to provide care to Resident #5 during the hours of 10:30 PM to 6:30 AM on 05/31/21 and 06/01/21. On 05/31/21

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during the shift, she stated she had notified the nurse that Resident #5's leg was bruised and was told by the agency nurse she was aware and there was nothing she could do about it except leave a note for the MD. On 06/01/21, NA #3 stated she told another agency nurse Resident #5's leg was bruised and was told the same thing as the previous evening. NA #3 could not recall the names of the agency nurses she had notified. NA #3 recalled Resident #5 never really complained of any pain during her shift and her leg "wasn't that swollen, not like you would expect with a fracture", just bruised.

During an interview on 09/13/21 at 11:31 AM, Nurse #2 confirmed she was assigned to provide care to Resident #5 on 05/30/21 during the hours of 6:30 AM to 6:30 PM. Nurse #2 could not recall the exact time but stated she was in Resident #5's room, fluffing her pillows and assisting with repositioning her in bed, when she complained about her leg being sore. Nurse #2 added when she assessed Resident #5's legs, she didn't remember her having any swelling in either leg and explained both legs looked the same with no discoloration or other signs of a fracture. Nurse #2 stated she administered Resident #5's scheduled pain medication which was effective and since Resident #5 did not display signs of severe pain, she felt it was just the "normal aches and pains."

During an interview on 09/09/21 at 1:40 PM, Nurse # Nurse #4 confirmed she was assigned to provide care to Resident #5 on 05/30/21 during the hours of 6:30 PM to 6:30 AM. Nurse #4 stated during early morning rounds on 05/31/21, Resident #5 complained of pain in her right lower extremity and upon assessment, she noticed it

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was swollen but had no discoloration or signs of obvious fracture. Nurse #4 stated when Resident #5 received her scheduled pain medication and ice was applied, her pain lessened. Nurse #4 added she did not contact the on-call physician but did give report during shift change and left a communication note for the MD or Nurse Practitioner to evaluate.

The Nurses assigned to provide care to Resident #5 during both shifts on 06/01/21 and during the hours of 6:30 AM to 6:30 PM on 06/02/21 were no longer employed by the facility and unavailable for an interview.

During an interview on 09/13/21 at 11:47 AM, Nurse #5 confirmed she was assigned to provide care to Resident #5 on 06/02/21 during the hours of 6:30 PM to 6:30 AM. Nurse #5 could not recall the exact time but stated during the shift, Resident #5 was grimacing and she couldn't recall what Resident #5's response was but when she looked at her leg, she noticed it was bruised. Nurse #5 did not remember being told anything had happened to Resident #5's leg during shift report and nothing was written in the previous nurses' notes; however, she did receive the x-ray results confirming a fracture. Nurse #5 added she notified the on-call MD who gave orders to send Resident #5 to the hospital for evaluation and treatment.

Telephone attempts on 09/10/21 at 1:46 PM and 09/13/21 at 12:26 PM to speak with the facility's former MD who evaluated Resident #5 on 06/03/21 were unsuccessful.

Attempts to interview the radiologist who interpreted Resident #5's x-ray completed on

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F 684	Continued From page 17 06/02/21 were not successful. The Director of Nursing (DON) and Administrator at the time this incident occurred were no longer employed at the facility and unavailable for an interview. During an interview on 09/13/21 at 12:40 PM, the current DON explained she was not employed with the facility when Resident #5's fracture was identified and was not sure what their process was at the time related to notifying the physician with changes in condition. The DON stated in her opinion, they should have notified the on-call physician when the swelling was first identified. During interviews on 09/09/21/21 at 5:00 PM and 09/20/21 at 2:30 PM, the Regional Clinical Operations Consultant (RCOC) explained Resident #5 was noted to have mild swelling to her knee on 05/31/21 and upon exam an x-ray was ordered by the Nurse Practitioner (NP) on 06/02/21 which confirmed a fracture and she was sent to the Emergency Department for evaluation and treatment. The RCOC explained since Resident #5 had no known falls or injuries and Resident #5's scheduled pain medications were effective she felt it was appropriate for the nurse to leave a written communication note for the NP or MD.	F 684		
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	F 686		10/13/21

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F 686	Continued From page 18 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Wound Care Nurse Practitioner (NP) interviews the facility failed to provide pressure ulcer care per physician orders for 1 of 2 residents (Resident #11) reviewed for pressure ulcer care. Findings included: Resident #11 was admitted to the facility 12/07/20 with diagnoses including anemia and heart failure. Review of the significant change Minimum Data Set (MDS) dated 08/31/21 revealed Resident #11 had 1 unhealed stage 3 (a wound involving full-thickness skin loss) pressure ulcer that was not present on admission. The MDS further indicated Resident #11 had a pressure reducing device for his bed and chair and received pressure ulcer care. Review of Resident #11's wound treatment order dated 08/25/21 revealed the left buttock wound was to be cleaned with normal saline/wound cleanser, patted dry, santyl (an enzyme that helps remove dead skin and tissue) applied to the open area, covered with calcium alginate (an absorbent	F 686	1. Resident #11 is receiving wound treatment per physician□s order. 2. Residents with physician ordered pressure ulcer treatment have the potential to be affected by this alleged deficient practice. The Assistant Director of Nursing has reviewed current residents with pressure ulcer treatments to validate treatments are accurate and components are available in the facility. No other concerns were identified. 3. The Director of Nursing/Assistant Director of Nursing has educated the Licensed Nurses on completing pressure ulcer treatments as ordered by the physician, including all components specified and what steps to take should any component of the order not be available for use at the time of treatment. This education was completed by 10/13/21. Any Licensed Nurse not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire and agency orientation. 4. The Assistant Director of Nursing will randomly observe the provision of pressure ulcer wound care to validate all	

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F 686	Continued From page 19 dressing), and covered with a bordered gauze every day shift. An observation of Nurse #2 on 09/08/21 at 04:27 PM revealed she cleansed Resident #11's left buttock wound with normal saline, patted the wound dry, applied calcium alginate, and covered the wound with a bordered gauze. An interview with Nurse #2 on 09/08/21 at 05:09 PM revealed she was aware santyl was ordered for Resident #11's wound but she was unable to find santyl so she put a dry dressing on without santyl. She stated she did not notify the Wound Care NP santyl wasn't available and get an order for a dry dressing change and she should have. Nurse #2 was unable to state why she did not call the Wound Care NP and notify her that santyl wasn't available. An interview with the Director of Nursing (DON) on 09/08/21 at 06:50 PM revealed she expected nurses to follow physician orders for wound care and to notify the provider if the ordered wound treatment was not available. An interview with the Wound Care NP on 09/13/21 at 04:10 PM revealed she should have been notified if santyl wasn't available for Resident #11's wound care and she was not notified. She stated she could have given an order for a dry dressing or other wound treatment until the santyl was available. An interview with the Administrator on 09/15/21 at 05:54 PM revealed he expected nursing staff to follow physician orders for wound care or notify the provider if the ordered treatment was not available.	F 686	components of the order are carried out 3 times per week for 4 weeks then weekly for 2 months. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Director of Nursing for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a Peripheral Inserted Central Catheter (PICC; used to draw blood and give treatments) line after Intravenous (IV; process of administering medications/fluids through a tube inserted into a vein) antibiotics were discontinued for 1 of 3 residents reviewed for medication errors (Resident #6). Findings included: The hospital records for Resident #6 dated 12/31/20 to 01/13/21 noted in part, "PICC line was placed on 01/12/21 and he was deemed stable for discharge to the skilled nursing facility for long-term IV antibiotics." Resident #6 admitted to the facility on 01/13/21 with multiple diagnoses that included enterococcus (bacteria), bacteremia and hepatic failure. A nurse progress note dated 01/13/21 written by Nurse #1 read in part, "Resident #6 arrived from the hospital at approximately 1:30 PM. PICC is in right arm. Medications verified by the Medical Doctor (MD)." The admission Minimum Data Set (MDS) dated	F 694	1. Resident #6 no longer resides in the facility. 2. Residents with Peripherally Inserted Central Catheter (PICC) have the potential to be affected by this alleged deficient practice. As of 10/13/21, no current residents have a PICC. 3. The Director of Nursing/Assistant Director of Nursing has educated the Licensed Nurses on the need to continue PICC flushing in the absence of routine medication administration. This education was completed by 10/13/21. Any Licensed Nurse not receiving this education by this date will receive prior to next shift. This information will be presented in new hire and agency orientation. 4. The Director of Nursing will begin to monitor residents with PICC as applicable to validate flushing continues should routine medication administration cease weekly for 4 weeks then monthly for 2 months. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Director of Nursing for recommendations for a period of 3 months. Any concerns identified will be	10/13/21

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F 694	Continued From page 21 01/19/21 assessed Resident #6 with intact cognition and noted he received antibiotics 6 of 7 days during the MDS assessment period. Review of Resident #6's Medication Administration Record (MAR) for January 2021 revealed the following physician orders: *01/14/21 read in part, Heparin and NaCl (Sodium Chloride) lock flush 10-0.9 unit/milliliter % - use one syringe intravenously every 4 hours for maintenance of PICC line (daily flushing of the PICC line with Sodium Chloride Solution and Heparin keeps the line clear and prevents blood clotting). The order was initialed on the MAR as completed every 4 hours starting at 5:00 PM on 01/14/21 and discontinued on 01/21/21 after the last dose of antibiotic was administered at 9:00 PM. *01/25/21 read in part, Dextrose-Sodium Chloride Solution (solution used to supply water, calories, and electrolytes to the body) 5-0.45% - use two liters intravenously via PICC line every shift. The order was initialed as administered at 10:30 PM on 01/25/21 and 6:30 AM on 01/26/21. The hospital records dated 01/26/21 to 02/03/21 noted in part, "Resident #6 was recently discharged from this facility on 01/13/21 following a hospital stay for recurrent enterococcus faecalis bacteremia. Blood cultures cleared and the patient was discharged with a recommendation for Ampicillin 2 grams (gm) every 4 hours and Rocephin 2 gm every 12 hours through 02/18/21. In reviewing available records in the system, it appears the patient never received Rocephin at discharge, and according to notes his Ampicillin was discontinued on 01/21/21. PICC line remains in place. Given the patient's	F 694	addressed at time of discovery.	

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F 694	Continued From page 22 presentation, I suspect he has developed recurrence of bacteremia and therefore we should remove the PICC line and place peripheral IV (thin tube inserted in the vein of the lower arm or back of hand)." The DON and Administrator at the time this incident occurred were no longer employed at the facility and unavailable for an interview. During an interview, the current DON revealed she started her employment at the facility the last week of June 2021 and was not present during Resident #6's stay at the facility. The DON couldn't speak as to why Resident #6's order for the Heparin and NaCl lock flush was discontinued but explained when a PICC line remained in place it was standard practice to continue assessing the site for infection and flushing the line to prevent it from becoming clogged. During an interview on 09/09/21 at 11:40 AM and 09/13/21 at 12:52 PM, the Regional Clinical Operations Consultant explained Resident #6's order for the Heparin and NaCl lock flush was done in conjunction with the IV antibiotics administered every 4 hours and was mistakenly discontinued on 01/21/21 when the antibiotic therapy was completed. The Regional Clinical Operations Consultant reviewed the nurse progress notes for Resident #6 and stated on 01/25/21 it was noted he was started back on IV fluids via PICC line with no complications.	F 694		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		10/12/21

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F 760	Continued From page 23 medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to prevent a significant medication error by not accurately transcribing and administering medication orders from the hospital discharge summary prescribed to treat a bacterial infection for 1 of 3 residents reviewed for medication errors (Resident #6). As a result, Resident #6 was not administered 24 doses of Rocephin (antibiotic) and 24 doses of Ampicillin (antibiotic) and subsequently readmitted to the hospital for suspected severe sepsis (life-threatening complication of an infection) secondary to incompletely treated bacteremia (presence of bacteria in the bloodstream). Findings included: The hospital records for Resident #6 dated 12/31/20 to 01/13/21 noted in part, Resident #6 presented to the Emergency Department (ED) the morning of 12/31/20 for reported increased weakness, recurrent falls, and left arm pain. On arrival to the ED, he was afebrile with stable vital signs. Labs showed stable renal functions, urinalysis without evidence of infection, chest x-ray showed possible faint infiltrate at the lung bases, nonspecific. Resident #6 was admitted and placed on Intravenous (IV; process of administering medications/fluids through a tube inserted into a vein) antibiotics. On 01/04/21 Infectious Disease (ID) consult was done with recommendation to continue monitoring blood cultures. Throughout the hospitalization, he had multiple sets of positive blood cultures through 01/06/21 and finally negative on 01/07/21 and	F 760	Past noncompliance: no plan of correction required.	

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01/08/21. ID recommended 6 weeks of Ampicillin and Rocephin through 02/18/21. Peripherally Inserted Central Catheter (PICC; used to draw blood and give treatments) line was placed and he was deemed stable for discharge to the skilled nursing facility for long-term IV antibiotics.

The hospital discharge summary dated 01/13/21 for Resident #6 included the following orders: "Ampicillin 2 grams (gm) via IV every 4 hours for 37 days and Rocephin 2 gm every 12 hours for 37 days through 02/18/21."

Resident #6 admitted to the facility on 01/13/21 with multiple diagnoses that included enterococcus (bacteria), bacteremia and hepatic failure.

A nurse progress note dated 01/13/21 written by Nurse #1 read in part, Resident #6 arrived from the hospital at approximately 1:30 PM. PICC is in right arm. Medications verified by the Medical Doctor (MD).

The admission Minimum Data Set (MDS) dated 01/19/21 assessed Resident #6 with intact cognition and noted he received antibiotics 6 of 7 days during the MDS assessment period.

Review of Resident #6's Medication Administration Record (MAR) for January 2021 revealed an order for Ampicillin Sodium Solution Reconstituted 2 gram via IV every 4 hours for infection related to Escherichia Coli (E. Coli; infection caused by bacteria) and bacteremia until 01/21/21. The order for Ampicillin was initialed on the MAR as administered daily starting at 5:00 AM on 01/14/21 and discontinued on 01/21/21 after the last dose was administered at 9:00 PM.

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Ampicillin was not administered from 01/22/21 through his discharge to the hospital on 01/26/21, resulting in a total of 24 missed doses. There was no order for Rocephin from the time of his admission on 01/13/21 through his discharge on 01/26/21, resulting in a total of 24 missed doses.

The hospital records dated 01/26/21 to 02/03/21 noted in part, Resident #6 was recently discharged from this facility on 01/13/21 following a hospital stay for recurrent enterococcus faecalis bacteremia. Blood cultures cleared and the patient was discharged with a recommendation for Ampicillin 2 gm every 4 hours and Rocephin 2 gm every 12 hours through 02/18/21. In reviewing available records in the system, it appears the patient never received Rocephin at discharge, and according to notes his Ampicillin was discontinued on 01/21/21. PICC line remains in place. The infectious disease service became aware of this on 01/25/21 and recommended blood cultures times 2, resume Ampicillin and Rocephin unless repeat blood cultures positive. The following day, the resident was sent to the Emergency Department (ED) with a fever. ED work-up was notable for lactic acid above 4, white blood cell count 7,000 but with left shift and bandemia (blood infection). Patient was febrile to 102.3 degrees Fahrenheit on arrival, tachycardic (rapid heartbeat) in the 120s, blood pressure generally above 120 systolic. Is referred for inpatient admission for suspected severe sepsis secondary to incompletely treated bacteremia. I suspect the rapid return of positive blood cultures likely indicates recurrent enterococcal bacteremia, or more accurately incompletely treated enterococcal bacteremia.

During a telephone interview on 09/10/21 at 10:10

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AM, the Infectious Disease (ID) physician explained the type of infection Resident #6 had was very difficult to treat and usually his blood cultures did not come back as positive until after his antibiotics were finished. She stated she was "alarmed" when notified that Resident #6 had not received the antibiotic Rocephin in addition to Ampicillin which were both on the hospital discharge summary and should have been administered as ordered. As a result, she added his bacteremia relapsed and directly related to him becoming septic and hypotensive (abnormally low blood pressure). The ID physician further stated Resident #6 had a history of bacteremia and was not doing well even before this incident occurred.

During a telephone interview on 09/09/21 at 10:32 AM, Nurse #1 confirmed she completed Resident #6's admission to the facility on 01/13/21. She was unable to recall who she spoke with to verify his admitting orders but stated it was either the MD or Nurse Practitioner (NP). Nurse #1 was unable to recall if the antibiotic order was changed when verified with the MD/NP or explain how the order for Rocephin was missed. Nurse #1 did state that the Director of Nursing (DON) became involved at one point when the error was discovered but could not remember the exact date or further specifics.

During a telephone interview on 09/09/21 at 11:13 AM, the previous MD for the facility could not recall if he had talked with Nurse #1 to verify Resident #6's admitting medication orders. He did state that while he may have questioned the dosage of the Rocephin, he would not have changed or discontinued the order until speaking with the ID physician. The MD stated Resident

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#6 should have received both the Ampicillin and Rocephin as ordered by the ID physician. The MD added on 01/26/21 Resident #6 was hypotensive and sent out to the hospital. The MD stated it was a significant medication error that Resident #6 did not receive both antibiotics as ordered and could have led to his hospital diagnosis of suspected severe sepsis secondary to incompletely treated bacteremia.

The DON and Administrator at the time this incident occurred were no longer employed at the facility and unavailable for an interview.

During interviews on 09/09/21 at 11:40 AM and 09/13/21 at 12:52 PM, the Regional Clinical Operations Consultant (RCOC) stated she could not understand how the medication order for Resident #6 was missed until she reviewed his medical records and discovered the initial hospital discharge summary sent from the hospital, that was used to create his list of medications upon his admission to the facility, did not contain the order for Rocephin. She added two days later they received a duplicate discharge summary that did contain the Rocephin order; however, the hospital did not inform them that anything had been added or changed, and the summary was given to the MD to sign and then uploaded into Resident #6's electronic medical record. Regarding the antibiotic medication being discontinued on 01/21/21 instead of 02/18/21 as ordered, she stated staff likely reviewed the narrative of the hospital course next to the medication list on the initial hospital discharge summary that contained a statement indicating the medication would be completed 01/21/20 and just didn't notice the statement was referring to a prior year. The RCOC explained when Resident

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#6's condition declined and prior to his rehospitalization on 01/26/21, the previous DON identified the transcription errors related to Resident #6's antibiotic orders in addition to the order for Rocephin that was not entered into the system or administered and Infectious Disease was notified on 01/25/21. She revealed Resident #6's medication error occurred prior to the facility being placed out of compliance due to a separate incident involving a medication error and the IV antibiotic error identified for Resident #6 was reviewed during the QAPI meeting held on 03/23/21.

The facility provided the following corrective action plan with a completion date of 03/05/21:

* Facility failed to administer Resident #6's IV medications as ordered per hospital discharge orders. Infectious Disease at Hospital was notified on 1/25/2021 by Director of Nursing of Resident #6 not receiving IV antibiotics at admission. The infectious disease service became aware of this on 01/25/21 and recommended blood cultures times 2, resume Ampicillin and Rocephin unless repeat blood cultures positive.

* A review of the discharge instructions for residents going to outside medical appointments or to the Emergency Room in February was conducted to ensure that any new medications were entered into the Electronic Medical Record (EMR) correctly. Review completed by the Medical Records Clerk (MRC) by 3-2-21. Any errors identified were corrected with the Physician and Responsible party being notified by the Director of Nursing (DON).

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F 760	Continued From page 29 * Measures put into place to prevent this same alleged deficient practice from recurring include: 1) All licensed nurses will be inserviced on the significance of this citation and how discharge instructions are to be handled. The DON is providing the inservice education. All nurses will be inserviced by 3-5-21. New nurses will be educated about this process during orientation as will agency nurses. 2) Discharge instructions from outside appointments/ER are to be reviewed by the Charge Nurse as well as the DON upon receipt. 3) New orders are to be entered into the EMR by the Charge Nurse immediately. 4) DON will receive a copy of the discharge instructions and these will be reviewed daily (M-F) in the morning meeting. In the meeting any new orders will be checked in the EMR for accuracy (DON/MDS nurse). 5) A monitor listing residents with outside appointments/ER visits will be started which reflects any new orders starting 3-1-21. This monitor will be used in the morning meetings to verify that no new orders were missed. This monitor will be maintained and completed by the DON/MDS nurses. * The results of the monitor will be presented by the DON in the monthly Quality Assurance Performance Improvement (QAPI) meeting starting in March. The QAPI team may make suggestions to adjust this plan/monitor in order to achieve compliance. The results of this monitor will be reviewed for a period of at least 3 months by the QAPI team. * Completion date 3-5-21 The facility's corrective action plan was validated	F 760		

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F 760	Continued From page 30 by the following: *On 03/30/21, the facility's plan of correction was validated upon review of the sign-in sheets for in-service education provided to nursing staff on how to enter and review new orders. Review of the monitoring audits revealed they were completed as specified in the plan of correction with no concerns identified. The facility was placed back into compliance effective 03/05/21. *On 09/20/21, The Director of Nursing described the process implemented to ensure the accuracy of all orders which consisted of reviewing all new orders during the clinical morning meetings, comparing the orders with the hospital discharge summary if related to a new admission, and double checking the order in the computer system to ensure the order was transcribed correctly. Interviews conducted with licensed nursing staff revealed they received re-education on the importance of accurately entering and reviewing new medication orders and were able to describe the process. Record review of sampled residents recently admitted and/or with new orders revealed no concerns.	F 760		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		10/13/21

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§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or

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F 842	Continued From page 32 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate Treatment Administration Records (TAR) and Medication Administration Records (MAR) for 4 of 4 sampled residents (Resident #11, Resident #4, Resident #8, and Resident #6) reviewed for wound care and medication errors. Findings included: 1. Resident #11 was admitted to the facility 12/07/20 with diagnoses including anemia and heart failure. The significant change Minimum Data Set (MDS) dated 08/31/21 revealed Resident #11 had 1 unhealed stage 3 (a wound with full thickness tissue loss) pressure ulcer not present on admission and received pressure ulcer care. a. Review of Resident #11's August 2021 TAR for left buttock wound care revealed no	F 842	1. Resident□s #11 and #4 have accurate treatment administration records and medication administration records. Resident□s #6 and #8 no longer reside in the facility. 2. Residents in the facility have the potential to be affected by this alleged deficient practice. The Assistant Director of Nursing has validated current residents have accurate Medication Administration and Treatment Administration Records for October as of 10/13/21. 3. The Director of Nursing/Assistant Director of Nursing has educated the Licensed Nurses on accurately documenting the provision of both treatments and medications in the medical record. This education was completed by 10/13/21. Any Licensed Nurse not receiving the education by this date will receive prior to next scheduled shift. This information will be presented in	

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F 842	Continued From page 33 documentation wound care was provided as ordered on 08/14/21, 08/16/21, 08/18/21, 08/19/21, 08/20/21, 08/23/21, 08/25/21, and 08/28/21. b. Review of Resident #11's September 2021 TAR for left buttock wound care revealed no documentation wound care was provided as ordered on 09/01/21, 09/04/21, and 09/05/21. Nurses who worked with Resident #11 were not available for interview during the investigation. An interview with the Director of Nursing (DON) on 09/15/21 at 4:55 PM revealed she expected nurses to maintain a complete and accurate MAR and TAR and if an ordered treatment wasn't done or ordered medication given there should be documentation on the MAR or TAR to indicate the reason. An interview with the Administrator on 09/15/21 at 5:24 PM revealed he expected nursing staff to document accurately on resident MARs and TARs. 2. Resident #4 was admitted to the facility 12/21/19 with diagnoses including hypertension (high blood pressure) and non-Alzheimer's dementia. Review of the quarterly Minimum Data Set (MDS) dated 04/14/21 revealed Resident #4 had no weight loss and no pressure ulcers. Review of Resident #4's physician orders revealed an order for weekly weights dated 10/23/20.	F 842	new hire and agency orientation. 4. The Director of Nursing or Assistant Director of Nursing will monitor treatment and medication administration records for accuracy 3 times per week for 4 weeks then weekly for 2 months. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Director of Nursing for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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a. Resident #4's MAR revealed no documentation of weights being recorded on the following dates: 10/23/20, 12/18/20, 12/25/20, 02/12/21, 02/19/21, 02/25/21, 03/12/21, 03/19/21, and 04/23/21.

b. Resident #4's TAR for May 2021 revealed no documentation treatments were administered as ordered as follows:
daily treatment to head wound on 05/05/21, 05/07/21-05/09/21, 05/14/21-05/16/21, 05/18/21, 05/20/21, 05/22/21, 05/23/21, 05/26/21-05/30/21.
daily pressure ulcer wound care to head on 06/09/21, 06/10/21, 06/12/21, 06/13/21 and 06/14/21.

Nurses who worked with Resident #8 were not available for interview during the investigation.

An interview with the Director of Nursing (DON) on 09/15/21 at 4:55 PM revealed she expected nurses to maintain a complete and accurate MAR and TAR and if an ordered treatment wasn't done or ordered medication given there should be documentation on the MAR or TAR to indicate the reason.

An interview with the Administrator on 09/15/21 at 5:24 PM revealed he expected nursing staff to document accurately on resident MARs and TARs.

3. Resident #8 was admitted to the facility 08/09/19 with diagnoses including hypertension, Alzheimer's disease, and non-Alzheimer's dementia.

Review of the quarterly Minimum Data Set (MDS) dated 08/07/21 revealed Resident #8 had 1 stage

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2 (a wound with partial-thickness skin loss) pressure ulcer not present on admission and 1 unstageable pressure ulcer not present on admission.

a. Resident #8's January 2021 MAR revealed no documentation the following medications were administered as ordered:
clonazepam 0.5 milligrams (mg) at 01:00 PM on 01/07/21
magnesium oxide 400mg at 4:00 PM on 01/15/21
pepcid 20mg at 5:00 PM on 01/19/21
pro-stat liquid 60 milliliters (ml) at 5:00 PM on 01/19/21
tylenol 650mg at 4:00 PM on 01/15/21
gabapentin 200mg at 12:00 PM on 01/07/21 and at 5:00 PM on 01/19/21
valproic acid 250mg/5 milliliter (ml) 5ml at 12:00 PM on 01/07/21 and at 5:00 PM on 01/19/21
blood glucose check at 11:30 AM on 01/07/21 and 4:30 PM on 01/15/21

b. Resident #8's January 2021 TAR revealed no documentation the following treatments were administered as ordered:
three times a week right lateral heel wound treatment 01/01/21, 01/04/21, 01/06/21, 01/08/21, 01/11/21, 01/15/21, 01/20/21, 01/22/21, 01/25/21, 01/27/21, 01/29/21
zinc oxide ointment to bilateral (both) buttocks every shift at 6:30 AM on 01/01/21, 01/02/21,01/04/21-01/12/21, 01/19/21-01/31/21; at 2:30 PM o 01/01/21, 0104/21, 01/06/21, 01/07/21, 01/11/21, 01/14/21, 01/15/21, 01/19/21-01/24/21, 01/26/21, 01/28/21, 01/29/21; at 10:30 PM on 01/01/21, 01/04/21-01/07/21, 01/11/21, 01/12/21, 01/14/21, 01/15/21, 01/19/21, 01/23/21-01/26/21

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c. Resident #8's February 2021 MAR revealed no documentation of the following medications were administered as ordered:
daily admelog insulin 100 units (u) /ml 5units daily on 02/09/21
daily aspirin 81mg on 02/09/21
daily miralax 17 grams on 02/09/21
daily multivitamin on 02/09/21
daily Norvasc 2.5mg on 02/09/21
risperdal 0.5mg at 9:00 AM on 02/09/21
daily sertraline 50mg on 02/09/21
pepcid 20mg at 5:00 PM on 02/09/21
pro-stat liquid 60ml at 9:00 AM on 02/09/21
tylenol 650mg at 8:00 AM on 02/09/21
gabapentin 200mg at 8:00 AM and 12:00 PM on 02/09/21
valproic acid 250mg/5ml 5ml at 8:00 AM and 12:00 PM on 02/09/21
blood glucose check at 11:30 AM on 02/09/21

d. Resident #8's February 2021 TAR revealed no documentation of the following treatments were provided as ordered:
daily right lateral heel treatment 02/01/21-02/11/21, 02/16/21, 02/19/21, 02/23/21, 01/25/21 -01/27/21
zinc oxide ointment to bilateral buttocks every shift at 6:30 AM on 02/01/21-02/04/21, 02/06/21-02/11/21, 02/16/21, 02/19/21, 02/23/21, 02/25/21-02/27/21; at 2:30 PM on 02/01/21-02/04/21, 0206/21-02/09/21, 02/11/21, 02/16/21, 02/17/21, 02/19/21, 02/22/21-02/24/21; at 10:30 PM on 02/01/21, 02/02/21, 02/06/21-02/11/21, 02/16/21, 02/17/21, 02/22/21, 02/23/21

e. Resident #8's MAR for March 2021 revealed no documentation the following medications were administered as ordered on:

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daily finasteride 5mg on 03/07/21 and 03/10/21
lantus insulin 100u/ml 25 units at 9:00 PM on 03/07/21 and 03/10/21
clonazepam 0.5mg at 1:00 PM on 03/03/21; 9:00 PM on 03/07/21, 03/10/21
blood glucose check at 6:30 AM on 03/07/21, 03/31/21; at 9:00 PM on 03/07/21, 03/10/21

f. Resident #8's March 2021 TAR revealed no documentation the following treatments were administered as ordered:
daily right lateral heel treatment 03/02/21-03/10/21, 03/17/21, 03/19/21, 03/22/21, 03/23/21, 03/24/21, and 03/25/21
zinc oxide to bilateral buttocks every shift at 6:30 AM on 03/03/21-03/10/21, 03/19/21, 03/22/21, 03/24/21, 03/25/2103/26/21; at 2:30 PM on 03/01/21-03/04/21, 03/07/21-03/10/21, 03/15/21, 03/16/21, 03/19/21, 03/22/21, 03/24/21, 03/25/21; at 10:30 PM 03/01/21-03/04/21, 03/06/21-03/09/21, 03/15/21, 03/16/21, 03/19/21, 03/22/21, 03/03/24/21

g. Resident #8's April 2021 MAR revealed no documentation the following medications were administered as ordered:
admelog 100u/ml 5 units at 9:00 on 04/20/21
daily aspirin 81mg on 04/20/21
daily vitamin b12 on 04/20/21
daily vitamin c 500mg on 04/20/21
clonazepam 0.5mg at 1:00 PM on 04/08/21, 04/20/21, 04/25/21
tylenol 650mg at 8:00 AM on 04/20/21
gabapentin 200mg at 8:00 AM on 04/20/21; at 12:00 PM on 04/20/21, 04/25/21
silver sulfadiazine (an antibiotic) cream 1% on day shift on 04/08/21
valproic acid 250mg/5ml 5ml at 8:00 AM on 04/20/21; at 12:00 PM on 04/20/21, 04/25/21

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h. Resident #8's May 2021 MAR revealed no documentation the following medications were administered as ordered:
daily aspirin 81mg on 05/13/21 and 05/14/21
daily vitamin d 2000 units 05/13/21
daily Claritin D (allergy medication) 10mg on 05/13/21

Nurses who worked with Resident #8 were not available for interview during the investigation.

An interview with the Director of Nursing (DON) on 09/15/21 at 4:55 PM revealed she expected nurses to maintain a complete and accurate MAR and TAR and if an ordered treatment wasn't done or ordered medication given there should be documentation on the MAR or TAR to indicate the reason.

An interview with the Administrator on 09/15/21 at 5:24 PM revealed he expected nursing staff to document accurately on resident MARs and TARs.

4. Resident #6 was admitted to the facility on 01/13/21 with multiple diagnoses that included enterococcus (bacteria), bacteremia (presence of bacteria in the bloodstream), and hepatic failure.

The admission Minimum Data Set (MDS) dated 01/19/21 assessed Resident #6 with intact cognition and noted he received antibiotics 6 of 7 days during the MDS assessment period.

a. Review of Resident #6's January 2021 MAR revealed the following physician orders were not initialed as administered:
Protonix Packet (medication used to treat acid reflux) give 40 milligrams (mg) on 01/14/21 and

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01/15/21
Ensure (liquid nutritional supplement) 237 milliliters (ml) one time a day on 01/15/21, 01/16/21, 01/17/21, 01/18/21, and 01/19/21

b. Review of Resident #6's February 2021 MAR revealed the following physician orders were not initialed as administered:
Ceftriaxone Sodium Solution (antibiotic medication) use 2 grams (gm) intravenously every 12 hours for 38 days on 02/04/21 at 6:00 AM, 02/18/21 at 6:00 PM, and 02/19/21 at 6:00 PM. The order was discontinued on 02/23/21.
Heparin Lock Flush Solution 10 unit/ml (keeps the line clear and prevents blood clotting) use 5 ml intravenously every 12 hours for maintenance on 02/04/21 at 6:00 AM and 02/18/21 at 6:00 PM. The order was discontinued on 02/18/21 at 7:59 PM.
Heparin Lock Flush Solution 10 unit/ml use 5 ml intravenously every 4 hours for maintenance on 02/18/21 at 5:00 PM. The order was discontinued on 02/18/21 at 7:54 PM.
Normal Saline Flush Solution 0.9% (Sodium Chloride) use 1 syringe intravenously every 12 hours for maintenance on 02/04/21 at 6:00 AM and 02/18/21 at 6:00 PM. The order was discontinued on 02/18/21 at 8:06 PM.
Ampicillin Sodium Solution Reconstituted (antibiotic medication) use 2 gm intravenously every 4 hours for bacterial infection for 38 days on 02/18/21 at 5:00 PM and 02/19/21 at 5:00 PM. The order was discontinued on 02/23/21 at 7:54 PM.
Heparin Lock Flush Solution 10 unit/ml use 5 ml intravenously every 4 hours for maintenance on 02/19/21 at 5:00 PM, 02/24/21 at 1:00 AM and 5:00 AM.
Normal Saline Flush Solution 0.9% use 1 syringe

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intravenously every 4 hours for maintenance on 02/24/21 at 1:00 AM and 5:00 AM.
Heparin Lock Flush Solution 10 unit/ml use 5 ml intravenously every 12 hours for maintenance on 02/21/21 at 6:00 AM, 02/23/21 at 6:00 AM, and 02/24/21 at 6:00 AM.
Normal Saline Flush Solution 0.9% (Sodium Chloride) use 1 syringe intravenously every 12 hours for maintenance on 02/23/21 at 6:00 AM and 02/24/21 at 6:00 AM.

c. Review of Resident #6's March 2021 MAR revealed the following physician orders were not initialed as administered:
Amitriptyline (antidepressant medication) 50 mg by mouth at bedtime on 03/10/21
Mirtazapine (antidepressant medication) 30 mg by mouth at bedtime on 03/10/21
Protein Liquid give 15 ml at bedtime for supplement on 03/10/21
Metoprolol Tartrate (medication used to treat hypertension) 25 mg twice a day on 03/10/21 at 5:00 PM
Heparin Lock Flush Solution 10 unit/ml use 5 ml intravenously every 12 hours for maintenance on 03/02/21 at 6:00 AM, 03/03/21 at 6:00 AM, and 03/10/21 at 6:00 PM. The order was discontinued on 03/17/21.
Heparin Lock Flush Solution 10 unit/ml use 5 ml intravenously every 4 hours for maintenance on 03/02/21 at 5:00 AM, 03/03/21 at 5:00 AM, 03/05/21 at 9:00 AM and 1:00 PM, 03/10/12 at 1:00 PM and 9:00 PM.
Normal Saline Flush Solution 0.9% use 1 syringe intravenously every 12 hours for maintenance on 03/03/21 at 6:00 AM, 03/03/21 at 6:00 AM, and 03/10/21 at 6:00 PM. The order was discontinued on 03/17/21 at 5:52 PM.
Normal Saline Flush Solution 0.9% use 1 syringe

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F 842	Continued From page 41 intravenously every 4 hours for maintenance on 03/02/21 at 5:00 AM, 03/03/21 at 5:00 AM, 03/05/21 at 9:00 AM and 1:00 PM, 03/10/21 at 1:00 PM and 9:00 PM Daptomycin Solution (antibiotic medication) Reconstituted use 500 mg intravenously one time a day on 03/10/21. The order was discontinued on 03/17/21. Potassium Chloride (medication used to treat low amounts of potassium in the blood) 20 milliequivalent by mouth twice a day on 03/10/21 at 5:00 PM. Nurses who worked with Resident #6 were not available for interview during the investigation. An interview with the Director of Nursing (DON) on 09/15/21 at 4:55 PM revealed she expected nurses to maintain a complete and accurate MAR and TAR. She added, if an ordered treatment wasn't done or ordered medication given there should be documentation on the MAR or TAR to indicate the reason. An interview with the Administrator on 09/15/21 at 5:24 PM revealed he expected nursing staff to accurately document on residents' MAR and TAR.	F 842		
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		10/13/21

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F 880	Continued From page 42 §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 disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 43 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 observations and staff interviews the facility failed to ensure staff handled soiled linen and a soiled brief in a sanitary manner for 1 of 1 resident (Resident #11) reviewed for infection control. Findings included: Review of a policy titled Handling Soiled Linen last updated July 2019, read in part: It is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. This policy pertains to soiled linen. "Linen" includes sheets, blankets, pillows, towels, washcloths, and similar items from departments such as nursing, dietary, rehabilitative services, beauty shops, and environmental services.	F 880	1. Resident #11 is receiving care in accordance with appropriate infection control standards regarding the handling of soiled linen and soiled briefs. 2. Residents in the facility have the potential to be affected by this alleged deficient practice. 3. A Directed Plan of Correction (DPOC) with the following components has been initiated by the facility: " The Infection Preventionist has educated all staff on safe handling of soiled linens and soiled briefs in accordance with transmission-based precautions including doffing of Personal Protective Equipment (PPE) " Documentation of training completed is via doffing of PPE competency and signature roster with timeline of completion for 10/13/21	

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F 880	Continued From page 44 1. Linen can become contaminated with pathogens from contact with intact skin, body substances, or from environmental contaminants. Transmission of pathogens can occur through direct contact with linens or aerosols generated from sorting and handling contaminated linen. 2. Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons. 3. Used or soiled linen shall be collected at the bedside and placed in a linen bag or designated linen receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. An observation of Nurse Aide (NA) #1 on 09/08/21 at 04:27 PM revealed she and Nurse #1 changed the soiled bottom sheet, bed pad, and brief for Resident #11. NA #1 was wearing gloves during resident care. NA #1 removed the soiled linen and brief from Resident #11's bed and laid the linen and brief on the floor of the resident's room. After NA #1 and Nurse #1 completed care for Resident #11, NA #1 placed the soiled linen in a trash bag, left the used brief on the floor, picked up the trash bag of soiled linen and the used brief in her left hand, opened the Resident #11's door, exited the room, walked down the hall to the soiled linen room carrying the uncovered soiled brief and bag of soiled linen wearing both gloves, and entered the soiled linen room. An interview with NA #1 on 09/08/21 at 05:03 PM revealed she usually placed soiled linen on the floor of a resident's room, finished resident care,	F 880	" Attestation statement of completion provided by the facility Infection Preventionist " Root cause analysis conducted by facility Infection Preventionist in conjunction with the Quality Assurance and Performance Improvement Committee and Governing Body on 10/8/21 4. The Infection Preventionist will randomly observe staff handling soiled linen, soiled briefs and doffing of PPE 2 times per week for 4 weeks then weekly for 2 months. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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moved the soiled linen to a trash bag, exited the room, and took the soiled linen to either the soiled linen room or soiled linen cart outside the resident's door while wearing soiled gloves. She explained she did not know how to get the soiled linen out of a resident room without wearing soiled gloves in the hall. NA #1 stated she should have bagged the used brief before leaving Resident #11's room but she got in a hurry and overlooked the fact that the brief was not enclosed in a trash bag.

An interview with the Director of Nursing (DON) on 09/08/21 at 06:50 PM revealed all soiled linen and soiled briefs should be placed in a trash bag and not on the resident's floor when changing a resident's bed. She stated NAs were trained to place soiled linen and soiled briefs in a trash bag, remove their soiled gloves and place them in the trash bag with the soiled disposable brief, tie up the trash bags, and carry the trash bags to the soiled utility without wearing soiled gloves in the hall.

An interview with the Administrator on 09/15/21 at 05:54 PM revealed he expected soiled linen and soiled briefs to be placed in a trash bag in the resident's room as soon as they were removed, soiled gloves should be placed in the trash bag and tied up, and the trash bag should be transported to the soiled linen room or placed in a soiled linen barrel placed right outside the resident's room. He stated soiled gloves should not be worn in the hall and briefs should not be carried in the hall without being enclosed in a trash bag