STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted from 6/20/22 through 7/13/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # CEPM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/20/22 through 7/13/22. Event ID# CEPM11. Immediate Jeopardy was identified at: CFR 483.21 at tag F660 at a scope and severity J Immediate Jeopardy began on 4/1/22 and was removed on 7/14/22. An extended survey was conducted. The following intakes were investigated NC00190936, NC00188778, NC00188637, NC00188459, NC00188278, NC00186783, NC00185227, NC00184682, NC00183387, NC00183359, NC00182398, NC00182051, NC00181995, and NC00181883. 16 of the 50 complaint allegations were substantiated resulting in the following deficiencies: F600, F660, F677, F686, F758.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		8/4/22

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

Electronically Signed | 07/30/2022

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F 600	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, Police, staff and resident interview, the facility failed to protect a resident's right to be free from mistreatment for 1 of 1 resident investigated for staff to resident abuse (Resident #14). Resident #14 sustained a scratch on her face and nose from the altercation with the staff and was crying stating that the altercation made her feel scared and anxious. Findings included: Resident #14 was admitted to the facility on 7/12/21 with multiple diagnoses including cerebro-vascular accident (CVA) with hemiplegia/paresis, major depressive disorder, generalized anxiety disorder, chronic respiratory failure dependence on trilogy (a volume -control and pressure control machine used to help people with respiratory diseases where a person needs assistance because they cannot breathe on their own) and supplemental oxygen and chronic post-traumatic stress disorder (PTSD) (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Resident #14's care plan (initiated on 7/12/21) was reviewed. The resident was care planned for	F 600	This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this Allegation of Compliance does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Corrective Action for those Residents found to have been affected Investigation into abuse allegation initiated immediately on 3/3/22. Facility investigation findings submitted to N.C. Department of Health Human Services on 3/8/2022. NA #8 terminated on 3/8/2022 as a result of the investigation. How the facility will identify other residents having the potential to be affected: The facility Social Services Director “SSD” has conducted an audit of all interviewable residents on 7/16/22	

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F 600	Continued From page 2 the use of the Trilogy machine at bedtime and required continuous oxygen therapy related to respiratory failure with hypoxia. The quarterly Minimum Data Set (MDS) assessment dated 12/22/21 indicated that Resident #14's cognition was intact with Brief Interview for Mental Status (BIMS) score of 15, and she did not have any behaviors. The assessment further indicated that the resident was totally dependent on the staff for transfer and uses a wheelchair for mobility. Review of Facility Reported Incident (FRI) dated 3/3/22 revealed an allegation of abuse. The allegation detail was Nurse Aide (NA) #8 hit Resident #14 in the face. The facility's abuse investigation revealed that on 3/3/22 around 6 AM, NA #8 provided incontinent care for Resident #14. The resident requested to change her Trilogy mask to an oxygen tubing. The NA was unable to find the tubing and the resident became agitated, started yelling at the NA. The NA stated that the resident swung at her with her left arm and the NA instinctively grabbed resident's hand, leaned back, and let go of her hand. The resident pulled back and hit herself with her own left hand. The resident was wearing glasses and the nose piece of the glasses created the bruising under resident's eye. The resident stated that she felt anxious and expressed sadness that the altercation had happened. After conducting a thorough investigation, the allegation of abuse was substantiated, and NA #8 was terminated. The corrective actions taken following the incident were: the Nurse Practitioner	F 600	ensuring that residents were free from abuse. Nursing staff have completed skin assessments for 64 non-interviewable residents with BIMS of 8 and below on 7/16/22, with no concerns identified. Systemic changes made to ensure that deficient practice will not recur: The facility has reviewed its' policies on Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property and Abuse Identification. Director of Health Services or designee educated all staff on preventing, identifying, and reporting allegations of abuse, neglect, misappropriation of resident property and injuries of unknown origin by 8/3/22. Staff will not be allowed to work until the education listed has been completed following 8/3/22. The facility has reviewed the orientation process for all new hires to ensure education on preventing, identifying, and reporting allegation of abuse, neglect, misappropriation of resident property and injuries of unknown origin is included in general orientation. The facility Administrator educated Interdisciplinary Team "IDT" on completing assigned Daily Compliance Rounds using the Compliance Rounds form by 8/3/22. Compliance rounds are to be completed by the IDT or designed daily Monday – Friday. The Compliance Round Form has been reviewed and modified to include a question asking interviewable residents if they are treated with dignity and respect.	

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F 600	Continued From page 3 (NP), Police, and the State were notified. Nurse #8 remained with the resident until the Police arrived for safety. Skin assessment conducted and Resident #14 was noted to have bruises under her right eye and nose and NA #8 was immediately suspended pending investigation. The facility had conducted an audit of all interviewable residents ensuring that residents were free from abuse. All staff were trained on preventing, identifying, and reporting allegations of abuse, neglect, misappropriation of resident property and injuries of unknown origin. The facility's corrective action did not include an audit of non-interviewable residents to ensure nobody had been affected and did not mention that a monitoring tool had been developed on what to audit, how to audit and who was responsible for the audit. Resident #14 was observed on 6/20/22 at 12:15 PM. She was up in wheelchair in her room and was on oxygen via nasal cannula. A Trilogy machine was observed at bedside. Resident #14 was observed to have right side paralysis. Resident #14 reported that sometime in March of 2022 (unable to remember exact date), NA #8 came to her room around 6 AM to provide incontinent care. She asked the NA to remove her Trilogy mask and to replace it with oxygen tubing. The NA stated that she looked and could not find an oxygen tubing in the room. The resident responded that the tubing was there last night and to look for it, but the NA insisted that she could not find it and for the resident to find it herself. When the NA was about to leave the room, the resident started yelling not to leave her without oxygen. Resident #14 stated that it scared her, she could not breath without the oxygen. The NA started yelling at her and hit her	F 600	The completed Compliance Rounds Forms will be reviewed by the Administrator / Director of Health Services / designee ensuring that all findings are promptly addressed and investigated as necessary. Monitoring of performance to make sure that solutions are sustained. The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) The Social Service Director or designee will interview 10 residents per week x4 weeks, and then 10 residents per month x3 months ensuring that all residents had not experienced or witnessed abuse or neglect. 2) The Director of Health Services or designee will conduct a skin assessment for 5 non-interviewable residents weekly x4, and then monthly x3 reviewing for signs and symptoms of abuse. 3) Monthly the Administrator will report to QA a summary of all allegations confirming timely reporting and a thorough investigation completed. 4) IDT will complete daily compliance rounds and report all findings during daily stand-up meeting. Any adverse findings identified will be immediately reported to Administrator / Director of Health Services “DHS”.	

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F 600	Continued From page 4 in the face causing her eyeglasses to break. She had scratches on her face that were bleeding when the nurse assessed her. The resident added that the Police was called, and he came and interviewed her. She added that she had a roommate at that time, but she was demented. Resident #14 indicated that the incident with NA #8 made her feel scared and anxious and she was crying, it reminded her of her history of abuse. She reported that she asked to be transferred to another nursing facility, but nobody was willing to accept her due to her Trilogy machine. Nurse # 8 was interviewed by telephone on 6/21/22 at 9:58 AM. Nurse #8 reported that he was working the night when NA #8 and Resident #14 had an altercation. He was at the nurse's station when NA #8 reported that she had an altercation with Resident #14. He went to Resident #14's room and observed Resident #14 crying and alleging that NA #8 hit her. When he assessed the resident, she had a small laceration on her face (right side under the eye) and a scratch on her nose with slight bleeding on them. Nurse #8 added that Resident #14 was alert and oriented, used trilogy machine at night and oxygen vial nasal cannula at daytime. The Nurse stated around 6 AM, her Trilogy mask was switched to a nasal cannula. Resident #14 was dependent on oxygen. Nurse #8 indicated that NA #8 reported that during the altercation, Resident #14 tried to hit her with her arm, and when she tried to block it, the resident hit her face with her arm. The Police was called, and NA #8 was suspended and then was terminated. Review of Nurse #8 written statement dated 3/3/22 revealed that NA #8 came to report the incident with Resident #14. NA informed him that she went to	F 600	Results from monitoring listed will be presented by the Administrator / DHS to the QA team monthly. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Dates when the corrective action will be completed. 8/4/2022	

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F 600	Continued From page 5	F 600		

the resident's room to provide incontinent care and the resident requested her trilogy mask be replaced with nasal cannula. The NA could not find the cannula in the room. The NA indicated that the resident was getting agitated and started swinging at the NA. While the NA was avoiding being hit, she grabbed the resident's hand and in the process the resident's hand went back and hit her glasses which caused an injury to the resident's right eye. Nurse #8 further stated that when interviewed, Resident #14 revealed that NA #8 woke her up to be changed. The resident requested for the Trilogy mask to be taken off and replaced with the nasal cannula, but the NA could not find the cannula in the room. The resident asked the NA to get another one, but the NA responded that she had no time for it and the altercation started. The resident stated that NA hit her in the process. The report indicated that the NA took the oxygen tubing from the resident's electric wheelchair and that was the tubing the resident was using when Nurse #8 entered the room.

Nurse #9 was interviewed by telephone on 6/22/22 at 8:35 AM. The Nurse stated that she was assigned to Resident #14 when the altercation between NA #8 and Resident #14 happened. The Nurse reported that NA #8 came and informed her to check on Resident #14. She went to the resident's room around 6 AM on 3/3/22. Resident #14 was crying alleging NA #8 hit her. She has a scratch on her face with blood under her right eye. She could not remember whether the resident was on Trilogy mask or nasal cannula that morning. Nurse #9 explained that Resident #14 was on Trilogy machine at night and around 6 AM every day, the Trilogy mask was changed to a nasal cannula. NA #8

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F 600	Continued From page 6	F 600		

was in resident's room the morning of 3/3/22 providing care. The resident asked the NA to change her Trilogy mask to a nasal cannula. The NA could not locate the nasal cannula in the room and the resident asked the NA to get another one and the NA replied, "I don't have time for that". The resident got mad and started yelling and claimed that the NA hit her. When she interviewed NA #8, the NA stated that when the resident started swinging her left arm, she grabbed her left arm and when she let it go, her left arm hit her face causing her eyeglasses to break. Nurse #9 reported that she notified the Police who came and interviewed the staff and the resident. Review of Nurse #9 written statement (undated) revealed that at 6 AM on 3/3/22, NA #8 asked Resident #14 if she needed to be changed. The resident requested if she could change her Trilogy mask to a nasal cannula/oxygen tubing and the NA replied that she could not find it. The resident asked her to look, and the NA replied, "I don't have the time, it was not in here". The resident told the NA "Well, you need to look" and the NA replied, "you need to get up and look your d--- self". The resident reported that the NA knocked her glasses on her face. The written statement further indicated that NA #8 informed Nurse #9 that she and Resident #14 had an issue. The resident tried to hit her, and she grabbed the resident's hand and the momentum had caused the injury.

NA # 8 was interviewed by telephone on 6/22/22 at 10:10 AM. The NA reported that it was around 6 AM on 3/3/22 when she went to check on Resident #14 during her last round. Resident #14 asked to change her Trilogy mask to a nasal cannula. She looked and could not find a nasal cannula in her room. The resident got mad and

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F 600	Continued From page 7	F 600		

was upset saying that she could not breath without oxygen. She left the resident's room and informed the nurse to check on the resident as she was angry. The NA was unable to remember if she left the resident on a mask or nasal cannula that morning. She explained that when the resident started swinging her left arm, she grabbed it. When she let the resident's left arm go, her arm hit her face causing her eyeglasses to break. When the resident started yelling "you hit me" and she saw a scratch on the resident's face, she panicked and left the room to get the nurse. NA #8 commented that she should have left the room when the resident started yelling and swinging but she did not. Review of NA #8 written statement dated 3/3/22 revealed that she went in to provide care to Resident #14. The resident asked to change her Trilogy mask to nasal cannula, and she could find the nasal cannula in the room. The resident started yelling that it was there, and she told her to stop yelling and to tell her where the nasal cannula was. The NA tried to finish providing incontinent care, when the resident swung her hand to her face telling her to look for the nasal cannula. The NA grabbed the resident's hand, and it went back to her glasses which cut/scratched her face. She then went to get the nurse for help.

The Social Worker (SW) was interviewed on 6/22/22 at 10:35 AM. The SW reported that she interviewed Resident #14 on 3/3/22 regarding the abuse allegation with NA #8. The resident was tearful during the interview and expressed sadness and when she asked her "how are you feeling now", she replied that she was feeling anxious. The SW stated that a written statement of the interview was completed. Review of the SW written statement dated 3/3/22 revealed that

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F 600	Continued From page 8	F 600		

at 6 AM Resident #14 was sleeping when NA #8 entered her room to provide incontinent care. The resident asked the NA to change her Trilogy mask to an oxygen tubing. NA #8 indicate that she could not find the tubing anywhere and the resident insisted that it must be there as it was there last night. The NA became impatient unable to find the tubing, told the resident, "don't yell at me". The resident responded, "you yell at me first". NA then said, "I'll just leave you here then you can get up and find it yourself". Resident replied, "you can't do that, I can't breathe without the oxygen". The resident stated that the Trilogy mask was removed, and the tubing was not applied. The argument continued over whether oxygen tubing was there and whether the NA would look for it or bring another tubing. The resident stated that the NA reached out and hit her in the eye with her hand. The resident was wearing glasses and the nose pad scratched and bruised her eye. The resident yelled several times "you hit me" and the NA reiterated each time "you hit me first". The resident stated that she was paralyzed on her right side and was unable to hit anyone with that hand. The NA replied," you hit at me, you can do that".

The Facility's Nurse Consultant and the Director of Nursing (DON) were interviewed on 6/22/22 at 11:10 AM. They both reported that the Administrator was not coming to the facility on Wednesday (6/22/22) and Thursday (6/23/22) but he will be available by calling him. The DON called the Administrator, and he was interviewed by telephone. When asked about their corrective action plan for the abuse allegation dated 3/3/22, he stated that he investigated the abuse allegation dated 3/3/22 on Resident #14 and had sent the 24 hour and 5 - day report to the State.

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An audit was completed on 3/3/22 by the SW by interviewing alert and oriented residents regarding abuse. Investigation was completed and was substantiated, and NA #8 was terminated. All staff were in-serviced on abuse. The Administrator added that the allegation of abuse was discussed on their March 2022 Quality Assurance (QA) meeting. When asked about their monitoring tool and if abuse was incorporated to their QA, he stated that he had the QA and would send it to the DON. He added that all the documents regarding the allegation of abuse with Resident #14 were in the folder including the staff statements, audits, and in-service records.

Review of the documents regarding the abuse allegation dated 3/3/22 with Resident #14, provided by the DON revealed that the audit was completed for alert and oriented residents only with BIMS above 9 and not for confused residents with BIMS below 9. The March 2022 QA revealed "allegation of abuse 3/3/22 - results from Interdisciplinary team (IDT) daily compliance rounds to be reviewed ongoing during monthly Quality Assurance Performance Improvement (QAPI) meeting ensuring all residents free from abuse. Monitoring will be on-going x (times) 3 months and concerns identified will be addressed during monthly QAPI meetings". There was no monitoring tool developed as to what to audit, how to audit and who will audit.

The Facility's Nurse Consultant and the Director of Nursing (DON) were interviewed on 6/22/22 at 11:15 AM. The DON stated that she started as DON of the facility in May 2022. She reviewed the abuse investigation dated 3/3/22 and she identified that the facility missed to audit the

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confused residents with BIMS below 9 to ensure nobody was affected. She explained that the facility should have completed a head-to-toe assessment for all residents with BIMS below 9. The DON stated that when a resident's behavior started to escalate, the staff was expected to step back and let the resident calm down. This abuse allegation was substantiated since NA #8 failed to deescalate the resident's behavior; she restrained the resident instead by grabbing her arm. The DON further indicated that she had been monitoring for abuse by reviewing the 24-hour report, but she did not have any monitoring tool to document her audit.

The Police was interviewed by telephone on 6/23/22 at 10:38 AM. The Police verified that he was dispatched to the facility on 3/3/22 due to allegation of assault. He met with Resident #14 and she was crying. The Police stated that the interview from the resident, nurse and NA #8 were written on his report. Review of the Police report was conducted. The report indicated that on 3/3/22 at approximately 6:19 AM, the Police was dispatched to the facility on a report of an assault. On arrival, the Police met with Nurse #9 who indicated that NA #8 and Resident #14 were involved in an altercation. NA #8 stated that when she was in Resident #14's room attempting to change the oxygen tubing, the resident yelled at her. The NA stated that she could not find the tubing and that was when the resident yelled. The NA asked the resident to stop yelling at her and the resident tried to hit her. The NA reported that she grabbed resident's arm and pushed back to avoid being hit and the resident was hit in the face. The Police interviewed Resident #14. He observed the resident was crying which made it difficult to understand at first. Once the resident

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F 600	Continued From page 11 calmed down, the resident explained that the NA hit her in the face. The resident stated that when the NA could not find the tubing, she told the resident "I should just leave you're a-" and struck her in the right side of her face. The resident reported that the NA told her to go ahead and report her because she did not care. Nurse #9 came in and assessed the resident. The nurse saw the marks on resident's face and stated that they were not there last night when she put the Trilogy mask on the resident. The resident had a bruise on her right eye along with other red marks in the same area that was consistent with the recent trauma. The Police report revealed that NA #8 was charged for abuse on an elderly person.	F 600		
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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 18 residents whose MDS assessments were reviewed. (Resident #21, #223, #72) Findings included: 1. Resident #21 was admitted to the facility on 7/23/2019, and diagnoses included stroke and dementia. Nursing documentation dated 1/13/2022 revealed Resident #21 was found on the floor, physician and resident's representative were notified, and	F 641	Facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 18 residents whose MDS assessments were reviewed. Resident #21 admitted to the facility on 7/23/19. Resident remains at baseline. MDS assessment (1/26/22) modified by MDS Director on 6/22/22 to include fall that occurred on 1/13/22. Resident #223 admitted to the facility on 9/16/21. Resident discharged to another skilled nursing facility on 11/5/21. MDS assessment (9/22/22) modified by MDS	8/4/22

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F 641	Continued From page 12 she was sent to the emergency room for an evaluation. Hospital emergency room records indicated Resident #21 was seen on 1/13/2022 for an unwitnessed fall with swelling to the left forehead. The Minimum Data Set (MDS) assessment dated 1/26/2022 indicated no falls since admission or the prior MDS assessment. On 6/23/2022 at 9:55 a.m. in an interview with the MDS Coordinator, she stated observations and record review was used to gather information for MDS assessments. She stated a fall was indicated in the event history for 1/13/2022 and that should have been recorded on the quarterly MDS assessment dated 1/26/2022. On 6/23/2022 at 10:43 a.m. in an interview with the Director of Nursing, she stated quarterly MDS assessments needed to include accurate and current information. 2. Resident #223 was admitted to the facility on 9/16/2021, and diagnoses included post COVID respiratory infection and muscle weakness. A review of pressure ulcer risk assessment dated 9/16/2021 revealed Resident #223 was at risk for developing pressure ulcers. The admission Minimum Data Set (MDS) assessment dated 9/22/2021 indicated Resident #23 was cognitively intact, required extensive assistance with bed mobility and transfers and was always incontinent of bowel. The MDS assessment did not indicate a pressure ulcer risk	F 641	Director on 6/22/22 to include a pressure ulcer risk assessment indicating that resident #223 is at risk of developing pressure ulcers/injuries. Resident #72 was admitted to the facility on 2/25/22. Resident discharged home on 3/24/22. Discharge MDS assessment (3/24/22) inactivated by MDS Director on 7/28/22 to reflect resident #72 Discharge Return Not Anticipated completed 7/28/22. The Case Mix Director will review all residents with falls from previous assessment ARD to current assessment ARD and any assessment identified as incorrectly coded for falls will be modified to reflect accuracy of the MDS and resubmitted by 8/3/22. The facility will conduct a Pressure Ulcer Risk Assessment audit of all residents and any assessment identified as missing will be completed and the MDS assessment will be modified and resubmitted by 8/3/22. The facility will conduct an audit of all discharges over the past 30 days ensuring an accurate discharge location and the MDS assessment will be modified and resubmitted by 8/3/22. The facility has reviewed its MDS Assessment Accuracy Policy with no revisions needed. Clinical Reimbursement Consultant or designee provided education to the Case Mix Director on the MDS Assessment Accuracy Policy by 8/3/22.	

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F 641	Continued From page 13 assessment had been conducted. On 6/23/2022 at 9:55 a.m. in an interview with the MDS Coordinator, she stated the admission MDS dated 9/22/2021 did not indicate a clinical or formal skin assessment was conducted or if Resident #223 was at risk for developing pressure ulcers, and it should have been included. On 6/23/2022 at 10:43 a.m. in an interview with the Director of Nursing, she stated quarterly MDS assessments needed to be accurate and include current information. 3. Resident # 72 was admitted to the facility on 2/25/22. The discharge Minimum Data Set (MDS) assessment dated 3/24/22 indicated that Resident #72 was discharged to the hospital on 3/24/22. Review of the progress note written by the Social Worker (SW) dated 3/24/22 at 1:34 PM revealed that Resident #72 was discharged to home. Review of the progress note written by the Nurse Practitioner (NP) dated 3/24/22 revealed that Resident #72 was discharged to home. The SW was interviewed on 6/22/22 at 1:50 PM. She reported that Resident #72 was discharged to home on 3/24/22. The MDS Nurse was interviewed on 6/22/22 at 1:52 PM. The MDS Nurse reviewed the progress notes written by the SW and the NP and the discharge MDS assessment dated 3/24/22. The	F 641	The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1)Director of Health Services and/or designee will review the accuracy of 5 assessments per week x4 weeks and then x10 assessments per month x3 months. Results from monitoring listed will be presented by the Administrator and/or Director of Health Services to the QA team monthly x3 months. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Dates when the corrective action will be completed. 8/4/2022	

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F 641	Continued From page 14 MDS Nurse verified that she coded the MDS assessment dated 3/24/22 incorrectly. She confirmed that Resident #72 was discharged to home and not hospital. The Director of Nursing (DON) was interviewed on 6/23/22 at 12:10 PM. The DON stated that she expected the MDS assessments to be coded accurately. She added that the MDS Nurse was new to her position, but a corporate MDS Nurse was assisting her.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		8/4/22

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F 656	Continued From page 15 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for 2 of 18 residents reviewed for comprehensive care plans. (Resident #223, #222) Findings Included: 1. Resident #223 was admitted to the facility on 9/16/2021, and diagnoses included post joint replacement surgery, COVID respiratory infection, Diabetes Mellitus Type II and depression. Resident #223's care plan dated 9/17/2021 included one focus area: full code status. No documentation of a comprehensive care plan was located in the electronic medical record. The admission Minimum Data Set (MDS) assessment dated 9/22/2021 indicated Resident	F 656	Facility failed to develop a comprehensive care plan for 2 of 18 residents reviewed for comprehensive care plans. (Resident #223, #222) Resident #223 admitted to the facility on 9/16/21. Resident discharged to another skilled nursing facility on 11/5/21. Resident #222 admitted to the facility on 2/22/22. Resident discharged home on 4/1/22. The facility will conduct a review of all residents care plans to ensure that each resident has a baseline care plan in place within 48-hours of admission as well as a comprehensive care plan with measurable objectives and timetables addressing each residents needs identified to be completed by 8/3/22.	

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F 656	Continued From page 16 #223 was cognitively intact, one upper extremity was impaired, and he required extensive assistance with bed mobility and transfers. The MDS further indicated Resident #223 had a urinary catheter for urine elimination and was always incontinent of bowel (stool). The MDS indicated Resident #223 had a surgical wound, was receiving antidepressants and opioids (pain medications) and was on isolation for an active infectious disease. The care area assessment triggered the following focused areas: activities of daily living, urinary incontinence and indwelling catheter, psychosocial well-being, activities, falls, nutritional status, dehydration, pressure ulcers and psychotropic medication use for the comprehensive care plan. On 6/21/2022 at 12:58 p.m. in an interview with the MDS Coordinator, the comprehensive care plan was completed within fourteen days of admission. She stated the baseline care plan only included a focus on his full code status, and she was unable to locate a comprehensive care plan for Resident #223 in the electronic medical record. She stated she was not the MDS Coordinator in 2021 and was unable to explain why Resident #223 did not have a comprehensive care plan. On 6/23/2022 at 9:10 a.m. in an interview with the Director of Nursing (DON), she stated comprehensive care plan was completed within a week of admission by the MDS Coordinator. She stated completion of baseline and comprehensive care plans had been identified as a problem, and the facility was currently working on updating residents ' care plans in the daily morning meetings.	F 656	The facility has reviewed its Care Plan policy for clarity with no revisions needed. Administrator and / or Designee provided education to MDS Nurse, Dietary Manager, Social Services, Therapy Director, Activities Director re-educating to the policy by 8/3/22. The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1)Director of Health Services and / or nurse managers to review all new admissions Monday Friday during clinical stand-up ongoing ensuring the baseline care plan is in place within 48 hours. 2)Director of Health Services and/or nurse managers will review 3 resident comprehensive care plans weekly x4 weeks, and then 2 monthly x3 months ensuring development and completion of the comprehensive care plan. Results will be presented by the Case Mix Director or Administrator to the QA team monthly x3 months. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Dates of compliance. 8/4/22	

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F 656	Continued From page 17	F 656		

2. Resident #222 was admitted to the facility on 2/22/2022 with diagnoses that included sepsis related to chronic venous ulcerations of bilateral lower extremities.

Resident #222's baseline care plan initiated 2/22/2022 had a focus for discharge but it did not indicate where the resident expected to discharge, it was left blank. The resident's discharge goal was left blank. The care plan also had a focus for barriers to discharge but it was not completed and therefore did not identify any barriers to discharge. The care plan had a focus for anticoagulation use related to the resident's diagnosis, but the diagnosis was left blank. The resident had a focus for risk of falls related to diagnosis, but diagnosis was left blank. Resident #222 also had a focus for activities of daily living decline (ADL) related to her diagnosis, but diagnosis was left blank.

Resident #222's medical record indicated she was discharged home on 4/1/2022. Between 2/22/2022 and 4/1/2022 there were no updates to the resident's care plan.

The resident's discharge Minimum Data Set (MDS) with observation end date 4/1/2022 indicated the resident was cognitively intact. She required two persons assistance for transfers, walked in her room only once or twice during the assessment period, locomotion in room was with set up only, locomotion in the facility occurred only once or twice during the assessment period, required assistance of one for dressing and toileting, and required the assistance of two persons for personal hygiene during the assessment period.

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F 656	Continued From page 18 An interview was conducted with the MDS coordinator on 6/21/2022 at 1:30 PM. She stated the baseline care plan was essentially a template pulled from the electronic medical record system used by the facility and the care plan was never individualized at admission or updated during the resident's stay. She stated the care plan should have been updated to reflect the resident's discharge plan, discharge goals, and barrier to discharge as well as the diagnosis related to her risk of falls, risk of ADL decline, and reason for anticoagulation use. The MDS coordinator stated it was an oversight on her part. On 6/23/2022 at 9:10 am an interview was conducted with the Director of Nursing (DON) who stated completion of baseline care plans and comprehensive care plans had been identified as a problem, and the facility was currently working updating care plans during the morning interdisciplinary team (IDT) meetings.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		8/4/22

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F 657	Continued From page 19 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to review and revise the care plan in the areas of activities and medication for 2 of 18 sampled residents (Resident #39 and Resident #15) and failed to conduct care plan meetings with residents or resident representatives for 4 of 18 sampled residents reviewed for care plans (Resident #39, Resident #50, Resident #62, and Resident #21). The findings included: 1. Resident #39 was admitted on 6/4/20 with diagnoses that included diabetes mellitus Type 2 and dysarthria and anarthria (brain damage). A record review of the most recent Minimum Data Set (MDS) dated 5/3/22 revealed Resident #39 was cognitively intact. a. Review of the care plan (reviewed) date 5/4/22 revealed Resident #39 was care planned for activities. The goal indicated the resident would receive in room visits with independent activities. Interventions indicated the resident would receive	F 657	Facility failed to review and revise the care plan in areas of activities and medication for 2 of 18 sampled residents (Resident #39, #15) and failed to conduct care plan meetings with residents or resident representatives for 4 of 18 sampled residents reviewed for care plans (Resident #39, #50, #62, and #21). Resident #39 admitted to the facility on 6/4/20. Resident remains at baseline. Care plan updated on 7/29/22 to reflect preference to participate in group activities. Care plan meeting has been scheduled and revised care plan completed by 8/3/22. Resident #15 admitted to the facility on 10/20/16. Resident remains at baseline. Care plan for psychotropic medication discontinued on 6/22/22. Resident #50 admitted to the facility on 8/15/18. Resident remains at baseline.	

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F 657	Continued From page 20 in room activities and would be assisted with group activities. During an interview on 6/21/22 at 10:00 AM, Resident #39 indicated he does not receive one to one activities. Resident indicated he goes to group activities that were conducted in the facility. During an interview on 6/21/22 at 3:15 PM, the activity director stated Resident #39 attended group activities and was no longer receiving independent activities. The activity director stated Resident #39's care plan was not revised. The activity director indicated that he does not revise the residents care plans. All care plans were revised by the MDS coordinator. During an interview on 6/22/22 at 3:00 PM, MDS coordinator indicated care plans with regards to falls, antibiotics, nursing, medication and change in conditions were revised by her. The MDS coordinator stated that she does not create, review, or revise residents care plans for Dietary, Social Work and Activities. The care plan was revised by the respective departments. During an interview on 6/23/22 at 11:43 AM, the Director of Nursing (DON) stated the resident's care plans should be revised by individual department. The MDS coordinator was not responsible to revise care plans for Dietary, Activities and Social Work. DON further stated it was her expectation that the care plan were reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated the care plans should reflect the actual status of the resident based on the assessment.	F 657	Care plan meeting has been scheduled and revised care plan completed by 8/3/22. Resident #21 admitted to the facility on 7/23/19. Resident remains at baseline. Care plan meeting has been scheduled and revised care plan completed by 8/3/22. Resident #62 admitted to the facility on 6/3/21. Resident remains at baseline. Care plan meeting has been scheduled and revised care plan to be completed by 8/3/22. The Case Mix Director or designee has reviewed all resident care plans for revisions and updates, and any revisions and/or updates addressed by 8/3/22. The Social Services Director and/or designee have completed and mailed care plan meeting letters to all residents and/or responsible parties notifying them of scheduled care plan meetings date and time completed by 8/3/22. Interdisciplinary team is to review each care plan during the care plan meeting with the resident and/or responsible party ensuring any revisions and updates to the care plan are completed. The facility has reviewed its Care Plan policy for clarity with no revisions needed. Administrator and / or Designee provided education to MDS, Social Services, Activities Director, Dietary Manager, Therapy Director, and Nurse Manager	

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F 657	Continued From page 21 b. Review of Resident #39's care plan revealed the care plan was reviewed and revised on 5/4/22, but there was no indication that resident participated in the care plan meeting or development of the care plan. During an interview on 6/20/22 at 1:55 PM, Resident #39 indicated during the last 6 months he had not been invited to attend a care plan meeting and did not recall participating in developing his plan of care. During an interview on 6/21/22 at 1:45 PM, the Social Worker indicated the facility had not conducted quarterly and annual care plan meetings with residents or family members since October 2021. The interdisciplinary team met with families and residents only during admission when the base line care plan was developed. The Social Worker stated she reviewed her part of the assessment with the resident during the quarterly review in May 2022. During an interview on 6/21/22 at 2:30 PM, the MDS coordinator stated that currently no care plan meetings were conducted with residents and family members after MDS assessments were completed. The families and residents were not invited to care plan meeting when the care plan was reviewed or revised. The MDS coordinator further stated the interdisciplinary team met with the resident and family members during the new admission or readmission for baseline care plan. Meeting was either conducted in the resident room or in a bigger room within 24-48 hours of admission. The family may be present or may participate over the phone. No care plan meeting were conducted for quarterly or annual assessments.	F 657	re-educated to the policy by 8/3/22. The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1)Interdisciplinary team is to review each care plan during the care plan meeting with the resident and/or responsible party ensuring any revisions and updates to the care plan are completed. 2)Licensed Nursing Home Administrator LNHA or designee will review scheduled care plan meetings weekly x4 weeks, and then monthly x3 months ensuring care plan meetings are conducted Quarterly, Annually, and with Significant Changes. 3)Licensed Nursing Home Administrator LNHA or designee will review 3 resident care plans weekly x4 weeks, and then 5 resident care plans monthly x3 months ensuring all care plan revisions and updates addressed. Results of the monitoring will be presented by the Case Mix Director or LNHA to the QA team monthly. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date of compliance. 8/4/22	

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During an interview on 06/23/22 11:43 AM, the director of nursing (DON), indicated that currently the interdisciplinary team meeting with the resident and/or the family were conducted only for baseline care plan to discuss resident's goals and preferences. Other care plan meetings were not conducted at this time. The facility was in the process of conducting these care plan meeting and have not reached that point yet. The DON further indicated that she was hired by the facility in May 2022 and unsure if care plan meeting with residents and families were conducted prior to her hire. The DON stated it was her expectation that the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated residents and/or resident's representatives should be involved in the care plan meeting and make decision about their care.

2. Resident #50 was admitted on 8/15/18 with diagnoses that included diabetes mellitus Type 2, renal osteodystrophy, and dependence on renal dialysis. A record review of the most recent quarterly Minimum Data Set (MDS) dated 5/19/22 revealed Resident #50 was cognitively intact.

Review of Resident #50's care plan revealed the care plan was last reviewed and revised on 3/20/22. The care plan was not reviewed after the recent MDS assessment. There was no indication that the resident participated in the care plan meeting or development of the care plan.

During an interview on 6/20/22 at 11:18 AM, Resident #50 stated he did not have a care plan meeting for a long time. Interdisciplinary team

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had not invited him to any care plan meetings.

During an interview on 6/21/22 at 1:45 PM, the Social Worker indicated the facility had not conducted quarterly and annual care plan meetings with residents or family members since October 2021. The interdisciplinary team met with families and residents only during admission when the base line care plan was developed. The SW further stated she had reviewed her part of the assessment with the resident.

During an interview on 6/21/22 at 2:30 PM, the MDS coordinator stated that currently no care plan meetings were conducted with residents and family members after MDS assessments were completed. The families and residents were not invited to care plan meetings when the care plan was reviewed or revised. The MDS coordinator stated the interdisciplinary team met with the resident and family members during the new admission or readmission for baseline care plan. Meeting was either conducted in the resident room or in a bigger room within 24-48 hours of admission. The family may be present or may participate over the phone. No care plan meeting were conducted for quarterly or annual assessments.

During an interview on 06/23/22 11:43 AM, the director of nursing (DON), indicated that currently the interdisciplinary team meeting with the resident and/or the family were conducted only for baseline care plan to discuss resident's goals and preferences. Other care plan meeting were not conducted at this time. The facility was in the process of conducting these care plan meeting and have not reached that point yet. The DON further indicated that she was hired by the facility

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in May 2022 and unsure if care plan meeting with residents and families were conducted prior to her hire. The DON acknowledged that the residents care plan was not reviewed after the quarterly assessment. The DON stated it was her expectation that the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated residents and/or resident's representatives should be involved in the care plan meeting and make decision about their care.

3. Resident #62 was admitted on 6/3/21 with diagnoses that included diabetes mellitus Type 2, and congestive heart failure. A record review of the most recent quarterly Minimum Data Set (MDS) dated 6/2/22 revealed Resident #62 was cognitively intact.

Review of Resident #62's care plan revealed the care plan was reviewed and revised on 6/7/22. There was no indication that the resident participated in the care plan meeting or development of the care plan.

During an interview on 6/20/22 at 11:18 AM, Resident #62 stated she did not have a care plan meeting for a long time and does not recall staff speaking with her about her goals and progress.

During an interview on 6/21/22 at 1:45 PM, the Social Worker indicated the facility had not conducted quarterly and annual care plan meetings with residents or family members since October 2021.The interdisciplinary team met with families and residents only during admission when the base line care plan was developed. The Social Worker further stated the resident's last

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assessment was on 5/13/22 and the resident did not have a care plan meeting.

During an interview on 6/21/22 at 2:30 PM, the MDS coordinator stated that currently no care plan meeting were conducted with residents and family members after MDS assessments were completed. The families and residents were not invited to care plan meeting when the care plan was reviewed or revised. The MDS coordinator stated the interdisciplinary team met with the resident and family members during the new admission or readmission for baseline care plan. Meeting was either conducted in the resident room or in a bigger room within 24-48 hours of admission. The family may be present or may participate over the phone. No care plan meeting were conducted for quarterly or annual assessments.

During an interview on 06/23/22 11:43 AM, the director of nursing (DON), indicated that currently the interdisciplinary team meeting with the resident and/or the family were conducted only for baseline care plan to discuss resident's goals and preferences. Other care plan meeting were not conducted at this time. The facility was in the process of conducting these care plan meeting and have not reached that point yet. The DON further indicated that she was hired by the facility in May 2022 and unsure if care plan meeting with residents and families were conducted prior to her hire. The DON stated it was her expectation that the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated residents and/or resident's representatives should be involved in the care plan meeting and make

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decision about their care.
4. Resident #15 was admitted to the facility on 10/20/16 with multiple diagnoses including depression. The quarterly Minimum Data Set (MDS) assessment dated 3/28/22 indicated that Resident # 15 had not received any antidepressant medication during the assessment period.

Review of the doctor's orders for Resident #15 revealed that Cymbalta (an antidepressant drug) was discontinued on 1/9/22.

Review of the Medication Administration Records (MARs) from February through June 2022 revealed that Resident #15 had not received an antidepressant medication Cymbalta.

Review of Resident #15's care plan that was initiated on 7/20/20 and was last reviewed on 3/28/22 was conducted. One of the care plan problems, was resident was on a psychotropic drug Cymbalta. The approaches included to assess and implement non- drug intervention, monitor for side effects and pharmacist to review medications.

The MDS Nurse was interviewed on 6/22/22 at 1:52 PM. The MDS Nurse stated that she started working at the facility as the MDS Nurse in February 2022. She reviewed the doctor's orders and the care plan and verified that Resident #15 was no longer receiving an antidepressant medication since January 2022. She reported that the use of the antidepressant drug Cymbalta should have been resolved when the care plan was reviewed in March and June of 2022.

The Director of Nursing (DON) was interviewed

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on 6/23/22 at 12:10 PM. The DON stated that she expected the care plan to be reviewed/revised as needed. She added that the MDS Nurse was new to her position, but a corporate MDS Nurse was assisting her.

5. Resident #21 was admitted to the facility on 7/23/2019. Her diagnoses included stroke and dementia.

A review of Resident #21's medical record indicated the last care plan conference for Resident #21 was held on 12/09/2020 with Resident #21's representative present.

Nursing documentation revealed a care plan meeting for 9/30/2021 was rescheduled for 10/4/2021. There was no documentation discovered indicating the care plan meeting was conducted on 10/4/2021.

A review of the Minimum Data Set (MDS) assessments revealed an annual MDS was conducted on 11/3/2021 and quarterly assessments were conducted on 1/26/2022 and 4/18/2022. The quarterly assessment dated 4/18/2022 indicated Resident #21 was severely cognitively impaired and required assistance with all activities of daily living.

In a phone interview with Resident #21's representative on 6/20/2022 at 11:24 p.m., she stated she was not receiving invitations to care plan meetings. She stated a care plan meeting scheduled last year was canceled, and she was never informed the care plan meeting was rescheduled.

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Resident #21's comprehensive care plan was last reviewed on 6/21/2022.

An interview with the MDS Nurse was conducted on 6/22/22 at 11:04 p.m. She stated in February 2022 when she assumed the role as MDS Nurse, the facility was not conducting care plan meetings due to COVID, and care plan meetings had not resumed. She stated she was responsible for scheduling quarterly and annual care plan meetings, notifying residents and resident representatives of the care plan meetings and conducting the care plan meetings with the interdisciplinary team members.

In an interview with the Social Worker on 6/22/2022 at 11:04 a.m., she stated the facility had not conducted quarterly and annually care plan meetings with residents and resident representatives since October 2021. She stated care plan meetings with Resident #21's representative had not been conducted. She stated she reviewed the care plan with resident representatives quarterly and could not recall speaking with Resident #21's representative when the assessment was conducted on 4/18/2022. She stated the facility was not conducting in-person care plan meetings due to COVID, but the facility had the technology capability to connect with resident representatives outside of the facility.

In an interview with the Director of Nursing (DON) on 6/23/2022 at 1:40 p.m., she stated prior to her arrival to the facility in May 2022, quarterly and annual care plan meetings were not conducted at the facility. She stated the MDS nurse and social worker would work on scheduling quarterly and annual care plan meetings with residents and

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F 657	Continued From page 29 resident representatives.	F 657		
F 660 SS=J	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information	F 660		8/4/22

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F 660	Continued From page 30 regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by:	F 660		

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F 660	Continued From page 31 Based on record review, and interviews with family, home health, and staff, the facility failed to assess a resident's home environment to identify and evaluate barriers at the discharge location and arrange for home health services to commence the day after discharge. Upon arrival home, the transport driver assisted Resident #222 out of the vehicle and onto the sidewalk in front of her residence. The residence had 6 stairs leading to the front door and no wheelchair ramp. The resident's husband was present at the residence. The facility transporter left before the resident ascended the stairs into the residence. Resident #222 was unable to ascend all the stairs due to weakness and her husband was unable to assist her. The Resident's husband called the Fire Department to assist with getting Resident #222 from the sidewalk into the residence. The resident was home for several hours but was unable to safely ambulate in her residence. Emergency Medical Services were called around 5:30 PM and transported the resident to the hospital where she was admitted for generalized weakness, dehydration, deconditioning and intravenous fluid administration. This deficient practice affected 1 of 2 residents (Resident #222) reviewed for discharge. Immediate jeopardy began on Friday, 4/1/2022 when Resident #222 was discharged from the facility and transported to her residence via facility transporter and facility transport van around 2:00 PM. The immediate jeopardy was removed on 7/14/2022 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to	F 660	Corrective Action for those Residents found to have been affected Resident #222 admitted to the facility on 2/22/22. Resident discharged to home on 4/1/22. How the facility will identify other residents having the potential to be affected: The Social Worker completed a review on 7/6/2022 of all community discharges, from 4/1/2022 through 7/5/2022, validating home health was offered, Durable medical equipment was ordered if needed, education provided to resident / responsible party, and that the post discharge follow up phone calls made to the residents / responsible party after discharge. Seventeen residents where discharged home from 4/1/2022 to current. Of the seventeen residents, thirteen were provided home health services with three residents declining home health and Durable medical equipment. Systemic changes made to ensure that deficient practice will not recur: On 7/6/2022 the Home Safety Assessment screening form was reviewed and revised by the Vice President of Therapy Services and the Director of Clinical Operations for Therapy Services. This screening form includes a home safety assessment to determine the need for a virtual home visit, onsite home visit or if no visit is needed to determine	

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F 660	Continued From page 32 ensure monitoring of systems put into place related to the discharge planning process are effective and to complete staff training. The findings included: Resident #222 was admitted to the facility on 2/22/2022 with diagnoses that included sepsis related to chronic venous ulcerations of bilateral lower extremities. Resident #222's admission care plan initiated 2/22/2022 had a focus for discharge but it did not indicate where the resident expected to discharge. The resident's discharge goal was left blank. The second goal for discharge indicated the resident, family, caregiver would be able to verbalize understanding of the resident's discharge summary. The care plan also had a focus for barriers to discharge but it was not completed. Interventions for discharge planning included: " Evaluate the competency and capacity of the caregiver. " Involve resident, resident representative, and caregiver in the discharge process. " Anticipate resident's needs post discharge. " Resident teaching (left blank) Progress notes provided by the Social Worker (SW) revealed the following information: " On 3/11/2022 the SW spoke with resident regarding a notice of Medicare Non-Coverage (NOMNC). Resident and husband both desired her to have more therapy and stated they would wait and hope the NOMNC would not be issued. SW reminded them of the need to plan ahead and try to get a first-floor apartment. Husband stated he could not afford to hire a mover. SW available to continue to advise on options and	F 660	residents mobility within the home, equipment and or home modification needs in the home prior to discharge. This process ensures that the facility has thoroughly evaluated potential barriers of the discharge prior to discharge. On 7/6/2022 the Director of Health Services and / the clinical Competency Coordinator began educating the Interdisciplinary Team, including but not limited to the Social Worker, Activity Director, Nurse Managers / Coordinator, Therapy Outcomes Manager, Certified Dietary Manager, Nurse Navigator, Case Mix Director on discharge planning and making appropriate referrals per policy (Discharge Planning) to include the home safety assessment evaluations by therapy. Monitoring of performance to make sure that solutions are sustained. The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) All upcoming discharges will be reviewed daily by the IDT during daily stand-up meetings ensuring safe discharge. 2) Social Services Director or designee will place follow up phone calls to the community discharged residents / responsible party ensuring; resident is	

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F 660	Continued From page 33 assist as needed for safe discharge. " On 3/11/2022 the SW also documented the resident lived in a single-story apartment with 5 steps at entrance. SW documented the resident functioned at a wheelchair level, would not be able to install a ramp at the apartment complex she resided in, and would need to be able to navigate the steps. SW indicated the steps presented a barrier to safe discharge at that time. The SW indicated the resident had no children, only her husband to provide care at time of discharge. " On 3/14/2022 NOMNC served to resident by SW with last date of care 3/16/2022. The resident stated she did not feel like she was ready to go home as she had just started walking and had 6 steps to enter her apartment with no possibility of a ramp. Resident stated she was looking forward to working with physical therapy on stairs. Resident stated she would speak to her husband regarding appealing. " On 3/15/2022 SW documented she faxed appeal as well as referral for home health in preparation for discharge. " On 3/16/2022 SW documented she spoke with the resident's husband regarding discharge plans. He stated there was no room in the residence for a wheelchair and preferred to discuss discharge after learning the outcome of the appeal. The husband stated there was no first-floor apartment available until summer and the resident would have to come home if the appeal was lost. The SW inquired about Medicaid eligibility and the husband stated they would not qualify for Medicaid due to assets. The SW recommended paid caregiver services and the husband stated they had no money for paid caregiver services. " On 3/16/2022 SW documented a	F 660	adapting back to home environment / prior level of care environment, appropriate level of caregiver support, and to identify any further resources they may require. These calls will be made 24 hours following discharge, then 72 hours post discharge, and then weekly x4 weeks. Any concerns identified will be reported to the IDT and addressed promptly. Results of the post-discharge follow-up calls will be presented by the Social Services Director or LNHA to the QA team monthly. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Dates when the corrective action will be completed. 8/4/2022	

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conversation with resident separate from her husband. Resident stated she needed more therapy to be able to climb her stairs however stated she would return home regardless of safety concerns if she lost her appeal. SW spoke to resident regarding the potential to remain in the facility and apply for Medicaid. Resident refused. SW offered assistance finding a senior apartment, but resident refused.

" On 3/17/2022 SW documented she contacted the resident's apartment complex manager regarding policy for ramps. The SW then called the resident's husband who stated he could not afford ramp rentals. An appointment was set up with resident and her husband to discuss possibility of Medicaid application.

" 3/18/2022 Resident and her husband met with SW regarding options for a safe and orderly discharge. Both were open to making room in the residence for a wheelchair and exploring ramp installation. The resident and her husband were given the address and contact number for the department of social services as well as contact information for local ramp rental companies.

" On 3/23/2022 NOMNC served to resident and appeals instructions reviewed.

" On 3/28/2022 SW documented resident was making progress toward discharge goal of 6 stairs to enter residence. Husband unable to secure ramp for residence at that time. Stairs continued to be a barrier at that time.

" On 3/29/2022 resident was served NOMNC with last date of care 3/31/2022. Resident stated she did not wish to appeal and planned to discharge home on 4/1/2022. There was no ramp in place at that time, but the resident stated she felt comfortable navigating steps. The plan was for resident to continue working with physical therapy through home health.

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The Physician Assistant (PA) who assessed Resident #222 on 3/30/2022 at 12:52 PM documented in the resident's medical record she saw the resident for discharge planning. For disposition the PA documented the following: "Patient suffers from weakness and debility which impairs her ability to use stairs to get in and out of her home. A cane or walker will not resolve these issues with transfers into her home because of instability and risk of falling. A ramp that allows her to get in and out of her home is medically necessary to prevent falls and allow her to attend her medical appointments without requiring transportation from an ambulance company."

Resident #222's medical record included a physician's order dated 3/31/2022 that read, "Patient to discharge home on 4/1/2022 with family and home health. PT/OT to evaluate and treat as indicated, nursing for medication and wound management, and CNA for ADL assistance. Start of Care: 4/5/2022."

The occupational therapy (OT) discharge summary for Resident #222 with end of care date 3/31/2022 revealed the resident did not meet activities of daily living (ADL) goals and was discharged with 50% ADL impairment. Pertinent OT goals included the resident will be modified independent in all aspects of self-care and activities of daily living within the home in order to return home with spouse safely. The OT discharge summary indicated the goal was not met. The summary also indicated she was discharged home with recommendations of home health.

Resident #222's discharge included a discharge

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summary by physical therapy (PT) with end of care date 3/31/2022. The discharge revealed the resident was able to maintain balance while sitting and standing. The resident required partial assistance from another for mobility indoors and stairs. The discharge summary also revealed the resident used a wheeled walker as assistive device. For mobility with 4 steps, the resident required verbal cues, steadying and or contact guarding assistance for completing activity. The summary indicated she was discharged home with home health.

On 6/21/2022 at 12:25 PM an interview was conducted with the Physical Therapy Director. She recalled Resident #222 and stated the resident was able to ambulate with walker and navigate 3 steps with stand by assist. She further stated Resident #222's discharge was hindered by insurance not covering many things like durable medical equipment, home health, and additional days for rehabilitation. Her husband was adamant they would not pay out of pocket for additional days in the facility and he would not allow the SW to apply for assistance on the resident's behalf. The Physical Therapy Director stated the SW assisted Resident #222 with multiple appeals, but all appeals were denied. When asked about stairs, the Physical Therapy Director stated the resident was able to ascend and descend 3 steps with stand-by assistance, but she was concerned the resident's husband, who was also had mobility issues, would not be able to provide the standby assistance the resident needed.

A progress note by the SW dated 3/31/2022 indicated Home Health Provider #1 was able to accept resident's insurance with a start of care

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date 4/5/2022.
An interview was conducted with the SW on 6/22/2022 at 9:19 AM. She stated there was difficulty getting home health set up due to the resident's insurance. The soonest home health could start was 4/5/2022. The resident's husband was aware of the 4/5/2022 start date. She stated the facility attempted to assist the resident with getting a wheelchair ramp, but the resident lived in a second-floor apartment and either could not afford, or the complex would not allow them to place a ramp. She stated they tried to get them to move to an apartment on the floor level, but the husband stated there would not be an apartment available until August and he did not have a means to move all of their things down to a ground level apartment. She stated the resident's husband stated several times he did not want to spend money or accept assistance to make it so the resident could return to the apartment. The SW stated the resident was able to transfer herself, walk with a walker, and navigate steps when she was discharged. She felt like it was a safe discharge at the time and the resident's husband was not going to pay for the resident to stay additional days.

A second interview was conducted with the SW on 7/1/2022 at 3:00 PM. She stated she did not complete a home assessment for Resident #222 to assess for barrier to discharge. She further stated the facility quit doing home assessments during the pandemic and had only recently started completing home assessments again. When asked if she was aware the resident did not have a ramp in place at the time of her discharge, she stated she was aware there was no ramp in place at the time of discharge. When asked if a referral was made to Adult Protective

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Services at the time of the resident's discharge, she stated she did not make a referral.

On 7/1/2022 at 2:15 PM a telephone interview was conducted with the Admissions Coordinator for Home Health Provider #1. She stated she received the referral for Resident #222 on 3/31/2022 and accepted the referral with a start date of 4/5/2022. She further stated that was the first available date they could start services due to staff shortages.

Documentation provided by the Administrator indicated Home Health Provider #2 accepted the referral for wound care with a start date of 4/3/2022 and a nurse visit was scheduled for 10:30 AM to address the resident's dressing changes.

On 6/22/2022 at 11:24 AM an interview was conducted with the Treatment Nurse. She stated she recalled Resident #222. She stated the resident got daily wound care for venous ulcers of bilateral lower legs. The Treatment Nurse stated the resident's venous ulcers were healing when she left the facility. She stated the resident could transfer from bed to wheelchair on her on and could stand bedside on her own. She was steady with assistance when using a walker. She did not believe resident would be steady enough to go up or down stairs. She did recall seeing the resident's husband and he had decreased mobility as well.
Resident #222's discharge orders dated 3/11/2022 included a wound care order for acetic acid solution, 0.25%; amount 60 milliliters irrigation to be used as wound soak every other day on Monday, Wednesday, and Friday.

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On 7/6/2022 at 10:30 AM a telephone interview was conducted with the Admissions Coordinator for Home Health Provider #2. She stated she accepted the referral for Resident #222 on 3/31/2022 with start date of 4/3/2022. She could not recall if 4/3/2022 was the first date they could staff the referral or if that was the date the facility requested start of services.

The resident's discharge Minimum Data Set (MDS) with observation end date 4/1/2022 indicated the resident was cognitively intact. She required two persons assistance for transfers, walked in her room only once or twice during the assessment period, locomotion in room was with set up only, locomotion in the facility occurred only once or twice during the assessment period, required assistance of one for dressing and toileting, and required the assistance of two persons for personal hygiene during the assessment period.

Progress notes dated 4/1/2022 revealed Resident #222 left the facility via facility transport with medications, orders, and all belongings in hand. Husband stated he would meet resident at the home. Resident stated she was ready to go home.
On 6/21/2022 at 1:50 PM an interview was conducted with the Facility Transporter. He stated he took Resident #222 home on 4/1/2022. He stated he could not remember if the resident was discharged with a wheelchair or walker. He stated he assisted her out of the vehicle and up to the curb. Her husband was waiting for her and said he could help her inside. He recalled the resident was able to get up the steps, 3-4, and she was on the top step when he pulled away from the curb.

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On 6/21/2022 at 5:02 PM a phone interview was conducted with Resident #222's husband who was also her responsible party (RP). He stated the facility did not ask to perform a home visit. He stated Resident #222 was transported from the facility to her residence on 4/1/2022 around 2:00 PM by the facility transporter. The transporter provided standby assistance for Resident #222 when she exited the transport van and when she stepped onto the curb. At that time, the transporter got into the van and drove off before Resident #222 ever got up the 6 steps to the residence. The husband stated Resident #222 was able to go up the first 4 steps but was unable to make it up the final 2 steps and into the residence. The husband called the local fire department who assisted the resident into the residence. He stated the resident sat in a chair in the living area of the residence for several hours but was unable to ambulate around the residence due to weakness. He further stated he had to call Emergency Medical Services (EMS) to transport the resident back to the hospital the evening of 4/1/2022.

Fire Department and EMS records dated 4/1/2022 indicated they arrived on scene at 2:06 PM for a lift assist call. Upon arrival they found the resident on the stairs. The firemen assisted the resident to a stand position, but she still could not get up the stairs. The resident was assisted onto a stair chair and was lifted up the stairs. A second attempt was made to assist resident into the apartment, but she was unable to get over the step at the threshold of the residence. She was placed back on the stair chair and assisted into the residence. The resident was assisted to a stand and pivot into a recliner. Emergency

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Medics advised resident she should allow them to transport her to the Emergency Room (ER) for evaluation, but the resident and her husband refused. A second call to EMS was made on 4/1/2022 at 5:37 PM when they found the resident sitting in a chair in her bedroom. She was found to be hypotensive and tachycardic and stated she was unable to get around her residence. The resident and her husband agreed to transport to hospital.

Hospital records dated 4/1/2022 revealed Resident #222 was admitted to the ER on 4/1/2022 at 7:10 PM and was admitted to the hospital with what the admitting Physician referred to as , "generalized weakness, deconditioning, and dehydration". Resident #222 was given intravenous fluids for dehydration and intravenous iron for anemia. The hospital discharge summary dated 4/5/2022 indicated Resident #222 was discharged to a skilled nursing facility for ongoing physical therapy, occupational therapy and daily wound care.

An interview was conducted with Nurse Practitioner (NP) #2 on 6/23/2022 at 9:15 AM. She stated she provided care for Resident #222 while she was in the facility but did not see Resident #222 on the date of her discharge. She further stated the last time she saw Resident #222 she could stand and pivot, but she never personally saw the resident ambulate any distance.

On 6/23/2022 at 9:28 AM an interview with the Director of Nursing (DON). She stated she was not the DON in the facility at the time of Resident #222's discharge. She further stated she would have handled the situation differently. She stated

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she had provided education to the staff regarding situations where the resident does not want to stay in the facility, but the facility did not feel like the resident was ready to safely discharge.

The Administrator was notified of immediate jeopardy on 7/7/2022 at 8:20 AM.

The facility provided the following credible allegation of immediate jeopardy removal.

The facility discharged resident home on 4/1/2022 via facility van transportation. Prior to discharge the facility failed to assess a resident's home environment for any discharge barriers or level of caregiver support. As the result of the facility's failure, the resident required Emergency Medical Services assistance which ended with the resident transferring to the hospital on the same day of discharge.
Residents who have been discharged from the facility and residents with potential discharge to the community have the potential to be impacted.
The Social Worker completed a review on 7/6/2022 of all community discharges, from 4/1/2022 through 7/5/2022, validating home health was offered, Durable medical equipment was ordered if needed, education provided to resident / responsible party, and that the post discharge follow up phone calls made to the residents / responsible party after discharge.
Seventeen residents where discharged home from 4/1/2022 to current. Of the seventeen residents, thirteen were provided home health services with three residents declining home health and Durable medical equipment. The purpose of this audit was to ensure all other residents discharging to the community received a thorough discharge assessment which

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appropriately identified and addressed potential barriers of the discharge and were provided appropriate equipment and resources. The purpose of this review was to identify no other resident was affected by this practice.

" 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.

The facility has two residents discharging on 7/6/2022, resident number one is being discharged to home with granddaughter who is her care giver and her daughter who is the Responsible Party has taken Family Medical Leave for this transition. The Responsible Party declined a home evaluation by therapy stating she already has needed items in place. Resident / Responsible Party has signed a form stating her refusal for a therapy home evaluation. Home Health has been confirmed to start on 7/7/2022, Therapy Services and wound care consultation has been set up for home discharge. Per Physician Assistant discharge summary dated 7/6/2022, the resident is medically stable and cleared for discharge.

Resident number two who is alert and oriented and his own Responsible Party, is being discharged home with a roommate, per their wishes, Against Medical Advice. They state they can receive the same services at home, and he will be able to sleep in his own bed and eat his own food. Therapy offered a home evaluation and resident has declined the evaluation. Resident was requested by the Nurse Navigator RN to stay in facility for at least twenty-four more hours for the facility to obtain home health services, but

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resident declined. Resident refused the medication when offered by the Director of Nursing stating he has everything he needs at home. The Physician Assistant saw the resident prior to discharge on 7/6/2022 and discussed risks involved with leaving the facility against medical advice. When the resident leaves the facility, Adult Protective Service "APS" was notified on 7/6/2022 by the Social Worker of the discharge against medical advice. The decision to make an APS referral was determined by the facility interdisciplinary team based on the resident's discharge against medical advice. This notification has been documented in the medical record.

To correct the deficient practice the facility will initiate discharge planning upon admission with the resident and/or responsible party for determination of long-term placement or short-term placement with return to the community. For community discharges, community resources will be offered to include but not limited to Therapy screen to identify if a virtual, onsite home, or no site visit is needed for equipment and services needed at home, home health agencies, Therapy services, meals on wheels, community care services, outpatient clinics and social service agencies. Physician / Physician Extender will assess facility discharges to ensure that the resident is medically stable for discharge prior to discharge. For residents who choose to discharge back to the community against medical advice, the community resources will be offered to include but not limited to Therapy screen to identify if a virtual, onsite home, or no site visit is needed for equipment and services needed at home, home health agencies, Therapy services, meals on wheels, community care services, outpatient clinics and

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social service agencies. However, the decision to make an APS referral will be determined by the facility interdisciplinary team based on if the resident discharges against medical advice or if there is an unsafe situation creating a barrier to discharge. Interdisciplinary team will communicate the need for an APS referral to Social Worker / Nurse Navigator. Adult protective Services will be notified by a facility representative (Social Worker / Nurse Navigator) that the resident has discharged against medical advice. An Adult Protective Service referral may also be made if the Interdisciplinary team believes the resident may be in an unsafe situation.

On 7/6/2022 the Home Safety Assessment screening form was reviewed and revised by the Vice President of Therapy Services and the Director of Clinical Operations for Therapy Services. This screening form includes a home safety assessment to determine the need for a virtual home visit, onsite home visit or if no visit is needed to determine residents' mobility within the home, equipment and or home modification needs in the home prior to discharge. This process ensures that the facility has thoroughly evaluated potential barriers of the discharge prior to discharge. The Therapy Outcome Coordinator began educating the Licensed Therapist on 7/6/2022 regarding the home screening evaluation, any therapist not educated by 11:00 pm 7/6/2022 will be removed from the schedule until education has been completed. The Therapy Outcome Coordinator will maintain a log of therapist educated and therapist not educated. On 7/6/2022 the Director of Health Services and / the clinical Competency Coordinator began educating the Interdisciplinary Team, including but

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not limited to the Social Worker, Activity Director, Nurse Managers / Coordinator, Therapy Outcomes Manager, Certified Dietary Manager, Nurse Navigator, Case Mix Director on discharge planning and making appropriate referrals per policy (Discharge Planning) to include the home safety assessment evaluations by therapy. Interdisciplinary Team members who have not been educated by 7/6/2022 11:00pm will be removed from the schedule until the education has been completed. The Director of Health Service is maintaining a log of employees educated.

On 7/6/2022 the Director of Health Services and/or Clinical Competency Coordinator began education with the Social Worker and Nurse Navigator, on placing follow up phone calls to the community discharged residents / responsible party ensuring; resident is adapting back to home environment / prior level of care environment, appropriate level of caregiver support, and to identify any further resources they may require. These calls will be made 24 hours following discharge, then 72 hours post discharge, and then weekly for four weeks. Concerns voiced by the discharge resident and/or Responsible Party will be brought forth to the Interdisciplinary Team for follow up and any recommendations for additional services will be provided.

On 7/6/2022 the Director of Health Services educated the van driver on ensuring residents are safely within the home prior to leaving the resident's property when the facility provides transportation. This includes assisting the resident into the home and that if the resident / responsible party refuses the van driver is to maintain visualization until the resident is inside the home. This education was provided to the one van driver currently employed. This education

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will be provided for all newly hired van drivers during general orientation prior to transporting residents.
On 7/13/2022 the Director of Health Services educated the van driver on the discharge process to include, when facility is providing discharge transportation home, the resident is to be assisted into the home, and if assistance is refused, visualize the resident entering home. When the resident's family member / responsible party is to be providing transportation home, Therapy will assess, educate, and practice car transfers safely into and out of the vehicle. This process is already incorporated in the Discharge Location Checklist Form.
When the resident is transported home through a contracted transportation company, Therapy will ensure a safe discharge by conducting a Home Safety Assessment and Safe Community Discharge checklist. The company will provide transportation to the resident's home and if the driver determines resident is unable to safely enter the dwelling, driver will notify the facility and/or EMS. Facility does post-discharge 24-hour follow-up calls for all discharges.
The Administrator was responsible for the credible allegation.
The facility's credible allegation of Immediate Jeopardy removal was validated on 7/13/22. The validation was evidenced by staff interviews, record reviews and review of in-service documentation to verify education had been provided to staff that addressed the process of discharge planning and making appropriate referrals. Interviews were conducted with the facility's van driver, Therapy Outcomes Manager, Nurse Managers, Physician Assistant, and Medical Director to discuss their role to ensure a safe discharge for residents. Although the

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F 660	Continued From page 48 facility's Nurse Navigator was no longer employed by the facility (as of 7/12/22), interviews with the Clinical Competency Coordinator, Director of Nursing and Social Worker confirmed the discharge responsibilities of the Nurse Navigator were currently being shared among them. The interventions for a safe community discharge included offering resources such as a Therapy screen to identify if a home site visit was required to assess the equipment and services needed at home; the resident being assessed by the physician/physician extender prior to discharge; and making a referral to Adult Protective Services (APS) if the resident was discharged Against Medical Advice (AMA) and/or under circumstances which suggested an unsafe discharge. Further measures to ensure a safe discharge to the community included addressing the resident's mode of transportation to his/her home via the facility van, a family member/responsible party, or through a contracted transportation company. The staff interviews confirmed follow-up phone calls were also being made to the community discharged residents to ensure their needs were being met. The Administrator was notified on 7/13/22 the credible allegation for the immediate jeopardy removal was validated on this date (7/13/22) with a removal date of 7/14/22.	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		8/4/22

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F 677	Continued From page 49 Based on observation, record review and interviews with resident, staff, and transportation driver, the facility failed to: 1) Provide the necessary Activities of Daily Living (ADLs) assistance to ensure that Resident #39 was ready for a scheduled outpatient appointment for 1 of 5 residents reviewed for ADL care. Resident #39 missed his scheduled ophthalmology appointment because the staff did not prepare him to for the appointment; and 2) Provide incontinence care for 1 of 5 dependent residents (Resident #14) reviewed for ADL care. The findings included: 1. Resident #39 was admitted to the facility on 6/24/20 with diagnoses that included diabetes mellitus type 2 and dysarthria and anarthria (brain damage). Review of the quarterly Minimum Data Set (MDS) assessment dated 5/3/22 indicated Resident #39 was assessed as having adequate vision and used corrective lens. Resident #39 was assessed as cognitively intact and needed limited assistance of one person for transfers, dressing and personal hygiene. The resident needed total assistance of one person physical assistance for toileting and extensive assistance of one person for bathing. Review of the revised care plan dated 5/4/22 revealed Resident #39 was care planned for ADL function and rehabilitation potential. ADL decline was related to recent hospitalization. The goals were to improve ADL function to maintain independence, ADL needs would be met, and independence potential maximized within constraints of disease. Interventions included	F 677	Corrective Action for those Residents found to have been affected Resident #39 appointment was rescheduled immediately, and the necessary ADL care provided by NA #2. NA #2 and Nurse #1 verbally educated by DHS on ensuring timely ADL leading up to appointments. NA #13 provided incontinence care to resident #14 on 6/20/22. How the facility will identify other residents having the potential to be affected: The facility Director of Health Service or designee will audit the last 30 days of appointments ensuring; no appointments have been missed, and residents have received necessary ADL care in order to promptly attend scheduled appointments. Facility DHS, Nurse Manager, or designee has audited 100% of all dependent residents requiring incontinence care on 7/29/22 ensuring ADL and incontinence care has been provided. Systemic changes made to ensure that deficient practice will not recur: The Clinical Competency Coordinator CCC or designee began educating all certified nursing assistants on providing timely ADL/ incontinence care. This education has been added to the general orientation for all newly hired Certified Nursing Assistants.	

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F 677	Continued From page 50 encouraging resident to do as much as possible, setting up resident for ADLs and providing assistance devices as needed. Review of the appointment sheet revealed Resident #39 had an eye appointment on 6/20/22 at 9:50 AM. During an interview on 6/20/22 at 12:10 PM, Resident #39 stated he had a regular annual eye appointment scheduled on 6/20/22 at 10:00 AM. The appointment was scheduled in advance. Resident #39 further stated the assigned nurse had not informed the nurse aide (NA) about the appointment. Resident #39 indicated he was not ready when transportation had arrived to take him for the appointment. Resident #39 further indicated that because the nursing assistant had not gotten him ready in time, the appointment had to be rescheduled. The resident indicated he needed assistance with dressing and personal hygiene. Resident #39 further indicated when the transportation staff came to his room to pick him up, he was not yet dressed and ready for the appointment. During an interview on 6/20/22 at 3:06 PM, the transportation staff stated he came to the facility to pick up the resident between 9:15 to 9:20 AM on 6/20/22. The transportation staff further stated that when he went into the resident's room, he observed that the resident was still in bed and was not ready for his appointment. The transportation staff stated Resident #39 had indicated to him that the NA had not gotten him ready for the appointment. Transportation staff further stated that Resident #39 indicated, he was going to reschedule the appointment.	F 677	Nurse manager or designee will visually audit 5 resident rooms Monday-Friday x4 weeks, ensuring ADL care has been provided in a timely manner and that incontinence care has been provided for dependent residents. Concerns identified will be reported to the DHS/LNHA. Director of Health Services, Nurse Manager, or designee will monitor all appointments daily to ensure attendance. Resident appointments will be reviewed by the IDT Monday □ Friday during daily stand-up meetings. On 8/3/22 date the facility implemented daily compliance rounds to attain and maintain consistency in providing quality resident care with emphasis on activity of daily living (grooming) and incontinence care. The Licensed Nursing Home Administrator or designee will re-educate the Interdisciplinary Disciplinary Team (IDT) on completing assigned Daily Compliance Rounds using the Compliance Rounds form with emphasis on ADL and incontinent care. Compliance Rounds are to be completed by the IDT or designee daily Monday □ Friday. The completed Compliance Rounds Forms will be reviewed by the LNHA/DHS/designee ensuring that all findings are promptly addressed and investigated as necessary. Monitoring of performance to make sure that solutions are sustained. The analysis of the compliance rounds	

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F 677	Continued From page 51 During an interview on 6/20/22 at 12:40 PM, Nurse #1 stated Resident #39 had an eye appointment earlier that day, that he missed. Nurse #1 stated all appointment sheets were printed by the night shift (7PM -7AM) Nurses. The morning shift (7 AM - 7 PM) Nursing Assistant's (NAs) were responsible to check the appointment sheet and get the residents ready for their appointment when the transportation arrived. Nurse #1 indicated she was unaware that Resident #39 had an appointment that morning. Nurse #1 further indicated that the transportation staff had notified her that the resident had cancelled his appointment. During an interview on 06/20/22 at 1:30 PM, Nurse Aide (NA) #1 indicated she arrived at 9:00 AM on 6/20/22. Resident #39 was up in his bed as she entered the room at 9:30 AM and he stated that he had missed his appointment. She indicated she was not aware of the appointment. She had not checked the appointment sheets. During an interview on 6/20/22 at 3:30 PM, NA #2 stated she was assigned to Resident #39 that morning until NA #1 arrived. NA #2 indicated she was unaware that Resident #39 had an appointment that morning and did not get him ready. NA #2 stated usually the assigned nurse notified her when a resident had an appointment. NA #2 indicated she was not notified by the Nurse. NA #2 stated she woke him up and served him his breakfast tray. The resident did not mention he had an appointment. NA #2 indicated the resident needed limited assistance with dressing and personal hygiene. During an interview on 6/21/22 at 9:00 AM, the Appointment Scheduler indicated Resident #39	F 677	with emphasis on ADL and incontinent care will be presented by the Director of Health Services or designee to the Quality Assurance and Performance Improvement Committee team monthly. Findings will be addressed promptly by the QA team. the QA team will determine the frequency of ongoing monitoring. Dates when the corrective action will be completed. 8/4/2022	

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had a scheduled appointment on 6/20/22. Every Friday the appointment sheets of all residents for the upcoming week were printed. The scheduler stated a copy of the appointment sheet was given to the resident, and copies were given to the Nurses, Therapy Department, and Director of Nursing. A copy of the appointment sheet was also placed in the appointment folder near the nursing station. It also contained the transportation arrangement information.

During an interview on 6/23/22 at 9:06 AM the Director of Nursing (DON) stated the nurses assigned to the resident were responsible to inform the nurse aides of any scheduled appointments for the day so the that the residents were ready . The DON further stated appointment folders were at the nursing stations the Friday prior. Nursing staff were responsible to ensure residents were ready when transportation arrived.

2. Resident #14 was admitted to the facility on 7/12/21 with re-entry on 9/10/21 after a hospital stay. Her cumulative diagnoses included cerebrovascular accident (CVA) with hemiparesis/hemiplegia (mild to severe weakness on one side of the body), respiratory failure, heart failure and edema.

The physician ' s medication orders for Resident #14 included an order initiated on 5/26/22 for 40 milligrams (mg) furosemide (a diuretic) to be administered to the resident once daily each morning.

The resident ' s most recent Minimum Data Set (MDS) was an annual assessment dated 6/14/22. This assessment revealed Resident #14 was

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cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. No behaviors were reported. The assessment also indicated Resident #14 required extensive assistance with bed mobility, transfers and personal hygiene with 1-person physical assistance for toileting occurring on 1-2 occasions during the 7-day look back period. The MDS assessment indicated Resident #14 was occasionally incontinent of bladder and frequently incontinent of bowel.

Resident #14 ' s current care plan addressed a problem related to her risk for alteration in fluid balance related to the diagnosis of congestive heart failure, diabetes, and use of a diuretic medication (Last Reviewed/Revised on 6/21/22). The planned interventions indicated the resident ' s medications would be provided as ordered by the physician. Another problem addressed by the care plan read, "Resident with manipulative behaviors such as often refusing care including showers and ADL (Activities of Daily Living) assistance such as bedmaking and will often state staff refused to provide care. The interventions included: "Staff will offer ADL care daily and if refused will report to nurse and re-offer" (Last Reviewed/Revised on 6/22/22).

The resident ' s July 2022 Medication Administration Record (MAR) revealed Resident #14 ' s furosemide was last documented as administered on 7/13/22 at 6:21 AM.

An interview was conducted on 7/13/22 at 1:52 PM with Nursing Assistant (NA) #13. The NA was observed as she was approaching the door to Resident #14 ' s room. When asked, the NA reported she was assigned to care for Resident

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#14 and her roommate on this hallway in addition to several residents on another hallway. At that time, the NA was asked when she last provided incontinence care for Resident #14. The NA responded by saying her shift started at 7:00 AM. She reported Resident #14 typically "called out" by using her call light to request incontinence care around 10:00 AM. However, the NA stated she was on "the other side" (referring to the other hall) and did not know whether or not the resident had used her call light. When the question was asked again, the NA reported she had not provided incontinence care to Resident #14 during her shift thus far. This answer was repeated to her for verification and the NA confirmed she had not provided incontinence care to the resident since she started her shift at 7:00 AM.

An observation and interview was conducted on 7/13/22 at 1:55 PM with Resident #14. The resident verbalized she was upset, stating she had gone several hours without staff providing incontinence care for her. The resident estimated it had been more than 4 hours since she had been changed. At the time of this interview, an observation of the bottom sheet of Resident #14 ' s bed was visualized. The bottom sheet was visibly wet, starting from the area of the resident ' s right hip and continuing approximately 6 inches towards the edge of the bed. The resident was asked if she had spilled a liquid on herself or the bed. She stated "No" and reiterated the sheet was wet because she had not been changed for several hours. A lingering odor of urine was detected in the room at the time of this interview and observation.

As the interview with Resident #14 continued, she

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reported putting on her call light three times on this date (7/13/22) to request incontinence care. The resident stated, "I ' ve been ringing and ringing and no one answered." Upon further inquiry, she reported someone (not identified) came in each time she rang her call light and turned it off without providing the incontinence care. The resident was then asked when NA #13 had last been in her room. The resident responding by stating, "I haven ' t seen her."

A follow-up interview was conducted on 7/13/22 at 3:10 PM with NA #13. During the interview, the NA confirmed once again that she had not provided incontinence care for Resident #14 prior to 1:50 PM. However, the NA reported the resident was not correct when she reported to the surveyor that the NA had not been in the room. The NA stated she herself brought in the resident ' s breakfast and lunch trays. When she brought in Resident #14 ' s lunch tray, she stated the resident told her she needed incontinence care. The NA reported she told the resident staff were passing lunch trays at that time so she would have to come back to take care of it. When asked, the NA reported she did not have a chance to return to the room until she was observed preparing to do so at 1:50 PM. To her knowledge, the resident had not refused incontinence care that morning or afternoon.

An interview was conducted on 7/13/22 at 3:34 PM with Nurse #1. Nurse #1 was assigned to Resident #14 ' s hall and reported she administered the medications for this resident around 9:00 AM that morning. Upon further inquiry, the nurse reported Resident #14 tended to want ADL care done "on her terms." At the time of the medication administration, the

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F 677	Continued From page 56 resident was still in bed and did not express any care needs. When the Nurse Manager went back to check Resident #14 ' s blood sugar around 11:30 AM, the resident stated she was still on her computer and wasn ' t ready to get up out of bed. The resident reportedly did not say she was needing incontinence care at that time. When asked what time the lunch trays came out for Resident #14 ' s hall, the nurse reported the trays came out around 12:10 PM. When asked, Nurse #1 reported she did not go into Resident #14 ' s room today to answer the resident ' s call light. She also stated she had not been made aware of Resident #14 ' s call light being put on to request assistance on this date. An interview was conducted on 7/13/22 at 2:20 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported Resident #14 would refuse ADL care on occasions. However, the DON stated she would expect staff to address a resident ' s concern immediately when a call light was activated and for ADL care to be provided upon any request for incontinence care. If staff were not able to help the resident immediately, she expected them to tell the resident why and assure him/her they would return to provide the assistance needed. When asked how often she would expect staff to provide incontinence care or check on a resident, the DON stated routine checks with rounding should be conducted every two hours if the resident hadn ' t called out requesting assistance before that.	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	F 686		8/4/22

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F 686	Continued From page 57 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to ensure the alternating pressure reducing mattress was set according to the resident's weight for 1 of 4 (Resident #20) residents reviewed for pressure injuries. The findings included: Resident #20 was admitted on 9/27/2021 for diagnoses that included advanced kidney disease and muscle weakness. The resident's quarterly Minimum Data Set (MDS) dated 6/11/2022 indicated Resident #20 was severely cognitively impaired, required extensive assistance with all activities of daily living, and had one unstageable pressure injury that was not present on admission. Resident #20's care plan was last revised on 6/17/2022 and included a focus for pressure injuries to the heel and sacrum. Interventions included repositioning resident routinely.	F 686	Corrective Action for those Residents found to have been affected Resident #20 admitted to the facility on 9/27/21. Resident discharged to another skilled nursing facility on 11/5/21. How the facility will identify other residents having the potential to be affected: Facility Wound Nurse and/or designee will audit 100% of all residents utilizing an alternating pressure reducing mattress ensuring accurate settings are in place on 7/30/22. Systemic changes made to ensure that deficient practice will not recur: Education will be provided by Director of Health Services “DHS” or designee to the nursing department and Interdisciplinary Team on the manufacturer’s settings for alternating pressure reducing mattress’	

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F 686	Continued From page 58 Record review revealed Resident #20's most recent weight was 121.8 lbs on 6/9/2022. On 6/22/2022 at 11:00 AM during a wound care observation, the resident was observed to be on an alternating pressure reducing air mattress. The console indicated the mattress should be set according to the resident's body weight. The mattress was set at 300 pounds (lbs). During the wound care observation on 6/22/2022 at 11:00 AM the wound care nurse was interviewed. When asked if the resident was 300lbs, she stated he was not. When asked who monitored the pressure reducing air mattresses for proper settings, she stated she did not know. She further stated she did check to make sure the air mattress was on and inflated. On 6/22/22 at 11:14 AM an interview was conducted with Nurse #10. She was assigned to Resident #20. She stated she did not monitor mattress settings. She did not know who monitored the alternating air mattress for proper setting. She stated she only made sure the air mattress was turned on. On 6/22/2022 at 11:38 AM an interview was conducted with the maintenance director. He stated he and his assistant placed air mattress on the bed, but they did not turn the mattress on or set the mattress to the resident's weight. On 6/23/2022 at 11:15 AM and interview was conducted with the Director of nursing. She stated she expected pressure reducing air mattresses to be set according to the resident's	F 686	and how to properly set up the mattress to meet the specific needs of the resident by 8/3/22. Orientation process revised to include education listed above for all new nurse hires. Monitoring of performance to make sure that solutions are sustained. The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) Wound Nurse or designee will be responsible for ensuring mattress equipment settings are set according to the resident’s weight for all newly admitted residents who require a pressure reducing mattress. 2) Wound Nurse or designee will be responsible for ensuring mattress settings accurate with ongoing monitoring. 3) Wound Nurse or designee will be responsible for auditing any newly placed air mattresses to ensure mattress equipment settings are accurate. Results will be presented by the Director of Health Services and/or the Administrator to the QA team monthly x3 months. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing	

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F 686	Continued From page 59 weight.	F 686	monitoring. Dates when the corrective action will be completed. 8/4/2022	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		8/4/22

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F 758	Continued From page 60 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview with staff and the Nurse Practitioner, the facility failed to ensure as needed psychotropic medications were time limited in duration for 1 of 5 residents reviewed for unnecessary medications (Resident # 32). The findings included: Resident #32 was admitted 5/25/2015 with diagnoses that included vascular dementia and anxiety. Resident #32's quarterly Minimum Data Set (MDS) dated 4/18/2022 indicated the resident was severely cognitively impaired, was sometimes understood others but was rarely understood by others. She received antipsychotics 7 out of 7 days and received hospice care during the assessment period.	F 758	Corrective Action for those Residents found to have been affected Resident #32 admitted to the facility on 5/25/15. Resident remains at baseline. A stop date has been added to the as needed “PRN” Psychotropic medication for Resident #32 on 6/27/22. How the facility will identify other residents having the potential to be affected: Facility Infection Preventionist or designee will audit 100% of all PRN medication orders ensuring a 14 day stop date is in place by 8/3/22. Systemic changes made to ensure that deficient practice will not recur: The Director of Nursing has provided education to the Physicians/Nurse Practitioner/Physician Assistant on	

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F 758	Continued From page 61 The resident's comprehensive care plan, last revised 3/31/2022, included a focus for psychotropic drug use related to anxiety and agitation. Resident #32's active orders include an order for lorazepam 0.5mg oral as needed (prn) for restlessness and agitation with a start date of 6/2/2022 and no end date. The order was written by Nurse Practitioner #2. A pharmacy review was conducted 6/22/2022 and recommended an end for lorazepam 0.5mg oral prn for restlessness and agitation. A telephone interview was conducted with Nurse Practitioner #2 on 6/23/2022 at 4:30 PM. She stated she was not aware prn orders of lorazepam needed to have an end date when the resident was under hospice care. On 6/23/2022 at12:37 PM an interview was conducted with the Director of Nursing (DON). She stated she was aware prn orders of lorazepam required an end date even when the resident was under hospice care.	F 758	ensuring any PRN Psychotropic medication order has a 14 day stop date in place by 8/3/22. The Director of Health Services and/or Nurse Managers will review all new psychotropic PRN (as needed orders) daily in clinical stand-up ensuring the presence of a stop date for any PRN Psychotropic medications. Monitoring of performance to make sure that solutions are sustained. The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) All new orders to be reviewed in clinical stand-up Monday – Friday. 2) All PRN Psychotropic medications to be audited monthly ensuring a stop date is in place. Results will be presented by the Director of Health Services and/or the Administrator to the QA team monthly x 3 months or until substantial compliance is achieved. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Dates when the corrective action will be	

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F 758	Continued From page 62	F 758	completed. 8/4/2022	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to label and date food items in 1 of 2 nourishment refrigerators (300/400 hall). The failure had the potential to affect food served to residents. Findings included: The 300/400 nourishment room was observed on 6/21/22 at 2:50 PM. The following food items were observed inside the nourishment room refrigerator:	F 812	Corrective Action for those Residents found to have been affected All residents have the potential to be affected. The Certified Dietary Manager cleaned the refrigerators / freezers of the nourishment room on 6/21/22 and 6/23/22. How the facility will identify other residents having the potential to be affected:	8/4/22

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F 812	Continued From page 63 Cooked green beans in a plastic container- unlabeled and undated Cooked macaroni and cheese in a plastic container - unlabeled and undated Broccoli cheddar soup in a plastic container (opened)- unlabeled and dated 6/5/22 Sliced sharp cheddar (10 slices) in opened zip lock bag - unlabeled and undated Nurse #1 was interviewed on 6/21/22 at 2:54 PM. She stated that dietary department was responsible for checking the nourishment refrigerator. The Dietary Manager (DM) was interviewed on 6/21/22 at 2:55 PM. She indicated that nursing department was responsible for checking the nourishment refrigerators to ensure resident's food were dated and labeled and to discard expired food items. The DM observed the 300/400 nourishment refrigerator and observed the unlabeled and undated food items and stated that nursing was not checking the refrigerator. The DM was observed to discard the food items in the refrigerator that were unlabeled, undated, and expired. A follow up observation of the 300/400 hall nourishment refrigerator was conducted on 6/23/22 at 12:05 PM. There were 3 pieces of fried chicken in the box stored in the refrigerator that was undated. The Registered Dietician (RD) was interviewed on 6/23/22 at 1:01 PM. The RD stated that she expected the facility to follow the policy in dating and labeling of food items stored in the nourishment refrigerators. She added that the	F 812	The facility completed a review of all nourishment refrigerators / freezers on 6/23/22 and 6/27/22. All items not labeled / dated or out of date has been removed, Facility has all designated resident food storage refrigerators / freezers items ensuring that 1) items are labeled and dated; 2) items discarded according to their use by date; 3) clean and sanitary environment/equipment; 4) resident items only are stored in the nourishment refrigerators. Systemic changes made to ensure that deficient practice will not recur: The Certified Dietary Manager, Director of Health Services and/or designee began education to the Nursing and Dietary staff to be completed by 8/3/22 to the facility Nourishments policy and that nourishment refrigerators / freezers are for resident food items only. Staff will not be allowed to work until the education listed has been completed following 8/3/22. This education has been added to the general orientation of all staff upon hire. Signs have been posted in the nourishment rooms to identify all food placed in the refrigerator / freezer must be labeled and dated and will be throw out on day three. The Dietary department will be responsible for ensuring: 1)nourishment kitchens and equipment are clean and sanitary; 2)food/drink items are properly labeled and dated; 3) only permissible food/drink items are stored in nourishment refrigerators.	

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F 812	Continued From page 64 DM had already informed her of the undated/unlabeled food in the nourishment refrigerator and she would in-service the staff of the policy.	F 812	Monitoring of performance to make sure that solutions are sustained. The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: The nourishment rooms will be audited by the Certified Dietary Manager or designee x5 days weekly x4, and then weekly x1 month ensuring sanitary food practices. The Certified Dietary Manager will present the findings of the tracking, trending and analysis of the nourishment refrigerator / freezer review to the Administrator at the Quality Assurance / Performance Improvement Committee monthly x 3 monthly or until substantial compliance is achieved for review and revision as needed. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Dates when the corrective action will be completed. 8/4/2022	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		8/4/22

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F 867	Continued From page 65 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification survey in September 2019, April 2021 and subsequently recited in June 2022 on the current recertification and complaint survey. The recited deficiencies were in the areas of develop an accurate assessment (F641) and food procurement, Store/Prepare/Serve -sanitary (F812) These deficiencies were recited in the current recertification survey. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. The findings included: These tag were cross referenced to: F 641 - Accuracy of Assessment Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 18 residents whose MDS assessments were reviewed. (Resident #21, #223, #72) During the previous survey on 4/29/21, the facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate the Preadmission Screening and Resident Review (PASRR) Level II	F 867	Corrective Action for those Residents found to have been affected No residents were identified in the 2567. The Administrator will complete the Electronic education in RELIAS training Quality Assurance / Performance Improvement developing and sustaining a quality culture by 8/3/2022. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected by this practice. Systemic changes made to ensure that deficient practice will not recur: The Administrator and Director of Health Services initiated reeducation on 7/29/22 on the QAPI process for all staff on the QAA/QAPI Committee with emphasis on identifying areas that may lead to deficiency practice. Education to be completed by 8/3/2022. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on ensuring that any areas of non-compliance are addressed to prevent further deficient practices related to accurate completion of the MDS assessments and proper storage of resident food items stored in facility	

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F 867	Continued From page 66 status (Resident #61, Resident #52, Resident #2, Resident# 31, Resident#29) for 5 of 18 residents whose MDS assessments were reviewed. During the recertification survey on 9/20/19, the facility failed to accurately code Activities of Daily Living (ADL) on the Minimum Data Set (MDS) assessments for 2 of 21 residents reviewed for ADL's (Resident #84 and Resident # 111), F812 - Food Procurement, Store/Prepare/Serve-Sanitary Based on observation and staff interview, the facility failed to label and date food items in 1 of 2 nourishment refrigerators (300/400 hall). The failure had the potential to affect food served to residents. During the previous recertification survey on 4/29/21, the facility failed to keep clean and failed to label and date food for 1 of 2 nourishment refrigerator/freezers reviewed for food storage (400-hall). The facility was also cited during the 9/20/19 recertification survey for failure to maintain and clean following kitchen equipment; the stove, oven, steam table, plate warmer, plate/dome rack, refrigerator, and freezer. During an interview on 3/29/18 at 4:59 PM, the Administrator indicated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. The Administrator indicated when problem areas were identified the quality assurance and performance improvement (QAPI) plan was laid out. Individual staff should report	F 867	refrigerator/freezer. Monitoring of performance to make sure that solutions are sustained. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on areas that have led to repeated citations and/or deficiencies. This will ensure that the facility has identified areas of non-compliance and are addressed to prevent further deficient practices related to accurate completion of the MDS assessments and proper storage of resident food items stored in facility refrigerator/freezer. At least a member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant, or area vice president will attend QAPI meetings x3 months, and then quarterly x3 quarters to ensure that any areas leading to deficiency practice identified during clinical and compliance rounds are acted upon by the facility according to QAPI process. The administrator will report to the QAPI committee any areas of non-compliance x3 months and then quarterly x3 quarters for recommendations as needed. Dates when the corrective action will be completed. 8/4/2022	

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F 867	Continued From page 67 progress or lack of progress and reason for the lack of progress. The root cause should be analyzed, and all effort should be made to resolve this issue. The team should continuously monitor until the deficient area concerns have been resolved.	F 867		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		8/4/22

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F 883	Continued From page 68 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include the immunization status in the electronic medical record for influenza vaccine for 1 of 5 sampled residents (Resident #24) and for pneumococcal vaccine for 5 of 5 sampled residents (#21, #14, #24, #48, #50) . The facility also failed to offer and administer the influenza vaccine for 1 of 5 sampled residents (#24) and the pneumococcal vaccine for 5 of 5 residents (#21, #14, #24, #48, #50) reviewed for influenza and pneumococcal immunizations. Findings Included:	F 883	Resident # 21, #24, # 14, # 48 and # 50 consents have been obtained and placed in the electronic health record. Pneumococcal consents/refusals have been obtained and documented in the electronic medical record ensuring vaccines administered for consenting residents by 8/3/22. Resident # 24 received the influenza vaccine on 11/1/21 and the immunization status has been placed in the electronic medical record. Resident offered and refused the pneumococcal vaccine on 1/3/22 and documentation updated in the	

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F 883	Continued From page 69 1. Resident #24 was admitted to the facility on 1/3/2022 with diagnoses including stroke with aphasia (difficulty speaking) and leg fractures. The quarterly Minimum Data Set (MDS) assessment dated 4/5/2022 indicated Resident #24 was cognitively intact. A review of Resident #24's immunization record on the electronic medical record showed no influenza vaccine status in the resident ' s electronic record. On 6/23/2022 at 10:50 a.m. in an interview with the infection preventionist, she stated she did not have a document identifying residents who had not received the influenza vaccine. She stated she confirmed influenza vaccine status by asking the resident and entering data in the electronic medical record. She stated influenza vaccines were administered in October 2021. She stated when Resident #24 was admitted to the facility on 1/3/22 that was still considered the flu season, but she had been concentrating on COVID vaccines and had not been monitoring influenza vaccine status of new residents. On 6/23/2022 at 1:18 p.m. in an interview with the Director of Nursing, she stated the facility offered the influenza vaccine on admission and annually. She stated the infection preventionist was responsible for entering the vaccination information in the electronic medical record that showed the influenza vaccine was offered, administered or refused. The DON stated she would conduct an audit on all residents for the influenza vaccine. 2. a. Resident #21 was admitted to the facility on	F 883	electronic medical record. Director of Health Services and/or Infection Preventionist has reviewed all residents□ influenza and pneumococcal records to ensure their immunization consents are uploaded into the electronic health record and their immunization are placed in the electronic health record completed by 8/3/22. The Director of Health Services educated the Infection Preventionist on the Influenza and Pneumococcal policy and the need to ensure all residents immunization status is in the electronic medical record, as well as the residents have been offered and administered the immunization as indicated, to be completed by 8/3/22. This education has been added to the general orientation of any newly hired Infection Preventionist. The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1)The Infection preventionist will maintain a list of residents with dates of administration of pneumococcal vaccinations. All residents will be offered the pneumococcal vaccine as appropriate and influenza vaccine annually unless contraindicated. 2)The Infection preventionist and/or designee began reviewing the pneumococcal and influenza status of	

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F 883	Continued From page 70 7/23/2019 with diagnoses including stroke and dementia. The quarterly Minimum Data Set (MDS) assessment dated 4/18/2022 indicated Resident #21 was severely cognitively impaired. A review of Resident #21's immunization record on the electronic medical record showed no pneumococcal vaccine status in the resident's record. b. Resident #14 was admitted to the facility on 7/12/21 with diagnoses including anxiety and depression. The quarterly Minimum Data Set (MDS) assessment dated 3/14/2022 indicated Resident #14 was cognitively intact. A review of Resident #14's immunization record on the electronic medical record showed no pneumococcal vaccine status in the resident ' s record. c. Resident #24 was admitted to the facility on 1/3/2022 with diagnoses including stroke with aphasia (difficulty speaking) and leg fractures. The quarterly Minimum Data Set (MDS) assessment dated 4/5/2022 indicated Resident #24 was cognitively intact. A review of Resident #24's immunization record on the electronic medical record showed no pneumococcal vaccine status in the resident ' s record. d. Resident #48 was admitted to the facility on	F 883	new admissions to ensure they have signed a consent or refusal documented in the electronic medical record and will administer immunizations as indicated with documentation in the electronic medical record. 3)Director of Health Services and/or designee will review pneumococcal and influenza status of new admissions to ensure they have signed a consent or refusal documented in the electronic medical record and will administer immunizations as indicated weekly x4 weeks then monthly x3 months. The Infection Preventionist or designee will present the analysis of the immunization review to the Administrator at the Quality Assurance and Performance Improvement Committee, monthly x 3 monthly or until substantial compliance is achieved, for review and revision. The Quality Assurance committee will determine the ongoing monitoring of this review. Date of compliance. 8/4/2022	

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10/19/2021, and diagnoses included Diabetes Mellitus and anxiety disorder.

The annual Minimum Data Set (MDS) assessment dated 5/13/2022 indicated Resident #48 was moderately cognitively impaired.

A review of Resident #48's immunization record on the electronic medical record showed no pneumococcal vaccine status in the resident's record.

e. Resident #50 was admitted to the facility on 8/15/2018, and diagnoses included Diabetes Mellitus and anxiety disorder.

The quarterly Minimum Data Set (MDS) assessment dated 5/19/2022 indicated Resident #50 was cognitively intact.

A review of Resident #50's immunization record on the electronic medical record showed no pneumococcal vaccine status in the resident ' s record.

On 6/23/2022 at 10:50 a.m. in an interview with the infection preventionist, she stated most residents had received the pneumococcal vaccine and did not have a document identifying residents who had not received the pneumococcal vaccine. She stated residents were asked their pneumococcal vaccine status and entered the information in the electronic medical record. When informed residents #21, #14, #24, #48, #50 pneumococcal vaccine status was not in the electronic medical record, she stated since October 2021 as the infection preventionist she had been concentrating on COVID vaccines and had not offered the

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pneumococcal vaccine or monitored the pneumococcal vaccine status of the residents.

On 6/23/2022 at 1:18 p.m. in an interview with the Director of Nursing, she stated the facility offered the pneumococcal vaccine on admission and annually. She stated the infection preventionist was responsible for entering the vaccination information in the electronic medical record that showed the pneumococcal vaccine was offered, administered or refused. The DON stated she would conduct an audit on all residents for the pneumococcal vaccine.

3. Resident #24 was admitted to the facility on 1/3/2022 with diagnoses including stroke with aphasia (difficulty speaking) and leg fractures.

The quarterly Minimum Data Set (MDS) assessment dated 4/5/2022 indicated Resident #24 was cognitively intact.

A review of Resident #24's immunization record on the electronic medical record did not reflect she was offered the influenza vaccine, declined the influenza vaccine or was administered the influenza vaccine.

On 6/23/2022 at 10:50 a.m. in an interview with the infection preventionist, she stated in October 2021 the unit managers assisted her in administering influenza vaccine to residents and entering the influenza vaccine data in the electronic record. She stated influenza vaccination status was addressed on admission, and new admitted residents after October 2021 had not been offered the influenza vaccine because she had been concentrating on COVID vaccinations.

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On 6/23/2022 at 1:18 p.m. in an interview with the Director of Nursing, she stated the facility offered the influenza vaccine on admission and annually. She stated the infection preventionist was responsible for offering, administering or documenting refusal of the influenza vaccine. The DON stated she would conduct an audit on all residents for influenza vaccination.

4. a. Resident #21 was admitted to the facility on 1/3/2022 with diagnoses including stroke with aphasia (difficulty speaking) and leg fractures.

The quarterly Minimum Data Set (MDS) assessment dated 4/5/2022 indicated Resident #21 was cognitively intact.

A review of Resident #21's immunization record on the electronic medical record did not reflect she was offered the pneumococcal vaccine, declined the influenza vaccine or was administered the influenza vaccine.

b. Resident #14 was admitted to the facility on 1/3/2022 with diagnoses including stroke with aphasia (difficulty speaking) and leg fractures.

The quarterly Minimum Data Set (MDS) assessment dated 4/5/2022 indicated Resident #14 was cognitively intact.

A review of Resident #14's immunization record on the electronic medical record did not reflect she was offered the pneumococcal vaccine, declined the influenza vaccine or was administered the influenza vaccine.

c. Resident #24 was admitted to the facility on

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1/3/2022 with diagnoses including stroke with aphasia (difficulty speaking) and leg fractures.

The quarterly Minimum Data Set (MDS) assessment dated 4/5/2022 indicated Resident #24 was cognitively intact.

A review of Resident #24's immunization record on the electronic medical record did not reflect she was offered the pneumococcal vaccine, declined the influenza vaccine or was administered the influenza vaccine.

d. Resident #48 was admitted to the facility on 1/3/2022 with diagnoses including stroke with aphasia (difficulty speaking) and leg fractures.

The quarterly Minimum Data Set (MDS) assessment dated 4/5/2022 indicated Resident #48 was cognitively intact.

A review of Resident #48's immunization record on the electronic medical record did not reflect she was offered the pneumococcal vaccine, declined the influenza vaccine or was administered the influenza vaccine.

e. Resident #50 was admitted to the facility on 1/3/2022 with diagnoses including stroke with aphasia (difficulty speaking) and leg fractures.

The quarterly Minimum Data Set (MDS) assessment dated 4/5/2022 indicated Resident #50 was cognitively intact.

A review of Resident #50's immunization record on the electronic medical record did not reflect she was offered the pneumococcal vaccine, declined the influenza vaccine or was

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F 883	Continued From page 75 administered the influenza vaccine. On 6/23/2022 at 10:50 a.m. in an interview with the infection preventionist, she stated she stated since October 2021 as the infection Preventionist, she had not offered the pneumococcal vaccine to residents because she had been concentrating on COVID vaccinations. On 6/23/2022 at 1:18 p.m. in an interview with the Director of Nursing, she stated the facility offered the pneumococcal vaccine on admission and annually. She stated the infection preventionist was responsible for offering, administering or documenting refusal of the pneumococcal vaccine. The DON stated she would conduct an audit on all residents for pneumococcal vaccination.	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in	F 886		8/4/22

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

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

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

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

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages,

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F 886	Continued From page 77 contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct COVID-19 testing for Nursing Assistant (NA) #12 and to document COVID-19 testing and results for 5 of 5 staff (NA #12, NA #11, Housekeeper #1, Business Office Manager #1, and Nurse #5) reviewed for COVID-19 testing during the outbreak period from 4/29/2022 to 6/2/2022. This occurred during a COVID-19 pandemic. Findings included: A review of the facility's "COVID Testing and Re-Testing" policy dated 1/25/2022 stated to perform expanded viral testing of all partners, providers, contractors, consultants and residents in the nursing home if there is an outbreak in the facility. Vaccinated and unvaccinated partner, provider, contractor, and consultant will be tested twice weekly for at least two weeks until no new positives. A review of the facility's COVID-19 tracking document revealed the facility's outbreak status started on 4/29/2022. The last positive COVID-19 test was on 5/19/2022, and the outbreak ended on 6/2/2022. a. A review of NA #12's employment time sheet revealed her first day of employment was 5/17/2022. A review of the facility's COVID-19 staff testing	F 886	The facility failed to conduct COVID-19 testing for Nursing Assistant (NA) #12 and to document COVID-19 testing and results for 5 of 5 staff reviewed for COVID-19 testing during the outbreak period from 4/29/22 to 6/2/22. The facility immediately completed facility wide outbreak testing for all residents and staff on 6/23/22. The facility has implemented testing on 6/23/22 for all staff and residents utilizing the COVID-19 Outbreak frequency indicated in the “COVID-19 Testing Policy”. Facility has reviewed its “COVID-19 Testing Policy”. Infection Preventionist has been educated on COVID-19 testing protocol and frequency of testing required and test results are documented accordingly. All staff have been re-educated on the COVID-19 Testing Policy. Frequency of testing during a COVID-19 outbreak is x2 weekly for staff and x1 weekly for residents. Frequency of testing while not in a COVID-19 outbreak will be determined by the COVID-19 transmission rate of the county in which the facility resides. Testing frequency for staff will vary based upon the county transmission rate and staff vaccination	

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F 886	Continued From page 78 logs dated 5/17/2022, 5/20/2022, 5/24/2022, 5/27/2022, 5/31/2022 revealed no documentation that NA #12 was tested on 3 of 5 testing dates during the timeframe the facility was in outbreak status (5/20/2022, 5/27/2022, and 5/31/2022) since her employment with the facility began on 5/17/2022. On 6/23/2022 at 12:23 p.m. in a phone interview with NA #12, she stated staff were tested on specific days, and she had been COVID-19 tested three different times since beginning her employment with the facility. She stated she worked full time at the facility, and COVID-19 tests were conducted when she was scheduled to work and had not been told to come in for COVID-19 testing when not scheduled to work. b. The facility's COVID-19 staff testing logs dated 5/3/2022, 5/6/2022, 5/10/2022, 5/13/2022, 5/17/2022, 5/20/2022, 5/24/2022, 5/27/2022, 5/31/2022 were reviewed. There was no documentation NA #11 was COVID-19 tested during the timeframe the facility was in outbreak status. On 6/23/2022 at 9:20 a.m. in an interview with NA #11, she stated she was tested for COVID-19 every week on Tuesday and Friday from 5/3/2022 through 5/31/2022. c. A review of the facility's COVID-19 staff testing logs dated 5/3/2022, 5/6/2022, 5/10/2022, 5/13/2022, 5/17/2022, 5/20/2022, 5/24/2022, 5/27/2022, 5/31/2022 revealed no documentation that Housekeeper #1 was tested on 5 of the 9 testing dates during the timeframe the facility was in outbreak status (5/3/2022, 5/6/2022, 5/10/2022, 5/17/2022, and 5/20/2022).	F 886	status, and the varying frequencies are indicated in the “COVID-19 Testing Policy”. The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1)The Infection Preventionist will be responsible for ensuring COVID-19 testing for staff and residents is completed according to the COVID-19 Testing Policy weekly ongoing. 2)The Administrator or the Director of Health Services will be responsible for the monitoring of testing completion weekly x4 weeks, and monthly x3 months, ensuring testing is completed according to the COVID-19 Testing Policy. Results will be presented by the Infection Preventionist and/or the Administrator to the QA team monthly x3 or until substantial compliance is achieved . Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date of compliance. 8/4/22	

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In an interview with Housekeeper #1 on 6/23/2022 at 9:20 a.m., she stated she had worked with the facility for ten years and was COVID-19 tested twice a week from 5/3/2022 through 5/31/2022.

d. A review of the facility's COVID-19 staff testing logs dated 5/3/2022, 5/6/2022, 5/10/2022, 5/13/2022, 5/17/2022, 5/20/2022, 5/24/2022, 5/27/2022, 5/31/2022 revealed no documentation that Business Office Manager #1 was tested on 3 of the 9 testing dates during the timeframe the facility was in outbreak status (5/6/2022, 5/13/2022, and 5/17/2022).

In an interview with Business Office Manager #1 on 6/23/2022 at 9:58 p.m., she stated during the COVID-19 outbreak all staff were tested on Tuesday and Friday and administration informed her when to COVID-19 test. She confirmed she was tested on 5/6/2022, 5/13/2022, and 5/17/2022.

e. A review of the facility's COVID-19 staff testing logs dated 5/3/2022, 5/6/2022, 5/10/2022, 5/13/2022, 5/17/2022 revealed no documentation Nurse #5 was tested on 3 of the 5 testing dates during the timeframe the facility was in outbreak status (5/3/2022, 5/6/2022 and 5/10/2022).

In an interview with Nurse #5 on 6/23/2022 at 1:06 p.m., she stated the facility tested the staff twice a week for COVID-19. She confirmed she was tested on 5/3/2022, 5/6/2022 and 5/10/2022.

On 6/23/2022 at 10:50 a.m. in an interview with the Infection Preventionist, she stated she was responsible for conducting COVID-19 testing in

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the facility and documenting test results, and all staff were required to be tested twice a week when the facility was in outbreak status. She stated her COVID-19 testing hours were from 10 a.m.- 1:00 p.m. and 2:00 p.m.- 4:00 p.m. for staff on Tuesdays and Fridays. She stated information on COVID-19 staff testing was shared with the staff on the television screens in the hallways. She revealed the facility did not enforce staff not being able to work if not COVID-19 tested during designated testing dates. She was not able to provide any further information on COVID-19 testing for NA #12, NA #11, Housekeeper #1, Nurse #5 and Business Office Manager #1.

In an interview with the Director of Nursing (DON) and the Administrator on 6/23/2022 at 1:18 p.m. the DON, who started with the facility in May 2022, stated all staff should have been tested twice a week during outbreak status. She stated she identified that all staff members were not tested during the outbreak after arriving to the facility as the DON in May 2022, and she instructed the IP to print a staff roster to track staff COVID testing and results and to let department heads know if staff had not been tested. She stated staff members were not to work if they had not been tested. She stated she had asked the IP for staff testing information, and the IP had not provided staff testing documentation or communicated to her that all staff were not COVID-19 tested.

In an interview with the Administrator and the DON on 6/23/2022 at 1:18 p.m., the Administrator stated all staff should had been tested twice a week and would had been unable to work if not tested. He stated The IP was responsible for testing and documenting COVID -19 testing

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F 886	Continued From page 81 results, and he provided the IP with a staff roster which included telephone numbers to call staff and asked department heads to remind staff of testing during the outbreak. He stated he did not know why staff members were not tested, and the IP did not report to him staff were not reporting to the IP for COVID-19 tests as required during outbreak status.	F 886		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:	F 888		8/4/22

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F 888	Continued From page 82 (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses	F 888		

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as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received

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F 888	Continued From page 84 monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their policy for all employees to be vaccinated or have an approved exemption prior to employment and failed to have a process for tracking vaccination status for 2 of 5 staff members (Nurse Aide #11, Nurse Aide #12) reviewed for COVID-19 vaccination of facility staff. The facility was in a new outbreak status due to one staff member testing COVID-19 positive on 6/21/21. All residents tested negative for COVID-19 on 6/22/2022. Findings included: A review of the facility's "Mandatory COVID-19 Vaccination Policy" dated revised 8/13/2021 stated on or before October 1, 2021, all partners (employees) must: (a) receive a COVID-19 vaccine; (b) establish they have received an approved COVID-19 vaccine from another source; or (c) obtain an approved exemption form the organization as a medical or religious	F 888	Staff member NA #11 received 2nd dose of the COVID-19 vaccine on 5/24/22. Staff member NA #12 is no longer employed with the facility. Facility has audited all active employees ensuring; a) employee is fully vaccinated "1 dose of single dose series or 2 doses of 2-dose series" or b) obtain an approved exemption from the organization as a medical or religious accommodation. All other employees have been fully vaccinated and/or have an exemption. The Facility Administrator, Director of Nursing and/or Nurse Managers have reviewed its "Mandatory COVID-19 and Influenza Vaccination Policy" and educated the Human Resources, Talent Acquisition, and Infection Preventionist educated on ensuring that prior to hire, all newly hired staff must be fully vaccinated	

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F 888	Continued From page 85 accommodation. This vaccination mandate applies to all new hires or candidate for hire in roles covered by the mandate. A review of the facility's "Mandatory COVID-19 and Influenza Vaccination Policy" dated revised 4/1/2022 stated all partners (employees) must: (a) be "fully vaccinated" or (b) obtain an approved exemption from the organization as a medical or religious accommodation. Partners receiving the COVID-19 vaccination were also required to receive any subsequent vaccine shots to become "fully vaccinated." For example, partners who receive the Moderna or Pfizer vaccines will need to receive both of the two doses of the 2-dose series to achieve compliance with this policy. For a new hire to meet the requirements of this policy, a new hire must (a) have received their first shot prior to employment and complete their subsequent vaccine shots at the time interval required to become "fully vaccinated" or (b) obtain an approved exemption from the organization as a medical or religious accommodation. A review of the National Healthcare Safety Network (NHSH) data reported the week of 6/5/2022 indicated 99% of the staff had completed COVID-19 vaccinations and 100% of the staff had completed or was partially COVID-19 vaccinated. A review of the facility's COVID-19 Staff Vaccination Status for Providers spreadsheet listed 86 staff members and indicated two staff members were partially vaccinated. All other staff members were marked as completely vaccinated, and there were no exemptions documented. 1. A review of the facility's COVID-19 Staff	F 888	for COVID-19 or obtain an approved exemption from the organization as a medical or religious accommodation. The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1)Human Resources and Infection Preventionist will be responsible for ensuring that prior to hire, all newly hired staff must be fully vaccinated for COVID-19 or obtain an approved exemption from the organization as a medical or religious accommodation. 2)The Director of Health Services and/or Administrator will audit all new hires utilizing the facility PowerBI COVID-19 Staff Vaccination Tracking tool ensuring that they have been fully vaccinated prior to hire weekly x4 weeks and then monthly x3 months. Analysis of the review of employees being fully vaccinated prior to hire will be presented by the Administrator or designee to the Quality Assurance and Performance Committee team monthly x3 for review and revision and the Quality Assurance team will determine the frequency of ongoing monitoring. Date of Compliance 8/4/22	

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Vaccination Status for Providers spreadsheet indicated NA #11 was partially vaccinated.

A review of NA #11's employment time sheets for March 2022 to June 2022 revealed her first day of employment was 3/1/2022, and she had worked weekly in the facility.

NA #11's COVID-19 vaccination records documented the first dose was received on 3/2/2022, and the second dose was on 5/24/2022.

On 6/23/2022 at 9:20 a.m. in an interview with NA #11, she stated the facility offered and she received her first dose of the COVID-19 vaccine during her the first week on employment and had received her second dose of the COVID-19 vaccine since employment. She stated her daily assignments included providing resident care, and N-95 mask, gloves and goggles were required when providing resident care at all times. She stated COVID-19 testing was conducted weekly on Tuesday and Thursdays, and while she was waiting to receive the second COVID-19 vaccine, there was no provisions made to her daily assignments.

On 6/23/2022 at 10:50 a.m. in an interview with the Infection Preventionist (IP), she stated fully COVID-19 vaccination included the single dose or two doses of COVID-19 vaccine, and staff should not be hired if not fully COVID-19 vaccinated. She stated NA #11 had received her first dose after employment at orientation and staff were wearing N-95 masks and goggles. When asked why NA #11 received her second dose over 8 weeks after the first dose, she stated she had an open-door policy for staff to receive COVID-19 vaccinations,

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and she did not schedule COVID-19 vaccinations or use a spread sheet to track COVID-19 vaccinations.

On 6/23/2022 at 1:18 p.m. in an interview with the Director of Nursing (DON) and the Administrator per phone, the Administrator stated all of the facility's staff were fully vaccinated, and the facility required newly hired staff to have the first dose of COVID-19 vaccine to begin working in the facility. The Administrator stated he thought partially vaccinated staff were allowed to work but just needed to be tested for COVID-19 on a regular basis. The DON stated she did not know newly hired staff needed to be fully vaccinated before employment.

2. A review of the facility's COVID-19 Staff Vaccination Status for Providers spreadsheet indicated NA #12 was partially vaccinated.

NA #12's COVID-19 vaccination records documented the first dose was received on 12/7/2021, and there was no second dose documented.

A review of NA #12's employment time sheets for May 2022 to June 2022 revealed her first day of employment was 5/17/2022, and she had worked weekly in the facility. Her time sheet recorded her last day working was on 6/19/2022.

On 6/23/2022 at 12:23 p.m. in a phone interview, NA #12 stated she received her initial dose of COVID-19 vaccination but had not received a second dose due to pregnancy. She stated the baby was born in January 2022. She stated the facility had not offered her the COVID-19 vaccine

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prior to or after employment and knew she needed to schedule her second dose of COVID-19 vaccine. She stated she started working at the facility on May 17, 2022, and after two days in classroom orientation, her work assignments included providing resident care. She stated N-95 masks, and gloves were required when providing resident care and had been tested for COVID-19 three times since her employment.

On 6/23/2022 at 10:50 a.m. in an interview with the Infection Preventionist (IP), she stated staff should not be hired if not fully COVID-19 vaccinated, and NA #12 knew she had to get the second dose of the COVID-19 vaccine. The IP stated the facility offered the staff COVID-19 vaccines, but NA #12 had not been scheduled to receive her second dose of COVID-19 vaccine. She stated she had an open door policy for staff to receive COVID-19 vaccinations, and she did not schedule COVID-19 vaccinations or use a spread sheet to track COVID-19 vaccinations. She stated the facility was out of COVID-19 vaccine and was unable to specify how long the facility was out of the COVID-19 vaccine. She stated she informed the Director of Nursing on 6/22/2022.

On 6/23/2022 at 1:18 p.m. in an interview with the Director of Nursing (DON) and the Administrator per phone, the Administrator stated all of the facility ' s staff were fully vaccinated, and the facility required newly hired staff to have the first dose of COVID-19 vaccine to begin working in the facility. The Administrator stated he thought partially vaccinated staff were allowed to work but just needed to be tested for COVID-19 on a regular basis. The DON stated she did not know

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F 888	Continued From page 89 newly hired staff needed to be fully vaccinated before employment. The DON further stated the facility was out of the COVID-19 vaccine, and the COVID-19 vaccine had been reordered to offer for staff and residents as a booster dose.	F 888		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide Nursing Assistants (NAs) with annual dementia training for 5 out of 5 sampled Nurse Aides reviewed for required in-service training (NAs #1, #2, #5, #7 and #9). The findings included:	F 947	Corrective Action for those Residents found to have been affected No residents were identified in the 2567. How the facility will identify other residents having the potential to be affected:	8/4/22

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F 947	Continued From page 90 NA #1's date of hire was 11/16/2021.Review of in-service records revealed she was not provided annual dementia training. NA#2's date of hire was 2/6/2022. Review of in-service records revealed she was not provided dementia training. NA#5's date of hire was 6/30/2013. Review of in-service records revealed she was not provided annual dementia training. NA#7's date of hire was 6/30/2013. Review of in-service records revealed she was not provided annual dementia training. NA#9's date of hire was 9/27/2021. Review of in-service records revealed she was not provided annual dementia training. On 6/21/2022 at 10:22 AM an interview was conducted with NA#7. She stated she did not recall receiving dementia training in the last year. On 6/23/2022 at 9:28 AM an interview was conducted with the Director of Nursing (DON). She stated she began her employment as DON in May of 2022. The facility did not have a staff development coordinator (SDC). She had filled the role since May and recently hired (1 week ago) a new SDC. The DON was not able to find proof of annual dementia training for NAs #1, #2, #5, #7 and #9. It was her expectation that all staff receive dementia care training.	F 947	The facility implemented the required CMS training titled “Dementia Training Hand in Hand Modules 1 – 5” for all employed CNAs to be completed by 8/3/22. Systemic changes made to ensure that deficient practice will not recur: The Director of Nursing and/ or Clinical Competency Coordinator has assigned the required Centers for Medicare & Medicaid Services “CMS” training titled “Dementia Training Hand in Hand Modules 1 – 5” for all employed Certified Nurse Aides “CNA” to be completed by 8/3/22. Staff will not be allowed to work until the education listed has been completed following 8/3/22. All newly hired CNAs will be required to complete “Dementia Training Hand in Hand Modules 1 -5” within 90 days on employment. The Director of Health Service, Clinical Competency Coordinator and/or designee will assign the titled “Dementia Training Hand in Hand Modules 1 – 5” training annually. The Clinical Competency Coordinator will monitor the required dementia training monthly ensuring timely annual completion by all facility CNAs. Monitoring of performance to make sure that solutions are sustained. The Administrator is responsible for the Plan of Correction implementation. The	

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F 947	Continued From page 91	F 947	QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: The Director of Health Service, Clinical Competency Coordinator and/or designee will assign the titled “Dementia Training Hand in Hand Modules 1 – 5” training annually. The Clinical Competency Coordinator will monitor the required dementia training monthly ensuring timely annual completion by all facility CNAs. The analysis if the Dementia hand and hand training modules will be presented by the Clinical Competency Coordinator and/or the Administrator to the Quality Assurance and Performance Improvement Committee team monthly for review and revision. The QA team will determine the frequency of ongoing monitoring. Dates when the corrective action will be completed. 8/4/2022	