STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	C 08/25/2022

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AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

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E 000	Initial Comments An unannounced Recertification and complaint survey were conducted on 08/22/22 through 08/25/22. The facility was found in compliance with the requirment CFR 483.73, Emergency Preparedness Event ID #73OY11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 08/22/22 through 08/25/22. There were 36 allegations investigated and 8 were substantiated. Event ID #73OY11. Intakes (NC00191680, NC0019154, NC00191518, NC00191493, NC00190735, NC00190416, NC00189848, NC00189854, NC00189433, and NC00188765).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		9/22/22

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

Electronically Signed | 09/19/2022

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F 580	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident, staff, Nurse Practitioner, and family interviews, the facility failed to notify the responsible party of fall when a resident (Resident #66) fell from a lift for 1 of 2 residents reviewed for falls. Findings included: Resident #66 was admitted to the facility on	F 580	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Facility failed to notify the resident	

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F 580	Continued From page 2 5/7/19 with diagnosis that included multiple myeloma, chronic pain, and osteoarthritis (OA). A quarterly Minimum Data Set (MDS) dated 4/28/22 indicated Resident #66 was cognitively intact and required total dependence of 2 staff for transfers. An incident report dated 6/2/22 at 2:37 PM revealed Resident #66 experienced a fall in the bathroom. The incident report indicated a Nurse Aide transferred Resident #66 from the commode using a sit to stand lift when her knees buckled and Resident #66 slid out of the lift pad and onto the floor. The incident report listed a granddaughter being notified of the fall on 6/2/22 at 2:49 PM. However, a review of the notification was placed to Resident #66's granddaughter who is not listed as a contact party in the resident's electronic medical record. A progress note dated 6/2/22 written by Nurse Practitioner (NP) #1 revealed Resident #66 experienced a fall. The note indicated NP #1 was summoned to the room of Resident #66 where she was found to be in the bathroom floor lying on her right side. Resident #66 and staff had reported the fall occurred when Resident #66 fell from the sit to stand lift in the bathroom and had reported the only pain she had at the time was in the back of the head. At the time of the fall on 6/2/22, NP #1 indicated there was no visible swelling or open areas on the head nor loss of consciousness immediately post fall to the floor. A progress note dated 6/3/22 written by NP #1 revealed Resident #66 was up in her wheelchair and complained of right upper extremity pain with movement. The note indicated during the	F 580	representative of a fall. Resident #66 documentation stated the granddaughter was notified and there was not a granddaughter listed under the resident's emergency contact list. Resident #66 continues to reside in the facility, and has had no negative outcomes as a result of the resident's representative not being notified on 6/2/22, the day of the fall. The resident's daughter was aware of the fall on 6/3/22. All current residents who have had a fall have the potential to be affected by their representative not be notified of a fall. An Audit going back 30 days from 8/1/22 to 8/31/22 was completed on 9/1/22 by the Regional Director of Clinical Services. There were no other issues identified where the resident's representative was not notified of a fall. The Director of Nursing or designee educated all licensed nurses of notification of falls to the resident representative listed on the resident's face sheet. Education completed on 9/16/22. All newly hired licensed nurses and agency licensed nurses will receive this same education prior to taking an assignment and working with residents. Fall notification will be reviewed in clinical morning meeting, any negative findings will be addressed promptly. The Director of Nursing or designee will audit 5 falls weekly for 12 weeks for	

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F 580	Continued From page 3	F 580		

examination, family entered the room and agreed to allow for a x-ray of the right shoulder and elbow to be performed.

A telephone interview with Family Member (FM) #1 was conducted on 8/23/22 which revealed she nor Resident #66's responsible party had been notified of Resident #66's fall until she arrived at the facility to visit on 6/3/22 and found Resident #66 to being examined by NP #1 who explained to her that Resident #66 had a fall on 6/2/22 from a sit to stand lift. FM #1 indicated she had spoken with the nurse on 6/3/22 who explained she was unsure why the family had not been notified of the fall. FM #1 stated the nurse told her Resident #66 had the fall after she was improperly transferred using a sit to stand lift and had bumped her head and her right shoulder during the fall.

An interview on 8/23/22 at 2:40 PM with MDS Nurse #1 revealed she attended the huddle immediately following Resident #66's fall on 6/2/22. MDS Nurse #1 indicated she assisted in completing the incident report; however, she only entered data related to the details of the fall and she did not contact a member of Resident #66's family to notify them of the fall.

An interview on 8/23/22 at 3:19 PM with Nurse #8 revealed she attended the huddle immediately following the fall and assessed Resident #66 for injuries. Nurse #8 explained she did not recall notifying Resident #66's family at the time of the fall, but she thought the Director of the Nursing (DON) at the time had planned to notify the family of the fall.

An interview with a former DON (DON #3) on 8/24/22 at 3:55 PM revealed she was the DON at

notification to the resident's representative beginning 9/12/22.

The Administrator will report the data obtained during the audit process to the facility Quality Assurance and Performance Improvement committee for further review and recommendations monthly for 3 months.

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F 580	Continued From page 4 the time of Resident #66's fall, but vaguely recalled hearing about the incident. She indicated she had not contacted Resident #66's responsible party to notify them of the incident. She was usure who had contacted the family but stated if the granddaughter was not listed on the emergency contact screen in Resident #66's medical record, no information should have been provided to her. An interview with the Regional Clinical Nursing Director (a former interim DON #2) on 8/25/22 at 9:57 AM revealed she had assisted with some investigations for incidents around this time; however, she could not recall any details of the fall for Resident #66 and did not remember notifying Resident #66's family of the fall.	F 580		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the regulatory timeframes for 1 of 6 residents reviewed for MDS (Resident #69). Findings included: Resident #69 was admitted to the facility on 4/26/22.	F 638	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to complete and submit a Minimum Data Set (MDS) assessment according to the Resident Assessment Instrument (RAI) manual guidelines.	9/22/22

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F 638	Continued From page 5 A review of Resident #69's medical record revealed the most recent quarterly MDS had an assessment reference date (ARD, the last day of the assessment period) of 7/14/22. The assessment had not been signed as completed by the registered nurse until 8/02/22. An interview with MDS Nurse #2 was completed on 8/24/22 at 10:24 AM. MDS Nurse #2 indicated she completed individual sections on the MDS for Resident #69 on 7/29/22 but did not sign it as completed until 8/02/22. She stated she had been taught that all quarterly MDS's were to be completed within 14 days of the ARD. She explained the facility had an abundance of admissions and both she and MDS Nurse #1 had taken vacation days which caused the facility to get behind on completing assessments timely. An interview with the Director of Nursing and Administrator on 8/25/22 at 4:39 PM revealed they expected MDS's to be completed in the designated timeframe.	F 638	Resident #69 quarterly Minimum Data Set assessment was not signed until 8/2/22, outside of the 14 day completion requirement. Resident #69 continues to reside in the facility, and has had no negative outcomes from her quarterly MDS assessment being submitted outside of the RAI manual guidelines. All residents with Minimum Data Set assessments have the potential to have their assessment submitted outside of the RAI manual guidelines. An audit on 9/6/22 was conducted by the regional MDS consultant at least 30 days back, 7/2/22 through 9/5/22, to identify other residents who have had their MDS assessments submitted outside of the RAI manual guidelines. The Regional MDS Consultant educated the MDS Coordinator Nurses of the RAI manual timeline for completing and submitting MDS assessments. Education was completed on 9/7/22. All new MDS coordinators will not complete any MDS assessments until the have had this same training. All MDS submissions will be reviewed weekly by the Administrator to ensure compliance with timely submissions for 12 weeks. Audits will begin the week of 9/12/22. The administrator will report the data obtained during the audit process to the	

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F 638	Continued From page 6	F 638	facility Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for 3 months.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Nurse Practitioner interview the facility failed to ensure the correct medications were administered to the correct resident (Resident #153) and failed to administer an antianxiety medication as ordered (Resident #403) for 2 of 4 residents reviewed for unnecessary medications. The findings included: 1. Resident #153 was admitted to the facility on 08/10/22 with diagnoses that included acute pulmonary edema, compression fracture, high blood pressure, obstructive sleep apnea and others. Review of an Admission Minimum Data Set (MDS) dated 08/16/22 revealed that Resident #153 was cognitively intact and had no behaviors or rejection of care. The MDS further revealed that Resident #153 required limited to extensive assistance with activities of daily living and received 5 days of an antidepressant and 6 days of a diuretic during the assessment reference	F 658	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to administer medications as outlined in the comprehensive care plan. On 8/22/22 resident #153 was administered medications that were not prescribed to her. Resident #403 was not administered her scheduled Buspar 8/21/22 at 8:00pm and 8/22/22 at 6:00am. Resident #153 no longer resides in the facility. She was immediately reviewed by the nurse practitioner on 8/22/22. She has had no negative side effects noted from receiving the wrong medications. Resident #403 still resides in the facility. On 8/23/22 the resident was reviewed by the Nurse Practitioner and no adverse	9/22/22

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F 658	Continued From page 7 period. Review of the medications that Resident #153 received on 08/22/22 that were not prescribed for her included: Bupropion HCL 300 milligrams (mg), Vitamin D 125 microgram (mcg), Dexamethasone 6 mg, Zinc Sulfate 220 mg, Vitamin C 500 mg, Baclofen 10 mg, Metoprolol (used to treat high blood pressure) 12.5 mg, Norco (pain medication) 7.5/325 mg, and Senna/Docusate 8.6/50 mg. Review of an Incident Audit Report dated 08/22/22 at 10:27 AM read that Resident #153 had been given the wrong medications. Description of actions taken read; Unit Manager (UM) #2 notified the Nurse Practitioner (NP), orders were obtained to hold some of Resident #153's medications and to increase monitoring of the resident. The report was electronically signed by the Director of Nursing (DON). Resident #153 was interviewed on 08/22/22 at 12:35 PM and stated that this morning Nurse #9 brought her medication in and when she looked at the pills in the cup, they did not look like her usual pills, and she questioned Nurse #9 about one of the pills in the cup and Nurse #9 stated she did not know what the pill was and would have to check on that. Resident #153 stated as she was swallowing the medication Nurse #9 stated that she had her eye drops and insulin and Resident #153 stated "I don't take eye drops or insulin" and then asked Nurse #9 "whose medication did you just give me?" Nurse #9 left the room and then UM #2 came in. Resident #153 stated she told UM #2 that I thought Nurse #9 had given me the wrong medication and she stated that she would go and check on that.	F 658	outcomes were observed from not receiving Buspar on 8/21/22 and 8/22/22. On 9/2/22 the Director of Nursing reviewed resident #403 to ensure all medication s were available, no other issues were identitified. All residents in the facility have the potential for their medications not to be given as outlined in their comprehensive care plan. On 9/2/22 the Director of Nursing or designee interviewed alert and oriented residents residing in the facility to determine if they have any concerns regarding receiving the wrong medications. Point Click Care 24 hour report and vital signs for all non-interviewable residents were reviewed for 8/19/22 to 8/22/19 by the Director of Nursing for changes in condition that may indicate administration of incorrect medications. There were no other concerns identified. The Director of Nursing reviewed the missed medication report from 9/12/22 to 9/13/22 checking for other potential medications not available. All discrepancies were immediately resolved. The Director of Nursing or designee educated all licensed nurses and medication aides on the five rights of medication administration and on reordering medications and the procedure for medications not available by 9/16/22. All newly hired licensed nurses and certified medication aides including agency licensed nurses and certified medication aides will have this same	

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Resident #153 stated that UM #2 returned about 15-20 minutes later and stated that Nurse #9 had given me another residents medication and that they had spoken to the NP, and she had given the staff some orders and that they would keep a close eye on her for any adverse reactions. Resident #153 added that Nurse #9 had come back in and apologized to her for the mistake.

The NP was interviewed on 08/23/22 at 3:34 PM and stated that she was notified of the medication error with Resident #153. She stated that she reviewed the medications that Resident #153 had gotten by accident and then reviewed what medications she should have gotten. She stated that Resident #153 was prescribed a blood pressure medication and because she had received another residents blood pressure medication, she held the prescribed medication for Resident #153. The NP stated that there was no adverse outcome from the medication and a lot of the medications were similar in nature and she had asked the staff to monitor Resident #153 closely and let her know of any changes and there had been none reported.

Nurse #9 was interviewed on 08/22/22 at 3:54 PM and stated that this was her first day at the facility and "I just made a mistake." She explained that the computer on the medication cart did not work for some reason, so she was having to look at one cart at the computer and the other cart to pull the medications and she had pulled the wrong medication and administered them to Resident #153. Nurse #9 stated that she pulled the resident in the next room's medication and did not verify the picture in the electronic record to ensure she was giving the correct medications to the correct resident. Nurse #9 stated she realized

education prior to taking as assignment and working with residents.

The Director of Nursing or designee will audit 5 nurse and/or certified medication aide medication observations per week and 5 resident medications for availability for 12 weeks beginning 9/12/22.

The Administrator will report the data obtained during the audit process to the facility Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for 3 months.

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F 658	Continued From page 9	F 658		

she had given the wrong medication to the wrong resident when she was about to give insulin and Resident #153 stated she did not receive insulin. She stated she immediately went and looked at the medications she had given, notified UM #2 and the NP. Nurse #9 stated she had also apologized to Resident #153 and before she could resume her medication pass the facility had re-educated her on medication administration and they were still working to get the computer fixed. She added the NP had given an order to hold some of Resident #153 medications and to monitor her closely through the shift. Nurse #9 stated she could not say for sure what caused the mistake but stated going between two medication carts contributed to the error.

UM #2 was interviewed on 08/24/22 at 3:39 PM and reported that she was notified of the medication error with Resident #153 immediately after it occurred. She stated that Nurse #9 had the medication cart parked outside of one resident room and pulled the medication for the next room down on the hallway and did not look at the picture to verify who she was administering medication too. UM #2 stated that she was aware that the computer was not working but Nurse #9 never came to her and stated that using another computer was an issue or she would have just given her laptop to Nurse #9 to use. UM #2 stated that she went down to Resident #153's room and examined her and spoke to her then notified the NP of the error. She stated she went through the medications that Resident #153 had received by mistake and the NP had given an order to hold Resident #153's blood pressure medication. She added that she had checked on Resident #153 throughout the day, and she had no adverse effects from receiving the wrong medication.

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F 658	Continued From page 10	F 658		

The Director of Nursing (DON) was interviewed on 08/24/22 at 4:30 PM and reported that she was made aware of the medication error with Resident #153 and as soon as the error was reported it was reported to the NP and the resident was assessed. The DON stated that she immediately went and re-educated Nurse #9 on the five rights of medication administration before allowing her to resume her medication pass. The DON stated that she had completed the incident report and they determined that the rooms were right next to each other, and it was accident that she went in the wrong room. The DON stated she also educated Nurse #9 on reviewing the picture in the electronical medical record and asking the resident their name and date of birth before administering the medication. The DON further stated that she was aware that the computer on the medication cart was not working, and they had put an Information Technology (IT) ticket in, and the computer had since been fixed.

2. Resident #403 was admitted to the facility on 08/16/22 with diagnoses that included anxiety disorder and depression.

A review of Resident #403's admission minimum data set assessment was unable to be completed due to her recent admission to the facility.

Review of Resident #403's physician orders revealed an order dated 08/16/22 for buspirone HCl (antianxiety) tablet 30 milligrams (mg) to be given every 8 hours for anxiety.

Review of Resident #403's medication administration record for August revealed no documentation of resident #403 had received her

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scheduled dose of buspirone HCl tablet 30mg on 08/21/22 at 8:00 PM and on 08/22/22 at 6:00 AM.

Review of staffing schedules for 08/21/22 and 08/22/22 revealed Nurse #1 to be scheduled as the nurse for Resident #403.

During an interview with Nurse #1 on 08/25/22 at 6:53 AM, she verified she did not give Resident #403 two doses of her scheduled buspirone HCl tablet 30mg on 08/21/22 at 8:00 PM or on 08/22/22 at 6:00 AM. She reported she was unable to give Resident #403 because she did not have any on the medication cart for Resident #403 and she did not have access to the facility's back-up medication system.

During an interview with the Nurse Practitioner on 08/25/22 at 10:15 AM, she reported that although it was best not to miss doses of buspirone HCl, the medication "builds up" in the system and it is not a fast acting medication and it would not, in her opinion, be a significant medication error.

During an interview with the Director of Nursing on 08/25/22 at 2:30 PM, she reported if a medication was not available on the cart to be dispensed, then the nurse should go to the facility's back-up medication system and see if the medication was kept there and provide the right dose to the resident if so. If the facility's back-up medication system did not have the medication, then the nurse should sign off the medication administration record as such with the correct code. The nurse should then document a progress note and notify the physician of the missed dose. The Director of Nursing reported someone working in the facility at that time would have had access to the back-up medication

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F 658	Continued From page 12 system and would have been able to access it for Nurse #2. She reported she was unsure if buspirone HCl was carried in their system, but it should have been checked. She reported she would speak with Nurse #1 to ensure she knew the process.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed provide bathing assistance to dependent residents for 3 of 5 residents (Resident #1, Resident #81 and Resident #82) reviewed for activities of daily living. The findings include: 1. Resident #1 was admitted to the facility on 04/28/22. The admission Minimum Data Set (MDS) assessment dated 05/05/22 revealed Resident #1 was cognitively intact and totally dependent on staff for bathing. The MDS also indicated the Resident had the behavior of rejecting care 1 to 3 days in the look back period. Resident #1's care plan revised on 06/02/22 revealed he was at risk for altered moods and behaviors related to behavioral disturbances. The goal that his mood and behavior would remain	F 677	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to provide resident #1, #81 and #82 with activities of daily (ADL) care. Resident #1 still resides in the facility. He was given a bed bath and his beard shaved the week of survey. Resident #81 was given a shower, shaved and nail care provided during the week of survey. Resident #82 received a shower on 9/1/22. All residents in the facility have the potential to not receive ADL care provided by the staff per their preference. Residents were interviewed by the unit	9/22/22

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F 677	Continued From page 13 stable would be attained by utilizing interventions such as always approach in a calm relaxed manner and to explain procedures before providing assistance. The Resident did not have a care plan that was specific to refusing showers. A review of the facility's shower schedule revealed Resident #1 was scheduled to receive his shower on Wednesday and Saturday on second shift. A review of Resident #1's medical record for the month of August 2022 revealed there was no documentation of the Resident refusing his showers. A review of Resident #1's bathing record revealed there was no documentation of showers given from 08/01/22 through 08/20/22. The facility could not provide a Bath/Shower sheets for Resident #1 for 08/01/22 through 08/20/22. On 08/22/22 at 12:01 PM during an observation and interview with Resident #1, the Resident was lying on his bed watching TV. The Resident's hair was dry and stiff, and he had facial hair (beard and mustache) that was approximately a quarter inch long. The Resident stated he was used to shaving every day when he was at home. Resident #1 explained that he was supposed to get two showers a week, but it had been about a month since he has had his shower which was given to him by his daughter. The Resident remarked the staff gave him bed baths instead. The Resident stated he did not know what days he was supposed to get his showers because he did not get them consistently to keep up with what	F 677	managers on their shower/bath preference. New shower schedule was created on 8/17/22. A second review of the shower preference schedule was completed on 9/14/22 by the Director of Nursing and updates were made based on the preferences and recommendations. On 9/14/22 an audit of nail care was performed by the Director of Nursing and all appropriate nail care was provided to all residents. On 9/14/22 an audit of resident shaving preferences was completed by the Director of Nursing. The Director of Nursing or designee educated all licensed nurses and certified nurse aides on giving showers to residents as scheduled and providing activities of daily living (ADL) as preferred by the resident by 9/16/22. All newly hired licensed nurses and certified nurse aides as well as agency licensed nurses and certified nurse aides will have this same education prior to taking an assignment and working with residents. Shower compliance will be reviewed in clinical morning meeting for completion. Director of Nursing will delegate actions as needed. The Director of Nursing or designee will audit 10 residents per week to ensure ADL compliance was achieve for 12weeks beginning on 9/12/22. The Director of Nursing will report the	

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day he was supposed to get them. The Resident stated he has never been asked his preference of what days he would prefer his showers.

On 08/23/22 at 1:26 PM Resident #1 was lying in bed with a goatee well defined. The Resident explained that he received a bed bath and was shaved. The Resident continued to explain that he would have rather had a shower, but he was not given a choice of which he preferred.

On Wednesday 08/03/22 Nurse Aide #1 and Nurse Aide #2 was scheduled to work with Resident #1 for the second shift.

On Saturday 08/06/22 Nurse Aide #3 and Nurse Aide #4 was scheduled to work with Resident #1 for the second shift.

On Wednesday 08/10/22 Nurse Aide #3 and Nurse Aide #5 was scheduled to work with Resident #1 for the second shift.

On Saturday 08/13/22 Nurse Aide #6 and Nurse Aide #4 was scheduled to work with Resident #1 for the second shift.

On Wednesday 08/17/22 Nurse Aide #1 and Nurse Aide #5 was scheduled to work with Resident #1 for the second shift.

On Saturday 08/20/22 Nurse Aide #3 and Nurse Aide #5 was scheduled to work with Resident #1 for the second shift.

An interview was conducted with Nurse Aide (NA) #1 on 08/24/22 at 3:31 PM. The NA stated she worked from 7:00 AM to 7:00 PM and confirmed she worked with Resident #1 on 08/03/22 and

data obtained during the audit process to the facility Quality Assurance and Performance Improvement committee for further review an recommendations monthly for 3 months.

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08/17/22. The NA explained that she had never given the Resident a shower or bed bath but that her coworker could have showered him after she left for the day. The NA stated they were supposed to complete a Bath/Shower sheet on every resident scheduled for a shower even if the resident refused their shower.

Multiple attempts were made to interview Nurse Aide #2 and Nurse Aide #6, but the attempts were unsuccessful.

On 08/24/22 at 9:20 AM an interview was conducted with Nurse Aide (NA) #3. The NA stated she worked from 7:00 AM to 7:00 PM and confirmed she worked with Resident #1 on 08/06/22, 08/10/22 and 08/20/22. The NA explained that she had never given the Resident a shower but that his showers were scheduled for second shift and the NA who relieved her was responsible for his showers. The NA stated they were supposed to complete a Bath/Shower sheet on the resident even if the resident refused their shower.

On 08/24/22 at 4:10 PM an interview was conducted with Nurse Aide #4 who explained that she had never worked with Resident #1.

On 08/24/22 at 3:54 PM an interview was conducted with Nurse Aide (NA) #5. The NA stated she worked from 7:00 PM to 7:00 AM and confirmed she worked with Resident #1 on 08/10/22, 08/17/22 and 08/20/22. The NA explained that every time she approached the Resident about his shower, he states that he gets his shower during the day, but she knew that wasn't true. The NA continued to explain that she had never reported to management that he

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refused his showers on second shift or that he would prefer his showers on first shift. The NA stated she has never showered Resident #1. The NA reported they were supposed to fill out a Bath/Shower sheet when they gave the residents a shower and even if the resident refused their shower.

On 08/24/22 at 5:03 PM an interview was conducted with Nurse #1 who stated she worked from 7:00 AM to 7:00 PM and was frequently assigned to Resident #1. The Nurse explained that the nurse aides were supposed to report shower refusals so that they could speak with the residents and coax them into taking their showers. She continued to explain that if they can't get the resident to take their showers then they were supposed to document the refusal in the residents' medical record. The Nurse stated she has never been told that Resident #1 refused his showers. The Nurse reported the staff were supposed to complete a Bath/Shower sheet on the resident even if the resident refused their shower.

During an interview with Nurse Aide (NA) #7 on 08/25/22 at 9:07 AM the NA explained that she was scheduled to give showers that shift. She stated having a person scheduled to give showers was hit and miss, there was no consistency in it. She continued to explain that she knew some staff would fill out shower sheets on residents that they were given showers but she knew for a fact that the resident was not given a shower because she was assigned to the resident that day.

An interview was conducted with the Administrator and Director of Nursing on 08/25/22

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at 1:32 PM. The Administrator explained that they had identified issues with the residents' showers and developed a Performance Improvement Plan (PIP) last week. She stated they obtained shower preferences from the residents and updated their shower schedules. She continued to explain that her expectation was for the nurse aides to complete Bath/Shower sheets on the residents when they give showers even if the resident refuses the showers. She stated the nurse aides should also report shower refusals to the nurses so that they can document the refusals in the residents' medical record and investigate why they were refusing their showers. The Administrator stated the residents should receive two showers a week unless they preferred to have more.

2. Resident #81 was admitted to the facility on 04/11/22.

The quarterly Minimum Data Set (MDS) assessment dated 07/19/22 revealed Resident #81 was cognitively intact and required total assistance with bathing. The MDS indicated the Resident had no behaviors of rejection of care.

A review of the facility's shower schedule revealed Resident #81 was scheduled to receive his shower on Tuesday and Friday on first shift.

A review of Resident #81's medical record revealed there was no documentation of the Resident refusing his showers.

A review of Resident #81's bathing record revealed he received a shower on:

Monday, 08/02/22 by Nurse Aide #3 and Tuesday

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08/16/22 by Nurse Aide #3. It is noted that on 08/05/22, 08/12/22 and 08/19/22 the record indicated Resident #81 received a bed bath.

The facility provided a Bath/Shower sheet for Resident #81 for:

Friday, 08/12/22 by Patient Care Aide (PCA) #1 that indicated Resident #81 refused a bed bath after asking three times before his appointment. No shave or nail care was marked as being provided.

Tuesday, 08/16/22 by an unidentified staff that indicated only nail care had been provided.

Friday, 08/19/22 by Nurse Aide #3 that indicated Resident #81 received a bed bath and no nail care or shave was provided. The record stated the Resident had dialysis that day.

Tuesday, 08/23/22 by unidentified staff that indicated Resident #81 received a shower, shave and nail care.

On 08/22/22 at 4:25 PM an interview and observation were conducted with Resident #81. The Resident was sitting in his wheelchair, his facial hair (beard) was approximately a half inch long and his hair was dry. There were no odors of incontinence about the Resident. The Resident explained that he didn't like a beard and the staff were supposed to shave him when they gave him a shower. The Resident continued to explain that he was supposed to receive two showers a week which was what he wanted, but they were hit and miss. He stated he got a shower one day during the previous week.

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On 08/23/22 at 1:39 PM during an interview and observation of Resident #81, the Resident was lying in bed, well groomed and shaven. The Resident stated he got a shower that morning and they shaved his facial hair off which he appreciated because he didn't like facial hair.

On 08/24/22 at 9:25 AM during an interview with Nurse Aide (NA) #3 she explained that Resident #81 was alert and oriented and did not refuse care. She stated the Resident was scheduled for his showers on Tuesday and Friday for first shift and when she worked, she tried to give him his showers in the mornings before he left for his appointments if it was possible but sometimes she gave him bed baths. She reported the last time she showered the Resident was on 08/16/22. The NA explained that they were supposed to complete a Bath/Shower sheet on the residents whether they gave them a shower or not and if they refused the shower they were supposed to document it on the shower sheet and give it to the nurse so they could document their refusal.

An interview was conducted with Nurse Aide (NA) #1 on 08/24/22 at 3:36 PM who confirmed she worked with Resident #81 on 08/12/22 on the 7:00 AM to 7:00 PM shift. The NA explained that she gave the Resident a shower about 2 weeks ago but could not remember if it was on 08/12/22.

Attempts were made to interview PCA #1, but the attempts were unsuccessful.

Attempts were made to interview Nurse Aide #8, but the attempts were unsuccessful.

On 08/24/22 at 5:03 PM an interview was

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conducted with Nurse #1 who stated she worked from 7:00 AM to 7:00 PM and was frequently assigned to Resident #81. The Nurse explained that the nurse aides were supposed to report shower refusals so that they could speak with the residents and coax them into taking their showers. She continued to explain that if they can't get the resident to take their showers then they were supposed to document the refusal in the residents' medical record. The Nurse stated she has never been told that Resident #81 refused his showers and in fact, the Resident looked forward to his showers. The Nurse reported the staff were supposed to complete a Bath/Shower sheet on the resident even if the resident refused their shower.

During an interview with Nurse Aide (NA) #7 on 08/25/22 at 9:07 AM the NA explained that she was scheduled to give showers that shift. She stated having a person scheduled to give showers was hit and miss, there was no consistency in it. She continued to explain that some staff would fill out shower sheets on residents that they were given showers, but she knew for a fact that the resident was not given a shower because she was assigned to the resident that day.

An interview was conducted with the Administrator and Director of Nursing on 08/25/22 at 1:32 PM. The Administrator explained that they had identified issues with the residents' showers and developed a Performance Improvement Plan (PIP) last week. She stated they obtained shower preferences from the residents and updated their shower schedules. She continued to explain that her expectation was for the nurse aides to complete Bath/Shower sheets on the residents

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when they give showers even if the resident refuses the showers. She stated the nurse aides should also report shower refusals to the nurses so that they can document the refusals in the residents' medical record and investigate why they were refusing their showers. The Administrator stated the residents should receive two showers a week unless they preferred to have more.

3. Resident #82 was admitted to the facility on 04/08/21.

The quarterly Minimum Data Set (MDS) assessment dated 07/19/22 revealed Resident #82's cognition was moderately intact and had no behaviors of rejection of care. The MDS noted the Resident required physical help in part of bathing with the assist of one staff.

A review of the facility shower schedule revealed Resident #82 was scheduled to receive showers on Monday and Thursday second shift.

The facility could not provide a Bath/Shower sheet for Resident #82 for August 1, 2022 through August 22, 2022.

A review of Resident #82's medical record revealed there was no documentation that the Resident had refused his scheduled showers.

A review of Resident #82's bathing record revealed he received a shower on:

Thursday 08/18/22. The schedule revealed Nurse Aide #1 and Nurse Aide #5 worked on the second shift.

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There were no scheduled showers marked as received from Monday, 08/01/22 through Monday, 08/15/22.

On 08/22/22 at 10:39 AM during an interview and observation with Resident #82 the Resident was lying in bed with hair disheveled and dry. The Resident had facial hair (beard) approximately one fourth inches long and explained that he normally did not wear a beard. The Resident continued to explain that he was supposed to get two showers a week, but it had been months since he had had a shower and his hair hadn't been washed in that amount of time as well. The Resident added they ask me what I want, and I tell them showers, but they give me bed baths instead. He added that he didn't know what days he was supposed to get his shower because he doesn't get them enough to know.

During an interview with Resident #82 on 08/23/22 at 1:30 PM the Resident was lying on his bed. The Resident pointed to his beard and stated he still had his beard and he had not received a shower.

On 08/24/22 at 1:19 PM Nurse Aide (NA) #3 confirmed she worked with Resident #82 during the 3:00 to 11:00 PM shift on 08/01/22, 08/11/22 7:00 AM to 7:00 PM shift, and 08/15/22 7:00 AM to 7:00 PM shift. The NA stated she did not give the Resident a shower that in fact, she has never given the Resident a shower. The NA explained that Resident #82 was scheduled to receive his showers on the second shift.

On 08/24/22 at 3:42 PM an interview was conducted with Nurse Aide (NA) #1. The NA stated she worked with Resident often from 7:00

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AM to 7:00 PM. The NA explained that she has never given Resident a shower that maybe her coworker had. The NA stated they were supposed to complete a Bath/Shower sheet on every resident scheduled for a shower even if the resident refused their shower.

An interview conducted with Nurse Aide (NA) #10 on 08/24/22 at 3:57 PM. The NA explained that he worked the 11:00 to 7:00 AM shift and had never given Resident #82 a shower.

An interview was conducted with Nurse Aide (NA) #9 on 08/24/22 at 4:18 PM. The NA confirmed she worked with Resident #82 on 08/08/22 but stated she had never given the Resident a shower.

On 08/24/22 at 4:42 PM an interview was conducted with Nurse Aide (NA) #5. The NA explained that she often worked with Resident #82 on the 7:00 PM to 7:00 AM shift. The NA stated had never given the Resident a shower because he always refused. She continued to explain that the staff were supposed to complete a shower sheet when they complete a shower and report it to the nurse if the residents refused their showers, but she did not always do that.

Attempts were made to interview Nurse Aide #12 who worked on 08/15/22 but the attempts were unsuccessful.

On 08/24/22 at 5:03 PM an interview was conducted with Nurse #1 who stated she worked from 7:00 AM to 7:00 PM and was frequently assigned to Resident #82. The Nurse explained that the nurse aides were supposed to report shower refusals so that they could speak with the

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F 677	Continued From page 24	F 677		

residents and coax them into taking their showers. She continued to explain that if they can't get the resident to take their showers then they were supposed to document the refusal in the residents' medical record. The Nurse stated she has never been told that Resident #82 refused his showers and in fact, the Resident looked forward to his showers. The Nurse reported the staff were supposed to complete a Bath/Shower sheet on the resident even if the resident refused their shower.

During an interview with Nurse Aide (NA) #7 on 08/25/22 at 9:07 AM the NA explained that she was scheduled to give showers that shift. She stated having a person scheduled to give showers was hit and miss, there was no consistency in it. She continued to explain that she knew that some staff would fill out shower sheets on residents that they were given showers, but she knew for a fact that the resident was not given a shower because she was assigned to the resident that day.

An interview was conducted with the Administrator and Director of Nursing on 08/25/22 at 1:32 PM. The Administrator explained that they had identified issues with the residents' showers and developed a Performance Improvement Plan (PIP) last week. She stated they obtained shower preferences from the residents and updated their shower schedules. She continued to explain that her expectation was for the nurse aides to complete Bath/Shower sheets on the residents when they give showers even if the resident refuses the showers. She stated the nurse aides should also report shower refusals to the nurses so that they can document the refusals in the residents' medical record and investigate why

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F 677	Continued From page 25 they were refusing their showers. The Administrator stated the residents should receive two showers a week unless they preferred to have more.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to apply a left-hand splint as ordered for 1 of 4 residents reviewed with limited range of motion (Resident #91). The findings included: Resident #91 was admitted to the facility on 11/11/19 with diagnoses that included hemiplegia following a cerebral vascular accident.	F 688	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to apply a hand splint for resident #91. The hand splint was not available to apply per provider's order.	9/22/22

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F 688	Continued From page 26 Review of a physician order dated 10/28/21 read: left hand splint as tolerated through the day and night with splint to be removed at least once a shift for range of motion and hand hygiene. Review of a care plan updated on 04/13/22 read in part; alteration in musculoskeletal status related to contracture of left hand and diagnoses of left sided hemiplegia. The goal read; Resident #91 will remain free of complications related to left hand contracture through the review date. The interventions included: resident to wear left hand splint as tolerated throughout the day and night with the splint being removed at least each shift for range of motion and hygiene. Review of a quarterly Minimum Data Set (MDS) dated 07/30/22 revealed that Resident #91 was moderately cognitively impaired and required extensive to total assistance with activities of daily living and had an impairment to one upper extremity. An observation of Resident #91 was made on 08/22/22 at 3:08 PM. Resident #91 was resting in bed and appeared to be sleeping. She was observed to have no splint in place to her left hand that was resting on top of her blanket on her bed. An observation of Resident #91 was made on 08/23/22 at 12:57 PM. Resident #91 was up in her wheelchair in the dining room eating the last few bites of her lunch. She was observed to have no splint in place to her left hand. An observation of Resident #91 was made on 08/23/22 at 3:21 PM. Resident #91 remained in the dining room drinking of cup of coffee with no	F 688	Resident #91 continues to reside in the facility. The hand splint was ordered during survey. The resident remains on therapy caseload and has had no negative outcomes due to not wearing her hand splint as ordered. All current residents who have splint orders have the potential to be affected. Audit completed for presence and application of splints per physician order by the Director of Rehabilitation and Minimum Data Set nurse on 9/5/22. The Director of Nursing or designee provided education to all licensed nursing staff on following physician's orders for application of splints and notification to management if the device is not able to be applied per physician order. Education completed 9/16/22. All newly licensed nursing staff including agency licensed nurses will have this same education prior to taking as assignment and working with residents. The Director of Nursing or designee will audit 5 residents per week who have orders for splints to ensure application and documentation compliance as ordered for 12 weeks beginning 9/12/22. The Director of Nursing will report the data obtained during the audit process to the facility Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for 3 months.	

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splint observed on her left hand. Resident #91 was observed to have a rolled-up wash cloth in her left hand.

An interview with the Rehab Director was conducted on 08/24/22 at 9:38 AM. The Rehab Director stated that yesterday (08/23/22) the staff came and asked about Resident #91's splint. She stated the facility maintenance department had been stripping and waxing the floors in Resident #91's room so all her personal belongings had been boxed up and moved into the hallway. The Rehab Director stated that she personally went through all the boxes of Resident #91's belonging and was unable to find her left-hand splint. She stated she was unsure of how long the left-hand splint had been missing but when she was unable to find the splint, she had gone to the dining room and placed a rolled-up wash cloth in Resident #91's left hand for protection and then ordered her a new left-hand splint. The Rehab Director stated that Resident #91 had a lot of arthritic changes in her left arm/hand and that at the end of her recent therapy treatment in April 2022 Resident #91 was tolerating the splint most days and when she was tired of it, she wound ask for the splint to be removed.

Nurse Aide (NA) #7 was interviewed on 08/24/22 at 1:53 PM who confirmed that she cared for Resident #91 on 8/22/22 and 8/23/22 NA #7 stated that Resident #91 had a splint that she had been applying to her left hand but for the last 3 weeks the splint had been missing and she had reported it to Nurse #1 yesterday (08/23/22) about the missing splint and Nurse #1 had replied that there was nothing she could do about the missing splint. NA #7 stated that when she had the splint to apply to Resident #91, she generally

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wore it for most of her shift.

NA #23 was interviewed on 08/24/22 at 2:02 PM who confirmed that she cared for Resident #91 on Monday 08/22/22. She stated that she was not aware of any splint that Resident #91 had, and she had never seen Resident #91 wear a splint.

An observation of Resident #91 was made on 08/24/22 at 2:06 PM. Resident #91 has just returned to her room from the shower room and was resting in bed. She was observed to have no splint in place to her left hand but did have a rolled-up wash cloth in her left hand.

Nurse #1 was interviewed on 08/24/22 at 3:27 PM who confirmed that she routinely cared for Resident #91 2-3 days a week. Nurse #1 stated she was not aware of any splint that Resident #91 had. She stated that she would look on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) for that information and she stated that it was not on her MAR/TAR and had not been communicated to her in report. Nurse #1 again stated she knew nothing about Resident #91's splint nor had any staff member reported anything to her about the splint being missing.

Review of Resident #91's MAR dated August 2022 revealed that on 08/24/22 the following entry was added for validation by staff: Splinting: Patient to wear her left-hand splint as tolerated throughout the day/night with splint removed at least each shift for range of motion and hygiene to left hand. May use wash cloth until splint arrives.

The Interim Director of Nursing (DON) was

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F 688	Continued From page 29 interviewed on 08/24/22 at 4:35 PM who stated that Resident #91 had a splint and she had been wearing it. She stated that yesterday (08/23/22) she heard that Resident #91 ' s left hand splint was missing, and we put a rolled-up wash cloth in her left until the new splint arrived. The DON stated she did not know how long the left-hand splint had been missing and that when it went missing it should have been reported to the nurse who should have notified the therapy department. The DON added that the NAs or the nurses should be applying the splint as ordered and that information could be in the electronic medical record.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, family, and Nurse Practitioner (NP) interviews the facility failed to have a working call bell for the resident to use to call for help and the resident attempted to get up and fell into the floor and then the facility failed to investigate the fall out of bed which required the resident to be sent to the Emergency Room (ER) and was diagnosed with an acute nondisplaced nasal fracture (Resident #156). Resident #156 fell from his bed during the night and was transferred off the floor back to bed	F 689	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Resident #156 had a fall on 6/26/22. The facility failed to ensure the resident had a working call light. The facility failed to investigate the self-reported fall. The	9/22/22

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and developed a nosebleed and had to be transferred to the ER where he was diagnosed with a nondisplaced nasal fracture and required silver nitrate (used to burn the skin to stop bleeding). The facility also failed to transfer a resident using the correct mechanical lift which resulted in the resident falling from the lift (Resident #66) for 2 of 3 residents reviewed for accidents.

The finding included:

1. Resident #156 was admitted to the facility on 06/17/22 with diagnoses that included: End Stage Renal Disease, right above knee amputation, and others.

Review of physician orders dated 06/17/22 included the following medications: Aspirin 81 milligrams (mg) by mouth every day, Eliquis (blood thinner) 5 mg by mouth every day, and Plavix (blood thinner) 75 mg by mouth every day.

Review of the Admission Minimum Data Set (MDS) dated 06/23/22 indicated that Resident #156 was moderately cognitively impaired and required extensive assistance of two staff members for bed mobility and transfers. The MDS further indicated that Resident #156 had a fall history prior to admission but had no falls since admission to the facility.

Review of Resident #156's medical record revealed no documentation of a fall occurring.

Review of a Skilled Nursing Facility (SNF) to Hospital transfer form dated 06/26/22 at 9:13 AM read in part; Reason for transfer: Fall. The form indicated that Resident #156 was capable of

facility failed to educate staff on resident #66's transfer status which resulted in her falling from a sit to stand lift. The facility failed to provide staff education on the use of mechanical lifts.

Resident #156 no longer resides in the facility. Resident #66 still resides in the facility and has had no major negative outcomes related to improper transfers. Vital signs remain at baseline.

All residents have the ability to have their call light malfunction, have self reported falls not investigated and have staff unaware of their transfer status. An audit was conducted by the Director of Rehabilitation on 8/17/22 on all resident transfer statuses. Care plans were updated as needed. On 9/7/22 the Regional Director of Clinical Services and Director of Nursing reviewed all falls from 9/1/22-9/7/22 to ensure all assessments were complete and residents remained at baseline. Any negative findings were communicated with the physician and resident representative. All current alert and oriented residents were interviewed to validate that no other residents had self-reported falls by the Director of Nursing or designee. On 6/29/22 and 9/5/22 an audit of all call lights were completed by the Maintenance Director to ensure function. Any issues identified were corrected immediately.

The Director of Nursing or designee educated all staff on the falls procedure including investigation of all reported falls

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F 689	Continued From page 31 decision making and ambulated independently and the family and NP were made aware of the transfer. The form was signed by Nurse #2. Resident #156's family member was interviewed on 08/23/22 at 5:01 PM. The family member stated that he came to the facility on 06/26/22 between 10:00 AM and 11:00 AM and when he walked into the room, he noted a bloody towel laying on the bed. The son stated a staff member whom he did not know stated that Resident #156 had a nosebleed, and they were trying to get it stopped. The staff member also informed him that Resident #156 had fallen out of bed on the previous shift, but no one had reported it to them except Resident #156. He added that Nurse Aide (NA) #18 was also trying to get the bleeding stopped. The family member stated that he stayed with Resident #156 until breakfast came and after breakfast, he began to shave Resident #156 and during that time he kept having to stop because Resident #156's nose kept dripping with blood and it kept dripping then became a steady stream of blood. The family member stated he went to the staff and stated that he was concerned that Resident #156's nose kept bleeding and he was on a blood thinner and did not want him to "bleed out." The staff member returned about 15 minutes later and stated she had gotten authorization to transfer him to the ER and Resident #156 was transferred to the ER where they discovered he had a nasal fracture. Resident #156 was discharged to the hospital on 06/26/22. Review of an ER to Hospital Admission dated 06/26/22 read in part, Fall: right epistaxis (nosebleed) improved. Management of epistaxis	F 689	and neuro-checks for all falls that include head injury. All staff educated on the procedure to report call lights that are not functioning and to provide the resident with an alternate communication method by 9/16/22. Department heads were educated by the administrator on checking for call light function during environmental rounds by 9/16/22. All new staff, including agency staff, will have this same education prior to taking as assignment and working with residents. Incidents will be reviewed in clinical morning meeting for proper notification, and interventions. Administrator or designee will audit 5 resident records weekly x 12 week to ensure compliance of investigation and completion of neuro-checks. Administrator or designee will audit 10 resident call lights per week for proper function for 12 weeks. Audits to begin 9/12/22. The Administrator will report the data obtained during the audit process to the Quality Assurance and Performance Improvement committee for further review and recommendations monthly for 3 months.	

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included the use of silver nitrate which stopped the bleeding. Nondisplaced nasal fracture.

Review of the facility schedule for 06/25/22 revealed that Nurse #4 was assigned to the unit where Resident #156 resided from 7:00 PM to 7:00 AM, Nurse #5 was schedule on a unit next to where Resident #156 resided from 7:00 PM to 7:00 AM, Nurse #6 and Nurse #7 were scheduled on the other side of the facility from 7:00 PM to 7:00 AM.

Review of the facility schedule for 06/26/22 revealed that Nurse #2 was assigned to the unit where Resident #156 resided from 7:00 AM to 7:00 PM and NA #18 was assigned to care for Resident #156 from 7:00 AM to 11:00 PM.

NA #18 was interviewed on 08/24/22 at 12:33 PM and confirmed that she had worked with Resident #156 on 06/26/22 at 7:00 AM until he was transferred to the hospital. She stated she had not received any report that morning because she was running late to work. NA #18 stated when she got to work, she went to check on Resident #156 and he stated he had fallen out of bed during the night and laid in the floor for 2 hours and then when the staff came in, they were stern with him about not using his call bell, which he stated did not work. NA #18 stated that while she was in the room with Resident #156 his nose started bleeding and she applied pressure and immediately went and got Nurse #2 who immediately came to the room and tried to get the bleeding stopped by applying pressure, but his nose kept dripping then became a steady stream. She stated that Resident #156 told Nurse #2 the same story about falling out of bed during the night, but the fall never got reported to Nurse #2

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from the previous shift. NA #18 stated that NA #17 had cared for Resident #156 through the night and added Resident #156 would not be able to get himself up if he fell out of bed. NA #18 stated that while she was in the room with Resident #156 his family came in and when they saw the nosebleed, they requested him to be sent to the ER for evaluation and so Nurse #2 arranged the transfer. NA #18 stated she saw no other injuries except the nosebleed.

NA #17 was interviewed on 08/24/22 at 5:36 PM and confirmed that she was working with Resident #156 on 06/25/22 at 7:00 PM to 7:00 AM on 06/26/22. NA #17 stated that when she arrived for her shift at 7:00 PM she had made a round and Resident #156 was resting in bed, and she stated she again checked on him between 11:00 PM to 12:00 AM and again was resting in bed. She stated that when she made her third round between 2:00 AM and 3:00 AM she found Resident #156 on the floor. NA #17 stated she asked Resident #156 why he had not turned on his call light if he needed something and Resident #156 indicated that he had turned the call light on, and it was not working. NA #17 stated she pressed the call light to test it out and it was in fact not working. NA #17 stated she went and got a nurse but did not know who the nurse was. She stated that they picked Resident #156 up off the floor and placed him back in the bed, but she did not see any injuries, no bleeding or bruising and no knots on his head. NA #17 stated that once Resident #156 was back in the bed she left the room while the nurse remained at bedside. She stated she did not get any vital signs nor was she asked to get vital signs. NA #17 stated she did not do anything with the call bell but did let the nurse know that it was not working. NA #17 was

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informed that Nurse #4 was scheduled to be on the unit where Resident #156 resided, and she stated she was certain the nurse was not Nurse #4 but did not know who the nurse was that assisted her in getting Resident #156 out of the floor that night.

Nurse #5 was interviewed on 08/24/22 at 5:51 PM and stated she had no knowledge of Resident #156 falling out of bed. She stated if a resident fell, she would have to complete all the required paperwork in addition to the head-to-toe assessment and notify the provider/family but again she stated she knew nothing about Resident #156 falling out of bed nor did she assist in getting him back in the bed.

Nurse #7 was interviewed on 08/24/22 at 6:02 PM and confirmed that she worked at the facility through an agency. She stated she had no recollection of Resident #156 and had no knowledge of a fall or transfer to the hospital.

Nurse #4 was interviewed on 08/24/22 at 6:07 PM and stated that had no knowledge of Resident #156 falling out of bed or being transferred to the hospital. She stated if a resident fell during her shift she would immediately complete a head-to-toe assessment including range of motion, administer any first aide that was needed, notify the provider/family, and document the fall in the medical record.

Nurse #6 was interviewed on 08/24/22 at 6:29 PM and confirmed that she worked at the facility through an agency. She stated she had no recollection of Resident #156 or any fall out of bed or transfer to the hospital.

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Attempts to speak to Nurse #2 were made on 08/23/22, 08/24/22, and 08/25/22 without success.

The interim Director of Nursing (DON) was interviewed on 08/24/22 at 3:52 PM and confirmed that she had worked at the facility since March 2022 but had only been the interim DON since 08/23/22. She stated she recalled discussing Resident #156 in the clinical stand-up meeting because he had gone out to the hospital because he stated he fell and wanted to go to the hospital. The interim DON stated she did not believe he fell and knew nothing about a nosebleed and knew nothing about how or why he fell. She added she knew that staff were interviewed by one of the previous DON's but there was no documentation of those interviews. The Interim DON stated she had no incident report, no investigation, no documentation that she could find regarding a fall for Resident #156.

The former DON was interviewed on 08/25/22 at 7:14 PM who confirmed that she was the DON during the time Resident #156 was in the building. She stated she vaguely recalled the event. She stated that when Resident #156 went to the hospital he reported a fall, and we had no record of the fall, and she was very confused because he could not have gotten himself up. The former DON stated she believed that they had interviewed the staff that worked that night and she had placed the interviews in a folder and left them in the facility. She stated that the current DON should be able to locate them.

The NP was interviewed on 08/25/22 at 3:42 PM and stated that sometime on the morning of 06/26/22 someone from the facility had called her

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but she could not recall who and stated that Resident #156 reported he fell out of bed and wanted to go to the ER to be evaluated. She stated that she agreed, and he was transferred to the ER. The NP stated to her knowledge there was no injuries, and she was not aware of any nosebleed. The NP stated that after she arrived at work that morning there was discussion in the morning meeting about it and she was told that they had talked to the staff that worked and no one saw him fall so she did not believe that there was a fall.

The Administrator was interviewed on 08/25/22 at 5:18 PM and stated she had been at the facility for three months. She stated that she recalled Resident #156 reporting that he fell during the night and discussing that he would not have been able to put himself back into bed because of his recent amputation. The Administrator stated that from what she could remember Resident #156 had a nosebleed and the family wanted him transferred to the ER. She stated that when a resident fell, she expected the staff to report the fall, complete the required head to toe assessment and a full investigation should have been conducted by the former DON.

2. Resident #66 was admitted to the facility on 5/7/19 with diagnoses that included multiple myeloma, chronic pain, and osteoarthritis (OA).

A therapy screen form dated 3/30/22 indicated Resident #66 was screened by physical therapy and was appropriate for the use of a total body lift with 2 person staff assistance due to decrease range of motion (ROM) of the bilateral upper extremities (BUE) and OA of bilateral knees.

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A quarterly Minimum Data Set (MDS) dated 4/28/22 indicated Resident #66 was cognitively intact and required total dependence of 2 staff for transfers.

An incident report dated 6/2/22 at 2:37 PM written by MDS Nurse #1 revealed Resident #66 experienced a fall in the bathroom. The incident report indicated a Nurse Aide (NA) #21 transferred Resident #66 from the commode using a sit to stand lift when her knees buckled, and Resident #66 slid out of the lift pad and onto the floor.

An interview on 8/23/22 at 2:40 PM with MDS Nurse #1 revealed she attended the huddle immediately, (facility meeting to discuss a resident fall or incident) following Resident #66's fall on 6/2/22. MDS Nurse #1 indicated she assisted in completing the incident report; however, she only entered data related to the details of the fall.

An interview with NA #21 on 8/24/22 at 1:58 PM revealed she was the NA assigned to Resident #66 on 6/2/22 and verified she and another agency NA, whom she could not recall the NA's name, transferred Resident #66 to the commode using a sit to stand lift after Resident #66 requested to go to the toilet. NA #21 stated she was new to the facility at that time and was not familiar with Resident #66 so when Resident #66 requested to go to the commode using the sit to stand lift she did not verify what transfer status she was assigned through the use of the Kardex or the EMR (electronic medical record), but instead asked the Medication Aide assigned to her hall who told her if Resident #66 requested to go to the bathroom with the lift to take her. She

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could not recall the MA's name whom she had asked. NA #21 stated when she and another agency NA used the sit to stand lift to transfer Resident #66 from the commode, Resident #66's knees buckled and she let go of the lift with her hands causing her to fall out of the bottom of the lift sling and to the floor landing on her right side and bumping her head on the floor. NA #21 explained when Resident #66 fell she put a pillow under her head and went to the resident's door to summon other staff for assistance. NA #21 indicated multiple staff came to the room to assist and examine Resident #66 while she was in the floor before she was transferred back to her bed using the Hoyer lift. NA #21 stated she recalled Resident #66 complaining of her head hurting after she fell but did not recall any open area or bleeding. NA #21 said she thought the straps had been placed on the correct position. NA #21 stated she had never been shown how to use the sit to stand lift and she could not recall being asked to write or give a verbal account of what occurred following the huddle meeting.

An interview with NA #20 on 8/24/22 at 1:42 PM revealed she was not assigned to Resident #66 on the 6/2/22, the date of the fall; however, was assigned to Resident #66's hall. NA #20 stated when she arrived at the time of the fall, Resident #66 was lying in the floor on her right side with her head in the direction of the toilet. NA #20 stated she assisted Resident #66 to be transferred from the floor to the resident's bed with the use of a Hoyer lift after her fall. NA # 20 stated she was aware in the past Resident #66 would request to go to the bathroom and wanted to use the sit to stand lift, but Resident #66's correct transfer status was a Hoyer lift for safety.

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An interview on 8/23/22 at 3:19 PM with Nurse #8 revealed she attended the huddle immediately following the fall and assessed Resident #66 for injuries. She indicated Medication Aide #1 (MA #1) was assigned to the hall on the date of the fall; however, MAs were unable to assess and she took over the care for Resident #66. Nurse #8 verified Nurse Practitioner (NP) #1 assessed Resident #66 and gave authorization to assisting her back to bed.

A progress note dated 6/2/22 written by NP #1 revealed Resident #66 experienced a fall. The note indicated NP #1 was summoned to the room of Resident #66 where she was found to be in the bathroom floor lying on her right side. Resident #66 and staff had reported the fall occurred when Resident #66 fell from the sit to stand lift in the bathroom and had reported the only pain she had at the time was in the back of the head. At the time of the fall on 6/2/22, NP #1 indicated there was no visible swelling or open areas on the head nor loss of consciousness immediately post fall to the floor.

An interview with NP #1 on 8/24/22 at 9:55 AM revealed she was summoned to the room of Resident #66 on the date of her fall (6/2/22). NP #1 verified she assessed the resident for injuries after she fell in the bathroom because NA #21 transferred Resident #66 to the toilet with a sit to stand lift despite her need for a total body lift which was her assigned transfer status. NP #1 verified Resident #66 complained of head pain, but upon exam, there were no open areas or visible swelling.

A progress note dated 6/3/22, with no time of note, written by NP #1 revealed Resident #66 was

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up in her wheelchair and complained of right upper extremity pain with movement. The note indicated during the examination, family entered the room and agreed to allow for an x-ray of the right shoulder and elbow to be performed.

A physician's order dated 6/3/22 revealed Resident #66 had an order which requested a right shoulder and elbow x-ray STAT.

An x-ray report of the right shoulder and elbow dated 6/4/22 indicated Resident #66 had a no acute injury to the right elbow; however, she had a right anterior dislocation of the glenohumeral (shoulder) joint and no acute fracture present.

A nurse progress note dated 6/6/22 at 2:20 PM indicated Resident #66's x-ray reports had been received by the facility and indicated a right shoulder dislocation and the NP was notified. The note further explained the NP ordered Resident #66 to be referred to orthopedic for follow-up care for the acute right shoulder dislocation. The note referenced attempts to make an appointment for Resident #66 with an orthopedic office and they refused to see Resident #66 without an emergency room examination. Resident #66's responsible party was contacted and agreed to transfer to the emergency room and was transported via emergency medical services (EMS) on 6/6/22 at 4:20 PM.

An emergency room report dated 6/6/22 indicated Resident #66 was examined for a fall from a sit to stand lift 4 days prior and x-rays of the right and left shoulder were ordered and obtained. Upon examination, Resident #66 vocalized a pain level of a #7 of 10 to the right shoulder. The report further indicated an x-ray of the right shoulder

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F 689	Continued From page 41 indicated there was no dislocation of the glenohumeral found; however, the joint space as not well demonstrated. An interview with the former DON #3 on 8/24/22 at 3:55 PM revealed she was the DON at the time of Resident #66's fall, but vaguely recalled hearing about the incident. She indicated she could not recall if any investigation was completed by herself; however, stated if she had been involved, she would have obtained statements from the resident and staff involved, determined the root cause of the incident, and provided education to staff to prevent further incidents from occurring. She indicated to her knowledge, NA #21 should have been trained by her agency prior to working in the facility and she was unable to verify if any additional education had been provided to NA #21 regarding the proper use of the lifts and how to identify the assigned transfer status for each resident. She stated all NAs in the facility should follow the proper transfer status for each resident for safety. An interview with the Interim Director of Nursing and Administrator on 8/25/22 at 4:39 PM revealed all NAs should transfer residents using the designated transfer status assigned to each resident to ensure safety. The Interim DON verified Resident #66's transfer status was a total body lift at the time of the incident.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		9/22/22

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F 695	Continued From page 42 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to secure an oxygen tank that was stored upright on the floor in a resident room for 1 of 2 residents (Resident #16) reviewed for respiratory therapy. The finding included: Resident #16 was admitted to the facility on 02/08/22 with diagnoses that included coronary artery disease. The quarterly Minimum Data Set assessment dated 06/04/22 revealed Resident #16 was cognitively intact and did not receive oxygen therapy. During an initial tour of Resident #16's room on 08/22/22 at 11:52 AM an observation was noted of an oxygen tank standing unsecured beside the Resident's bedside table and approximately one fourth amount of oxygen left in the tank. On 08/22/22 at 4:06 PM a second observation was made of the unsecured oxygen tank in Resident #16's room during an interview with Nurse #1. The Nurse acknowledged the oxygen tank standing unsecured beside the Resident's bedside table. The Nurse explained that the oxygen tank should not have been left in the Resident's room but should have been taken to the medication room where the oxygen tanks	F 695	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to secure an oxygen tank. Resident #16 was observed to have an oxygen tank sitting on the floor in her room. Resident #16 continues to reside in the facility. The oxygen tank was removed from the resident's room during survey and properly secured. This resident no longer uses oxygen. The resident has had no negative outcomes related to having an unsecured oxygen tank in her room. All resident rooms for those ordered oxygen were audited on 9/1/22 by the Regional Director of Clinical Services for unsecured oxygen tanks. No discrepancies were found. Director of Nursing or designee will provide education to all staff on facility policy for securement of oxygen tanks by 9/16/22. All new hires will have this same education prior to taking an assignment and working with residents. Administrator	

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F 695	Continued From page 43 were stored. The Nurse continued to explain that it was a safety hazard to store the oxygen tank upright, especially if the tank contained oxygen, for fear of explosion. She stated Resident #16 used to be on oxygen but was recently weaned off but as many times as she had been in the Resident's room, she had not noticed the free standing oxygen tank. The Nurse took the oxygen tank to the medication room for safe storage. An interview was conducted with Resident #16 on 08/23/22 at 1:11 PM. The Resident explained that she used to be on supplemental oxygen but as of a couple of months ago, she didn't need to oxygen any longer. During an interview with the Unit Manager (UM) #1 on 08/23/22 at 1:31 PM the UM explained that the oxygen tanks should not have been stored in Resident #16's room but should have been taken to the medication room where they stored the oxygen tanks in a holder to prevent them from falling over. On 08/23/22 at 5:13 PM during an interview with the Administrator, she stated the oxygen tank should not have been stored in the Resident's room, but it should have been taken to the storage room and put in a container to prevent accidents. During an interview with the Director of Nursing on 08/25/22 at 1:53 PM she explained that Resident #16 was recently weaned off the supplemental oxygen and the oxygen tank should have been taken back to the storage room for safe storage.	F 695	will educate department head staff to monitor for unsecured oxygen while completing environmental rounds by 9/16/22. All new department head staff will receive this same education upon new hire onboarding. Director of Nursing or designee will audit 5 resident with oxygen per week for unsecured oxygen tanks for 12 weeks beginning 9/12/22. The Administrator will report the data obtained during the audit process to the facility Quality Assurance and Performance Improvement committee for further review and recommendations monthly for 3 months.	

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F 697	Continued From page 44	F 697		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, staff, pharmacy, and Nurse Practitioners (NP) interviews, the facility failed to manage a resident's pain when she was provided the incorrect dosage of a narcotic pain medication for 1 of 1 resident reviewed for pain management (Resident #38). Findings included: Resident #38 was admitted to the facility on 3/25/21 with diagnosis that included mononeuropathy with unspecified lower limb (damage to the nerves). A review of Resident #38's physician orders revealed an order for Norco (Hydrocodone/Acetaminophen- a narcotic pain medication used to treat moderate to severe pain). The order read as follows: An order dated 3/25/21 for Norco 10/325mg (milligram)- give 1 tablet by mouth every 6 hours PRN (as needed) for pain. A review of Resident #38's physician's orders revealed the following additional pain management orders:	F 697	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to control resident #38 pain. Resident #38 still resides in the facility. The correct ordered medication has been provided as ordered since 8/25/22. All residents in the facility have the potential to not have adequate pain control. On 9/13/22 the Director of Nursing conducted an audit of all resident pain scores for a 72 hour look back period. The Nurse Practitioner was informed and interventions initiated for any issues identified. On 9/7/22 the Director of Nursing completed an audit of all current narcotic pain medication orders, and the availability of the correct medication. Any issues identified were immediately	9/22/22

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F 697	Continued From page 45 An order dated 8/19/21 for Gabapentin 100 mg-give 1 capsule twice daily for neuropathy pain. An order dated 4/6/22 for Cyclobenzaprine 5mg-give 1 tablet twice daily for back pain. A Minimum Data Set (MDS) assessment dated 6/21/22 indicated Resident #38 was cognitively intact and had no episodes of refusals of care. The assessment further indicated she received scheduled pain medications, received PRN (as needed) pain medications, had occasionally experienced pain over the last 5 days and had received 7 days of opioid medications during the reference period of 7 days. A review of Resident #38's physician orders revealed an additional order for Norco. The order read as follows: An order dated 7/4/22 for Norco 5/325mg now x 1 dose due to medication not available from pharmacy. A progress note dated 7/5/22 written by Nurse Practitioner #2 revealed Resident #38 had polyosteoarthritis which she had a current medication regimen that included Norco 10-325 mg every 6 hours as needed for pain - and the recommendations was to continue the same medication regimen for pain. A review of Resident #38's July 2022 medication administration record (MAR) indicated Norco 5/325mg was administered on 7/4/22 at 5:35 AM. It also indicated Norco 10/325mg was administered 7/1, 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/12, 7/13, 7/14, 7/15, 7/17, 7/18, 7/19,	F 697	addressed. The Director of Nursing or designee educated all licensed nurses on the 5 rights of medication administration, pain control procedures, use of the Omni call and reordering of narcotic pain medication by 9/16/22. All newly hired licensed nurses, including agency licensed nurses, will have this same education prior to taking as assignment and working with residents. Director of Nursing or designee will review medication availability in clinical morning meeting and will follow up on any concerns promptly. The Director of Nursing or designee will audit 5 residents for availability of narcotic pain medication weekly for 12 weeks beginning 9/12/22. The Director of Nursing will report the data obtained during the audit process to the facility Quality Assurance and Performance Improvement committee for further review and recommendations monthly for 3 months.	

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7/20, 7/21, 7/22, 7/23, 7/24, 7/25, 7/26, 7/27, 7/28, 7/29, 7/30, and 7/31. The July MAR also revealed Resident #38's pain level had reached a level #7 on 7/28 and a #8 on 7/29.

According to a Controlled Medication Utilization Record dispensed from the pharmacy on 7/25/22 indicated Resident #38 was administered Norco 5/325 mg on 7/26, 7/27, 7/28, 7/29, 7/30, and 7/31.

According to pain documentation for July 2022 in addition to the levels listed on the July MAR, Resident #38 had a pain level that reached a level #7 on 7/26/22.

A comparison of the Medication Administration Record to the Control Medication Utilization Record was performed which revealed Resident #38 received Norco 5/325 mg without a physician's order for the dosage on 14 separate occasions during the date range of 7/26/22 through 7/31/22. However, the MAR indicated Resident #38 had received the dosage of Norco 10/325 mg which was the prescribed dosage.

A review of Resident #38's August 2022 MAR indicated Norco 10/325 mg was administered on 8/1, 8/3, 8/4, 8/6, 8/7, 8/8/, 8/9, 8/10, 8/11, 8/12, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, and 8/24. It also revealed Resident #38's pain level had reached a level #8 on 8/3, #6 on 8/4, #7 on 8/6, #8 on 8/7.

According to a Controlled Medication Utilization Record dispensed from the pharmacy on 7/25/22 indicated Resident #38 was administered Norco 5/325 mg on 8/1, 8/2, 8/3, 8/4, 8/5, 8/6, and 8/7.

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According to pain documentation for August 2022, in addition to the levels listed on the August MAR, Resident #38 had a pain level that reached a level #8 on 8/2/22.

A comparison of the Medication Administration Record to the Control Medication Utilization Record was performed which revealed Resident #38 received Norco 5/325 mg without a physician's order for the dosage on 10 separate occasions during the date range of 8/1/22 through 78/7/22. However, the MAR indicated Resident #38 had received the dosage of Norco 10/325 mg which was the prescribed dosage.

A progress note dated 8/2/22 written by Nurse Practitioner #2 revealed Resident #38 had polyosteoarthritis which she had a current medication regimen that included Norco 10-325 mg (milligram) every 6 hours as needed for pain - and the recommendations was to continue the same medication regimen for pain.

An observation and interview with Resident #38 on 8/22/22 at 1:39 PM revealed she was sitting in her recliner and voiced she had concerns that her pain was not controlled during July and part of August 2022. Resident #38 stated, at times, her pain had reached a level #10 and she indicated she was unsure if she was being administered her pain medication because her pain was not being controlled like it had previously been when she received her pain medication consistently. Resident #38 vocalized she was aware there had been some concerns with the facility not having her Norco available from the pharmacy and she had to go without it at times. Resident #38 was unable to identify specific dates, but clarified her pain was unmanaged for periods during July and

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August. She vocalized, "my pain has been so bad at times, I almost think I wasn't given anything but Acetaminophen."

A follow-up interview with Resident #38 on 8/24/22 at 9:34 AM revealed that during parts of July and August 2022 she had experienced pain in her lower back and legs which she described as achy with frequent cramps that went down the backs of both legs. She indicated she had made staff administering medications, the DON, and her NP that she was having pain and did not feel like her pain was being managed correctly but was not provided a solution and could not recall the dates she spoke with individuals.

A telephone interview with the dispensing pharmacy on 8/24/22 at 8:00 AM revealed they had record of Resident #38 receiving Norco 10/325 mg since admission; however, after a telephone conversation with the facility about dispensing concerns, the pharmacy received a faxed prescription written by NP #2 on 7/25/22 which read Norco 5/325 mg: give one tablet every 6 hours PRN for pain with a quantity written for #120; therefore, the pharmacy filled the order despite not receiving notification through the electronic medical record the order had been received by the facility.

An interview with Nurse Practitioner #2 on 8/24/22 at 8:53 AM revealed she had taken over the primary care of Resident #38 and was aware she had chronic pain. Nurse Practitioner #2 stated she had been made aware early in July 2022 that the facility was experiencing difficulty obtaining Resident #38's narcotic pain medications and new scripts had to be written frequently and sent in order for the pharmacy to

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be able to dispense small quantities at a time. She stated Resident #38 had been consistently receiving Norco 10/325 mg which was effective in managing her pain. She indicated NP #1, the Director of Nursing (DON), the pharmacy, and herself had a telephone conference call. After concluding the call, she faxed a prescription into the pharmacy which read Norco 5/325 mg give 1 every 6 hours as needed for pain. NP #2 stated she did not verify the current order before writing the script and inadvertently had written the prescription for the incorrect dosage. She stated this was discovered within a couple days of writing the prescription because she notified the facility Resident #38 had been complaining of pain after Resident #38 had approached her with pain management concerns. She indicated she spoke with the DON and notified her the resident should be receiving Norco 10/325 mg every 6 hours PRN for pain and that the Norco 5/325 mg was a one-time order and she had inadvertently faxed the pharmacy a script that included the incorrect dosage. The DON indicated she would correct the concern. NP #2 stated she had not heard anything else from the DON or staff and was not aware Resident #38 continued to receive the incorrect dose of Norco 5/325 mg until 8/7/22.

An interview with the Interim Director of Nursing, Administrator, and Corporate Nurse Consultant on 8/24/22 at 9:00 AM revealed they had no knowledge Resident #38 had received the incorrect dosage of a controlled opioid during July and August 2022.

An interview with NP #1 on 8/24/22 at 9:55 AM revealed she had assisted in managing the care of Resident #38 in the absence of NP #2 being in the building and recalled that Resident #38 had

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approached her during July 2022 and indicated her pain was not being managed well. NP #1 stated that she, NP #2, and the DON had a telephone conference call with the pharmacy related to the dispensing of Resident #38's opioid medication. NP #1 stated there had been difficulty obtaining her medication when requested and had to write a new script every 3 days or so because the pharmacy was not dispensing more than 12 at a time. NP #1 stated she was aware NP #2 had faxed in a new script to the pharmacy for Resident #38's medication; however, had never been notified the incorrect dose had been written on the script faxed nor that Resident #38 was receiving the dosage of Norco 5/325 mg without a physician's order and had not been notified of any plans of changes in Resident #38's physician's pain management regimen to decrease the dosage from Norco 10/325 mg to Norco 5/325 mg every 6 hours PRN pain.

A telephone interview with the DON on 8/24/22 at 1:08 PM revealed she was not longer employed at the facility; however, she recalled the telephone conference call between herself, the two facility NP's, and the pharmacy related to concerns with the dispensing of Resident #38's ordered medication: Norco 10/325 mg and the need for the providers being asked to write a new prescription every few days due to the pharmacy only dispensing a very small quantity at a time. She could not recall the exact date of the conference call; however, stated she thought NP #2 was going to fax in a new script to the pharmacy following the call. The DON did indicate NP #2 had spoken with her regarding the incorrect dosage being dispensed from the pharmacy and to her recollection, the concern had been corrected. She did not know Resident

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F 697	Continued From page 51 #38 had continued to receive the incorrect dosage until 8/7/22. A follow-up interview with the Interim Director of Nursing and the Administrator on 8/25/22 at 4:39 PM revealed the Interim DON stated all staff administering medications should compare the order written in the electronic medical record to the controlled medication utilization record as well as to the card dispensed from pharmacy before administering any medication to any resident. All staff administering medications should follow the 6 Rights: right resident, right medication, right dose, right time, right route, and right documentation. The Interim DON indicated the Norco 5/325 should not have been administered except on 7/4/22 when the one-time order was obtained from the provider when the medication was unavailable from pharmacy. She stated Resident #38 should have received Norco 10/325mg every 6 hours PRN pain and that the staff should not have signed they provided a medication that was not available in the facility.	F 697		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;	F 790		9/22/22

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F 790	Continued From page 52 §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Resident interviews the facility failed to obtain routine dental services for a resident (Resident #81) who reported chipped teeth for 1 of 1 resident reviewed for dental services. The finding included: Resident #81 was admitted to the facility on 04/11/22.	F 790	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to provide resident #81 with dental services. Resident #81 still resides in the facility.	

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F 790	Continued From page 53 The admission Minimum Data Set assessment dated 04/18/22 revealed Resident #81 was cognitively intact and had inflamed bleeding gums or loose natural teeth. The quarterly Minimum Data Set assessment dated 07/19/22 indicated Resident #81 had no issues with his dental/oral status. A review of Resident #81's medical record indicated a steady weight gain from 04/11/22 at 121 pounds to 08/12/22 at 133.8 pounds. Resident #81 consumed an average meal intake of 75-100%. Further review of the medical record revealed the Resident had not received attention from a dentist since admission. A review of the facility's record of dental visits to the facility on 05/02/22, 05/04/22, 08/01/22 and 08/10/22 revealed Resident #81 was not on the lists. On 08/22/22 at 4:25 PM during an interview with Resident #81 he explained that his bottom back teeth were chipping, and he had not seen a dentist for a routine exam and cleaning since before he was admitted to the facility. Unable to visualize the back teeth due to the position of him sitting in his wheelchair but his front teeth were noted to be yellow. The Resident continued to explain that shortly after he was admitted to the facility, Facility Transporter #1 made him an appointment to see a local dentist which was in July, but they had to cancel the appointment because he had to be on a stretcher for the visit and the dental office could not accommodate a stretcher.	F 790	During survey the resident was reviewed by the nurse practitioner, denied pain and no immediate interventions were needed. A dental appointment has been scheduled. All current resident in the facility were audited on 9/1/22 by the facility Social Worker for the need to be seen by the dentist. No other issues identified. Administrator educated the Social Worker of the expectation to offer dental services to all residents by 9/16/22. New hire social workers will have this same education during orientation. Administrator or designee will audit 5 residents per week for 12 weeks to ensure they have been offered dental services beginning 9/12/22. The Administrator will report the data obtained during the audit process to the facility Quality Assurance and Performance Improvement committee for further review and recommendations monthly for 3 months.	

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On 08/24/22 at 9:18 AM an observation and interview were conducted with Resident #81. The Resident explained that he had dental pain on and off (but not at the time of the interview) and thought his back-bottom teeth were chipping. The Resident's right back bottom tooth was noted to be black but was unable to determine if the tooth was chipped. The Resident's gums were not noted to be red or inflamed. The Resident denied having oral abscesses and stated he had no difficulty in chewing his food. When asked if he had reported these issues to anyone the Resident stated he reported them to Facility Transporter #1 when she made his dental appointment that was cancelled.

During a telephone interview the Facility Transporter #1 on 08/25/22 at 5:17 PM she explained that Resident #81's nurse (who was no longer at the facility) came to her shortly after his admission to the facility and told her that he needed a dental appointment and it took her a while to find a dentist who would accept his insurance. She continued to explain that she found a dentist and made an appointment for July 5th for the non-emergent services to transport so he could be on a stretcher but before he could go to the appointment, the dentist cancelled because they were not able to get his insurance approved in time because the Resident's brother had his insurance card. She stated she learned about the cancellation when she returned to work on July 6th and she called the dentist back to reschedule the appointment but the office told her that they could not accommodate a stretcher, therefore, she was not able to obtain a dental appointment for Resident #81 before she left her employment from the facility. The transporter stated she was

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not able to orient her replacement to the position she vacated and did not report what was left undone.

On 08/25/22 at 11:15 AM during an interview with the Social Worker (SW), she explained that she was responsible for completing the paperwork and enrolling the residents with the professionals that come to the facility such as the dentists, eye doctors and podiatrists. The SW sent Resident #81's referral to the dentist who services the facility, but the dentist would not accept the Resident's insurance but stated they would see him if the Resident agreed to pay out of pocket which would have been $165.00. The SW discussed it with Resident #81, but he chose to see a local dentist who would accept his insurance. The SW stated she informed the Director of Nursing on (who was no longer at the facility) on 04/19/22 and that was the last she had heard anything about the situation. The SW stated she did not follow up on the situation. The SW explained that Facility Transporter #1 who was referenced by Resident #81 was no longer at the facility. The SW reviewed the facility's calendar of scheduled appointments and stated she could not locate where Resident #81 had seen a dentist or was scheduled to see a dentist.

An interview was conducted with the Nurse Practitioner (NP) on 08/25/22 at 12:01 PM. The NP explained that Resident #81 had not reported any issues with his teeth nor had his appetite or weight been affected but nevertheless she stated the facility should have followed through with obtaining the Resident a dental appointment.

An interview was conducted with the Administrator and the Director of Nursing on

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F 790	Continued From page 56 08/25/22 at 2:00 PM. The Administrator explained that she was not aware of any dental issues that Resident #81 was having but that the dental appointment should have been followed up on.	F 790		
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 discard out of date food items in the dry storage area in the kitchen. The facility also failed to maintain a clean kitchen when appliances and kitchen surfaces were found to be greasy and with leftover food particles were still attached in the kitchen. These practices had the potential to affect food served to residents. The findings included:	F 812	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to ensure food stored in dry storage was not expired. The facility also failed to maintain a clean kitchen.	9/22/22

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F 812	Continued From page 57 An observation of the kitchen was made on 8/22/22 at 9:53 AM with the Day shift cook (Cook #1). The following items were observed: In the general kitchen preparation area: -Two metal food tray pans were left sitting on top of the oven with food particles attached after meal service line -Thick heavy grease buildup and food debris were visible on the fryer and in the floor surrounding the fryer -Dried food particles were noted on the shelf below the oven -Thick grease buildup and food remnants were visible on the shelf below the steam table with water running down the side of the steam table and puddling onto the floor surface -Grill was visibly greasy with a thick dark colored substance attached and food particles on the front doors. -Meat slicer with visible pink colored pieces of meat substance attached -Plate warmer with top plate containing visible dry egg particles -Side by side refrigerator were greasy and contained a sticky substance on each door -Racks below the tea picture contained a dark colored substance -The icemaker machine had an electric razor, a magnifying glass, a container of toothpicks, and a slinky on its shelf next to the ice scooper In the dry storage area: -8 boxes of unopened oatmeal which contained a use by date of 7/18/22 -A bag of flour tortillas which contained a use by	F 812	Expired food was immediately discarded. No residents were served expired food no residents had negative outcomes related to expired food in dry storage. Areas identified during survey were cleaned during survey week. No residents have had negative outcomes related to the cleanliness of the kitchen. All residents have the potential to be affected by expired food stored in the building and the cleanliness of the kitchen. Audit of all food storage areas was conducted on 8/22/22 and no other expired items were found. Deep clean of the kitchen was completed 9/15/22. Administrator or designee will educate all staff on the procedure for food storage and to discard expired products immediately. All kitchen staff will be educated on the kitchen cleaning schedule by 9/16/22. All new hired staff will have this same education prior to taking an assignment and working with residents. Administrator or designee will audit food storage areas and cleanliness of the kitchen 5 times weekly for 12 weeks beginning 9/12/22. The Administrator will report the data obtained during the audit process to the facility Quality Assurance and Performance Improvement committee for further review and recommendations monthly for 3 months.	

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F 812	Continued From page 58 date of 6/20/22 -A 4 qt plastic container of pinto beans that contained a label with a use by date of 6/12/22 An interview with the Dietician on 8/22/22 at 9:53 AM revealed all dry foods should be discarded when the item has met its use by date. She explained the Dietary Manager was not in the facility because she was having to work as the evening shift cook on 8/22/22. An interview with the Dietary Manager (DM) on 8/25/22 at 11:15 AM revealed her current staff completed essential functions of the kitchen first and then tried to complete additional tasks as time would allow, but unfortunately, recently staffing crunches had left the kitchen with some strains which decreased its potential to be fully efficient. The DM indicated the expectation would be all kitchen surfaces were cleaned and sanitized daily and expired items were discarded.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		9/22/22

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F 842	Continued From page 59	F 842		

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

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

§483.70(i)(5) The medical record must contain-

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F 842	Continued From page 60 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to ensure a resident's medication administration record (MAR) accurately reflected medications provided to the residents for 1 of 5 residents reviewed for unnecessary medications. (Resident #45) The Findings Included: Resident #45 was admitted to the facility on 02/22/22 with diagnoses that included atherosclerotic heart disease and heart failure A review of Resident #45's physician orders revealed an order dated 07/19/22 for Coreg tablet (antihypertensive) 3.125 milligrams (mg) to be given two times a day for heart failure. The medication was to be not given if Resident #45's systolic blood pressure was below 100 and or his heart rate was less than 45 and the physician should be notified. A review of Resident #45's August medication administration record revealed there to be no documentation of Resident #45 receiving his Coreg Tablet 3.125mg on 08/03/22, 08/05/22, and	F 842	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to document resident #45 Coreg medication after she administered it on 8/3/22, 8/5/22, and 8/17/22. Resident #45 still resides in the facility. The medical record was corrected on 8/24/22 by the Director of Nursing. Resident #45 has had no negative outcomes from the nurse not documenting administration of his Coreg. All resident in the facility have the ability to not have their medications documented incorrectly by staff. On 9/14/22 a 48 hour audit of all residents' medical records were complete the Director of Nursing. Any issues identified with medications not documented were immediately corrected.	

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F 842	Continued From page 61 08/17/22 at the 4:00 PM administration time. Review of staffing schedules revealed Nurse #1 was scheduled as the nurse for Resident #45 on 08/03/22, 08/05/22, and 08/17/22 at the time the 4:00PM dose of Coreg was due to be administered. During an interview with Nurse #1 on 08/24/22 at 4:19 PM, she verified she worked on 08/03/22, 08/05/22, and 08/17/22 and was assigned to Resident #45. She stated she remembered the medication as she knew she had to take Resident #45's blood pressure and heart rate before knowing whether she should have given him the medication. She reported she did not know why the medication was not signed off as being given but stated she was "pretty confident" she had given Resident #45 the Coreg Tablet 3.125mg at 4:00 PM on 08/03/22, 08/05/22, and 08/17/22. She continued, stating she most likely forgot to sign off on the medication administration record that she had given Resident #45 the Coreg tablet 3.125mg and stated she was aware she should sign off on medications once they are given to residents. During an interview with the Director of Nursing on 08/25/22 at 2:17 PM, she reported she expected nurses to sign off on the medication administration record when medication was given to ensure the MAR was an accurate representation of the medications given.	F 842	Director of Nursing or designee educated all licensed nurses and medication aides on accurate documentation of medication by 9/16/22. All newly hired licensed nurses and certified medication aides, including agency licensed nurses and certified medication aides, will have this same education prior to taking an assignment and working with residents. Director of Nursing or designee will audit 5 residents per week for 12 weeks to ensure their medications were documented as ordered in the electronic health record beginning 9/12/22. The Director of Nursing will report the data obtained during the audit process to the facility Quality Assurance and Performance Improvement committee for further review and recommendations monthly for 3 months.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow	F 919		9/22/22

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F 919	Continued From page 62 residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on record review, family, and staff interview the facility failed to ensure a call light was functioning for 1 of 3 residents reviewed for accidents (Resident #156). The findings included: Resident #156 was admitted to the facility on 06/17/22 with diagnoses that included: End Stage Renal Disease, right above knee amputation, and others. Review of a Fall Care plan initiated on 06/19/22 read in part; Resident #156 was at risk for falls related to decreased mobility, weakness, and status post right above knee amputation. The goal read; Resident #156 will have no preventable injury from falls through review period. The interventions included: call bell within reach. Review of an Admission Minimum Data Set (MDS) dated 06/23/22 revealed that Resident #156 was moderately cognitively impaired. Review of the facility schedule for 06/25/22 revealed that Nurse #4 was assigned to the unit where Resident #156 resided from 7:00 PM to 7:00 AM and NA #17 was assigned to care for Resident #156 from 7:00 PM to 7:00 AM. The schedule further revealed Nurse #5 was working	F 919	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The facility failed to provide resident #156 with a working call light. Resident #156 no longer resides in the facility. All residents have the potential for their call light to malfunction. Maintenance Director conducted an audit of all call lights in the facility ensuring their function on 6/29/22 and then again on 9/5/55. No other issues were identified. Administrator or designee educated all staff on the procedure for answering call lights and the procedure of reporting a broken call light. Staff were also educated to provide residents with an alternate form of communication if the call light is not working until it can be repaired by 9/16/22. Administrator educated department heads to monitor call light function while completing routine environmental rounds by 9/16/22. All new staff will have this	

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F 919	Continued From page 63 on the same side of the building where Resident #156 resided just on a different hall. Nurse Aide (NA) #17 was interviewed on 08/24/22 at 5:36 PM and confirmed she was working with Resident #156 on 06/25/22 at 7:00 PM to 7:00 AM on 06/26/22. She stated that when she made her third round between 2:00 AM and 3:00 AM she found Resident #156 on the floor. NA #17 stated she asked Resident #156 why he had not turned on his call light if he needed something and Resident #156 indicated that he had turned the call light on, and it was not working. NA #17 stated she pressed the call light to test it out and it was in fact not working and did not come on. NA #17 stated she did not do anything with the call bell but did let the nurse know that it was not working. Resident #156's family member was interviewed on 08/23/22 at 5:01 PM via phone. The family member stated that he came to the facility on 06/26/22 between 10:00 AM and 11:00 AM. The staff member informed him that Resident #156 had fallen out of bed on the previous shift. The family member stated he asked Resident #156 what happened, and he stated that he had fallen out of bed and laid in the floor for a couple of hours and when the staff finally came in, they had "fussed" at Resident #156 for not using his call light to call for assistance. The family member stated that Resident #156 stated that he had used his call light, but it was not working and the NA that came in also tried the call light and confirmed that it did not work. Nurse #5 was interviewed on 08/24/22 at 5:51 PM and stated she no longer worked at the facility but stated when she did work at the facility	F 919	same education prior to taking an assignment and working with residents. Administrator or designee will audit 10 call lights weekly for function for 12 weeks beginning 9/12/22.	

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approximately 2-3 months ago, she had a few call lights that did not work on the unit where Resident #156 resided but could not recall specifically which rooms. Nurse #5 stated if she was aware a call light was not working, she would go to an empty room and take the call light cord and replace the one that did not work, if that did not fix the issue Nurse #5 stated she would notify someone in the Maintenance Department. Nurse #5 stated "a few times we had to scramble to find a working call bell." She added that she had no knowledge of Resident #156's call light not working, or she would have replaced it with a working one.

Nurse #4 was interviewed on 08/24/22 at 6:07 PM and stated that had no knowledge of Resident #156 call light not working or Resident #156 falling out of bed.

The Maintenance Director was interviewed on 08/24/22 at 6:22 PM and confirmed he had worked at the facility since June 21, 2022. The Maintenance Director stated that he checked call lights 1-2 times a week by sporadically going in/out of rooms and bathrooms to ensure that call light came on and sounds at the appropriate places. When asked if he had logs of his call light checks the Maintenance Director stated, "sometimes I keep up with which rooms I check but I don't log them anywhere." He continued to say that he has had no issues with the call light system but stated he recently had 2 rooms that the call light was not working, and he replaced the cords and that fixed the issue. He indicated if there was an issue with the call light system on the weekend the staff would call him, and he would come and fix the issue. The Maintenance Director stated he was not aware that the call light

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F 919	Continued From page 65 in Resident #156's room was not working on 06/25/22, but stated he kept extra call light cords in his office if anyone needed one. The Maintenance Director stated that standard procedure for reporting an item that needed repair was the staff would complete a work order and turn into him and then he would repair the issue. He added that he did not have any work order for a call light issue for Resident #156's room. The Administrator was interviewed on 08/25/22 at 5:18 PM who stated she had been at the facility since May 2022. The Administrator stated she had no work order for call light issues and had not heard about any issues with call lights not working.	F 919		