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{F 000}	INITIAL COMMENTS An unannounced onsite revisit from 01/02/24 through 01/05/24. Tag F600 and F 607 was corrected as of 01/05/24. Repeat tags were cited. New tags were cited as a result of the recertification and complaint investigation survey that was conducted at the same time of the revisit. The facility is still out of compliance.	{F 000}		
{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 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;	{F 842}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the

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facility failed to ensure a medication administration record was accurate (Resident #51) and failed to maintain complete and accurate medical records by not documenting a resident's discharge to the community Against Medical Advice (Resident #90) and a resident's transfer to the hospital (Resident #95) for 3 of 6 sampled residents reviewed for medication pass and closed record review.

Findings included:

1. Resident #51 was admitted to the facility on 12/14/22.

An observation was conducted on 1/4/24 at 8:22 AM. MA #1 was observed signing the medication administration record that two fiber gummies were administered. The fiber gummies were not in the medication cup that MA#1 took to Resident #51.

Review of Resident #51's medication administrated record (MAR) revealed that Medication Aid (MA) #1 had signed off as giving Resident #51 two fiber gummies during a medication pass observation on 1/4/24.

During the interview on 01/04/24 at 11:14 AM with MA #1 concerning the fiber gummies, MA # 1 stated she did not mean to sign off the medication due to not having the medication available at the time of medication pass. MA stated she should not have signed off the medication until it had been given.

On 1/5/24 at 12:51 PM, an interview was conducted with the Director of Nursing stating that no medication should be signed off until

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administered to the resident.

2. Resident #90 was admitted to the facility on 10/16/23.

The discharge Minimum Data Set (MDS) assessment dated 10/21/23 indicated Resident #90 discharged to the community with return not anticipated.

Review of Resident #90's medical record revealed a scanned copy of a Discharge AMA Form dated 10/21/23 that was signed by Resident #90, his family member and Nurse #5.

Review of the staff progress notes revealed no entry on or after 10/21/23 describing the events of Resident #90 discharging to the community AMA.

Telephone attempts on 01/03/24 at 2:29 PM and 01/04/24 at 10:53 PM for an interview with Nurse #5 were unsuccessful.

During an interview on 01/04/24 at 3:57 PM, the Assistant Director of Nursing (ADON) reviewed Resident #90's medical record and confirmed there was no staff progress note detailing the events of Resident #90's discharge on 10/21/23. The ADON explained when a resident discharged from the facility, normally they completed a recapitulation (summary) of the resident's stay but one wasn't done since Resident #90 decided to leave AMA. The ADON stated Resident #90's discharge should have been documented by Nurse #5 in a staff progress note and was not sure why one wasn't done.

During an interview on 01/05/24 at 1:18 PM, the Director of Nursing stated when Resident #90

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discharged from the facility AMA on 10/21/23, she would have expected for the nurse to have documented a progress note that included details such as the reason for Resident #90's discharge, what time he left the facility, his condition at the time of discharge, and any prescriptions and/or paperwork he was provided.

3. Resident #95 was admitted to the facility on 10/24/23.

The discharge Minimum Data Set (MDS) assessment dated 11/06/23 indicated Resident #95 discharged to the hospital with return not anticipated.

Review of the staff progress notes revealed the last documented progress note was an entry dated 11/06/23 at 9:30 AM written by the Assistant Director of Nursing (ADON). The progress note read in part, Resident #95's family is reporting Resident #95 ran a low-grade temperature over the weekend of 100 degrees and are requesting a urinalysis due to discoloration of her urine and increased confusion. Resident #95 is currently on Augmentin (antibiotic medication) due to cholecystitis (inflammation of the gallbladder). The ADON noted she would inform the medical provider of the family's concerns. There was no entry indicating Resident #95 was transferred to the hospital.

During an interview on 01/05/24 at 9:24 AM, the ADON explained on 11/06/23 after she had talked with Resident #95's family and informed the medical provider of their concerns, Resident #95's family went to the Director of Nursing (DON) stating Resident #95 needed to go to the

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{F 842}	Continued From page 5 hospital and they had already called Emergency Medical Services (EMS) for transport. The ADON couldn't recall the exact time but stated EMS arrived at the facility within minutes of the family informing the DON. The ADON stated she should have documented a progress note when Resident #95 was transported to the hospital at the family's request. During an interview on 01/05/24 at 1:19 PM, the DON explained Resident #95's family called EMS on 11/06/23 to transport her to the hospital and staff were not aware until EMS arrived at the facility. The DON stated she would have expected for the nurse to have documented a progress note indicating Resident #95 was sent to the hospital via EMS at the family's request.	{F 842}		
{F 867} SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective	{F 867}		

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systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

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{F 867}	Continued From page 7 (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	{F 867}		

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assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 06/22/22, complaint investigation survey completed on 08/01/23, and the complaint investigation survey completed on 11/20/23. This was for three repeat deficiencies: one in the area of infection control originally cited on 06/22/22 during a recertification survey, one in the area of resident records-identifiable information originally cited on 06/22/22 during the recertification survey, and one in the area of residents right to self-administer medications originally cited on 08/01/23 during a complaint investigation survey. In addition, the deficiency in the area of resident records-identifiable information was recited on 11/20/23 during a complaint investigation survey. All three deficiencies were subsequently recited on 01/05/24 during the recertification, follow-up and complaint investigation survey. The continued failure of the facility during four federal

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surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

This tag is cross referenced to:

F554: Based on observations, record review, resident and staff interviews, the facility failed to assess residents to determine if self-administration of medication was clinically appropriate for a resident who wanted to self-administer over-the-counter lubricating eye drops and had a physician order indicating the eye drops may be left at bedside and a resident observed with medicated creams left on a shelf in the resident's room for 2 of 3 sampled residents (Resident #66 and #55).

During the complaint investigation of 08/01/23, the facility failed to assess the ability of a resident to self-administer medications observed with medications at bedside.

F842: Based on record review and staff interviews, the facility failed to ensure a medication administration record was accurate (Resident #51) and failed to maintain complete and accurate medical records by not documenting a resident's discharge to the community Against Medical Advice (Resident #90) and a resident's transfer to the hospital (Resident #95) for 3 of 6 sampled residents reviewed for medication pass and closed record review.

During the recertification survey of 06/22/22, the facility failed to maintain an accurate Treatment

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Administration Record (TAR) for checking the placement of a left-hand splint.

During the complaint investigation of 11/20/23, the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of vaginal cream.

F880: Based on observations, record review, and staff interviews the facility failed to implement their infection control policies and procedures when Nurse Aide (NA #3) did not handle soiled linen in a sanitary manner and did not perform hand hygiene after removing gloves for 1 of 1 room (room 114) observed for infection control.

During the recertification survey of 06/22/22, the facility failed to follow the Center of Disease Prevention and Control (CDC) recommended guidance for personal protective equipment (PPE) usage for new admission residents who were not fully vaccinated when staff members were observed entering resident rooms with signage posted that indicated Contact Droplet Precautions without the use of a gown, gloves, or an N-95 respirator mask to deliver meal trays.

During an interview on 01/05/24 at 4:43 PM, the Administrator revealed he had only been employed at the facility since the end of November 2023 and it was hard for him to say where the breakdown occurred regarding the repeat deficiencies but felt it was likely due to having an all-new nursing administration team. The Administrator explained the QA committee met monthly to discuss various topics and if needed, develop strategies to put into place for improvement. The Administrator stated the QA committee would be reviewing and discussing the

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{F 867}	Continued From page 11 areas of concern identified during the current survey and with the strong and cohesive administration team he now had, he was confident they would be able to ensure monitoring was done so that going forward, compliance was achieved and maintained.	{F 867}		