| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 02/19/24 through 02/22/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #78CT11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint survey was conducted from 02/19/24 through 02/22/24. Event ID #78CT11. The following intakes were investigated NC00208562, NC00208515, NC00208893, NC00209978, NC00210381, NC00210413, NC00211309, NC00212525, NC00213424 and NC00213727. Seven (7) of the twenty three (23) allegations resulted in deficiencies. | F 000 | | |
| F 561 SS=E | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. | F 561 | | 3/16/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/15/2024

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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| F 561 | Continued From page 1<br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, interviews with residents and staff, the facility failed to honor residents' choice to eat their meals in the main dining room (Residents #2, #21, #22, #23, #51, and #53) for 6 of 6 sampled residents.<br><br>The findings included:<br><br>During a Resident Council group interview conducted on 02/21/24 at 9:52 AM, Resident #2, Resident #21, Resident #22, Resident #23, Resident #51, and Resident #53 all stated since the new corporation took over last year, they were not given the option to eat supper in the dining room during the week or lunch and supper on the weekends and they had brought up their concern during previous Resident Council meetings, most recently last month. The residents did state that on occasion, depending on who was the manager-on-call, they were able to eat lunch in the dining room on the weekends but not supper. The residents stated they were told a staff member had to be present in the dining room during the meal and there wasn't enough staff available which was why they had to eat in their rooms. Resident #2 and Resident #22 added when they had tried to go into the dining room to | F 561 | 1 - Residents #2, #21, #22, #23, #51 and #53 were educated during a special resident council meeting on 3.8.2024.Education included the residents ability to dine all three meals in the dining room.<br><br>2- On 3.11.2024 a house audit was completed by designated staff to confirm that all alert and Oriented residents are aware that they have the right to consume their meals in the dining room or in their room at their discretion. In the instance that the resident was unaware immediate verbal education was extended.<br><br>3- Education provided to current facility nursing staff and managers on 3.15.2024. Education is ongoing for new hires and agency staff. Center leadership will assign 1 hall per day to remain in the dining room at all three meals.<br><br>4- Activity Director and / or Nurse leadership will be responsible for overseeing the dining hall audits. Audits will be 5 times a week for 4 weeks, and | |

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| F 561 | Continued From page 2<br>eat supper they were told they would have to eat in their rooms because there wasn't enough staff for someone to stay in the dining room with them in case something happened and stated they really didn't understand when staff told them that because they ate in their rooms without staff present. The residents all voiced when given the option, they preferred to eat their meals in the dining room because it was their chance to visit and socialize with other residents.<br><br>During an interview on 02/21/24 at 2:33 PM the Activity Director stated residents had not voiced any concerns during the Resident Council meetings about not getting to eat in the dining room for supper or on the weekends and if they had mentioned it as a concern, she would have documented it in the resident council minutes. The Activity Director stated she came to the facility on the weekends she was the manager-on-call and if residents wanted to eat their lunch in the dining room, she stayed in there with them. She stated she was not at the facility when supper was served and was not sure if residents were given the option to eat in the dining room if they chose.<br><br>During a telephone interview on 02/21/24 at 3:04 PM, NA #1 stated residents typically went to the dining room to eat during lunch and only went to the dining room for supper if they were alert and could propel themselves but most of the time, they ate in their rooms. NA #1 stated she thought the reason residents didn't eat supper in the dining room was because there wasn't enough staff to stay with the residents while they ate.<br><br>During an interview on 02/21/24 at 4:00 PM, Nurse Aide (NA) #7 revealed when short-staffed, | F 561 | then 3 times a week for 8 weeks across various meal times. Results of the audits will be reviewed during monthly Quality Assurance Process Improvement(QAPI). Changes will be made to the plan as needed to maintain compliance.<br><br>Date of Compliance 3.16.2024 | |

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| F 561 | Continued From page 3<br>they did not serve supper in the dining room because there was not enough staff for someone to stay in the dining room with the residents while they ate. NA #7 explained it was too hard for staff to go back and forth from the hall to the dining room to check on the residents and it wasn't safe for the residents to eat in the dining room alone.<br><br>An observation of the meal service on 02/21/24 at 5:50 PM revealed staff on the halls passing meal trays to residents in their rooms. There were no residents observed eating in the dining room.<br><br>Review of the staff schedule for 02/21/24 revealed there were 4 Nurses and 6 Nurse Aides scheduled during the hours of 6:30 AM to 6:30 PM.<br><br>During an interview on 02/22/24 at 1:57 PM, the Director of Nursing (DON) explained there was always a staff member assigned to the dining room during meals in case residents wanted to eat in the dining room. The DON stated she was unaware residents had not been able to eat in the dining room during the evening or on weekends and stated they should always have that option per their preference.<br><br>During an interview on 02/22/24 at 5:33 PM, the Administrator stated residents should have the option to eat meals in the dining room if they preferred and staff just needed reeducation reminding them that it could be done. | F 561 | | |
| F 578 SS=F | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse | F 578 | | 3/16/24 |

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| F 578 | Continued From page 4 | F 578 | | |

to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:

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Based on medical record review, staff interviews, and review of the facility's Advance Directive policy the facility failed to provide written advance directive information and/or opportunity to formulate an advance directive and also failed to ensure a residents code status election was evident and accurately documented in the medical record for 10 of 10 (Resident #7, #12, #25, #27, #50, #63, #67, #71, #73, and #84) residents reviewed for advance directive.

Findings included:

a. Resident #50 was admitted to the facility on 03/09/22.

Review of a physician order dated 12/26/23 read, Advanced care planning-goals of care refer to state form. The order did not explain where the form was kept.

Review of the quarterly Minimum Data Set (MDS) dated 01/26/24 revealed that Resident #50 was severely cognitively impaired for daily decision making and had long/short term memory problems.

A review of the facilities advanced directives book that was kept at the nursing station revealed a Medical Order for Scope of Treatment (MOST) form that indicated Resident #50 desired CPR. The form was signed by the Medical Provider.

A review of the active physician's orders revealed there was no order for Resident #50 to be a full code (desired CPR).

Resident #50's medical record was reviewed with no evidence that written information regarding

F 578

" On 3.10.2024 Advance Directive was reviewed for resident #7, #12, #25, #27, #50, #63, #67, #71, # 73, #84. It was identified that the above mentioned residents failed to have consistent Advance Directive status across multiple reference points. Resident #73, # 84, and # 63 are no longer at the center. 3.12.2024 resident #7, #12, #25, #27, #50, #67, #71. were audited and corrected.

" On 3.13.2024, the Social Worker (SW) and Minimum Data Set (MDS) nurse completed house audit of advance directives for all current residents. Any identified residents that were not in the binder have been updated in both the advance directive binder and the electronic health record. Moving forward residents will be reviewed annually and during care plan meetings to confirm advance directive.

" Education provided to current facility nursing staff and managers on 3.12. 2024. Education is ongoing for newly hired facility and agency staff. The Social Worker will be responsible for getting resident code status upon admission and will be responsible for updating code status in the binder and care planning the resident code status. Education will be ongoing and will be extended to hires and agency upon orientation.

" The Administrator will monitor five (5) residents for concurrent advance

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advance directives had been offered or discussed and no evidence of the guardian being given an opportunity to formulate an advance directive.

b. Resident #71 was admitted to the facility on 04/03/23.

Review of a physician order dated 12/26/23 read, Advanced care planning-goals of care refer to state form. The order did not explain where the form was kept.

Review of the quarterly MDS dated 01/23/24 revealed that Resident #71 was cognitively intact.

Resident #71 was interviewed on 02/19/24 at 3:28 PM who stated she could not recall any conversation she had regarding advance directives or code status since she had been in the facility. She explained they may have discussed it but again stated she could not recall.

A review of the facilities advanced directives book that was kept at the nursing station revealed a MOST form that indicated Resident #71 desired CPR. The form was signed by the Medical Provider.

A review of the active physician's orders revealed there was no order for Resident #71 to be a full code (desired CPR).

Resident #71's medical record was reviewed with no evidence that written information regarding advance directives had been offered or discussed and no evidence of the resident being given an opportunity to formulate an advance directive.

c. Resident #84 was admitted to the facility on

directives between both the binder and Electronic Health Record. Audits will be completed two (2) times weekly for 4 weeks, then one (1) time a week for 8 weeks. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance

"      Date of Compliance:  3.16.2024

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12/21/23.

Review of a physician order dated 12/26/23 read, Advanced care planning-goals of care refer to state form. The form did not explain where the form was kept.

Review of the comprehensive MDS dated 12/29/23 revealed that Resident #84 was severely cognitively impaired for daily decision making.

A review of the facilities advanced directives book that was kept at the nursing station revealed a MOST form that indicated Resident #84 desired CPR. The form was signed by the Medical Provider.

A review of the active physician's orders revealed there was no order for Resident #84 to be a full code (desired CPR).

Resident #84's medical record was reviewed with no evidence that written information regarding advance directives had been offered or discussed and no evidence of the guardian being given an opportunity to formulate an advance directive.

d. Resident #63 was admitted to the facility on 11/17/2023.

A review of the facilities advanced directives book located at the nursing station revealed a Medical Order for Scope of Treatment (MOST) form dated 12/5/2023 that indicated Resident #63 was a Do Not Resuscitate (DNR).

A review of the active physician's orders revealed there was no order for Resident #63's to be a

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DNR.

The quarterly Minimum Data Set (MDS) dated 1/24/2024 revealed Resident #63 was moderately cognitively impaired.

Resident #63's care plan dated 2/6/2024 revealed goals and interventions for cardiopulmonary resuscitation to be implemented.

Resident #63's medical record was reviewed with no evidence that advance directive information had been offered or discussed and no evidence of the resident/guardian being given an opportunity to formulate an advance directive.

e. Resident #27 was admitted to the facility on 3/8/2020.

The annual MDS dated 11/10/2023 revealed Resident #27 was moderately cognitively impaired.

Resident #27's physician's orders were reviewed and revealed an order for Cardio-pulmonary Resuscitation (CPR) had been entered on 2/20/2024.

Resident #27's care plan dated 2/20/2024 revealed goals and interventions for Do Not Resuscitate (DNR) to be implemented.

A review of the facilities advanced directives book located at the nursing station revealed Resident #27 had a MOST form dated 12/5/2023 that indicated Resident #27 was a DNR.

Resident #27's medical record was reviewed with no evidence that advance directive information

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had been offered or discussed and no evidence of the resident/guardian being given an opportunity to formulate an advance directive.

f. Resident #7 was admitted to the facility on 03/18/13.

Review of Resident #7's quarterly Minimum Data Set assessment dated 01/02/24 revealed the Resident's cognition was severely impaired.

A review of Resident #7's electronic health record (EHR) revealed an order dated 12/26/23 for Advanced Care Planning-Goals of Care: Refer to state form Medical Order for Scope of Treatment (MOST) see MOST form for additional information. The order did not explain where the MOST form would be located. There was not a MOST form or specific advanced directive on the EHR.

A review of the Advanced Directive notebook maintained at the nursing desk revealed a MOST form dated 01/23/24 that indicated Resident #7 was a Full Code, attempt Cardiopulmonary Resuscitation (CPR).

Review of Resident #7's EHR revealed the Resident had a court appointed guardian and no evidence that written information regarding advanced directives had been offered or discussed and no evidence of the guardian being given an opportunity to formulate an advanced directive.

g. Resident #12 was admitted to the facility on 12/29/23.

Review of Resident #12's admission Minimum

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Data Set assessment dated 01/05/24 revealed her cognition was moderately impaired.

A review of Resident #12's electronic health record (EHR) revealed an order dated 01/12/24 for Advanced Care Planning-Goals of Care: Refer to state form Medical Order for Scope of Treatment (MOST) see MOST for additional information. The order did not explain where the MOST form would be located. There was no order for a specific advanced directive in the EHR.

A review of the Advanced Directive notebook maintained at the nursing desk revealed Resident #12's MOST form and a Do Not Resuscitation (DNR) form dated 01/19/24.

Review of Resident #12's EHR revealed no evidence that written information regarding advanced directives had been offered or discussed and no evidence of the Resident or responsible party being given an opportunity to formulate an advanced directive.

h. Resident #25 was admitted to the facility on 11/27/23.

A review of Resident #25's significant change Minimum Data Set dated 12/22/23 revealed the Resident's cognition was moderately impaired.

A review of Resident #25's electronic health record (EHR) revealed an order dated 12/26/23 for Advanced Care Planning-Goals of Care: Refer to state form Medical Order for Scope of Treatment (MOST) see MOST form for additional information. The order did not explain where the MOST form would be located. There was no

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order for a specific advanced directive in the EHR.

A review of the Advanced Directive notebook maintained at the nursing desk revealed Resident #25's MOST form and a Do Not Resuscitate (DNR) form.

Review of Resident #25's EHR revealed no evidence that written information regarding advanced directives had been offered or discussed and no evidence of the Resident or responsible party being given an opportunity to formulate an advanced directive.

i. Resident #67 was admitted to the facility on 12/14/22.

Review of Resident #67's annual Minimum Data Set assessment dated 12/13/23 indicated the Resident was cognitively intact.

A review of Resident #67's electronic health record (EHR) dated 12/15/23 revealed a Medical Order for Scope of Treatment (MOST) form for Cardiopulmonary Resuscitation (CPR) dated 12/15/23 that was scanned in the Miscellaneous (MISC) section. There was no physician order for the advanced directive.

A review of the Advanced Directive notebook maintained at the nursing desk revealed a MOST form dated 12/15/23 which indicated Resident #67 was to receive CPR.

Review of Resident #67's EHR revealed no evidence that written information regarding advanced directives had been offered or discussed and no evidence of the Resident or

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responsible party being given an opportunity to formulate an advanced directive.

j. Resident #73 was admitted to the facility on 01/28/24.

Review of Resident #73's admission Minimum Data Set assessment dated 02/02/24 revealed the Resident's cognition was severely impaired.

A review of Resident #73's electronic health record (EHR) revealed there was no order for an advanced directive on the EHR.

A review of the Advanced Directive notebook maintained at the nursing desk revealed a Do not Resuscitate (DNR) form and Medical Order for Scope of Treatment (MOST) form dated 12/05/23 which indicated Resident #73 was not to receive Cardiopulmonary Resuscitation.

Review of Resident #73's EHR revealed no evidence that written information regarding advanced directives had been offered or discussed and no evidence of the Resident or responsible party being given an opportunity to formulate an advanced directive.

An interview was conducted on 02/20/2024 at 3:37 pm with the Social Worker (SW). The SW stated before the facility changed ownership in July 2023 the only advanced directive form used in the facility was the golden Do Not Resuscitate (DNR) form that was completed by the previous Nurse Practitioner (NP). She reported facility staff did not know how to fill out the MOST forms and were uncomfortable using them. Previously, an order for the resident's code status was entered in the electronic health record (EHR), the golden

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DNR form was scanned into the EHR, the code status was visible on the EHR banner, and the paper copy was in the advanced directives book at the nurse's station. She reported one change that was made by administrative staff after the change of ownership was to shred all golden DNR forms, staff were instructed to remove code status information from the EHR and utilize MOST forms only which were not scanned into the resident's EHR, only kept in a book at the nurse's station. She reported that now on admission, the Unit Manager/Admissions Nurse/Hall Nurse was responsible for completing the MOST form with the resident and/or resident representative. The SW stated that the "MOST form initiative at the facility had fallen through the cracks because no one wanted to take ownership and responsibility for the process."

An interview was conducted on 02/20/2024 at 9:46 pm with Nurse #1. She reported the Corporate Nurse had told the facility staff not to use the golden DNR forms anymore and to only utilize the MOST forms. She was instructed by the Corporate Nurse to place a physician's order for advanced care planning, stating to refer to the MOST form in the EHR and to complete a MOST form for all residents in the facility. She verbalized that when the previous code status orders were removed from the EHR, it removed the code status from the profile and banner in the EHR as well. She reported the only way to currently identify a resident's code status was to physically look in the advanced directives book at the nurse's station. Nurse #1 stated she did not feel comfortable with the new process and verbalized that to the Director of Nursing (DON). She stated that DON got clarification again from the Corporate Nurse and confirmed that was the

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| F 578 | Continued From page 14 process that was to be implemented, so Nurse #1 stated she did as she was instructed. Nurse #1 was unaware that Resident #63 code status was documented incorrectly on the care plan and Resident #27's code status was documented incorrectly under orders in the EHR.<br><br>An interview was conducted on 02/22/2024 at 12:13 pm with the Corporate Nurse. She reported that when the new corporation took over, the facility was not using MOST forms and only utilized the golden DNR forms. The new administrative staff implemented the use of the MOST forms in December of 2023. She reported that when a resident was admitted, the admission nurse or hall nurse went over the MOST form with the resident or the resident representative, the provider signed the form, the family signed the form, the form was scanned into the EHR, and then the paper copy of the MOST form was placed in the advanced directives book at the nurse's station. The Corporate Nurse discussed she did not feel comfortable with code status information being entered into the EHR because of possibility of discrepancies. She indicated Nurse #1 was responsible for entering the code status in the EHR after the MOST form was completed. The Corporate Nurse verbalized that there had been confusion with Nurse #1, and she had misunderstood the instructions which were to complete the MOST form and enter an order for code status in the EHR. The Corporate Nurse was unaware that Resident #63's code status was documented incorrectly on the care plan and Resident #27's code status was documented incorrectly under orders in the EHR. She reported that there should be an order in the EHR that indicated if the resident was a full code or DNR and the MOST form should be scanned in to the | F 578 | | |

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EHR.

An interview was conducted on 02/22/2024 at 12:45 pm with the Director of Nursing (DON). The DON reported that advanced directives were not scanned into the EHR, should not be on the banner of the EHR, and an order should be entered into the EHR that instructed the staff to refer to the MOST form. The DON explained this was directed by the Corporate Nurse. She stated that Nurse #1 who was asked to remove all code status information from the medical record had expressed to her that she did not feel comfortable doing what was asked of her. The DON stated she again spoke to the Corporate Nurse and verified what the process was and relayed that information back to Nurse #1. She reported during a meeting on 02/13/2024, she was instructed to enter advanced directive orders as DNR or CPR and had not gotten around to getting all those orders re-entered into the EHR.

An interview was conducted on 02/22/2024 at 5:07 pm with the Administrator. She reported that it was the expectation that all advanced directive records matched in the EHR, care plan, and in the advanced directives book at the nurse's station.

F 622 SS=D — Transfer and Discharge Requirements
CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)

F 622 — Completion date: 3/16/24

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs

F 622

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cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this

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| F 622 | Continued From page 17 | F 622 | | |

section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:

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Based on record review, Guardian and staff interviews, the facility failed to provide written documentation which stated the reason the facility could not meet the resident's needs for 1 of 1 sampled resident (Resident #139).

The findings included:

Resident #139 was admitted to the facility on 01/30/17 with multiple diagnoses that included dementia unspecified severity without behavioral disturbance, bipolar disorder, persistent mood disorder, anxiety disorder, and paranoid schizophrenia.

A care plan initiated on 09/01/23 indicated Resident #139 exhibits or has the potential to demonstrate verbal behaviors related to poor impulse control and at times, told untrue stories about his care, about staff members and had paranoid thoughts. Interventions included to monitor medical conditions that may contribute to verbal behaviors, evaluate the nature and circumstances of the verbal behavior, and gently remove the resident from the environment while speaking in a calm, reassuring voice.

The quarterly Minimum Data Set (MDS) dated 09/15/23 assessed Resident #139 with intact cognition and displaying no psychosis or behaviors, such as physical or verbal aggression, during the MDS assessment period. Resident #139 required setup or clean up assistance with eating, oral hygiene, and toileting hygiene, partial to moderate assistance with bathing/showering, and supervision with upper and lower body dressing and putting on/taking off footwear. He was independent with bed mobility, transfers and walking.

F 622

1- Resident #139 has since been discharged from the center. No corrective action can be taken for this resident.

2- All current residents with an active 30-day discharge have the potential to be impacted by this deficient practice. Audit of all current 30-day discharges have been reviewed to determine if a formal appeal has been filed and if applicable clear documentation as to why other residents are at risk of being endangered.

3- Education was conducted with Social Worker and DON on 3.11.2024 by the Administrator about the discharge process / transfer requirements as related to 30-day discharge. Check list will need to be completed to ensure all elements of proposed 30- day discharge has been met prior to the resident being transferred / discharged from the center.

4- Administrator to monitor proposed 30 day discharge to ensure criteria has been met 1 time a week for 12 weeks. Results of audits will tracked and trended and be reviewed during monthly Quality Assurance Process Improvement any changes will be made to the plan as necessary to maintain compliance.

Date of Compliance: 3.16.2024

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| F 622 | Continued From page 19<br><br>A staff progress note dated 10/25/23 at 8:40 AM written by the Administrator read in part, received notice of an event that took place at 6:15 AM which included the police being called by another resident on Resident #139. Upon coming to the facility, Resident #139 became confrontational with staff and began to try and assert dominance by slamming his walker toward the staff member and yelling. Resident #139 continued to escalate. Crisis hotline has been notified to have someone evaluate for a possible Involuntary Commitment (IVC) due to behaviors and non-compliance with medication.<br><br>A staff progress note dated 10/25/23 at 09:42 AM written by the Director of Nursing (DON) read in part, mental health consultant enroute and should arrive within the hour to evaluate Resident #139. Resident #139 calm at this time, in his room talking with another resident.<br><br>A staff progress note dated 10/25/23 at 7:14 PM read in part, Resident #139 was observed screaming and yelling at the DON today and difficult to redirect. Resident #139 was sent to the hospital for an evaluation.<br><br>The discharge MDS dated 10/25/23 for Resident #139 was coded as "return not anticipated."<br><br>Review of a Nursing Home Notice of Transfer/Discharge form dated 10/31/23 and signed by the Administrator on 11/01/23 revealed the date of the discharge was 10/25/23, date of IVC. The reasons for the discharge were marked as "it is necessary for your welfare and your needs cannot be met in this facility" and "the safety of individuals in this facility is endangered | F 622 | | |

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due to the clinical or behavioral status of the resident." The location of the transfer/discharge was noted as the hospital.

Review of Resident #139's medical record revealed no documentation of a physician's statement describing the specific needs and behaviors that could not be managed or met at the facility, facility efforts to meet those needs and specific services the receiving facility would provide to meet the needs of Resident #139.

During a telephone interview on 02/22/24 at 1:26 PM, Resident #139's Guardian revealed he received a discharge notice from the facility several days after Resident #139 was admitted for a psychiatric evaluation and although he would have preferred for Resident #139 to have been able to return to the facility after his psychiatric stay because it had been his home for the past 6 to 7 years, he did not appeal the discharge notice. The Guardian stated it took several months for the psychiatric hospital to get Resident #139 stabilized and when he was ready for discharge, placement was found at an Assisted Living Facility. During the telephone converstation, the Guardian voiced no concerns with Resident #139 being discharged to an Assisted Living Facility.

During an interview on 02/22/24 at 11:57 AM, the Social Worker (SW) revealed prior to Resident #139's behaviors escalating to the point an IVC was needed, he had been relatively stable and really didn't need a skilled level of care. The SW stated she had sent several referrals to various Assisted Living Facilities as well as Group Homes but had not received any bed offers.

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| F 622 | Continued From page 21<br>During interviews on 02/21/24 at 3:05 PM and 02/22/24 at 5:33 PM, the Administrator revealed she had started at the facility the first of October 2023 and she was not really sure of the history regarding Resident #139's behaviors but was told by staff that Resident #139 would become disgruntled, yell, refuse care, and was non-complaint with taking his medications. In addition, she stated other residents had voiced complaints about Resident #139's behaviors. The Administrator stated they tried to manage Resident #139's behaviors and he was being seen by psych services. She explained on 10/25/23 when Resident #139's behaviors escalated, the mental health crisis hotline was contacted and a consultant came to the facility to evaluate Resident #139 who felt Resident #139 had a need for an IVC and Resident #139 left cooperatively with police to the hospital. She stated a 30-day discharge notice was sent to Resident #139's Guardian because Resident #139's behaviors put other residents at risk of harm and she had to consider the safety of the other residents in the building. The Administrator could not provide an answer as to what needs the facility could not meet once Resident #139 was stabilized at the hospital but did state the hospital was able to do more for residents with mental health issues than the facility. She stated the process for sending Resident #139 out to the hospital for an IVC went very smoothly and felt it was what was needed for his safety as well as the safety of the other residents.<br><br>A telephone attempt on 02/22/24 at 6:02 PM to speak with the facility's Medical Director was unsuccessful. | F 622 | | |
| F 641 SS=D | Accuracy of Assessments | F 641 | | 3/16/24 |

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| F 641 | Continued From page 22<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to accurately code an attempted gradual dose reduction of an antipsychotic medication and failed to code a level 2 PASARR (preadmission screening and resident review) for 1 of 5 residents reviewed for unnecessary medications (Resident #2) and 1 of 2 residents reviewed for PASARR (Resident #61).<br><br>The findings included:<br><br>1. Resident #2 was admitted to the facility on 10/16/22 with diagnoses that included schizoaffective disorder, bipolar disorder, and major depressive disorder.<br><br>Review of Resident #2's physician orders revealed the following physician orders: Aripiprazole 2 milligram tablet - give one half tablet by mouth one time a day for schizophrenia, with a start date of 06/07/23 and a discontinue date of 12/22/23.<br><br>Review of Resident #2's pharmacy recommendations revealed a recommendation dated 12/18/23 that indicated Resident #2 was due for a gradual dose reduction for Aripiprazole 1 milligram started on 06/07/23. Per the recommendation, the physician agreed and stated to write a new order which reflected the reduction. This resulted in Resident #2's Aripiprazole being discontinued on 12/22/23. | F 641 | 1- Assessment coding for residents #2 and # 61 were both corrected by 2.22.2024 by the onsite Minimum Data Set Nurse.<br><br>2- All residents have the potential to be affected by this deficient practice. Third Party Minimum Data Set Consultant Nurse completed house audit on 3.13.2024 for all assessments completed within the last 30 days to ensure that gradual dose reductions (GDRs) and Level PASARR. Any corrections will be addressed and submitted.<br><br>3- Education was conducted by Third Party Minimum Data Set Consultant Nurse with the center's Minimum Data Set Nurse (MDS) on 3.11.2024 for accurate completion of assessments as related to capturing GDR and Level II PASARR. During Assessment lookback MDS will coordinate with DON and SW to confirm that all GDR and PASARR is captured in the assessment. Education completed on 3.15.2024 with Clinical Leadership and Social Worker on how to communicate changes on 3.15.2024. Education will be ongoing for new hires into the clinical leadership team or social worker during orientation. | |

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Further review of Resident #2's physician orders revealed an order for Aripiprazole oral tablet - give 1 milligram by mouth at bedtime for schizophrenia, with a start date of 01/05/24.

Review of Resident #2's quarterly Minimum Data Set assessment dated 01/12/24 revealed Resident #2 had received antipsychotics on a routine basis, a gradual dose reduction had not been attempted, and a gradual dose reduction had not been clinically contraindicated.

During an interview with MDS Nurse #1 on 02/22/24 at 10:56 AM revealed she had completed Resident #2's quarterly Minimum Data Set assessment dated 01/12/24. She indicated she typically is made aware of changes in resident medications but for some reason, she was not made aware of Resident #2's gradual dose reduction. She reported she would immediately complete a modification to accurately reflect Resident #2's attempted gradual dose reduction of her Aripiprazole.

During an interview with the Director of Nursing on 02/22/24 at 2:13 PM she reported she expected Minimum Data Set assessments to be completed accurately. She reported the gradual dose reduction the facility attempted in December 2023 should have been caught and coded on Resident #2's quarterly assessment completed on 01/12/24.

2. Resident #61 was admitted to the facility on 03/21/22 with diagnoses that included schizophrenia and post traumatic stress disorder.

A review of Resident #61's medical record

F 641

4- Director of Nursing (DON) / Third Party Minimum Date Set Consultant Nurse will audit 3 assessments per week for 4 weeks to ensure accurate coding of the PASARR and GDR. Audits will then be reduced to 1 assessments per week for 8 weeks Results of audits will tracked and trended and be reviewed during monthly Quality Assurance Process Improvement any changes will be made to the plan as necessary to maintain compliance.

Date of Compliance 3.16.2024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 641 | Continued From page 24<br>revealed a Level II Preadmission Screening and Resident Review (PASRR) Determination Notification letter dated 04/11/22 which indicated that Resident #61 had a Level II PASRR number ending in a "B" which was indicative of a PASRR Level II determination with no limitation on the timeframe.<br><br>Resident #61's annual Minimum Data Set (MDS) assessment dated 12/29/23 revealed the Identification Information section of the MDS assessment did not report the Resident had a PASRR Level II determination.<br><br>An interview was conducted with the MDS Nurse on 02/21/24 at 5:07 PM. The Nurse confirmed that she completed Resident #61's 12/29/23 annual MDS assessment and acknowledged that the MDS was coded as No for the Level II determination assessment. The MDS Nurse stated that she was aware Resident #61 had a Level II PASRR and that it was a mistake that she coded the assessment wrong.<br><br>On 02/22/24 at 12:25 PM during an interview with the Director of Nursing (DON) she indicated that she was aware Resident #61 had a Level II PASRR and stated she expected the MDS assessment to accurately reflect the Level II PASRR.<br><br>An interview was conducted with the Administrator on 02/22/24 at 1:04 PM who stated her expectation was for the MDS assessments to be coded correctly. | F 641 | | |
| F 644 SS=B | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2) | F 644 | | 3/16/24 |

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F 644

Continued From page 25

§483.20(e) Coordination.
A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on record review, and resident and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASARR) for a resident with a change in condition regarding his depression for 1 of 1 resident reviewed for PASARR (Resident #19).

The findings included:

Resident #19 was admitted to the facility on 05/20/15 with diagnoses that included major depressive disorder, anxiety disorder, and bipolar disorder.

Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated 12/22/23 revealed he had moderate cognitive impairment. No moods or behaviors were noted.

F 644

1- PASARR Level II for resident #19 was corrected on 2.21.2024. On-site assessment has been completed and effective 2.29.2024 resident is now a Level II.

2- All resident with the proper psych diagnosis has the risk of impacted. House audit was completed by 3.15.2024 and any resident identified as not having a level II PASARR will be submitted for review. Social Worker (SW) has now been added to the email list from the psych provider to ensure that she has direct access to the progress notes from psych, and any behaviors new or unusual will be discussed in morning meeting.

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F 644 Continued From page 26

Review of Resident #19's psychological progress notes written by the psychological physician revealed the following note dated 12/27/23: "Admits to daily depression today without thoughts of self-harm or suicide. Admits to increased sleep during the day and decreased at night. Discussed trial of low dose [sertraline] for depression/anxiety and sleep control but he denies, stating that he doesn't like medication. He would benefit from psychotherapy when available. Staff report no concerns. Will continue to monitor mood."

An interview with Resident #19 on 02/19/24 at 11:14 AM, revealed he felt depressed, and had not seen anyone for his depression, nor was taking any medications but stated he would like to speak with someone.

During an interview with the Social Worker #1 on 12/21/24 at 4:45 PM, she reported Resident #19 received psychological services and was seen by the psych physician. She also stated the psych notes written by the physician were reviewed by the Unit Manager and she should relay important information regarding a change in condition to her. Social Worker #1 explained she was responsible for requesting PASARR reviews but reported if she was not made aware of any significant changes or new diagnoses, she would not know to request a review. Social Worker #1 indicated she would have liked to have been made aware of what was in the psych physician's progress note and would have considered it a change in condition when Resident #19 reported having depressive symptoms.

An interview with Unit Manager #1 on 02/22/24 at

F 644

3- Regional Consultant completed education with the Social Worker (SW) on 3.12.2024 for completing a level II PASARR and what warrants a level II PASARR. Education will be ongoing for any newly hired administrative staff upon during orientation.

4- Minimum Data Set (MDS) nurse / designee will be responsible for monitoring compliance by reviewing 2 residents per week for 4 weeks then reduce it to 1 resident per week for 8 weeks. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain compliance.

Date of compliance: 3.16.2024

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| F 644 | Continued From page 27<br>09:03 AM, revealed she received psych progress notes from the physician via email. She stated she printed copies of the notes and sent a copy to MDS Nurse #1 for review of new diagnoses. She indicated she did not provide copies of the notes to the social worker.<br><br>During an interview with MDS Nurse #1 on 02/22/24 at 10:56 AM, she indicated she sometimes received psych notes from Unit Manager #1 and stated she only looked for new diagnoses or medications.<br><br>During an interview with the Administrator on 02/22/24 at 5:17 PM, she reported that psych notes should be reviewed by the unit manager and any new diagnoses, medications, or recommendations should be discussed during their morning meetings. She indicated that Resident #19 should have been referred for a PASARR review after the psych provider reported a change in his condition and recommended psychotherapy. | F 644 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain | F 656 | | 3/16/24 |

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| F 656 | Continued From page 28<br>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to develop a care plan in the area of Level II Preadmission Screening and Resident Review (PASRR) (Resident #61) and failed to implement the care | F 656 | 1- Care plan for resident #61 was corrected on 2.21.24 by Minimum Data Set nurse to reflect Level II PASARR. Implementation and monitoring of the application of the hand splint for resident | |

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F 656

Continued From page 29

plan in the area of range of motion (Resident #50) for 2 of 31 residents reviewed for care planning.

The findings included:

1. Resident #61 was admitted to the facility on 03/21/22 with diagnoses that included schizophrenia and post traumatic stress disorder.

A review of Resident #61's medical record revealed a Level II PASRR Determination Notification letter dated 04/11/22 which indicated that Resident #61 had a Level II PASRR number ending in a "B" which was indicative of a PASRR Level II determination with no limitation on the timeframe. The results of the determination of a Level II PASRR were used for formulating a determination of need, an appropriate care setting and a set of recommendations for services to help develop Resident #61's care plan.

A review of Resident #61's care plan last revised on 01/10/24 revealed there was no care plan developed for the Resident's Level II PASRR status.

An interview was conducted with the MDS Nurse on 02/21/24 at 5:07 PM. The Nurse confirmed that she revised Resident #61's care plan dated 01/10/24 and acknowledged that she did not formulate a care plan for the Resident's Level II PASRR status. The MDS Nurse stated that she was aware Resident #61 had a Level II PASRR and that it was a mistake that she did not develop the care plan.

On 02/22/24 at 12:25 PM during an interview with the Director of Nursing (DON) she stated that it

F 656

#50 has been corrected and managed by our Director of Rehab effective 2.21.2024. Splinting has been added to the Nurse Aid task list.

2- All residents have the potential to be impacted by this deficient practice. House audit completed on 3.15.2024 by Social Worker to ensure all PASARRs have been added to the care plan. The Director of Nursing (DON) or nurse designee will be responsible for ensuring splinting is added to the Nurse Aid task list.

3- Education was conducted by Director of Nursing or Staff Development Nurse with all clinical staff (therapy and nursing) about the requirement including the PASARR into the comprehensive care plan and implementation splinting as directed by the care plan and adding it the task list for Nurse Aid staff. Education with current staff to be completed by 3.15.2024. Education will be ongoing for new hire and agency.

4- DON / Nurse designee will be responsible for auditing assessments 3 times a week for 12 weeks. Results of audits will be reviewed during monthly Quality Assurance Process Improvement and changes will be made to the plan as necessary to maintain compliance.

Date of compliance: 3.16.2024

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| F 656 | Continued From page 30 | F 656 | | |

was her expectation for the MDS Nurse to formulate care plans for the residents that had Level II PASRRs.

An interview was conducted with the Administrator on 02/22/24 at 1:04 PM who stated her expectation was for the Resident's with a Level II PASRR status have care plans to address their status.

2. Resident #50 was admitted to the facility on 03/09/22 and readmitted to the facility on 09/14/23 with diagnoses that included hemiplegia.

Review of an active care plan revised on 11/17/22 read, Resident #50 requires assistance with activity of daily living care related to vascular dementia. The interventions listed included right resting hand splint may wear up to 8 hours per day.

Review of the quarterly Minimum Data Set dated 01/26/24 revealed that Resident #50 was severely cognitively impaired for daily decision making and had no behaviors or rejection of care. Resident #50 required limited to extensive assistance with activities of daily living and received no restorative splinting assistance.

An observation of Resident #50 was made on 02/19/24 at 11:14 AM. Resident #50 was resting in bed on his right side. There was no hand splint in place to either hand. On Resident #50's nightstand next to his bed there was a hand splint that was not in use.

An observation of Resident #50 was made on 02/20/24 at 9:27 AM. Resident #50 was resting in bed on his back. There was no hand split in place

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| F 656 | Continued From page 31 | F 656 | | |

to either hand. On Resident #50's nightstand next to his bed there was a hand splint that was not in use.

An observation of Resident #50 was made on 02/21/24 at 12:47 PM. Resident #50 was resting in bed on his back. There was no hand split in place to either hand. On Resident #50's nightstand next to his bed there was a hand splint in place that was not in use.

Nurse Aide (NA) #1 was interviewed via phone on 02/21/24 at 3:04 PM and confirmed that she had worked with Resident #50 on 02/19/24 and 02/20/24. She stated that Resident #50 had a hand splint that she thought he wore on his left hand, and it was put on during the day by either the NAs or the rehab staff and then they were supposed to take it off before they left for the day. NA #1 confirmed that NA #50 had not worn his splint this week which "was my fault, it probably slipped my mind." NA #1explained, that they had been really short staffed this week and "I have been trying to the best that I can do."

The Rehab Director was interviewed on 02/21/24 at 10:28 AM. The Rehab Director stated that the Occupational Therapist (OT) had recently worked with Resident #50, and he recently came off caseload on 02/19/24 and the plan was for him to wear his right-hand splint per his functional maintenance plan and plan of care. The Rehab Director added that Resident #50 was tolerating his right-hand splint 8 hours during the day but not at night.

Nurse #2 was interviewed on 02/21/24 at 12:20 PM who confirmed that she worked with Resident #50 on 02/19/24, 02/20/24, and 02/21/24 and was

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| F 656 | Continued From page 32<br>not aware of any splints that he was supposed to wear.<br><br>The DON was interviewed on 02/22/24 at 1:04 PM and stated that splints were a great tool, but we need to revamp the process and figure out why it was not working and correct it. The DON stated we verbally tell the staff about the splints, but we are not tracking that they are actually doing it. The DON stated she would expect the staff to apply the splint as directed by the care plan. | F 656 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to provide a shower, shave, clean, and trim a dependent resident's fingernails for 1 of 7 residents reviewed for activities of daily living (ADL) (Resident #63).<br><br>Findings included:<br><br>Resident #63 was admitted to the facility on 11/17/2023 with diagnoses which included muscle weakness and unsteadiness on feet.<br><br>The quarterly Minimum Data Set (MDS) dated 1/24/2024 revealed Resident #63 was moderately cognitively impaired and was totally dependent for toileting, showering, bathing, and personal hygiene. | F 677 | 1- Resident #63 was identified on 2.20.204 as having been bathed/showered provided by night shift on 2.19.2024. Upon observation it was identified that the resident appeared with facial hair and unclean hair. Resident was bathed and cleaned up on 2.20.24.<br><br>2- All resident have the potential of being affected by this practice. House audit was completed by Interdisciplinary Team for current residents. Any resident who appeared unclean was offered a shower on 2.20.2024.<br><br>3- Education provided to all current Nurse Aids, Licensed Practical Nurse, and | 3/16/24 |

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Resident #63's care plan dated 2/6/2024 revealed goals and interventions for ADL care which included substantial assistance for grooming and personal hygiene.

A record review for Resident #63 revealed he was scheduled for showers two times per week on Monday and Wednesday nights. The last documented shower was on 1/22/2024.

A review of Resident #63's shower sheet dated 2/19/2024 indicated that Resident #63 had received a shower, shave, and nail trimming by Nurse Aide (NA) #2 on night shift and was signed by Nurse #1.

An interview was conducted on 2/20/2024 at 4:49 pm with NA #2. NA #2 stated she worked full-time on night shift (7:00 pm to 7:00 am). She reported that she had been assigned to give Resident #63 a shower on 2/19/2024 and verbalized that she had given him a bed bath instead of a shower and changed his linens because he was sleepy. NA #2 stated that she had not washed Resident #63's hair, trimmed his nails, or shaved his facial hair. She reported that she was not able to complete his ADL care because the facility was short staffed and at the time there was only 2 NAs for 3 units which was approximately 60 residents.

An interview was conducted on 2/20/2024 at 9:46 pm with Nurse #1. She reported it was the responsibility of the NAs to check the shower book to identify which residents were scheduled to receive a shower. She reported the NAs then completed the showers and shower sheets, and then she reviewed the shower sheet and signed

F 677

Registered Nurse home staff and agency. Education included providing care on resident schedule shower days and documenting that care in Point of Care as well as the shower sheet. Current staff to be educated by 3.15.2024. Education will be ongoing for any new hires or agency staff.

4- Director of Nursing (DON) / Designee will review Point of Care documentation, shower sheet documentation and interview the resident for a total of 5 residents 5 times a week for 6 weeks. Then 5 resident for 2 times a week for 6 weeks. Any identified missed shower will require immediate action. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain compliance.

Date of compliance: 3.16.2024

F 677

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F 677

off that it was completed. Nurse #1 verbalized she had signed Resident #63's shower sheet on 2/19/2024, but because there was a heavy workload, she did not have time to go room to room to ensure showers had been completed. Nurse #1 reported she had witnessed NA #2 get a basin to set up for a bed bath and had felt certain she had completed a bed bath but had not looked at Resident #63 afterwards to verify that his hair had been wash, his fingernails cleaned and trimmed, or that he had been shaved.

An observation and interview with Resident #63 was conducted on 2/19/2024 at 10:52 am. Resident #63 was observed to have quarter inch long fingernails over the tip of the finger with a brown substance noted under all ten fingernails on both hands. His facial hair, including mustache and beard, were observed to be a quarter inch long. Resident #63 was only able to verbalize he needed to be shaved. His hair appeared oily, and he was wearing a white t-shirt stained with a brown liquid. No odors were noted.

An observation of Resident #63 was made on 02/19/24 at 5:01 pm revealed Resident #63 resting in bed with his eyes closed. He remained unkempt, dressed in a white T-shirt that was stained with a brown liquid, his fingernails were a quarter inch over the tip of the finger with a brown substance noted underneath. Resident #63's facial hair, including mustache and beard, were observed to be a quarter inch long and his hair appeared oily.

An observation was conducted on 2/20/2024 at 9:24 am. Resident #63's fingernails remained a quarter inch long over the tip of the finger with a brown substance underneath. His facial hair was

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| F 677 | Continued From page 35<br>observed to be a quarter inch long. Resident #63 was noted to have on a gown and his hair continued to appear oily.<br><br>On 2/20/2024 at 4:17 pm the shower schedule was reviewed with the Director of Nursing (DON) and she was asked to observe Resident #63. She confirmed that the resident had not had his nails trimmed, had not been shaved, and that his hair was dirty and had not been washed. She was unaware of the last time Resident #63 received a shower and reported it was the NAs responsibility to check the shower book to see which residents they were assigned and to complete a shower sheet after care was completed. The DON stated the Nurse was supposed to verify a shower was given and then sign the shower sheet. She reported she would get someone to shower and shave Resident #63.<br><br>A follow up interview was conducted with the DON on 02/22/24 at 12:45 pm who stated that she expected the staff to complete their assigned showers/bed baths and that included cleaning and trimming fingernails, shaving the resident, washing their hair, and providing clean linens. She further stated she did not understand why the staff were attempting to give showers between 6:30 pm and 10:00 pm when there were just the 2 NAs on the 3 units. The DON explained to the oncoming NAs that additional help was set to come in later on the shift around 10:00 PM and that would have been the preferred time to complete the shower and care that was needed for Resident #63. | F 677 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3) | F 688 | | 3/16/24 |

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| F 688 | Continued From page 36<br>§483.25(c) Mobility.<br>§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<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to apply a resting hand splint as directed by the functional maintenance program for 1 of 2 residents reviewed for range of motion (Resident #50).<br><br>The findings included:<br><br>Resident #50 was admitted to the facility on 03/09/22 and readmitted to the facility on 09/14/23 with diagnosis that included hemiplegia.<br><br>Review of an active care plan revised on 11/17/22 read, Resident #50 requires assistance with activity of daily living care related to vascular dementia. The interventions listed included right resting hand splint may wear up to 8 hours per day. | F 688 | 1- Resident # 50 was identified as not having a splint in place as directed in the care plan. Director of Rehab (DOR) implemented the use of splint on 2.21.2024. Splinting has been added to the task list for Nurse Aids.<br><br>2- All residents have the potential to be at risk of this deficient practice. House audit has been completed by DOR by 3.15.2024 for all resident who require the use of a splint.<br><br>3- Education provided to all current clinical home staff and agency. Education included application of the splint and documentation of the splint as indicated on the task list and care plan. Current | |

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Review of the quarterly Minimum Data Set dated 01/26/24 revealed that Resident #50 was severely cognitively impaired for daily decision making and had no behaviors or rejection of care. Resident #50 required limited to extensive assistance with activities of daily living and received no restorative splinting assistance.

Review of a functional maintenance program dated 01/22/24 through 02/19/24 and written by the Occupational Therapist. The program read, wash and dry patient's right hand, inspect skin for changes, report changes to nursing staff and rehab. Perform gentle Passive Range of Motion (PROM) to right hand and upper extremity all planes as tolerated by patient. Apply right hand orthotic (resting hand splint) x 8 hours a day. Remove right hand orthotic and inspect skin for any changes, report changes to nursing staff and rehab. The form contained the following: By signing below I attest that I have been trained on above Functional Maintenance Program and fully understand how to perform it after the patient is discharged from rehab. Nurse Aide (NA) #1 signed the form on 02/12/24.

An observation of Resident #50 was made on 02/19/24 at 11:14 AM. Resident #50 was resting in bed on his right side. There was no hand splint in place to either hand. On Resident #50's nightstand next to his bed there was a hand splint that was not in use.

An observation of Resident #50 was made on 02/20/24 at 9:27 AM. Resident #50 was resting in bed on his back. There was no hand split in place to either hand. On Resident #50's nightstand next to his bed there was a hand splint that was not in use.

F 688

staff to be educated by 3.15.2024. Education will be ongoing to include new hires and agency. Center has appointed a nurse aids who will be assigned to ensuring that the splinting is in place.

4- Director of Nursing/ Nurse Designee will review Point of Care documentation / splint log for a total 3 residents 5 times a week for 4 weeks. Then 3 resident for 2 times a week for 8 weeks Results of audits will tracked and trended and be reviewed during monthly Quality Assurance Process Improvement any changes will be made to the plan as necessary to maintain compliance.

Date of Compliance 3.16.2024

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| F 688 | | F 688 | | |

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An observation of Resident #50 was made on 02/21/24 at 12:47 PM. Resident #50 was resting in bed on his back. There was no hand split in place to either hand. On Resident #50's nightstand next to his bed there was a hand splint in place that was not in use.

NA #1 was interviewed via phone on 02/21/24 at 3:04 PM and confirmed that she had worked with Resident #50 on 02/19/24 and 02/20/24. She stated that Resident #50 had a hand splint that she thought he wore on his left hand, and it was put on during the day by either the NAs or the rehab staff and then we were supposed to take them off before we leave for the day. NA #1 confirmed that NA #50 had not worn his splint this week which "was my fault, it probably slipped my mind." NA #1explained, that they had been really short staffed this week and "I have been trying to the best that I can do." She explained that she generally worked the 100 unit (where Resident #50 resided) by herself and there was a lot of things that she just did not have time to complete. She added that one of the other NAs would be assigned the 200 hall and would generally have the top few rooms on the 100 hall but that really did not give her a lot of assistance because that NA spent the majority of their time on the 200-hall tending to those residents.

Nurse #2 was interviewed on 02/21/24 at 12:20 PM who confirmed that she worked with Resident #50 on 02/19/24, 02/20/24, and 02/21/24 and was not aware of any splints that he was supposed to wear.

The OT was interviewed on 02/22/24 at 11:26 AM who stated that when Resident #50 returned from

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| F 688 | Continued From page 39<br>the hospital in September 2023 her knowledge he was still wearing his resting hand splint. The OT stated that the splint application should never have been stopped, or it should have been re-initiated when he returned from the hospital. The OT stated in January 2024 she had a nursing referral indicating his splint had not been applied and wanted OT to re-evaluate the need for it. She further explained that Resident #50 had no increase in his contracture that only affected 1-2 fingers on his right hand, and he was easily able to tolerate the hand splint up to 8 hours during the day. The OT also explained the splint protected Resident #50's hand from bumping it on things when he was moving in the bed, or when the staff were moving him in bed or from one surface to another. The OT explained that she had developed the functional maintenance program for Resident #50, educated the staff, and then given the plan to the Director of Nursing for implementation via the nursing staff.<br><br>The Rehab Director was interviewed on 02/21/24 at 10:28 AM. The Rehab Director stated that the Occupational Therapist (OT) had recently worked with Resident #50, and he recently came off caseload on 02/19/24 and the plan was for him to wear his right-hand splint per his functional maintenance plan. She said that she had discussed with the OT the need to revamp the splinting program at the facility. The Rehab Director stated that she felt one way that she could increase compliance was to ensure that that each splint had a physician order so that the nurses would have a part in making sure that the splints were in place as ordered. The Rehab Director added that Resident #50 was tolerating his right-hand splint 8 hours but not at night and that is why she felt like revamping the system and | F 688 | | |

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| F 688 | Continued From page 40<br>obtaining physician orders would definitely increase compliance with splints in the building.<br><br>The DON was interviewed on 02/22/24 at 1:04 PM who stated that splints were a great tool, but we need to revamp the process and figure out why it was not working and correct it. She explained that she had just implemented going over 2 care plans in the morning meeting about 3 weeks ago to discuss things such as splints. The DON stated we verbally tell the staff about the splint, but we are not tracking that they are actually doing it. The DON reviewed the functional maintenance plan and stated she had not recalled seeing it and was familiar with it but stated she would expect the staff to apply the splint as directed. | F 688 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one | F 690 | | 3/16/24 |

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| F 690 | Continued From page 41<br>is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to keep an indwelling catheter bag off the floor to decrease the risk of infection and secured the tubing to prevent irritation for 1 of 1 resident reviewed with a catheter (Resident #84).<br><br>The findings included:<br><br>Resident #84 was admitted to the facility on 12/21/23 with diagnosis that included neuromuscular dysfunction of the bladder.<br><br>A physician order dated 12/21/23 read, perform catheter care everyday shift and night shift and as needed, change indwelling catheter when leaking or occluded.<br><br>The comprehensive admission Minimum Data Set (MDS) dated 12/29/23 revealed that Resident #84 was severely cognitively impaired, had no | F 690 | 1- On 2.21.2024 it was identified that resident #84 catheter bag was on the floor. Bag was replaced by nursing staff and assessed on 2.21 at 4:28 PM by room ambassador. Findings indicated that the bag was in the proper location with a cover.<br><br>2- All resident with an indwelling catheter have the potential to be impacted by this practice. Interdisciplinary Team completed house audit for compliance on 2.21.2024. Any issue identified at that time were immediately corrected.<br><br>3- The Staff Development Nurse or designee complete an in-service on 2.21.2024 for all current nursing staff, therapy, and department heads on the proper placement of the catheter bag. Current staff to be educated by 3.15.2024 | |

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| F 690 | Continued From page 42 | F 690 | | |

behaviors or rejection of care and required an indwelling catheter.

A care plan initiated on 01/02/24 read, Resident #84 required a catheter due to neurogenic bladder. The interventions included: monitor for skin irritation and report as indicated and keep catheter bag off the floor.

An observation of Resident #84 was made on 02/19/24 at 12:03 PM. Resident #84 was resting in bed; he was positioned with numerous pillows and wedges. He was observed to have an indwelling catheter that was not stabilized or anchored to either thigh area.

An observation of Resident #84 was made on 02/20/24 at 9:29 AM. Resident #84 was resting in bed; he was positioned with numerous pillows and wedges. Resident #84 was observed to have an indwelling catheter that was not stabilized or anchored to either thigh area and the catheter bag that contained approximately 400 milliliters (ml) of dark orange fluid was resting on the floor.

An observation of Resident #84 was made on 02/21/24 at 9:17 AM and again at 10:44 AM. Resident #84 remained in bed and was positioned with numerous pillows and wedges. He was observed to have an indwelling catheter that was not stabilized to either thigh area and the catheter bag that had approximately 275 ml of orange fluid in it was resting on the floor.

Nurse #2 was interviewed on 02/21/24 at 12:20 PM and confirmed that she had cared for Resident #84 on 02/19/24, 02/20/24, and 02/21/24. She explained that catheters were changed by the nurses depending on what the

for additional education about stabilized or anchoring to either thigh area. Education will be ongoing for all new hired and agency staff. Catheter placement will be added to the Ambassador Round sheet.

4- Director of Nursing / Nurse Designee will conduct rounds periodically to ensure that the catheter bag is in place. Audit will be 5 residents 5 times a week for 6 weeks then 5 residents 2 times a week for 6 weeks. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain compliance.
Date of compliance: 3.16.2024

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physician order specified, and the NAs emptied the catheter bag and reported the amount of output. Nurse #2 also stated that catheter bags should never be on the floor "because germs crawl up to the bag" and confirmed that the facility used the stabilizing device on the catheter tubing. However, Nurse #2 stated she "was not a fan" of them because they came off too easily. If the stabilizing device was not present during care the NAs would have to report that it needed to be replaced and Nurse Aide (NA) #1 had not reported that to her.

NA #1 was interviewed via phone on 02/21/24 at 3:04 PM. NA #1 confirmed that she cared for Resident #84 on 02/19/24 and 02/20/24. She stated that when she was providing care to Resident #84, she would clean his catheter and empty his catheter bag and report the amount to the nurse. NA #1 stated that if she noted the catheter leaking, she would report that to the nurse also. The catheter bag was supposed to be hanging on the side of the bed and not on the floor. NA #1 explained that at times the bag would fall off the side of the bed to the floor, but they tried to keep it off the floor. Additionally, NA #1stated that when she first started taking care of Resident #84, he had a stabilizing band to hold the catheter tubing place to keep it from pulling and causing irritation but then they switched it out to some type of sticker. NA #1 stated that the nurses were supposed to check the sticker for placement each day and ensure the stabilizing device was in place.

The Director of Nursing (DON) was interviewed on 02/22/24 at 1:17 PM and stated that the nurses were responsible for ensuring the care and maintenance of all catheters was done and

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| F 690 | Continued From page 44 are responsible for changing the catheters, ensuring they document the resident's output, and ensuing the NAs were providing catheter care on a daily basis. The DON stated that they should be utilizing stabilizing device on the thigh area to keep the catheter tubing from pulling and irritating the penis. Catheter bags should be hanging from the side of the bed frame and should never be on the floor. Finally, the DON stated that both the Nurses and NAs should be checking to make sure the residents catheter tubing was anchored appropriately, and all staff should be ensuring the catheter bag was not resting on the floor. | F 690 | | |
| F 695 SS=E | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to secure a free standing oxygen cylinder in a resident room (Resident #27), failed to ensure an oxygen filter was free from dust and debris (Resident #63), failed to ensure oxygen was delivered at the prescribed rate (Resident #25 and Resident #73), and failed to ensure oxygen in use signage was noted in the residents' environment (Resident #8, Resident #10, Resident #25, Resident #63, and | F 695 | 1- Resident #27 O2 cylinder has been removed from the room on 3.11.2024. Resident #63, #8, #10, #73 are no longer present at the center. Resident #25 O2 administration, orders and signage were all corrected on 2.21.2024 by on-site Respiratory Therapist (RT). Filters were also addressed at that time by our Maintenance Director. | 3/16/24 |

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Resident #73). These practices occurred for 6 of 6 residents reviewed for respiratory care and services.

Findings included:

1. Resident #27 was admitted to the facility on 3/8/2020 with a diagnosis of asthma.

The annual MDS dated 11/10/2023 revealed Resident #27 was moderately cognitively impaired and required the use of oxygen.

Resident #27's care plan dated 2/20/2024 revealed goals and interventions for use of oxygen.

A record review revealed Resident #27 had an active order for oxygen to be administered at a rate of 2 liters per minute via nasal cannula to maintain oxygen saturation above 90%.

An observation conducted on 02/19/24 at 10:42 AM revealed two oxygen cylinders beside Resident #27's refrigerator. One oxygen cylinder was observed to be in a secured portable rolling device and the other oxygen cylinder was full and free-standing in an upright position, unsecured on the floor. Additionally, Resident #27 was observed to be wearing oxygen via nasal cannula at 2 liters per minute and the vent on the back of the oxygen concentrator was dirty with dust.

An observation conducted on 2/20/2024 at 1:47 pm revealed two oxygen cylinders beside Resident #27's refrigerator. One oxygen cylinder was observed to be in a secured portable rolling device and the other oxygen cylinder was full and free-standing in an upright position, unsecured on

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2- House audit was completed by Respiratory Therapist (RT) on 2.21.2024 to include signage, storage or tanks, administration, and orders match. Any variation was addressed. Maintenance director cleaned all filters at that time.

3- Education to be conducted by Respiratory Therapist (RT) with all staff about the signage on the door, ensuring the filters are cleaned weekly, and o2 administration should match the current order. Current staff to be educated by 3.15.2024 Education will be ongoing for all new hires and agency staff. Cleaning of the filters have been added to TELS as a weekly task.

4-Respiratory Therapist (RT) / Nursing Leadership will audit orders, signage, storage of tanks and the cleanliness of the concentrators for 4 residents 3 times a week for 12 weeks. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain compliance.
Date of compliance: 3.16.2024

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the floor. Additionally, Resident #27 was observed to be wearing oxygen via nasal cannula at 2 liters per minute and the vent on the back of the oxygen concentrator was dirty with dust.

An observation conducted on 2/21/2024 at 8:32 am revealed two oxygen cylinders beside Resident #27's refrigerator. One oxygen cylinder continued to be secured in a portable rolling device and the other oxygen cylinder remained full and free-standing in an upright position, unsecured on the floor. Additionally, Resident #27 was observed to be wearing oxygen via nasal cannula at 2 liters per minute and the vent on the back of the oxygen concentrator was dirty with dust.

An interview was conducted on 2/21/2024 at 11:58 am with Resident #27's family member. She reported that the two oxygen cylinders beside Resident #27's refrigerator had been present since July 2023 and she visited Resident #27 multiple times per week. She verbalized that the tanks had remained in the same position, with one secured in a portable rolling device, and one upright and not secured, free-standing on the floor.

An interview was conducted on 2/21/2024 at 12:20 pm with Nurse #2. Nurse #2 reported she was an agency nurse on dayshift and primarily worked on 100 hall and confirmed that she had worked the unit on 02/19/24, 02/20/24, and 02/21/24. She reported that she had noticed the unsecured oxygen cylinder 'standing there like a missile' in Resident #27's room. She verbalized that she should have fixed it when she noticed it. Nurse #2 was unaware that the oxygen concentrator vent had been dirty.

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An interview was conducted on 2/21/2024 at 3:04 pm with Nurse Aide (NA) #1. NA #1 reported that she worked day shift (6:30 am to 6:30 pm) and worked almost every day of the week. She reported that she had noticed the unsecured portable oxygen tank in Resident #27's room. She verbalized both the secured and unsecured oxygen cylinders that had remained in the same place since she began working with Resident #27 last year. NA #1 stated she just assumed since no one had said anything about the tanks, they were allowed to be stored as they were.

An observation was conducted on 2/21/2024 at 4:57 pm of the oxygen storage room. The observation revealed a designated area where empty and full portable oxygen tanks could be stored in secured racks. There were also available portable rolling devices in the storage room not being used.

An interview was conducted on 2/22/2024 at 1:35 pm with the Director of Nursing (DON). The DON reported that oxygen cylinders should be in the oxygen supply room and secured in the racks when not being used. She stated that if an oxygen cylinder was being used, it should be secured into a rolling device. She verbalized she was unaware Resident #27 had an unsecured portable oxygen cylinder in her room and reported it should be secured in a portable device. She further explained that she assumed the Respiratory Therapist (RT) that was in the building twice a week was cleaning the vents and filters. The DON stated she had spoken to the RT earlier in the day and asked her to please clean the vents and filters when she was in the building.

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2. Resident #63 was admitted to the facility on 11/17/2023 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

The quarterly Minimum Data Set (MDS) dated 1/24/2024 revealed Resident #63 was moderately cognitively impaired and required the use of oxygen.

Resident #63's care plan dated 2/6/2024 revealed goals and interventions for oxygen use.

A record review revealed Resident #63 had an active order for oxygen to be administered at a rate of 2 to 4 liters per minute via nasal cannula to maintain oxygen saturation levels > 88% dated 11/21/2023.

An observation conducted on 2/19/2024 at 5:01 pm of Resident #63's room revealed no signage on the door or door casing stating oxygen was in use and the external filter on the oxygen concentrator was white with dust.

A second observation conducted on 2/20/2024 at 9:24 am of Resident #63's room revealed there was no signage present on the door casing stating that oxygen was in use. Resident #63 was observed wearing oxygen at 4 liters per minute and the external filter on the oxygen concentrator continued to be white with dust.

A third observation conducted on 2/21/2024 at 12:49 pm of Resident #63's room revealed oxygen signage on the door frame and the external filter on the oxygen concentrator continued to be white with dust.

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An interview was conducted on 2/21/2024 at 2:58 pm with Nurse #2 who confirmed that she cared for Resident #63 on 2/19/2024, 2/20/2024, and 2/21/2024. She reported that after oxygen orders were received from the physician, orders were then placed for oxygen tubing and filter/vents to be cleaned which typically occurred on Tuesday during night shift. She reported that she looked at the oxygen filters when she went in to a resident's room to check their oxygen. Nurse #2 was asked to observe Resident #63's oxygen filter and confirmed that it was dirty and needed to be cleaned. Nurse #2 immediately removed the external filter from the side of the oxygen concentrator and took it to the bathroom to wash the filter. Nurse #2 was unaware that Resident #63 did not have signage for oxygen use outside of his door.

An interview was conducted on 2/22/2024 at 1:35 pm with the Director of Nursing (DON). The DON reported that oxygen cylinders should be in the oxygen supply room and secured in the racks when not being used. She stated that if an oxygen cylinder was being used, it should be secured into a rolling device. She verbalized she was unaware Resident #27 had an unsecured portable oxygen cylinder in her room and reported it should be secured in a portable device. She further explained that she assumed the Respiratory Therapist (RT) that was in the building twice a week was cleaning the vents and filters. The DON stated she had spoken to the RT earlier in the day and asked her to please clean the vents and filters when she was in the building.

3. Resident #25 was admitted to the facility on 11/27/23 with diagnoses that included chronic

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obstructive pulmonary disease (COPD) and pneumonia.

Review of a significant change Minimum Data Set (MDS) assessment dated 12/22/23 revealed Resident #25's cognition was moderately impaired, and she received oxygen therapy.

A review of Resident #25's physician orders dated 02/19/24 indicated continuous oxygen at 4 liters per minute (l/m) to keep oxygen saturation above 90%. The orders also indicated to check oxygen saturation and pulse every day and night shifts.

A review of Resident #25's care plan revised on 12/29/23 revealed the Resident was at risk of respiratory complications related to COPD and oxygen use. The goal that the Resident will have no signs and symptoms of respiratory distress will be prevented by utilizing interventions that included providing oxygen as ordered by the physician.

The Medication Administration Record (MAR) for 02/2024 revealed Resident #25 received oxygen at 4 l/m and the Resident's oxygen saturation and pulse for 02/19/24 evening shift was pulse 74 and oxygen saturation 97%. The pulse and oxygen saturation for 02/20/24 day shift was pulse 72 and oxygen saturation 97%.

During an observation of Resident #25 on 02/19/24 at 11:54 AM the Resident was sleeping with an oxygen cannula in her nose delivering oxygen at 1.5 l/m continuously via an oxygen concentrator. There was no oxygen cautionary warning sign posted on the door or doorframe outside the Resident's room to indicate oxygen was in use.

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A subsequent observation of Resident #25 on 02/20/24 at 3:40 PM revealed the Resident received oxygen at 1.5 l/m via the oxygen concentrator. There was no oxygen cautionary warning sign posted on the door or doorframe outside the Resident's room to indicate oxygen was in use.

A subsequent observation of Resident #25 on 02/21/24 at 10:34 AM revealed the observation was unchanged.

On 02/21/24 at 10:54 AM and 11:14 AM an interview and observation were made of Resident #25 with Nurse #4. The Nurse explained the Resident's oxygen settings were ordered by the physician and the nurse who initiated the oxygen was responsible for setting the oxygen concentrator at the prescribed order. She indicated every nurse who worked with the resident should monitor the oxygen setting to ensure the oxygen was set at the prescribed amount. Nurse #4 stated she had checked Resident #25's oxygen saturation earlier that morning and it was at 94%. During the interview Nurse #4 pulled the Resident's physician order for the oxygen and noted the order was for 4 l/m continuous to keep saturation above 90% and stated that she had not checked the concentrator for the correct setting yet that day. Nurse #4 was accompanied to the Resident's room where she was wearing oxygen via the nasal cannula and the oxygen setting was on 1.5 l/m. The Nurse acknowledged the setting was not on the prescribed amount and adjusted the setting to 4 l/m. The Nurse stated she would get the order clarified. While exiting the Resident's room the Nurse was asked how the facility identified

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oxygen was in use in a resident's room and the Nurse explained that an oxygen sign was posted on the doorframe to indicate that oxygen was in use for safety purposes. The Nurse noted there was no oxygen cautionary sign posted on the Resident's doorframe outside the room. Nurse #4 stated she would obtain a sign and post it on the Resident's door as well.

4. Resident #73 was admitted to the facility on 01/28/24 with diagnoses that included pleural effusion (a buildup of too much fluid between the layers of pleura around the lungs).

A review of Resident #73's physician orders dated 01/31/24 indicated continuous oxygen at 2 liters per minute (l/m) via nasal cannula.

The admission Minimum Data Set (MDS) assessment dated 02/02/24 revealed Resident #73's cognition was severely impaired, and he received supplemental oxygen.

A review of Resident #73's care plan revised on 02/07/24 revealed the Resident exhibited respiratory complications due to diminished lung sounds and oxygen (was) used. The goal that Resident #73 wound does not experience signs or symptoms of respiratory distress would be attained by utilizing interventions such as administering oxygen as prescribed.

A review of Resident #73's Medication Administration Record (MAR) dated 02/2024 indicated the Resident received continuous oxygen at 2 l/m.

An observation of Resident #73 was made on 02/19/24 at 12:29 PM as the Resident was

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sleeping. The Resident was wearing an oxygen cannula that was delivering continuous oxygen via the concentrator at 3 l/m. There was no oxygen cautionary warning sign posted on the door or doorframe outside the Resident's room to indicate oxygen was in use.

A subsequent observation of Resident #73 was made on 02/20/24 at 2:51 PM. The Resident continued to receive oxygen via the nasal cannula at 3 l/m and there was no oxygen cautionary sign posted on the Resident's doorframe outside the room.

A subsequent observation was made of Resident #73 on 02/21/24 at 10:37 AM where the observation was unchanged.

On 02/21/24 at 10:54 AM and 11:05 AM an interview and observation were made of Resident #73 along with Nurse #4. The Nurse explained the Resident's oxygen setting was ordered by the physician and the nurse who initiated the oxygen was responsible for setting the oxygen concentrator on the prescribed amount of oxygen. She indicated every nurse who worked with the resident should monitor the oxygen setting to ensure the oxygen was set at the prescribed amount. During the interview Nurse #4 checked the Resident's order for the prescribed amount of oxygen and stated it should be at 2 l/m. Nurse #4 was accompanied to the Resident's room where he was wearing oxygen via the nasal cannula and the oxygen setting was on 3 l/m. The Nurse acknowledged the setting was not on the prescribed amount and adjusted the setting to 2 l/m. The Nurse stated she had not checked the Resident's oxygen setting yet that day. While entering the Resident's room the Nurse stated

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there was no cautionary oxygen sign posted outside the door to indicate oxygen was in use in the Resident's room and stated she would obtain one and post it outside the Resident's room.

An interview was conducted with the Director of Nursing (DON) on 02/22/24 at 12:14 PM. The DON indicated the nurse on the hall or the nurse who was covering for the medication aide should check the residents' oxygen order and ensure the oxygen was set at the prescribed amount every shift. She also informed that the person who initiated the oxygen order should ensure there was a cautionary oxygen sign posted outside the residents' door for safety purposes. The DON stated oxygen orders were discussed in the clinical meetings in the mornings and any issues should be caught during those meetings. The DON stated she was not aware that Resident #25 and Resident #73 did not have their oxygen settings set on the prescribed amounts and there were no oxygen signs posted outside their rooms and stated it would immediately be corrected.

On 02/22/24 at 12:57 PM during an interview with the Administrator she explained that the facility partnered with a Respiratory Therapist (RT), and they let the RT take over the oxygen therapy. The Administrator indicated they had conducted an audit on the residents who received oxygen and had placed oxygen cautionary signs outside the residents' rooms.

5. Resident #8 was admitted to the facility on 09/26/11 and had diagnoses that included adult failure to thrive and hypoxia (not enough oxygen in the tissues to sustain bodily functions).

A physician's order dated 01/25/24 read in part,

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Administrator explained the facility partnered with a Respiratory Therapist (RT) and they let the RT take over the oxygen therapy. The Administrator indicated they had conducted an audit on the residents who received oxygen and had placed oxygen cautionary signs outside the residents' rooms.

6. Resident #83 was admitted to the facility on 12/04/23 with diagnoses that included dementia.

The admission Minimum Data Set (MDS) dated 12/11/23 revealed Resident #83 had severe cognitive impairment and did not receive oxygen therapy during the MDS assessment period.

A physician's order dated 02/19/24 for Resident #83 read, oxygen at 2 liters per minute (LPM) via nasal cannula as needed to maintain oxygen saturation greater than 90%.

A physician's order dated 02/19/24 for Resident #83 read, comfort care.

An observation conducted on 02/19/24 at 11:17 AM revealed Resident #83 was lying in bed resting peacefully and wearing a nasal cannula that was delivering supplemental oxygen via the concentrator at 2 LPM. There was no sign posted on the door or doorframe of Resident #83's room to indicate oxygen was in use.

An observation conducted on 02/20/24 at 2:29 PM revealed Resident #83 lying in bed wearing a nasal cannula that was delivering supplemental oxygen via the concentrator at 2 LPM. There was no sign posted on the door or doorframe of Resident #83's room to indicate oxygen was in use.

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| F 695 | Continued From page 57<br><br>During interviews on 02/22/24 at 12:14 PM and 1:57 PM, the Director of Nursing (DON) revealed she was unaware there had been no oxygen sign posted on the outside of Resident #83's room. The DON explained that the person who initiated the oxygen order should have ensured there was a cautionary oxygen sign posted outside the residents' door for safety purposes.<br><br>During an interview on 02/22/24 at 12:57 PM, the Administrator explained the facility partnered with a Respiratory Therapist (RT) and they let the RT take over the oxygen therapy. The Administrator indicated they had conducted an audit on the residents who received oxygen and had placed oxygen cautionary signs outside the residents' rooms. | F 695 | | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions | F 700 | | 3/16/24 |

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| F 700 | Continued From page 58<br>are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to complete a bed rail assessment to determine the need for bed rail use for 1 of 1 sampled resident (Resident #41).<br><br>Findings Included:<br><br>Resident #41 was admitted to the facility on 02/17/22 with diagnoses that included vascular dementia and insomnia.<br><br>The quarterly Minimum Data Set (MDS) dated 11/22/23 assessed Resident #41 with severe cognitive impairment. Resident #41 was dependent on staff assistance for bed mobility with rolling left and right and bed rails were not used as a restraint.<br><br>An observation on 02/19/24 at 10:41 AM revealed Resident #41 lying in bed with bilateral quarter bed rails in the up position.<br><br>Review of Resident #41's electronic medical record on 02/20/24 revealed the last completed bed rail assessment was dated 02/17/22. There were no further bed rail assessments completed for the use of the bilateral quarter bed rails.<br><br>Additional observations conducted on 02/20/24 at 2:41 PM and 02/21/24 at 3:20 PM revealed Resident #41 lying in bed with bilateral quarter bed rails in the up position. | F 700 | 1- Resident #41 had bed rails in place without a current assessment for the needs. Assessment has since been obtained on 2.21.2024.<br><br>2- House audit has been completed by Director of Rehab (DOR) and Maintenance Director to gather a list of resident who are using bedrails currently. Findings from that audit will be reviewed by nursing leadership to ensure consent and assessment requirements have been met. Completion date for this is 3.15.2024.<br><br>3- Education on bedrail requirements as identified by regulation include routine assessment, consent, and safety. Current staff to be educated by 3.15.2024 . Education will be for all staff and ongoing for all new hires and agency.<br><br>4- Director of Nursing (DON) / Nurse leadership will be responsible for the monitoring. Audits will be completed for 3 resident two times a week for 4 weeks then 3 resident one time a week for 8 weeks. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain compliance. | |

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| F 700 | Continued From page 59 | F 700 | | |
| | During a joint interview on 02/21/24 at 2:55 PM, Nurse Aide (NA) #5 and NA #6 both stated Resident #41 had used bed rails since her admission to the facility. NA #5 and NA #6 both stated Resident #41 required total staff assistance with activities of daily living and did not use the bed rails independently but upon command was able to hold onto the bed rail when staff were providing care. | | Date of Compliance: 3.16.2024 | |
| | During an interview on 02/21/24 at 5:13 PM, the Director of Nursing (DON) stated in theory, the hall nurse should be completing bed rail assessments quarterly or as needed to determine the need for bed rail use. The DON explained when Resident #41 returned to the facility in 2022 it was likely the bed rails were already on the bed in the room when she was admitted. The DON stated she would have expected an updated bed rail assessment to be completed when the initial assessment indicated bed rails were not to be used and then quarterly assessments completed to determine if the bed rails were still needed. | | | |
| | During an interview on 02/22/24 at 5:33 PM, the Administrator stated when bed rails were needed, she expected for bed rail assessments to be completed per the facility policy. | | | |
| F 725 SS=D | Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) | F 725 | | 3/16/24 |
| | §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial | | | |

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| F 725 | Continued From page 60<br>well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and interviews with residents and staff, the facility failed to provide sufficient nursing staff to ensure residents choices were honored for eating meals in the main dining room, bathing and personal hygiene was provided as needed and resting hand splints were applied as directed for 8 of 15 sampled residents (Residents #2, #21, #22, #23, #50, #51, #53, and #63) reviewed for choices and activities of daily living.<br><br>This tag is cross-referenced to:<br><br>F561: Based on observations, record review, interviews with residents and staff, the facility failed to honor residents' choice to eat their meals | F 725 | 1- Scheduler, Administrator, Human Resources and Director of Nursing discussed staffing needs for sufficient staffing to provide nursing and related services to assure needs and safety requirements are met.<br><br>2- 3.14.2024 Administrator, Director of Nurse, scheduler, and Maintenance updated facility assessment and developed a staffing plan that included agency, on-call, and bonus structure for home staff to ensure needs for Activities of daily living and care plan interventions have the highest potential of being carried out by staff. | |

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in the main dining room (Residents #2, #21, #22, #23, #51 and #53) for 6 of 6 sampled residents.

F 677: Based on observations, record review, and staff interviews the facility failed to provide a shower, shave, clean, and trim a dependent resident's fingernails for 1 of 7 residents reviewed for activities of daily living (ADL) (Resident #63).

F 688: Based on observations, record review, and staff interviews the facility failed to apply a resting hand splint as directed by the functional maintenance program for 1 of 2 residents reviewed for range of motion (Resident #50).

Review of the facility's posted daily staffing sheets revealed the following:
On 02/19/24 the resident census was listed as 84.
On 02/20/24 the resident census was listed as 82.
On 02/21/24 the resident census was listed as 82.
On 02/22/24 the resident census was listed as 84.

During an interview on 02/20/24 at 4:42 PM, NA #4 stated she worked at the facility on Wednesday through Friday and every other Sunday and was assigned to provide resident showers unless she was pulled to work a resident hall due to the facility being short-staffed. NA #4 stated she was pulled to work a resident hall at least once a week due to staffing and then each hall NA was responsible for providing showers to their assigned residents.

During a telephone interview on 02/22/24 at 11:30 AM, NA #8 revealed she worked the weekends

F 725

3- 3.15.2024 education began on with all current clinical staff on the staffing plan. Special resident council meeting was also conducted to share this plan with resident council and to help educate on how the plan will look for them as residents. Newly hired and agency staff will be provided with education during orientation.

4- Audit will be conducted by Director of Nursing / Administrator / Scheduler on a daily basis for 12 weeks to ensure that all scheduled staff showed up and/ or the call in was filled appropriately. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain compliance.

Date of Compliance: 3.16.2024

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during the hours of 6:30 PM to 6:30 AM. NA #8 stated there was supposed to be one NA assigned to 100 Hall, one NA assigned to 200 Hall and 2 NAs assigned to 300 Hall but lately, it had been just her and 2 other NAs for all three resident halls. She stated when working short staffed it was hard to give resident showers but she was able to get her rounds done, it just took a little longer. She added when short-staffed, her priority was to just make sure her assigned residents were safe and clean.

During an interview on 02/21/24 at 3:50 PM, the Scheduler revealed when she took over the position at the end of October 2023, she was told the standard daily minimums for staffing were 4 Nurses and 7 NAs on the day shift (6:30 AM to 6:30 PM), a shower aide who worked 8-hours on the day shift Wednesday through Friday and 3 Nurses and 6 NAs on the evening shift (6:30 PM to 6:30 AM). The Scheduler stated for the most part, she was able to meet the preferred daily minimums; however, call-outs were a big issue as staff usually waited until the last minute to call-out. When that happened, she started calling staff for volunteers and if unable to cover the shift the Director of Nursing (DON) would have the Unit Managers fill in. In addition, they would reach out to sister facilities and/or use agency staff to help supplement the schedule if at all possible. She shared that in January 2024 the facility was fully-staffed and then in February 2024 staff left for various reasons which made staffing difficult. The Scheduler stated the current open positions at the facility were 3 NAs for the day shift and 2 NAs for the night shift.

During an interview, the DON acknowledged staffing was a challenge and explained staffing

F 725

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| F 725 | Continued From page 63<br>was good for a little while but then all of a sudden it just got worse. The DON stated the recruitment process remained ongoing and they were doing all they could to keep the shifts covered; however, they were not receiving many applicants for the open positions.<br><br>During an interview on 02/22/24 at 5:26 PM, the Administrator explained due to staffing challenges it was hard to have consistency and expect processes to work. The Administrator acknowledged staffing had been a challenge and they were actively trying to recruit more applicants for the open positions. | F 725 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to | F 761 | | 3/16/24 |

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| F 761 | Continued From page 64 | F 761 | | |

abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and staff interviews the facility failed to store schedule III and IV controlled medications in a locked compartment in the refrigerator in 1 of 1 medication room reviewed for medication storage.

The finding included:

On 02/21/24 at 3:10 PM an observation was made of the Main Medication room along with Nurse #4. The Nurse opened the refrigerator door to find a clear affixed box that contained 22 tablets of Marinol (a scheduled III controlled substance which means it has a low to moderate abuse potential) and 2 vials of Ativan (a scheduled IV controlled substance which means it carries a risk for abuse, addiction and dependence) stored in the clear box. The box was able to be opened without using a key to unlock the lock on the box.

An interview was conducted with Nurse #4 on 02/21/24 at 3:10 PM who explained that both the combination lock on the outside of the refrigerator and the clear box inside the refrigerator that stored the Marinol and Ativan should have been locked. She continued to explain that the clear box inside the refrigerator was hard to unlock so that was probably why the box was not locked. The Nurse stated the 100 hall Nurse (Nurse #2) held the key to the controlled medication box in the refrigerator.

1- Drug storage lock in the front med room was not double locked. While on-site on 2.21.2024 the pharmacy representative ordered a replacement, and has since been repaired.

2- Review of back all med room and front med room was completed to confirm both med rooms have operational double lock system in place for narcotics.

3- Education conducted by Staff Development Nurse 3.14.2024 to ensure that all current licensed nursing staff are ensuring that medications are double locked and are reporting any issues of with the locks through both the TELS system and to Pharmacy in a timely manner. Education will be ongoing for all new hires and agency staff.

4- Audits will be completed by nurse leadership 5 days a week for 4 weeks and then 3 days a week for 6 weeks. Audit will ensure operation of the double locking mechanism and that the narcotics are proper secured. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain compliance.

Date of Compliance: 3.16.2024

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| F 761 | Continued From page 65 | F 761 | | |

Continued From page 65

A second interview with Nurse #4 on 02/21/24 at 3:20 PM revealed that she was informed the lock on the controlled medication box in the refrigerator was broken. The pharmacy representative was in the building earlier in the day and had ordered another box for the refrigerator. The Nurse reported she did not know how long the box had been broken.

During an interview with Nurse #2 on 02/21/24 at 4:22 PM the Nurse confirmed that the key to the clear box in the medication room refrigerator was kept on the keys for 100 hall and explained the box was hard to unlock and that was why the box was left unlocked.

A review of the Reconciliation count sheets for the Marinol and Ativan on 02/21/22 at 4:22 PM was 22 tablets of Marinol and 2 vials of Ativan.

On 02/22/24 at 11:55 AM during an interview with the Director of Nursing (DON) she explained the pharmacy was alerted either on Monday or Tuesday of the present week that the locked box in the refrigerator was broken and needed to be replaced. Then the pharmacy consultant was notified again on 02/21/24 and reported a replacement box had been ordered. It should have been delivered last night (02/21/24), but it has not been delivered yet.

During an interview with the Administrator on 02/22/24 at 1:18 PM the Administrator explained that she was made aware the box in the medication room refrigerator was broken on 02/21/24 and a replacement box had been ordered.

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| F 867 | Continued From page 66 | F 867 | | |
| F 867 SS=F | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>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:<br><br>§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.<br><br>§483.75(c)(2) Facility maintenance of effective 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.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§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 | F 867 | | 3/16/24 |

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| F 867 | Continued From page 67<br>facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§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.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(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<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§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.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and | F 867 | | |

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| F 867 | Continued From page 68<br>implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§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.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and 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:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain | F 867 | 1 - The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor interventions the | |

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implemented procedures and monitor interventions the committee put into place following the recertification and complaint surveys conducted on 03/12/21 and 09/14/22. This failure was for 8 deficiencies that were originally cited in the areas of (F561) Self Determination, (F578) Request/Refuse/Discontinue Treatment/Formulate Advanced Directive, (F641) Accuracy of Assessments, (F656) Develop, Implement Comprehensive Care Plan, (F688) Increase/Prevent Decrease in ROM/Mobility, (F690) Bowel/Bladder Incontinence, Catheter, UTI, (F695) Respiratory/Tracheostomy Care and Suctioning, and (F761) Label/Store Drugs and Biologicals that were subsequently recited on the current recertification and complaint survey on 02/22/24. The repeat deficiencies during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program.

The findings include:

This tag is cross referenced to:

F-561: Based on observations, record review, interviews with residents and staff, the facility failed to honor residents' choice to eat their meals in the main dining room (Residents #2, #21, #22, #23, #51, and #53) for 6 of 6 sampled residents.

During the recertification and complaint survey conducted on 03/12/21 the facility failed to honor a resident's choice of two showers a week on Monday and Thursday for 1 of 3 residents reviewed for activities of daily living.

F-578: Based on medical record review, staff interviews, and review of the facility's Advance

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committee put into place following previous complaint and recertification surveys. This failure was for 8 deficiencies that were originally cited in the areas of (F561) Self Determination, (F578) Request/ Refuse / Discontinue treatment/Formulate Advance Directives, (F641) Accuracy of Assessments, (F656) Develop, Implement Comprehensive Care Plan, (F688) Increase / Prevent Decrease in ROM / Mobility, (F690) Bowel / Bladder Incontinence, Catheter, UTI, (F695) Respiratory / Tracheostomy Care and Suctioning, and (F761) Label / Store Drugs and Biologicals that were subsequently recited on the current recertification and complaint survey 2.22.2024.

2 - Plan of correction was put in to place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and further issues were identified throughout the monitoring period and were discontinued.

3- The Administrator initiated in-service to all administrative staff on 3.15.2024 regarding Quality Assurance Performance Improvement (QAPI) processes including identifying and prioritizing quality deficiences, systemically analyzing causes of systemic quality deficiencies, developing , and implementing corrective

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| F 867 | Continued From page 70<br>Directive policy the facility failed to provide written advance directive information and/or opportunity to formulate an advance directive and also failed to ensure a residents code status election was evident and accurately documented in the medical record for 10 of 10 (Resident #7, #12, #25, #27, #50, #63, #67, #71, #73, and #84) residents reviewed for advance directive.<br><br>During the recertification and complaint survey conducted on 03/12/21 the facility failed to maintain accurate advance directives throughout the medical records for 3 of 22 residents reviewed for advance directives.<br><br>F-641: Based on record review and staff interviews, the facility failed to accurately code an attempted gradual dose reduction of an antipsychotic medication and failed to code a level 2 PASARR (preadmission screening and resident review) for 1 of 5 residents reviewed for unnecessary medications (Resident #2) and 1 of 2 residents reviewed for PASARR (Resident #61).<br><br>During the recertification and complaint survey conducted on 09/14/22 the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications and cognition for 2 of 24 residents reviewed for MDS accuracy.<br><br>F-656: Based on observations, record reviews and interviews, the facility failed to develop a care plan in the area of Level II Preadmission Screening and Resident Review (PASRR) (Resident #61) and failed to implement the care plan in the area of range of motion (Resident #50) for 2 of 31 residents reviewed for care planning. | F 867 | action or performance improvement activities, and monitoring, and evaluating the effectivness of corrective action /performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action /performance improvement activities to evaluate the effectivness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No administrative staff member will work until they have received the education.<br><br>4- The Quality Improvement Performance Committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved 3 months of consistent compliance. Administrator will be responsible for the plan of correction.<br><br>Date of compliance 3.16.2024 | |

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| F 867 | Continued From page 71 | F 867 | | |

During the recertification and complaint survey conducted on 03/12/21 the facility failed to implement a respiratory care plan for the use of oxygen for 1 of 3 residents reviewed for respiratory management.

F-688: Based on observations record review, and staff interviews the facility failed to apply a resting hand splint as directed by the functional maintenance program for 1 of 2 residents reviewed for range of motion (Resident #50).

During the recertification and complaint survey conducted on 09/14/22 the facility failed to apply splints for 1 of 1 resident reviewed for range of motion.

F-690: Based on observations, record review and staff interviews, the facility failed to keep an indwelling catheter bag off the floor and secured to prevent irritation for 1 of 1 resident reviewed with a catheter (Resident #84).

During the recertification and complaint survey conducted on 09/14/22 the facility failed to ensure a resident's urinary catheter tubing and drainage bag did not touch the floor for 1 of 3 residents reviewed for catheters.

F-695: Based on observations, record review, and staff interviews the facility failed to secure a free standing oxygen cylinder in a resident room (Resident #27), failed to ensure an oxygen filter was free from dust and debris (Resident #63), failed to ensure oxygen was delivered at the prescribed rate (Resident #25 and Resident #73), and failed to ensure oxygen in use signage was noted in the residents' environment (Resident #8, Resident #10, Resident #25, Resident #63, and

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| F 867 | Continued From page 72 | F 867 | | |

Resident #73). These practices occurred for 6 of 6 residents reviewed for respiratory care and services.

During the recertification survey of 09/14/22 the facility failed to keep air filters on oxygen concentrators clean and free from dust buildup for 1 of 3 residents reviewed for respiratory care.

During the recertification survey of 03/12/21 the facility failed to administer oxygen as ordered and failed to replace oxygen cannula that had been placed on the floor for 2 of 3 residents reviewed for respiratory management.

F-761: Based on observations record reviews and staff interviews the facility failed to store schedule III and IV controlled medications in a locked compartment in the refrigerator in 1 of 1 medication room reviewed for medication storage.

During the recertification and completion of survey conducted on 09/14/22 the facility failed to remove expired medication and date open insulin pens from 1 of 3 medication carts (300 hall medication cart) and failed to remove loose unsecured pills from 2 of 3 medication carts (100 hall/200 hall cart and 300 hall cart) reviewed for medication storage.

An interview was conducted with the Administrator on 02/22/24 at 5:26 PM who explained the Quality Assurance (QA) committee met monthly which consisted of the Administrator, Director of Nursing, Pharmacist, Medical Director and the members of the Interdisciplinary Team (IDT) and they recently added a member of the direct care staff to the meetings as well. There

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| F 867 | Continued From page 73<br>was a format that the facility utilized to review any Performance Improvement Plans (PIP) and changes were made to the PIP when necessary. The Administrator continued to explain that any issues or concerns that came up during the meetings were addressed to find resolutions to the PIPs. The Administrator stated she anticipated repeat citations the facility received during the current survey and felt they were because of the instability of staffing and the fact that they did not have consistent staffing. She indicated she would educate, monitor and follow through with the plan of corrections when they were developed. | F 867 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza | F 883 | | 3/16/24 |

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| F 883 | Continued From page 74<br>immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and resident and staff interviews the facility failed to included documentation in the medical record of education regarding the benefits and potential side effects of the Influenza immunization for 2 of 5 (Resident #63, Resident #84) residents reviewed and failed | F 883 | 1- During recent site visit it was identified that resident #63, #84 was cited for not including documentation about benefits VS risk of immunizations. The mentioned residents have since been discharged from the center. Resident # 75 has since | |

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to include documentation in the medical record of education regarding the benefits and potential side effects of the Pneumococcal immunization for 2 of 5 residents reviewed (Resident #63 and Resident #75).

The findings included:

1. Resident #63 was admitted to the facility on 11/17/23.

The quarterly Minimum Data Set (MDS) dated 01/24/24 revealed that Resident #63 was moderately cognitively impaired for daily decision making. The MDS also indicated that Resident #63 had not received the influenza vaccine in the facility for this flu season and the reason indicated that it was not offered, and he was up to date with his Pneumococcal vaccine.

A review of Resident #63's medical record revealed that there was no information in the medical record that the Resident or legal representative was provided education regarding the benefits and potential side effects of the Influenza or Pneumococcal vaccination and no consent could be located in the medical record.

The Infection Control Preventionist (ICP) was interviewed on 02/22/24 at 9:37 AM. She explained that when a resident admitted to the facility the admission nurse would get the initial influenza and pneumococcal vaccine consent form signed, then, once signed the ICP stated she would enter the information into the electronic health record and order the vaccine from the pharmacy. Once the vaccine was received it would be given and the information entered into the electronic record and the consent form

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been provided with education on the risk and benefits of the Pneumonia and Flu vaccine information sheet on 3.13.2024.

2- House Audit was completed on 3.12.2024 by Medical Records to ensure consents were in place. Education has been mailed out to all resident / resident representatives on 3.13.2024. Upon admission nurse will provide a vaccine consent form along with information sheet. Upon completion the forms will be provided to Medical Records for scanning into the chart.

3- Education has been extended to all staff on 3.15.2024
by nurse leadership about the information statement and how it must be shared with the resident / resident representative. Even when a representative is appointed for an alert and oriented resident the forms should still be extended to the resident. Information statements have been added to the center consent forms. Education will be ongoing for all newly hired licensed nurses and agency nurses.

4- Staff Development Nurse / Medical Records will audit consent forms to ensure that all consents and educational elements have been signed upon admission or as consent change. Audits will include 3 admissions /readmissions 1 time per week for 12 weeks. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain

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| F 883 | Continued From page 76<br>scanned into the system. The ICP added that the education on the benefits and potential risk of the vaccine were all included on the consent form. The ICP further explained during the flu season the facility conducted an audit and obtained all new consents and the same process was followed. The ICP stated that Resident #63 influenza and pneumococcal consents may be in medical records office waiting to be scanned into the system, but she would have to check but stated that it should be in the electronic medical record.<br><br>A follow up interview was conducted with the ICP on 02/22/24 at 11:55 AM who stated that she had found Resident #63's influenza and pneumococcal consent in a notebook in an office and they had not been scanned into the medical record yet.<br><br>The Medical Records Clerk was interviewed on 02/22/24 at 11:57 AM. She stated that she scanned documents into the medical record generally on the same day that the information was given to her or placed in one of the 2 mailboxes she had in the facility. The Medical Record Clerk stated that she took on the additional task of scheduling and her time to get things scanned in was a bit longer, but she got to it as quickly as possible. She added the ICP had just brought her a stack of immunization consents to be scanned in and she would work on them soon.<br><br>The Director of Nursing (DON) was interviewed on 02/22/24 at 1;29 PM who stated that after the consents were signed and the vaccine given the consent should immediately be given to the Medical Records Clerk to scan it into the medical | F 883 | compliance.<br><br>Compliance Date 3.16.2024 | |

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| F 883 | Continued From page 77 | F 883 | | |

record and should not be kept in a binder in someone's office.

2. Resident #84 was admitted to the facility on 12/21/23.

Review of the comprehensive Minimum Data Set (MDS) dated 12/29/23 revealed that Resident #84 was severely cognitively impaired for daily decision making. The MDS also revealed that Resident #84 had not received the influenza vaccine in the facility this flu season and the reason stated was not offered.

A review of Resident #84's medical record revealed that there was no information in the medical record that the Resident or legal representative was provided education regarding the benefits and potential side effects of the Influenza immunization and no consent could be located in the medical record.

The Infection Control Preventionist (ICP) was interviewed on 02/22/24 at 9:37 AM. She explained that when a resident admitted to the facility the admission nurse would get the initial influenza vaccine consent form signed, then, once signed the ICP stated she would enter the information into the electronic health record and order the vaccine from the pharmacy. Once the vaccine was received it would be given and the information entered into the electronic record and the consent form scanned into the system. The ICP added that the education on the benefits and potential risk of the vaccine were all included on the consent form. She further explained during the flu season the facility conducted an audit and obtained all new consents and the same process was followed. The ICP stated that Resident #84's

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| F 883 | Continued From page 78 | F 883 | | |

influenza consent may be in medical records office waiting to be scanned into the system, but she would have to check but stated that it should be in the electronic medical record.

A follow up interview was conducted with the ICP on 02/22/24 at 11:55 AM who stated that she had found Resident #84's influenza consent in a notebook in an office and it had not been scanned into the medical record yet.

The Medical Records Clerk was interviewed on 02/22/24 at 11:57 AM. She stated that she scanned documents into the medical record generally on the same day that the information was given to her or placed in one of the 2 mailboxes she had in the facility. The Medical Record Clerk stated that she took on the additional task of scheduling and her time to get things scanned in was a bit longer, but she got to it as quickly as possible. She added the ICP had just brought her a stack of immunization consents to be scanned in and she would work on them soon.

The Director of Nursing (DON) was interviewed on 02/22/24 at 1;29 PM who stated that after the consents were signed and the vaccine given the consent should immediately be given to the Medical Records Clerk to scan it into the medical record and should not be kept in a binder in someone's office.

3. Resident #75 was admitted to the facility on 06/14/23.

Review of the quarterly Minimum Data Set (MDS) dated 11/15/23 revealed that Resident #75 was cognitively intact and indicated that Resident

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#75's Pneumococcal vaccination was not up to date and indicated it was not offered.

A review of Resident #75's medical record revealed that there was no information in the medical record that the Resident or legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal immunization and no consent could be located in the medical record.

The Infection Control Preventionist (ICP) was interviewed on 02/22/24 at 9:37 AM. She explained that when a resident admitted to the facility the admission nurse would get the initial pneumococcal vaccine consent form signed, then, once signed the ICP stated she would enter the information into the electronic health record and order the vaccine from the pharmacy. Once the vaccine was received it would be given and the information entered into the electronic record and the consent form scanned into the system. The ICP added that the education on the benefits and potential risk of the vaccine were all included on the consent form. The ICP stated that Resident #75's Pneumococcal consent may be in medical records office waiting to be scanned into the system, but she would have to check but stated that it should be in the electronic medical record.

A follow up interview was conducted with the ICP on 02/22/24 at 11:55 AM who stated that she had found Resident #75's Pneumococcal consent in a notebook in an office and it had not been scanned into the medical record yet.

The Medical Records Clerk was interviewed on 02/22/24 at 11:57 AM. She stated that she

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| **LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION** | **179 COMBS STREET SPARTA, NC 28675** |

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| F 883 | Continued From page 80<br>scanned documents into the medical record generally on the same day that the information was given to her or placed in one of the 2 mailboxes she had in the facility. The Medical Record Clerk stated that she took on the additional task of scheduling and her time to get things scanned in was a bit longer, but she got to it as quickly as possible. She added the ICP had just brought her a stack of immunization consents to be scanned in and she would work on them soon.<br><br>The Director of Nursing (DON) was interviewed on 02/22/24 at 1;29 PM who stated that after the consents were signed and the vaccine given the consent should immediately be given to the Medical Records Clerk to scan it into the medical record and should not be kept in a binder in someone's office. | F 883 | | |
| F 887 SS=E | COVID-19 Immunization<br>CFR(s): 483.80(d)(3)(i)-(vii)<br><br>§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:<br>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and | F 887 | | 3/16/24 |

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| F 887 | Continued From page 81<br>risks and potential side effects associated with the COVID-19 vaccine;<br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;<br>(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;<br>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and<br>(B) Each dose of COVID-19 vaccine administered to the resident; or<br>(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and<br>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:<br>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;<br>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and<br>(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). | F 887 | | |

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| F 887 | Continued From page 82 | F 887 | | |

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 3 of 5 (Resident #63, Resident #75, and Resident #84) residents reviewed for infection control.

The findings included:

a. Resident #63 was admitted to the facility on 11/17/23.

Review of the quarterly Minimum Data Set (MDS) dated 01/24/24 revealed that Resident #63 was moderately cognitively impaired.

Review of Resident #63's medical record revealed no information that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization.

b. Resident #75 was admitted to the facility on 06/14/23.

Review of the quarterly MDS dated 11/15/23 revealed that Resident #75 was cognitively intact.

Review of Resident #75's medical record revealed no information that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization.

c. Resident #84 was admitted to the facility on 12/21/23.

**Provider's Plan of Correction:**

1- During recent site visit it was identified that resident #63, #84 was cited for not including documentation about benefits VS risk of immunizations, and can no longer be provided with this information. Resident # 75 has since been provided with education on the risk and benefits of the COVID vaccine information sheet on 3.13.2024.

2- House Audit was completed on 3.12.2024 by Medical Records to ensure consents were in place. Education has been mailed out to all resident / resident representatives on 3.13.2024. Upon admission all residents will be provided with a blank consent for the vaccine as well as education. Upon completion of the packet Medical Records will be responsible for uploading this information into the resident's record.

3- Education has been extended to all staff by nurse leadership on 3.15.2024 on the vaccine portion of the admission packet and how the information statement must be shared with the resident / resident representative. Even when a representative is appointed for a alert and oriented resident the resident should still be extended the consent and the information statement. Information statements have been added to the center consent forms. Education will be ongoing for all new licensed nurses and agency nurses as part of orientation

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| F 887 | Continued From page 83<br><br>Review of the comprehensive Minimum Data Set (MDS) dated 12/29/23 revealed that Resident #84 was severely cognitively impaired for daily decision making.<br><br>A review of Resident #84's medical record revealed that there was no information in the medical record that the Resident or legal representative was provided education regarding the benefits and potential side effects of the COVID-19 immunization.<br><br>The Infection Control Preventionist (ICP) was interviewed on 02/22/24 at 9:37 AM. She explained that when a resident admitted to the facility the admission nurse would get the initial COVID-19 form signed, then, once signed the ICP stated she would enter the information into the electronic health record and order the vaccine from the pharmacy. Once the vaccine was received it would be given and the information entered into the electronic record and the consent form scanned into the system. The ICP added that the education on the benefits and potential risk of the vaccine were all included on the consent form. The ICP stated that Resident #63, Resident #75, and Resident #84's COVID-19 consent may be in medical records office waiting to be scanned into the system, but she would have to check but stated that it should be in the electronic medical record.<br><br>A follow up interview was conducted with the ICP on 02/22/24 at 11:55 AM who stated that she had found Resident #63 and Resident #84's consent in a notebook in an office and it had not been scanned into the medical record yet but the consents were not filled out completely. | F 887 | 4- Staff Development Nurse / Medical Records will audit consent forms to ensure that all consents and educational elements have been signed upon admission or as consent change. Audits will include 3 admissions /readmissions 1 time per week for 12 weeks. Results of audits will be reviewed during monthly Quality Assurance Process Improvement meeting and any changes will be made to the plan as necessary to maintain compliance.<br><br>Compliance Date 3.16.2024 | |

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| F 887 | Continued From page 84<br><br>The Medical Records Clerk was interviewed on 02/22/24 at 11:57 AM. She stated that she scanned documents into the medical record generally on the same day that the information was given to her or placed in one of the 2 mailboxes she had in the facility. The Medical Record Clerk stated that she took on the additional task of scheduling and her time to get things scanned in was a bit longer, but she got to it as quickly as possible. She added the ICP had just brought her a stack of immunization consents to be scanned in and she would work on them soon.<br><br>The Director of Nursing (DON) was interviewed on 02/22/24 at 1;29 PM who stated that after the consents were signed and the vaccine given the consent should immediately be given to the Medical Records Clerk to scan it into the medical record and should not be kept in a binder in someone's office. | F 887 | | |