STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

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E 000	Initial Comments An unannounced Recertification survey was conducted on 03/08/21 through 03/12/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness Event ID #P4V411.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and complaint survey was conducted from 03/08/21 through 03/12/21. There were eight allegations investigated and five were substantiated. Event ID #P4V411.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. 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. §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. §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. §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.	F 561		4/9/21

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

Electronically Signed | 04/02/2021

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F 561	Continued From page 1 §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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, 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 (Resident #68). The finding included: Resident #68 was admitted to the facility on 05/20/15 with diagnoses which included cerebral vascular accident. The recent quarterly Minimum Data Set (MDS) assessment dated 01/22/21 revealed Resident #68 was cognitively intact for daily decision making and was totally dependent on staff for bathing that required one staff assist. Review of the Shower Schedule revealed Resident #68 was scheduled for showers on Monday and Thursday day shift. During an interview with Resident #68 on 03/09/21 at 9:52 AM he explained that he was scheduled for two showers a week on Monday and Thursday on day shift but was only averaging one shower a week. The Resident continued to explain that he did not receive a shower on Monday (03/08/21) nor did he receive a shower on Thursday (03/04/21) but that the last shower	F 561	F561 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Resident #68 received a shower as requested on 3/11/21. 2. All residents with scheduled showers have the potential to be affected. An audit of the ADL sheets for the last 30 days was completed by the Administrative Nursing Team on 4/7/21. Staff member that failed to complete showers were followed up with by the CNE as necessary 3. The licensed nurses and Certified Nursing Assistants (CNAs) were in-serviced by the Nurse Practice Educator (NPE) on 4/2/21 to 4/8/21/regarding the shower schedule and the importance of showering the residents as scheduled. This education will be added to the orientation process/agenda	

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F 561	Continued From page 2 he received was on Monday (03/01/21) which was given to him by Nurse Aide (NA) #1. Resident #68 stated that he asked Nurse Aide #2 yesterday evening (Monday 03/08/21) if he was going to get his shower and was told by the NA that she did not have time to give him his shower. The Resident stated he did receive bed baths, but it was not the same as a full shower which was what he preferred. An interview was conducted with Nurse Aide #1 on 03/09/21 at 3:45 PM who confirmed she worked with Resident #68 on Monday 03/01/21 day shift and gave him his shower. The aide also informed that she worked on Thursday 03/04/21 day shift and gave Resident #68 a bed bath instead of a shower because she was extremely busy that day and had to help cover another hall. NA #1 stated Resident #68 was alert and oriented and loved his showers and never refused them. An interview was conducted with Nurse Aide #2 on 03/11/21 at 2:28 PM who confirmed she worked on 03/08/21 day shift and did not give Resident #68 his shower because she did not have enough time before the end of her shift to give him a shower. The NA stated she personally made sure Resident #68 received his shower today (03/11/21). During an interview with the Director of Nursing and the Administrator on 03/11/21 at 6:32 PM they stated that not having enough time was not an acceptable excuse to not give Resident #68 his showers and that they could have passed it along to the next shift to give Resident #68 his preferred showers on Mondays and Thursdays.	F 561	for newly hired nurses and CNAs including agency staff. The facility converted from paper to computerized Point of Care (POC) documentation on 4/1/21 to enhance the ability of the nursing assistants to document care and easier for the nurses to review. POC documentation will reviewed in the daily clinical meeting to ensure care is being provided and documented. 4. A shower audit of 5 residents per week will be completed by the Center Nurse Executive (CNE) or designee for the next two months, and then monthly thereafter or until 100% compliance is achieved for two consecutive months, to ensure showers are being completed as scheduled or requested. The CNE will follow up with staff as necessary. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and interventions based on the outcomes and direct further investigations.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		4/9/21

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F 578	Continued From page 3 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse 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.	F 578		

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F 578	Continued From page 4 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: Based on record review and staff interviews the facility failed to maintain accurate advance directives throughout the medical records for 3 of 22 residents reviewed for advance directives (Resident #29, Resident #42, and Resident #45). The finding included: 1. Resident #29 was initially admitted to the facility on 08/04/16 and recently readmitted to the facility on 02/19/21 with diagnoses that included: paraplegia, diabetes, chronic pain syndrome, and others. Review of a physician order dated 07/11/19 indicated that Resident #29 was a Full Code (cardiopulmonary resuscitation (CPR) to be started if his heart stopped beating). Review of the quarterly Minimum Data Set (MDS) dated 01/15/21 indicated that Resident #29 was moderately cognitively impaired for daily decision making and required total assistance with activities of daily living. Review of Resident #29's electronic medical record on 03/08/21 at 11:00 AM revealed that Resident #29 was a Full Code. Review of Resident #29's care plan on 03/08/21 at 11:30 AM revealed no care plan for code status. Review of the facility's Do Not Resuscitate (DNR)	F 578	F578 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. The physician orders were reviewed by the Social Service Director on 3/10/21 and the, Point Click Care orders, code status book and care plans were updated to accurately reflect the current code status for residents #29, #42, and #45. 2. All residents have the potential to be affected. The Social Service Director completed a 100% audit on 3/11/21 of resident□s code status and updated the code status books and care plans to accurately reflect the resident□s desired code status 3. The Social Service Director was in-serviced on 4/2/21 by the Center Executive Director regarding the regulation of maintaining accurate code status for each resident, the process of the admission/readmission nurse will verify the resident□s code status on	

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F 578	Continued From page 5 book at the nursing station on 03/08/21 at 12:20 PM revealed that Resident #29 had a DNR in place. An interview was conducted with Nurse #1 on 03/08/21 at 4:24 PM. Nurse #1 stated that the DNR book contained the code status of all the resident in the facility and in case of emergency or when sending a resident to the hospital the nursing staff would grab the DNR book located at the nurses station to save time from having to log into the electronic medical record. Nurse #1 stated that the facility had moved all medical records to their computer system but the DNR book remained at the nurse's station to assist the nursing staff in an emergency situation. An interview was conducted with the Social Worker (SW) on 03/10/21 at 3:56 PM. The SW stated at the facility the admission nurse would obtain the code status for each resident they admit, then when she saw the resident for their initial assessment, she would again discuss code status with the resident or the family. The SW stated that the nurse would find out the code status and then enter the order into the electronic medical record and she would assist with getting any additional paperwork completed and signed. The SW explained that recently the facility had moved to a paperless system and all the medical records were now in the electronic medical and no longer kept in charts at the nursing station. She stated when the Medical Record Clerk (MRC) was scanning documents into the electronic system she put the DNR book together and placed it at the nursing station. She indicated that she was working earlier in the day on code status and realized that Resident #29's code status had changed as Resident #29 was no	F 578	admission, obtain order, document, and update the code status book. If the resident is a Do Not Resuscitate (DNR) a copy of the State Issued DNR will be uploaded to the resident□s chart by Medical Records. The admission will be reviewed in the daily clinical meeting to ensure the code status was obtained and documented. The code status will be reviewed by the resident and/or responsible party at the quarterly care plan review to ensure the desired code status is in place. The Social Service Director will update the code status book and care plan as necessary for any changes. The licensed nurses and the Medical Records Coordinator were in-serviced 4/5/21 to 4/8/21 by the NPE regarding the admission/readmission nurse will verify the resident□s code status on admission, obtain order, document, and update the code status book. If the resident is a Do Not Resuscitate (DNR) a copy of the State Issued DNR will be uploaded to the resident□s chart by Medical Records. The admission will be reviewed in the daily clinical meeting to ensure the code status was obtained and documented. The code status will be reviewed the by the resident and/or responsible party at the quarterly care plan review to ensure the desired code status is in place. The Social Service Director will update the code status book and care plan as necessary for any changes. This education will be added to the orientation process/agenda for newly hired nurses, Social Service Directors and Medical	

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F 578	Continued From page 6 longer able to make decisions for himself and the family had decided to change his code status from Full Code to a DNR some time ago. The SW stated she got the DNR signed by the physician but can not recall if she asked any nursing personnel to enter the correct order into the electronic medical record. The SW stated that when Resident #29's family changed his code status to a DNR a new order should have been obtained and the DNR book at the nurses updated so that both medical records matched and were correct. An interview was conducted with the MRC on 03/11/21 at 10:40 AM. The MRC stated that everything from August 2020 to the present should be scanned into the resident electronic medical record. She added that when she scanned each resident record into the electronic record, she created the DNR book at the nurse's station for residents code status and placed it at the nurse's station to help the nurses have a quick reference of resident's code status. The MRC stated if a resident or resident family changed their code status the nurse would enter the order and then let her know to update the DNR book accordingly. She stated that no one notified her that Resident #29's code status had changed, or she would have updated the book to reflect the change. She added that each month since she created the DNR book she audited the book for completeness to make sure the paperwork was still present, but she was not auditing the electronic medical record versus the DNR book to make sure they matched. An interview was conducted with the Administrator and the Director of Nursing (DON) on 03/11/21 at 6:13 PM. The DON stated that	F 578	Records Coordinators including agency staff. 4. An audit will be completed monthly indefinitely to ensure orders, code status book and the care plans accurately reflect the wishes for each resident. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and interventions based on the outcomes and direct further investigations.	

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when a resident admitted to the facility the admission orders included code status. She stated that she could not speak to Resident #29's code status because he was admitted before she came to the facility but stated that the code status in the electronic medical record must match the DNR book at the facility and that MRC should be auditing them to ensure that they matched.

2. Resident #42 was readmitted to the facility on 01/22/21 with diagnoses that included end stage renal failure, chronic diastolic heart failure, dependence on renal dialysis and others.

Review of a physician order dated 01/22/21 read, Full Code.

Review of the quarterly Minimum Data Set (MDS) dated 01/30/21 indicated that Resident #42 was cognitively intact and was independent with activities of daily living.

Review of Resident #42's electronic medical record on 03/08/21 at 11:00 AM revealed that Resident #42 was a Full Code.

Review of Resident #42's care plan on 03/08/21 at 11:30 AM revealed no care plan for code status.

Review of the facility's Do Not Resuscitate (DNR) book at the nursing station on 03/08/21 at 12:20 PM revealed that Resident #42 had a DNR in place.

An interview was conducted with Nurse #1 on 03/08/21 at 4:24 PM. Nurse #1 state that the DNR book contained the code status of all the resident in the facility and in case of emergency

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or when sending a resident to the hospital the nursing staff would grab the DNR book located at the nurses station to save time from having to log into the electronic medical record. Nurse #1 stated that the facility had moved all medical records to their computer system but the DNR book remained at the nurse's station to assist the nursing staff in an emergency situation.

An interview was conducted with the Social Worker (SW) on 03/10/21 at 3:56 PM. The SW stated at the facility the admission nurse would obtain the code status for each resident they admit, then when she saw the resident for their initial assessment, she would again discuss code status with the resident or the family. The SW stated that the nurse would find out the code status and then enter the order into the electronic medical record and she would assist with getting any additional paperwork completed and signed. The SW explained that recently the facility had moved to a paperless system and all the medical records were now in the electronic medical and no longer kept in charts at the nursing station. She stated when the Medical Record Clerk (MRC) was scanning documents into the electronic system she put the DNR book together and placed it at the nursing station. She further explained that Resident #42 had briefly transferred to another facility and while he was there, he revoked his Do Not Resuscitate (DNR) order and when he returned to this facility, he told me that he wished to be a Full Code. The SW stated that the DNR needed to be removed from the DNR book at the nurse's station but stated she had been covering for other duties lately and the it was just on oversight on her part.

An interview was conducted with the MRC on

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03/11/21 at 10:40 AM. The MRC stated that everything from August 2020 to the present should be scanned into the resident electronic medical record. She added that when she scanned each resident record into the electronic record, she created the DNR book at the nurse's station for residents code status and placed it at the nurse's station to help the nurses have a quick reference of resident's code status. The MRC stated if a resident or resident family changed their code status the nurse would enter the order and then let her know to update the DNR book accordingly. She stated that no one notified her that Resident #42's code status had changed, or she would have updated the book. She added that each month since she created the DNR book she audited the book for completeness to make sure the paperwork was still present, but she was not auditing the electronic medical record versus the DNR book to make sure they matched.

An interview was conducted with the Administrator and the Director of Nursing (DON) on 03/11/21 at 6:13 PM. The DON stated that when a resident admitted to the facility the admission orders included code status. She stated that she could not speak to Resident #42's code status because he was admitted before she came to the facility but stated that the code status in the electronic medical record must match the DNR book at the facility and that MRC should be auditing them to ensure that they do matched.

3. Resident #45 initially admitted to the facility on 09/20/19 and recently readmitted to the facility on 02/23/21 with diagnoses that included Alzheimer's disease, dementia, diabetes, and others.

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Review of a physician order dated 09/25/19 read, Full Code.

Review of a readmission assessment dated 02/23/21 indicated that Resident #45 was a Full Code.

Review of Resident #45's electronic medical record on 03/08/21 at 11:00 AM revealed that Resident #45 was a Full Code.

Review of Resident #45's care plan on 03/08/21 at 11:30 AM revealed no care plan for code status.

Review of the facility's Do Not Resuscitate (DNR) book at the nursing station on 03/08/21 at 12:20 PM revealed that Resident #45 had a DNR in place.

An interview was conducted with Nurse #1 on 03/08/21 at 4:24 PM. Nurse #1 stated that the DNR book contained the code status of all the residents in the facility and in case of emergency or when sending a resident to the hospital the nursing staff would grab the DNR book located at the nurses station to save time from having to log into the electronic medical record. Nurse #1 stated that the facility had moved all medical records to their computer system but the DNR book remained at the nurse's station to assist the nursing staff in an emergency situation.

An interview was conducted with the Social Worker (SW) on 03/10/21 at 3:56 PM. The SW stated at the facility the admission nurse would obtain the code status for each resident they admit, then when she saw the resident for their initial assessment, she would again discuss code

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F 578	Continued From page 11	F 578		

status with the resident or the family. The SW stated that the nurse would find out the code status and then enter the order into the electronic medical record and she would assist with getting any additional paperwork completed and signed. The SW explained that recently the facility had moved to a paperless system and all the medical records were now in the electronic medical and no longer kept in charts at the nursing station. She stated when the Medical Record Clerk (MRC) was scanning documents into the electronic system she put the DNR book together and placed it at the nursing station. The SW explained that Resident #45 had recently returned from the hospital with the DNR in place and no one had entered an order changing his code status from Full Code to DNR. She again stated she had been covering other duties and it was just an oversight on her part.

An interview was conducted with the MRC on 03/11/21 at 10:40 AM. The MRC stated that everything from August 2020 to the present should be scanned into the resident electronic medical record. She added that when she scanned each resident record into the electronic record, she created the DNR book at the nurse's station for residents code status and placed it at the nurse's station to help the nurses have a quick reference of resident's code status. The MRC stated if a resident or resident family changed their code status the nurse would enter the order and then let her know to update the DNR book accordingly. She stated that no one notified her that Resident #45's code status had changed, or she would have updated the book accordingly. She added that each month since she created the DNR book she audited the book for completeness to make sure the paperwork

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F 578	Continued From page 12 was still present, but she was not auditing the electronic medical record versus the DNR book to make sure they matched. An interview was conducted with the Administrator and the Director of Nursing (DON) on 03/11/21 at 6:13 PM. The DON stated that when a resident admitted to the facility the admission orders included code status. She stated that she could not speak to Resident #45's code status because he was admitted before she came to the facility but stated that the code status in the electronic medical record must match the DNR book at the facility and that MRC should be auditing them to ensure that they do matched.	F 578		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		4/9/21

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F 656	Continued From page 13 (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to implement a respiratory care plan for the use of oxygen for 1 of 3 resident (Resident #42) reviewed for respiratory management. The findings included: Resident #42 readmitted to the facility on 01/22/21 with diagnoses of chronic diastolic heart failure, chronic obstructive pulmonary disease (COPD), and others. Review of a physician order dated 01/22/21 read, Oxygen at 2 liters per minute continuously. Review of the quarterly Minimum Data Set (MDS)	F 656	F656 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. The Care Plan for Resident #42 was revised by the Clinical Reimbursement Coordinator (CRC) on 3/9/21 to reflect the resident□s usage of oxygen. The oxygen flow rate was corrected upon notification	

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F 656	Continued From page 14 dated 01/30/21 indicated Resident #42 was cognitively intact for daily decision making. The MDS further revealed that Resident #42 required no assistance with activities of daily living. No shortness of breath was noted during the assessment reference period, and oxygen was used during the assessment reference period. Review of a MDS Kardex report for Resident #42 with no date provided did not list any oxygen use or oxygen orders. An observation and interview were conducted with Resident #42 on 03/08/21 at 3:55 PM. Resident #42 was in his recliner in his room and had oxygen cannula in his nose that was a connected to a concentrator. The concentrator was set to deliver 3 liters of oxygen. Resident #42 stated that he used his oxygen all the time and was supposed to be on 2 liters per minute. Review of a care plan revised on 03/09/21 read in part, COPD clinical management with chronic bronchitis, and shortness of breath. The goal of the care plan read; the patient will be able to speak in full sentences x 90 days. The interventions included: oxygen per orders. An observation of Resident #42 was made on 03/09/21 at 2:56 PM. Resident #42 was observed to be resting with his eyes closed in his recliner in his room. He had oxygen cannula in his nose that was connected to a concentrator. The concentrator was set to deliver 3 liters of oxygen. An interview was conducted with Nurse #1 on 03/09/21 at 4:22 PM. Nurse #1 confirmed that she was caring for Resident #42. Nurse #1 stated that Resident #42 was alert and oriented and	F 656	by the surveyor during the survey. 2. Any resident with orders to receive oxygen has the potential to be affected. An audit of Care Plans was completed by the Administrative Nursing Team on 4/8/21 of all residents receiving oxygen. If the Care Plan did not reflect the use of oxygen, the care plan was updated at that time. An audit was completed by the Administrative Nursing Team on 4/5/21 of all residents with orders for oxygen to ensure the oxygen was being administered at the correct rate. If the rate was incorrect, it was corrected at that time. 3. The Interdisciplinary Team was in-serviced by Regional Clinical Director on 4/2/21 regarding the regulation pertaining to the development and implementation of a comprehensive person centered care plan 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 to attain or maintain the resident's highest practicable physical, mental and psychosocial wellbeing. Any resident admitted with, or acquire new orders oxygen will be reported in the Daily Clinical Meeting as a means for informing the Interdisciplinary Team of oxygen orders so they can be accurately reflected on the Care Plan. The Clinical Reimbursement Coordinator will be responsible for ensuring the care plan and the Kardex is updated and implemented in	

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F 656	Continued From page 15 wore oxygen at 2 liters per minute continuously. An observation of Resident #42 was made on 03/10/21 at 3:32 PM. Resident #42 was in his recliner in his room and had oxygen in his nose that was connected to a concentrator. The concentrator was set to deliver 3 liters of oxygen. An interview was conducted with Nurse #5 on 03/10/21 at 4:23 PM. Nurse #5 confirmed she was caring for Resident #42. She stated that Resident #42 had an order for oxygen at 2 liters per minute. An interview was conducted with the Administrator and Director of Nursing (DON) on 03/11/21 at 5:49 PM. The DON stated that she had only been at the facility for one month and the facility was using the wrong Kardex system. She explained the MDS Kardex does not include the information from each of Resident #42's care plan. The other care plan Kardex has all the information that was contained in the care plan and that was what the staff use to implement Resident #42's care plan. The DON stated that the expectation was that all care plan interventions were implemented.	F 656	Point Click Care to ensure the care plan is implemented. The licensed nurses were in-serviced by the Nurse Practice Educator (NPE) 4/5/21 to 4/8/21 regarding ensuring the oxygen delivery rate of all residents with orders for oxygen is consistent with the rate indicated in the physician orders. This education will be added to the orientation process/agenda for newly hired nurses including agency staff. 4. The care plans and oxygen delivery rate of 5 residents identified with oxygen orders will be audited weekly by the Center Nurse Executive (CNE) for the next two months, and then monthly thereafter or until 100% compliance is achieved for two consecutive months, to ensure the care plans accurately reflect the use of oxygen and the oxygen is delivered at the correct rate. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and interventions based on the outcomes and direct further investigations.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		4/9/21

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F 658	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews the facility failed to obtain a resident's monthly blood pressure for 1 of 3 residents (Resident #68) reviewed for activities of daily living and failed to perform a wound dressing change for 1 of 3 residents (Resident #219) reviewed for wound care. The findings include: 1) Resident #68 was admitted to the facility on 05/20/15 with diagnoses that included hypertension, renal insufficiency and cerebral vascular accident. A review of the facility's policy for vital signs dated 11/01/19 indicated the vital signs would be obtained monthly for long term care residents. Review of Resident #68's medical record dated 04/23/20 revealed an order for Amlodipine Besylate (lowers blood pressure) give one tablet 10 mg (milligrams) by mouth one time a day for hypertension. The care plan updated 12/30/20 revealed Resident #68 was at risk for cardiovascular symptoms or complications related to hypertension and a history of a cerebral vascular accident. The goal for Resident #68's blood pressure to remain within normal limits would be obtained by utilizing interventions that included administering medications as ordered and assessing for effectiveness and side effects and report the abnormalities to the physician. Review of Resident #68's medical record	F 658	F658 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Resident #68 no longer resides at the facility so no corrective action can be completed for this resident. 2. Any resident with ordered treatments has the potential to be affected. The Treatment Administration Records (TAR)of all residents with ordered treatments was reviewed by Administrative Nursing Team on 4/2/21 to determine if all treatments were being completed and documented as ordered. Nurses failing to complete treatments and document will be followed up with by the CNE as necessary. 3. The licensed nurses were in-serviced by the NPE regarding physician orders, completing ordered treatments and documenting treatments as they are being completed. This education will be added to the orientation process. The missing documentation report for treatments will be reviewed in the daily clinical meeting and the nurses failing to complete and	

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F 658	Continued From page 17 indicated the last blood pressure recorded was on 01/14/21 which was 124/72 mmHg (millimeter of mercury). The recent quarterly Minimum Data Set (MDS) assessment dated 01/22/21 revealed Resident #68 was cognitively intact. During an interview with Resident #68 on 03/09/21 at 9:55 AM he voiced his concern that he received a daily medication for his high blood pressure, and he had not had his blood pressure taken in a month give or take two weeks. The Resident stated they take my other vital signs but not my blood pressure. An interview was conducted with Nurse Aide (NA) #1 on 03/10/21 at 8:27 AM. The NA explained that since COVID the aides obtained all the vital signs except the blood pressure on every resident the first thing in the morning. She continued to explain that the nurse would let them know which residents they needed to get the blood pressures on when they obtained the other vital signs. During an interview with Nurse #3 on 03/11/21 at 4:40 PM she explained the aides collected the vital signs of pulse, temperature and the oxygenation saturation on every resident in the mornings. The Nurse continued to explain that if a full set of vital signs which included the blood pressure was needed then the nurse would let the aides know in the morning which residents' they needed the blood pressures on. The Nurse informed that reasons for the blood pressure to be obtained was if the resident was experiencing an acute episode or if they were on blood pressure medications. When the Nurse was asked why Resident #68's blood pressure had not	F 658	document treatments will be followed up with as necessary. 4. Five residents with ordered treatments will be audited per week to ensure the ordered treatment is completed and documented as ordered, then ten residents per month until 100% compliance is maintained for two consecutive months. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and interventions based on the outcomes and direct further investigations.	

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been checked the Nurse stated she was not aware that his blood pressure needed to be checked.

An interview was conducted with Resident #68's Physician on 03/11/21 at 4:16 PM who explained his expectation was that the Resident's blood pressure be obtained at least monthly especially since Resident #68 was on a blood pressure medication.

During an interview with the Director of Nursing (DON) and Administrator on 03/11/21 at 6:32 PM the DON explained that in response to COVID the facility did away with obtaining the full set of vital signs and now collected what was called COVID vital signs which included the pulse, temperature and oxygen saturation every day. She continued to explain that the facility standard was for the full set of vital signs including the blood pressure be obtained once a week especially if the resident was on a blood pressure medication. She stated the system was broken and would be fixed.

#2. Resident #219 was admitted to the facility on 07/31/20 with diagnoses that included cerebral infarction acute kidney failure, congestive heart failure, urinary tract infection, and bells palsy. She subsequently discharged on 08/06/20.

A review of Resident #219's admission Minimum Data Set Assessment was unable to be completed due to Resident #219 discharging from the facility.

Review of Resident #219's electronic physician orders dated 07/31/2020 included "Cleanse wound on left side of groin with normal saline (NS) and pack with a 2x2 and cover with

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dry dressing every day and night shift".

Review of Resident #219's treatment administration record (TAR) revealed no treatment signed off as being completed on 08/03/2020 on the night shift and on 08/04/20 & 08/05/20 during the day shift.

Review of facility provided staff schedules revealed Nurse #6 worked the night shift on 08/03/20, Nurse #4 worked the day shift on 08/04/20, and the ADON worked the day shift on 08/05/20.

An interview with Nurse #6 was attempted on 03/11/21 at 1:59PM by phone but was unsuccessful.

During an interview with the ADON on 03/10/21 at 2:39 PM she reported she was new to the facility in August of 2020 and was working as a unit supervisor at the time. She reported during that time, she also worked the halls when there were staff call outs. She verified she was working the day shift on 08/05/20 and reported she believed she may have been training another nurse at that time. She reported that wound care treatments are reported on the TAR and that once a wound treatment was provided, the corresponding box on the TAR should be initialed and checked as completed. The ADON stated she knew she looked at her TARs for residents daily but reported she could not state with certainty that the treatment was completed if it was not signed off on the TAR. She stated if Resident #219's TAR was not initialed and checked as completed, then the assumption would be that it was not completed. She did not have an explanation on why it was not signed off as being completed.

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F 658	Continued From page 20 An interview with Nurse #4 on 03/10/21 at 5:59PM revealed she did work on 08/04/20 during the day shift as notated on the schedule. She stated she remembered Resident #219's name but did not remember Resident #219's care needs specifically. She stated when wound treatments were completed, they were to be signed off on the resident's TAR. She reported treatments were recorded on a separate document from medications and the nurses had to toggle between the two documents to ensure all treatments and medications were signed off when given. She stated if the TAR was not signed off as being completed, it would mean the treatment was not provided to the resident, or the treatment was provided and the providing nurse did not sign off on the TAR. She reported she did not remember 08/04/20 and whether or not she provided the ordered wound treatment to Resident #219. Nurse #4 stated without a signature on the TAR, it would be impossible to state with certainty the wound treatment was provided. An interview with the Director of Nursing on 03/11/20 at 7:33PM revealed TARs should be signed off as completed if the wound treatment was completed, and if the TAR was not signed off as completed, then the assumption was that the treatment was not provided. She reported there was no excuse for treatments to wounds to not be provided as ordered, nor would there be an excuse for nurses to not sign off on treatments that were provided.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		4/9/21

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F 689	Continued From page 21 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to determine the root cause analysis of a Resident's fall with no injury, in order to implement effective interventions to prevent further falls for 1 of 5 residents reviewed for accidents (Resident #44). The findings included: Resident #44 was admitted to the facility on 03/12/20 with diagnoses that included hypertension and diabetes mellitus and bipolar disorder. The care plan for falls last reviewed on 10/19/20 revealed Resident #44 was at risk for falls related to diabetes mellitus. The goal for the Resident to not have any falls before the next review would be attained by utilizing interventions which included keeping the bed in low position, keeping a clutter free environment, keeping the call light in reach, keeping the personal items in reach, assessing for acute changes in mental status and reporting to the physician as indicated. The recent quarterly Minimum Data Set (MDS) assessment dated 11/23/20 revealed Resident #44 had moderately intact cognition and required extensive assistance with the help of one staff for	F 689	F689 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. The chart for resident #44 was updated by Nurse #1 to reflect the fall. Nurse #1 was educated by the NPE on 4/1/21 regarding the process to follow after a fall including assessment, documentation, trying to determine the cause of the fall, implementing an intervention to prevent reoccurrence and notification of the physician and responsible party. 2. Any resident with falls have the potential to be affected. The Administrative Nursing Team completed a review on 3/10/21 of the incidents from the prior 30 days to ensure all aspects of the fall process were completed including assessment, documentation, trying to	

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F 689	Continued From page 22 transfers and ambulation. The MDS also indicated the Resident was not steady with only being able to stabilize with human assistance and Resident #44 had one fall without injury since the previous MDS assessment. An interview was conducted with the Maintenance Supervisor (MS) on 03/11/21 at 11:08 AM. The MS explained that he had manager on duty responsibilities on Sunday 01/17/21 when he observed Resident #44 on the floor and crawling out of his room into the hall and notified the staff. Review of Resident #44's medical record revealed no documentation of a root cause analysis was determined in response to a fall on 01/17/21. Observation of Resident #44 on 03/09/21 at 8:39 AM sitting in his room in his wheelchair by his bed. The Resident's call light was in his reach and his bed was in low position with the fall mat on the floor between the bed and wall. His room was clear of clutter in the floor. During an interview with Resident #44 on 03/09/21 at 8:39 AM he stated he remembered falling in his room but could not remember when or the circumstances of the fall. A telephone interview was conducted with Nurse #1 on 03/11/21 at 11:16 AM who explained she remembered that Resident #44 had a fall but could not remember the exact day. She stated that she was alerted by a staff member that the Resident was observed on the floor and assessed him to have no injury before she obtained help to put him back into his wheelchair. The Nurse explained that when there was a	F 689	determine the cause of the fall, implementing an intervention to prevent reoccurrence and notification of the physician and responsible party. 3. The licensed nurses were educated by the NPE on 3/22/21 to 4/8/21 regarding the process to follow after a fall including assessment, documentation, trying to determine the cause of the fall, implementing an intervention to prevent reoccurrence and notification of the physician and responsible party. This education will be added to the orientation process/agenda for newly hired nurses including agency staff Incidents from the prior day will be reviewed by the Interdisciplinary Team (IDT) in the daily clinical meeting to ensure all aspects of the process following a fall are completed. Any nurse failing to complete all aspects of the fall process. 4. The charts of 5 residents with falls will be audited by the CNE or designee per week then 10 per month until 100% compliance is maintained for two consecutive months to ensure all aspects of the fall process are completed including assessment, documentation, trying to determine the cause of the fall, implementing an intervention to prevent reoccurrence and notification of the physician and responsible party. The CNE will follow up with nursing staff as needed. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and	

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F 689	Continued From page 23 resident fall the nurse 1) assessed the resident for injury 2) obtained vital signs for witnessed falls and neuro checks and vital signs for unwitnessed falls 3) provided first aide if necessary 4) notify the provider of the fall and 5) complete a change in condition assessment which would automatically load the follow up documentation that was to be completed for risk management. The Nurse continued to explain that the change in condition form would prompt the nurse to determine the root cause analysis of the fall so the care plan could be updated. When the Nurse was asked if she completed the change in condition assessment and the root cause analysis form, she stated if she had she would have documented the procedures in the Resident's medical record. She continued to explain that the fall happened when she was new at the facility and did not know about completing the change in condition form which would have triggered the follow up to determine the root cause analysis. During an interview with the Administrator and Director of Nursing (DON) on 03/11/21 at 6:55 PM the DON explained that the process to follow after a fall was for the nurse to conduct a head to toe assessment before the resident was lifted from the floor using the total lift, vital signs and neuro checks were initiated for unwitnessed falls, notify the responsible party and the provider, complete the change in condition assessment. She continued to explain that the change in condition form would automatically upload more documentation that was necessary to complete the incident report for risk management, complete a fall scene investigation form to get to the root cause of the fall and update the care plan. The DON stated she looked for the fall documentation on Resident #44 for 01/17/21	F 689	interventions based on the outcomes and direct further investigations.	

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F 689	Continued From page 24 earlier in the day and it was not in his medical record. The DON added she knew the facility's fall process was broken.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Medical Director interviews the facility failed to administer oxygen as ordered (Resident #42) and failed to replace oxygen cannula that had been placed on the floor (Resident #60) for 2 of 3 residents reviewed for respiratory management. The findings included: 1. Resident #42 readmitted to the facility on 01/22/21 with diagnoses of chronic diastolic heart failure, chronic obstructive pulmonary disease, and others. Review of a physician order dated 01/22/21 read, Oxygen at 2 liters per minute continuously. Review of the quarterly Minimum Data Set (MDS) dated 01/30/21 indicated Resident #42 was cognitively intact for daily decision making. The	F 695	F695 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. The oxygen flow rate for resident #42 was corrected to 2 liters per minute by the assigned nurse upon notification by the surveyor during the survey. The oxygen tubing for resident #60 was replaced by the nurse on duty upon notification by the surveyor 2. Any resident with orders for oxygen has	4/9/21

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F 695	Continued From page 25 MDS further revealed that Resident #42 required no assistance with activities of daily living. No shortness of breath was noted during the assessment reference period, and oxygen was used during the assessment reference period. An observation and interview were conducted with Resident #42 on 03/08/21 at 3:55 PM. Resident #42 had a oxygen cannula in his nose that was a connected to a concentrator. The concentrator was set to deliver 3 liters of oxygen. Resident #42 stated that he used his oxygen all the time and was supposed to be on 2 liters per minute. Resident #42 denied changing his oxygen concentrator or even being able to reach it from his recliner. An observation of Resident #42 was made on 03/09/21 at 2:56 PM. He had an oxygen cannula in his nose that was connected to a concentrator. The concentrator was set to deliver 3 liters of oxygen. An interview was conducted with Nurse #1 on 03/09/21 at 4:22 PM. Nurse #1 confirmed that she was caring for Resident #42. Nurse #1 stated that Resident #42 was alert and oriented and wore oxygen at 2 liters per minute via nasal cannula. Nurse #1 stated that she generally checked Resident #42 's oxygen concentrator once a shift but stated she had not checked his concentrator thus far on her shift. An observation and interview were conducted with Resident #42 on 03/10/21 at 3:32 PM. Resident #42 had an oxygen cannula in his nose that was connected to a concentrator. The concentrator was set to deliver 3 liters of oxygen. Resident #42 stated that he had not noticed the	F 695	the potential to be affected. An audit was completed by the Administrative Nursing Team completed an audit on 4/1/21 of all residents with orders for oxygen to ensure the oxygen was being administered at the correct rate and the tubing is not on the floor. If the rate was incorrect, it was corrected at that time. If the tubing was on the floor, it was changed at that time. 3. The licensed nurses were in-serviced by the NPE on 4/2/21 to 4/8/21 regarding ensuring the oxygen delivery rate of all residents with orders for oxygen is consistent with the rate indicated in the physician orders and the facility staff were in-serviced by the NPE on 4/5/21 to 4/8/21 regarding immediately notifying a nurse if the oxygen tubing is found on the floor so it can be replaced. This education will be added to the orientation process/agenda for newly hired facility staff from all departments including agency staff Observing oxygen rates and oxygen tubing was added to the Partner Rounds Sheet. The Department Heads were in-serviced by the CED on 4/2/21 regarding adding observation of oxygen rates and tubing to the partner rounds. 4. The oxygen delivery rate and storage of oxygen tubing when not in use of 5 residents identified with oxygen orders will be audited weekly by the CNE for the next two months, and then monthly thereafter or until 100% compliance is achieved for two consecutive months, to ensure the oxygen is delivered at the correct rate and the tubing is properly stored when not in	

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F 695	Continued From page 26 staff checking his concentrator when they were in his room earlier in the day. An interview was conducted with Nurse #5 on 03/10/21 at 4:23 PM. Nurse #5 confirmed she was caring for Resident #42. She stated that if a resident had an order for oxygen the medical record system prompted the staff to check the resident's oxygen concentrator to ensure it was delivered at the correct dose once a shift. Nurse #5 stated but anytime the staff rounded they should be checking the concentrator and ensuring the correct dose was being delivered. A follow up interview with Nurse #5 was conducted on 03/10/21 at 4:32 PM. Nurse #5 stated she had not checked Resident #42's oxygen concentrator thus far on her shift. Nurse #5 stated that Resident #42 could change his oxygen concentrator, but she did not believe he would do that. An interview was conducted with the Medical Director (MD) on 03/11/21 at 4:03 PM. The MD stated that anyone that had an order for oxygen should receive the oxygen as ordered. He explained if the resident required more or less oxygen then prescribed the staff should contact the provider for an order change. An interview was conducted with the Administrator and Director of Nursing (DON) on 03/11/21 at 5:59 PM. The DON stated that the nursing staff should be checking oxygen concentrators at a minimum once a shift. If the physician order stated 2 liters, then she expected the oxygen to be delivered as prescribed at 2 liters.	F 695	use. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and interventions based on the outcomes and direct further investigations.	

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F 695	Continued From page 27	F 695		

2. Resident # 60 readmitted to the facility on 09/10/20 with diagnoses that included pneumonia, psychogenic hyperventilation, and Parkinson's disease.

Review of the most recent quarterly Minimum Data Set (MDS) dated 01/04/21 indicated that Resident #60 was severely cognitively impaired for daily decision making and required extensive assistance with activities of daily living. No oxygen was used during the assessment reference period.

Review of a physician order dated 02/17/21 read, Oxygen at 2 liters via nasal cannula continuously.

An observation of Resident #60 was made on 03/08/21 at 3:34 PM. Resident #60 was up in his wheelchair in his room. He proceeded to propel himself towards the doorway leading into the hallway. Resident #60 had an oxygen cannula in his nose that was connected to a concentrator. As Resident #60 got closer to the door his oxygen cannula began to pull on his face and Resident #60 removed the oxygen and threw the oxygen cannula on the floor and proceeded out into the hallway.

An interview with Nurse #1 was conducted on 03/08/21 at 2:33 PM. Nurse #1 was made aware that Resident #60 had removed his oxygen cannula and threw it on the floor. Nurse #1 stated "he does not need it" and continued on with the task she was performing.

An observation of Resident #60 was made on 03/09/21 at 3:21 PM. Resident #60 was up in his wheelchair and his oxygen cannula was lying on the floor in front of his oxygen concentrator.

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F 695	Continued From page 28	F 695		

An interview was conducted with Nurse Aide (NA) # 4 on 03/09/21 at 3:22 PM. NA #4 was made aware that Resident #60 did not have his oxygen on because it was lying on the floor. NA #4 stated that Resident #60 did need his oxygen and went to the supply closet and retrieved some pads for the ear loops. NA #4 returned to Resident #60's room and picked up the oxygen cannula that was lying on the floor, placed the pads to the ear loops, and then placed the oxygen cannula back in Resident #60's nose.

An observation was made of Resident #60 on 03/10/21 at 3:25 PM. Resident #60 was up in his wheelchair in his room. His oxygen cannula was lying on the floor in front of the oxygen concentrator.

An interview was conducted with NA #5 on 03/10/21 at 3:45 PM. NA #5 stated that Resident #60 needed his oxygen and proceed to the supply closet to retrieve some pads for the ear loops. NA #5 returned to Resident #60's room picked up the oxygen cannula that was lying on the floor, placed the pads on the ear loop, and then placed the oxygen cannula back in Resident #60's nose.

An interview was conducted with Nurse #5 on 03/10/21 at 4:23 PM. Nurse #5 confirmed that she was caring for Resident #60 and that he wore his oxygen continuously. Nurse #5 stated that if the oxygen cannula was on the floor the staff should be discarding the cannula and getting a new cannula due to infection control risk.

A follow up interview was conducted with NA #5 on 03/10/21 at 4:42 PM. NA #5 stated that he did not know that oxygen cannula that had been lying

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F 695	Continued From page 29 on the floor should not be replaced back on the resident. NA #5 stated he would go the supply closet and replace Resident #60 s oxygen cannula immediately. An attempt to speak to NA #4 was made on 03/11/21 at 12:27 PM with no success. An interview was conducted with the Administrator and Director of Nursing (DON) on 03/11/21 at 6:00 PM. If the staff discover an oxygen cannula that was lying on the floor, they should immediately report it to the nurse. The DON stated that the nurse should then throw the oxygen cannula away that was on the floor obtain new cannula, date it, and then apply it to the resident. The DON again stated that no oxygen cannula that had been on the floor should be placed back on the resident.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and Medical Director interviews the facility failed to respond to and manage a resident's complaint of pain for 1 of 3 residents reviewed with pain (Resident #29). The finding included:	F 697	F697 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared	4/9/21

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F 697	Continued From page 30 Resident #29 was initially admitted to the facility on 08/04/16 and recently readmitted on 02/19/21 with diagnoses that included paraplegia, contracture, chronic pain syndrome, and poly osteoarthritis. Review of a physician order dated 07/13/20 read, Tylenol 650 milligram (mg) by mouth every 4 hours as needed for pain or fever. Review of the most recent quarterly Minimum Data Set (MDS) dated 01/15/21 indicated that Resident #29 was moderately impaired for daily decision making and required total assistance with activities of daily living. The MDS further revealed that Resident #29 received scheduled pain medication and pain was not assessed during the assessment reference period. Review of a pain care plan revised on 02/23/21 read, Resident exhibits or is at risk for alteration in comfort related to paraplegia, neuropathy pain, and impaired range of motion to bilateral upper and lower extremities. The goal of the care plan read; Resident will experience decreased pain x 90 days. The interventions included: evaluate pain characteristic, utilize pain scale, advise resident to request pain medication before pain becomes severe, medicate resident as ordered for pain and monitor for effectiveness, and monitor for nonverbal signs of pain. Review of the Medication Administration Record (MAR) dated 03/01/21 through 03/30/21 revealed Resident #29 was verbally asked if he was hurting every shift. An observation and interview were conducted with Resident #29 on 03/09/21 at 10:01 AM.	F 697	and / or executed solely because it is required by both Federal and State laws. 1. The nurse assigned to resident #29 administered the pain medication after the second notification by the surveyor and assessed for effectiveness after administration. Resident indicated the pain medication was effective upon reassessment and his pain is being addressed as necessary. 2. Any resident identified with pain has the potential to be affected. An audit was completed by the Administrative Nursing Team on 4/2/21 of all residents receiving PRN pain medication in the last 60 days to determine if the medication is being delivered timely after request and if an assessment for effectiveness was completed after administration. 3. The licensed nurses were in-serviced by the NPE on 4/5/21 to 4/8/21 regarding ensuring PRN medication is being administered as soon as possible after request and completion of follow up assessments to determine if the medication was effective. They were instructed to follow up with the physician if the medication was not effective for further instructions. This education will be added to the orientation process/agenda for newly hired nurses including agency staff. 4. An audit will be completed by a	

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F 697	Continued From page 31 Resident #29 was resting in his bed turned slightly on his left side, his legs were slightly bent to the side. Resident #29 was dressed in hospital gown and was covered by a sheet. Resident #29 reported pain in his right hip, leg, and foot that was sharp/throbbing pain and was an 8 on a pain scale from 0-10. His hands were contracted but Resident #29 pointed to his right hip, leg, and foot displaying exactly where he was hurting. An interview was conducted with Nurse #3 on 03/09/21 at 10:13 AM. Nurse #3 confirmed that she was caring for Resident #29. Nurse #3 was made aware of Resident #29's complaint of pain in his right hip, leg, and foot and that he verbalized pain on a pain scale of an 8. Nurse #3 stated she would take care of it right away. An observation and interview were conducted with Resident #29 on 03/09/21 at 3:03 PM. Resident #29 was resting in his bed dressed in a hospital gown. He could not recall if he was given anything for pain but stated his pain still remained at a 7 on a pain scale and he again pointed to his right hip, leg, and foot. He stated, "if I get something for pain it usually helps me sleep so good." A follow up interview was conducted with Nurse #3 on 03/09/21 at 3:18 PM. Nurse #3 was again made aware that Resident #29 was still complaining of pain in his right hip, leg, and foot and that he rated his pain at a 7. Nurse #3 stated that she had lost track of time and had not given Resident #29 anything for pain earlier when notified that his pain was an 8 on a pain scale. Nurse #3 indicated that Resident #29 could have some Tylenol and she would take him some now.	F 697	member of the Administrative Nursing Team by interviewing 5 residents who receive PRN pain medication per week for 4 weeks, then 10 residents per month thereafter or until 100% compliance is achieved for two consecutive months, to ensure PRN pain medication is being administered timely after request and effectiveness assessments are being completed after administration. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and interventions based on the outcomes and direct further investigations.	

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A follow up interview was conducted with Resident #29 on 03/09/21 at 5:00 PM. Resident #29 stated that he had received something for pain and his pain was down to a 5. Resident #29 stated he had been resting well for the last hour or so and was appreciative that his pain was getting better.

An interview was conducted with Nurse #4 on 03/10/21 at 5:59 PM. Nurse #4 confirmed that she regularly took care of Resident #29. Nurse #4 stated she always asked Resident #29 if he was hurting and most of the time, he had no complaints of pain. If he complained of pain, she would ask him to use the pain scale or have him describe his pain before giving him something for pain.

A follow up interview was conducted with Nurse #3 on 03/11/21 at 1:05 PM. Nurse #3 states she asked each of the residents if they were hurting and if they had pain, she would ask them what the location of the pain was. Nurse #3 stated that if the resident was verbal, she relied on them to report the pain to her. She stated that Resident #29 was verbally able to voice his pain. Nurse #3 stated that on 03/09/21 when she became aware of Resident #29's complaints of pain she got busy and it just slipped her mind. She stated when she finally took Resident #29 his pain medication, he told her that his right hip was hurting, and he wanted something stronger for pain besides Tylenol. Nurse #3 stated she normally would have added the concern to the provider book for them to follow up, but she knew she would return to work on 03/11/21 and had planned on telling the provider today sometime but had not done so yet. Nurse #3 stated that Resident #29 also stated that he wanted to get out of bed more and that

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F 697	Continued From page 33 might help relieve some of his pain. An interview with the Medical Director (MD) was conducted on 03/11/21 at 4:03 PM. The MD stated that Resident #29 had a gradual decline over the last month or so but stated that he could definitely verbalize his pain. Once Nurse #3 was made aware of Resident #29's pain she should see if he had something for pain and medicate him and then determine if the pain medication was effective. If the pain medication was not effective or if the resident had nothing for pain the MD stated, he would expect a call from the staff. An interview with the Administrator and Director of Nursing (DON) was conducted on 03/11/21 at 6:21 PM. The DON stated that Nurse #3 should have immediately went and assessed the situation including a full pain assessment that included location, duration, and intensity. Once the pain assessment was complete Nurse #3 should have medicated Resident #29 completed a change of condition and then went back between 30-60 minutes later to reassess his pain that included finding out what his acceptable pain level was and if that was not met then the MD should have been notified.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and	F 732		4/9/21

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F 732	Continued From page 34 unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post the nurse staffing information in a prominent place to include the daily resident census and care hours provided by licensed and unlicensed personnel for 4 of 4 days of the the recertification survey. The finding included:	F 732	F732 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it	

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F 732	Continued From page 35 Observations made of the front lobby area during the recertification survey on 03/08/21 at 9:45 AM and 5:15 PM, 03/09/21 at 8:00 AM and 5:15 PM, 03/10/21 at 7:30 AM and 6:00 PM, and on 03/11/21 at 7:45 AM and 11:50 AM revealed the posted nurse staffing information was unable to be located. On 03/11/21 at 11:00 AM an interview was conducted with the Social Worker (SW) who was responsible for the scheduling of the nursing department since the previous Scheduler had left and had not been replaced. The SW stated although she was responsible for scheduling the nursing department, she had never been told she would be responsible for posting the nurse staffing information. The SW explained that she was aware of the posted nurse staffing information that used to be posted on the wall by the nursing station at the front entrance, but the information had not been posted in a while. The SW added posting the nurse staffing information was not one of her responsibilities. On 03/11/21 at 4:15 PM during an interview with the Administrator she explained the posted nurse staffing information had not been posted since she had been at the facility which was 05/25/20. The Administrator continued to explain that she knew the posted nurse staffing information was required to be posted daily to include the resident census and the number of care hours provided by the licensed and unlicensed staff. She indicated she had inquired about the information and was told that it used to be posted on the wall near the front entrance but was removed in order to redecorate and was never put back up. The Administrator stated she got so busy with her responsibilities then the pandemic hit, and she	F 732	is required by both Federal and State laws. 1. No residents were found to be affected by the facility failing to meet the staffing information posting. 2. All residents have the potential to be affected. The CED and Department Heads were in-serviced by the Regional Resource Nurse on 4/2/21 regarding the regulation for Posted Nurse Staffing Information requirement. 3. The CED and Department Heads were in-serviced by the Regional Resource Nurse on 4/2/21 regarding the regulation for Posted Nurse Staffing Information requirement. The CED will complete the staffing posting daily for the following day based on the projected nursing schedule. The posting sheet will be amended and posted daily by the CED Monday through Friday, and by the Manager on Duty, Saturday and Sunday based on the actual nursing hours. 4. An audit will be completed daily by the Admissions Director Monday through Friday, and by the Nursing Supervisor Saturday and Sunday for 4 weeks, then weekly for 2 months thereafter, or until 100% compliance is achieved for two consecutive months, to ensure the staffing posting requirements are met on a daily basis. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and	

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F 732	Continued From page 36 forgot about the posted nurse staffing information.	F 732	interventions based on the outcomes and direct further investigations.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not	F 756		4/9/21

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F 756	Continued From page 37 limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, Medical Director, and Consultant Pharmacist interview the facility failed to retain and follow up on the monthly pharmacist consultation report for 3 of 5 resident reviewed for unnecessary medications (Resident #4, Resident #45, and Resident #44). The findings included: 1. Resident #4 was admitted to the facility on 11/12/19 with diagnoses that included Alzheimer's disease and dementia. Review of a physician order dated 11/12/19 and revised on 04/20/20 read, Valproic (mood stabilizer) acid 125 milligrams (mg) by mouth twice a day for anxiety. Review of a "Consultation Report" issued on 05/25/20 read, Resident #4 "has received Valproic Acid twice daily for anxiety since 11/12/19. Please attempt a gradual dose reduction (GDR) while concurrently monitoring for reemergence of target behaviors and/or withdrawal symptoms." The bottom of the form where the provider would accept or deny the GDR and sign the form was blank. Review of the quarterly Minimum Data Set (MDS) dated 12/07/21 indicated that Resident #4 was severely cognitively impaired and required extensive to total assistance with activities of daily	F 756	F756 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. The practitioner was made aware of the missed GDR for residents #44 and #45 on 3/11/21 and the reductions were completed at that time 2. Any resident with pharmacy recommendations has the potential to be affected. A 30-day look back of 100% of the pharmacy recommendations was completed by the Administrative Nursing Team on 3/31/21 to ensure pharmacy recommendations were completed. If any pharmacy recommendation was determined not to be completed, the physician was notified to obtain orders for further direction. 3. The Administrative Nursing Team which included the Center Nurse Executive, the Assistant Director of Nursing, the Nurse Practice Educator, the Clinical Reimbursement Coordinator and the	

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F 756	Continued From page 38 living. An interview was conducted with the Administrator on 03/11/21 at 3:03 PM. The Administrator stated that she received the monthly consultant pharmacist reviews via email, and she would then forward them to the Director of Nursing (DON) so they could be printed and given to the providers for follow up. The Administrator stated she would have forwarded the GDR for Resident #4 to the previous DON for distribution to the provider. She added the above "Consultation Report" was a copy that the current DON printed off from the pharmacy because the facility could not locate the original copy of the report. An interview was conducted with the Nurse Practitioner (NP) on 03/11/21 at 3:13 PM. The NP stated that she received the consultant pharmacist reports from the DON, reviewed them, and made the decision to accept the recommendation or not. The NP stated she would document her acceptance or declination of the recommendation on the bottom of the form and sign the form then it would be scanned back to the pharmacy. The NP stated she does not recall ever seeing the report for Resident #4 that was issued on 05/25/20, she added generally she accepted the recommendation and then monitored how the resident responded. She again stated she does not recall reducing Resident #4's medication based off a recommendation from the pharmacist. An attempt to speak to the former DON was made on 03/11/21 at 4:00 PM and was unsuccessful.	F 756	Nursing Supervisor, was in-serviced by the Regional Resource Nurse on 4/2/21 regarding the pharmacy recommendation process of reviewing the recommendations with the physician. When the recommendations are received by the CNE they will be reviewed with the practitioner. Once reviewed the physician will address recommendations and implement orders if needed. The completed form will be faxed to pharmacy and uploaded into the medical record. This education will be added to the orientation process/agenda for newly hired Administrative Nursing Staff including agency staff. 4. The pharmacy recommendations will be audited monthly by the CNE or designee to determine if they were addressed and completed timely. The audit will be completed twice 100% compliance is met for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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An interview was conducted with the Medical Director (MD) on 03/11/21 at 4:03 PM. The MD stated that once he had the consultant pharmacist recommendation in his possession he would go ahead and fill out the form accepting or declining the recommendation and turn it back into the facility. The MD stated he did not recall ever seeing the recommendation for Resident #4 that was issued on 05/25/20, adding that the facility had been through several DONs and it was possible that the recommendation never made it to him for review. He stated he would have documented the acceptance or declination on the bottom of the form and signed it as well.

An interview was conducted with the Administrator and DON on 03/11/21 at 6:29 PM. The DON explained she had only been at the facility for around one month. She confirmed that no one could locate the original "Consultation Report" document for Resident #4 that was issued on 05/25/20 and she had no idea if the provider saw the recommendation or not. The Administrator explained that the facility had discovered an issue with the pharmacy recommendations in December of 2020 and at that time the DON had given her notice and the facility had an interim DON who decided after 3 days she was not going to return to the facility and they just did not have any time to fix the issue. The Administrator stated she could not fix the issue without the assistance of the DON and she had not had a stable DON until the current DON arrived at the facility one month ago. They both explained the pharmacy recommendations should be printed off and given to the provider for follow up and then returned to the facility and scanned back to the pharmacy. Again the Administrator and DON confirmed that they could

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not tell if the provider had seen or acted upon the recommendation issued on 05/25/20 for Resident #4.

An interview was conducted with the Consultant Pharmacist (CP) on 03/12/21 at 8:27 AM. The CP stated all of his record reviews for the last year have been conducted off sight due to the COVID pandemic. The CP explained that the facility had been through 3 to 4 DONs and it was very difficult to find a permanent replacement in the rural area where the facility was located. He added he had not met the current DON but needed to sit down with her and discuss the process. The CP explained the process was each month he would review each resident medical record and make recommendations to the MD. The MD would typically review the recommendation and accept or decline the recommendation and return them to the facility. Once the facility had them back in their possession, they would scan them into the electronic medical record so I could review the MD orders or rationale for declining the recommendation. The CP stated that a lot of the recommendations don't get scanned back into the medial record and he was unable to see what documentation was in the facility because he had not been able to come to the facility in over a year. He further explained he would look in other parts of the electronical medical record for evidence that the MD had reviewed the recommendation like the orders and laboratory reports but at times it was impossible to determine if the MD had reviewed the recommendation and accepted or declined it. The CP stated it was very difficult to follow up on his recommendations when he was not physically in the facility. The CP confirmed that Resident #4 has been on the Valproic acid for over a year with

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no response to the GDR that he recommended and no documentation of the declination.

2. Resident #45 was initially admitted to the facility on 09/20/19 and recently readmitted to the facility on 02/23/21 with diagnoses that include: Alzheimer's Disease and dementia.

Review of physician order dated 04/20/20 read, Risperdal (antipsychotic) 0.25 milligrams (mg) by mouth every day.

Review of a "Consultation Report" issued on 01/27/21 read, Resident #45 "has a diagnosis of dementia and receives Risperidone 0.25 mg daily. Please attempt a gradual dose reduction (GDR) to Risperidone 0.125 mg daily with the end goal of discontinuation, while concurrently monitoring for reemergence of target behaviors." The bottom of the form where the provider would accept or deny the GDR and sign the form was blank.

Review of the quarterly Minimum Data Set (MDS) dated 02/04/21 indicated that Resident #45 was moderately impaired for daily decision making and required total assistance with activities of daily living. The MDS further revealed that Resident #45 received 7 days of an antipsychotic medication during the assessment reference period.

An interview was conducted with the Administrator on 03/11/21 at 3:03 PM. The Administrator stated that she received the monthly consultant pharmacist reviews via email, and she would then forward them to the Director of Nursing (DON) so they could be printed and given to the providers. The Administrator stated

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she would have forwarded the GDR for Resident #45 to the previous DON for distribution to the provider. She added that the above "Consultation Report" was a copy that the current DON printed off from the pharmacy because the facility could not locate the original copy of the report.

An interview was conducted with the Nurse Practitioner (NP) on 03/11/21 at 3:13 PM. The NP stated that she received the consultant pharmacist reports from the DON, reviewed them, and made the decision to accept the recommendation or not. The NP stated she would document her acceptance or declination of the recommendation on the bottom of the form and sign the form then it would be scanned back to the pharmacy. The NP stated she does not recall ever seeing the report for Resident #45 that was issued on 01/27/21, she added generally she accepted the recommendation and then monitored how the resident responded. She again stated she does not recall reducing Resident #45's medication based off a recommendation from the pharmacist.

An attempt to speak to the former DON was made on 03/11/21 at 4:00 PM and was unsuccessful.

An interview was conducted with the Medical Director (MD) on 03/11/21 at 4:03 PM. The MD stated that once he had the consultant pharmacist recommendation in his possession he would go ahead and fill out the form accepting or declining the recommendation and turn it back into the facility. The MD stated he did not recall ever seeing the recommendation for Resident #45 that was issued on 01/27/21, adding that the facility had been through several DONs and it

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was possible that the recommendation never made it to him for review. He stated he would have documented the acceptance or declination on the bottom of the form and signed it as well. The MD further stated that Resident #45 was someone he would not recommend reducing medications stating that there were times when the medication was appropriate, and Resident #45 was not someone he would want to reduce medications on.

An interview was conducted with the Administrator and DON on 03/11/21 at 6:29 PM. The DON explained she had only been at the facility for around one month. She confirmed that no one could locate the original "Consultation Report" document for Resident #45 that was issued on 01/27/21 and that she had no idea if the provider saw the recommendation or not. The Administrator explained that the facility had discovered an issue with the pharmacy recommendation in December of 2020 and at that time the DON had given her notice and the facility had an interim DON who decided after 3 days she was not going to return to the facility and they just did not have any time to fix the issue. The Administrator stated she could not fix the issue without the assistance of the DON and she had not had a stable DON until the current DON arrived at the facility one month ago. They both explained the pharmacy recommendations should be printed off and given to the provider for follow up and then returned to the facility and scanned back to the pharmacy. Again the Administrator and DON confirmed that they could not tell if the provider had seen or acted upon the recommendation issued on 01/27/21 for Resident #45.

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An interview was conducted with the Consultant Pharmacist (CP) on 03/12/21 at 8:27 AM. The CP stated all of his record reviews for the last year have been conducted off sight due to the COVID pandemic. The CP explained that the facility had been through 3 to 4 DONs and it was very difficult to find a permanent replacement in the rural area where the facility was located. He added he had not met the current DON but needed to sit down with her and discuss the process. The CP explained the process was each month he would review each resident medical record and make recommendations to the MD. The MD would typically review the recommendation and accept or decline the recommendation and return them to the facility. Once the facility had them back in their possession, they would scan them into the electronic medical record so I could review the MD orders or rationale for declining the recommendation. The CP stated that a lot of the recommendation don't get scanned back into the medial record and he was unable to see what documentation was in the facility because he had not been able to come to the facility in over a year. He further explained he would look in other parts of the electronical medical record for evidence that the MD had reviewed the recommendation like the orders and laboratory reports but at times it was impossible to determine if the MD had reviewed the recommendation and accepted or declined it. The CP stated it was very difficult to follow up on his recommendations when he was not physically in the facility. The CP confirmed that Resident #45 remained on Risperdal with no follow up on the GDR he issued on 01/27/21.

3) Resident #44 was admitted to the facility on 03/12/20 with diagnoses which included bipolar

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disorder.

A review of Resident #44's Physician orders dated 04/22/20 revealed an order for Depakote DR (a delayed release medication used to treat the manic phase of bipolar disorders) 500 mg (milligrams) by mouth twice a day.

The recent quarterly Minimum Data Set (MDS) assessment dated 11/23/20 indicated Resident #44 had moderately impaired cognition and displayed no behaviors.

A Consultant Pharmacist recommendation dated 12/27/20 suggested the Physician consider a gradual dose reduction of Depakote DR 500 mg by mouth twice a day to Depakote DR 375 mg by mouth twice a day.

Resident #44's medical record revealed that as of 03/11/21 the Physician had not responded to the Consultant Pharmacist recommendation for the gradual dose reduction or provided a rationale to deny the gradual dose reduction for the Depakote DR 500 mg by mouth twice a day.

On 03/12/21 at 8:27 AM a telephone interview was conducted with the Consultant Pharmacist (CP) who explained that he had not been in the facility to conduct the monthly pharmacy reviews since the pandemic hit last year in February which had made it difficult to ensure that the pharmacy recommendations were addressed. He continued to explain that he had access to the electronic health record offsite, but the Director of Nursing did not always scan the addressed consults into the system for him to follow up on. He stated that the facility had recently been through three or four DONs and since the DON

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F 756	Continued From page 46 was the primary person to process the pharmacy recommendations there was often no follow through with the recommendations. The CP indicated it was not unusual for the pharmacy recommendations to be repeated several times before they were addressed by the Physician. On 03/11/21 at 4:03 PM an interview was conducted with Resident #44's Physician. The Physician explained he was in the facility once a week for rounds and would review and address the pharmacy recommendations that were left for him in his folder. The Physician stated he could not recall a pharmacy recommendation for a gradual dose reduction for Resident #44's Depakote. An interview was conducted with the Administrator and the Director of Nursing on 03/11/21 at 6:55 PM. The Administrator explained that she discovered the system was broken last month (February 2021) when she realized the previous Director of Nursing had not been following up on the pharmacy recommendations. The Director of Nursing informed that from now on the pharmacy recommendations would be emailed to her and she would be responsible for printing them off and hand delivering them to the Physician for his review to ensure they were addressed.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		4/9/21

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F 759	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff and Nurse Practitioner interviews, the facility failed to maintain a medication error rate of 5% or less as evidenced by 2 medication administration errors out of 25 opportunities. This resulted in a medication error rate of 8% which affected 1 of 6 residents (Resident #67) observed for medication administration. The finding included: Resident #67 was admitted to the facility on 11/13/20 with diagnoses which included heart failure and hypertension. A review of Resident #67's Physician orders revealed 1) Metoprolol Tartrate (for high blood pressure) 50 mg (milligrams) give one tablet by mouth two times a day for hypertension. Hold if systolic blood pressure was below 100. The order was active as of 11/13/20. The orders also included Fluticasone Propionate nasal spray (antihistamine) give one spray in each nostril one time a day which was ordered on 07/09/20 and discontinued on 08/07/20 due to Resident #67's refusal. On 03/10/21 at 8:46 AM an observation of a medication administration pass was made of Nurse #2 for Resident #67. The Nurse administered the medications Metoprolol Tartrate 50 mg tablet by mouth and Fluticasone Propionate nasal spray one spray in each nostril. Upon medication reconciliation of Resident #67's Physician orders and the medications given to Resident #67 by Nurse #2 it was noted that the	F 759	F759 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The Nurse Practitioner was notified of the medication errors for resident #67 on 3/10/21 and no new orders were received at that time. There were no negative outcomes for this resident. Nurse #2 was in-serviced by the NPE on 3/25/21 regarding the 6 rights of medication administration and preventing medication errors and was required to take the EMAR and Getting Organized in Medication courses in Vitalearn 3/25/21. 2. Any resident receiving medication has the potential to be affected. The licensed nurses were in-serviced 3/22/21to 4/8/21 regarding the 6 rights of medication administration and preventing medication errors which included a post test. The licensed nurses were in-serviced regarding preventing medication errors and medication pass observations were completed by the pharmacy consultant on 4/7/21. The nurses will not be able to pass medication until 5% or less error rate is attained.	

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F 759	Continued From page 48 Metoprolol Tartrate had the directive to hold the medication if the systolic blood pressure was below 100. The orders also indicated the Fluticasone Propionate nasal spray was discontinued on 08/07/20. An interview was conducted with Nurse #2 on 03/10/21 at 10:09 AM. The Nurse acknowledged the directive on the Metoprolol Tartrate medication card to hold the medication if the systolic blood pressure was below 100 and stated she should have checked Resident #67's blood pressure before she administered the medication. The Nurse also acknowledged that the Fluticasone Propionate nasal spray had been discontinued on 08/07/20. The Nurse stated if she had read the Medication Administration Record closer, she would not have made the medication errors. During an interview with the Nurse Practitioner (NP) on 03/10/21 at 10:17 AM she reviewed Resident #67's medication orders and acknowledged the directive on the Metoprolol Tartrate and the order to hold if the systolic blood pressure was below 100 and to discontinue the Fluticasone Propionate nasal spray on 08/07/20 due to her refusal of the medication. The NP explained that Resident #67 apparently had an issue with her blood pressure, or the order would have never been written. She continued to explain that she remembered writing the order to discontinue the nasal spray and she expected them to stop it since she wrote the order to discontinue the medication. On 03/11/21 at 7:11 PM an interview was conducted with the Administrator and the Director of Nursing. They stated that the nurse who	F 759	3. The licensed nurses will be required to take and pass the EMAR and Getting Organized in Medication courses in Vitalearn as well a medication administration observation will be completed during the orientation process. The nurse will not be allowed to independently complete a med pass without completion and passing of the course and completing a medication pass observation with a 5% or less error rate. 4. The NPE will complete 2 medication administration audits weekly for 2 months then 2 medication administration audits monthly thereafter, or until 100% compliance is achieved for two consecutive months, to ensure the nurses are maintaining an error rate of 5% or less. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and interventions based on the outcomes and direct further investigations.	

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F 759	Continued From page 49 discontinued the nasal spray on 08/07/20 should have removed the nasal spray from the medication cart. They also stated that if Nurse #2 had administered the Resident's medications according to the 5 rights (person, medication, amount, time and route) she would have known to check the blood pressure before she administered the blood pressure medication and she would have realized there was no order for the nasal spray.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and facility staff interviews, the facility failed to label and date opened food items in one of two kitchen refrigerators and one of one nourishment room	F 812	F 812 Preparation and execution of this plan of correction does not constitute admission	4/9/21

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F 812	Continued From page 50 refrigerators and failed to remove expired items from one of one nourishment room refrigerators. The Findings Included: A review of a facility policy titled "4.13 Food Brought in for Patient/Residents" and dated 06/15/18, revealed in part "Food items that require refrigeration must be labeled with patient's/resident's name and date the food was brought in". In addition, it read "Foods considered unsafe for consumption or beyond the expiration date will be discarded by staff upon notification to patient/resident". An observation of a kitchen refrigerator on 03/08/21 at 10:27 AM revealed one container of pasteurized liquid whole egg that was open and undated. There was also a half of a head of iceberg lettuce that had begun to brown that was opened and undated. An observation of the nourishment room refrigerator on 03/08/21 at 12:29PM revealed the following: - One box of ice cream bars that was opened and undated - One box of Low Fat Fudge Bars that was opened and undated - 4 individual processed cheese slices that were undated and beginning to harden - One container of Diet 5 cranberry juice that was opened and undated - One bag of sharp cheddar shredded cheese that was open and undated - One frozen pizza that was unlabeled and undated In addition to the above undated and unlabeled	F 812	or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. No residents were identified to be affected by the unlabeled and undated food in the kitchen refrigerators and the nourishment refrigerator. The opened box if ice cream bars, Low Fat Fudge Bars, individual processed cheese slices, container of Diet cranberry juice, bag of sharp cheddar shredded cheese and frozen pizza was removed and discarded from the kitchen refrigerators by the Dietary Manager upon notification of the Surveyor at the time of survey. The expired milk and the expired yogurt were removed and discarded from the nourishment refrigerator by the Dietary Manager upon notification by the Surveyor during the survey. The Dietary Manager will complete and document daily walk through of the kitchen, freezer, refrigerators, and nourishment refrigerator to ensure the food is dated and stored properly. The Dietary Staff was in-serviced by the Regional Dietary Manager on 3/11/21 to 3/12/121 regarding the proper labeling and storage of food, They were also in-serviced regarding the process for inspecting and labeling food in the nourishment refrigerators. The nursing staff were also in-serviced by the CNE 4/2//21 to 4/8/21 regarding the policy for labeling food in the nourishment	

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F 812	Continued From page 51 food items an opened carton of whole milk that expired effective 02/20/21 was observed on 03/08/21 at 12:29 PM, as well as five individual smoothie yogurt containers that had expired on 01/07/21 were observed in the nourishment room refrigerator at this time. During an interview with the Dietary Manager on 03/08/21 at 12:54PM he reported the food items mentioned above were brought in by residents and do not process through the kitchen staff. He reported he monitored the nourishment rooms for food only taken in by food vendors and any food coming in from outside of the facility by residents or resident families was handled by nursing staff. He reported he did not know the facility policy regarding who is responsible for outside food brought into the facility. Regarding the open container of liquid egg and the undated head of lettuce, he reported it was his expectation that all food that was opened in the kitchen and stored for use later was appropriately labeled with the open date and labeled. He reported there would be no excuse for food items in the kitchen to not be properly labeled and dated and stated he would address the concern with his staff. A follow up interview with the Dietary Manager on 03/11/21 at 1:43PM revealed he was under the assumption that the nursing staff were responsible for the food items in the nourishment room refrigerator but stated they would be implementing a new policy where all food items would be the responsibility of the food and nutrition staff to ensure they were properly dated and labeled. During an interview with the Administrator on 03/11/21 at 7:31PM, she reported the expectation	F 812	refrigerators. This education will be added to the orientation process/agenda for newly hired dietary staff, nurses, and CNAs including agency staff. The Administrator will audit by conducting random sanitation inspections in the kitchen and nourishment rooms at least 3 times weekly until 100% compliance regarding freezer and food labeling is maintained for at least two consecutive months Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 812	Continued From page 52 was that all food items in all refrigerators in the facility were properly dated, labeled, and discarded at their expiration date. She reported there was no excuse for the amount of undated, unlabeled food in the nourishment room refrigerator.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		4/9/21

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F 842	Continued From page 53 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to maintain complete and accurate medical records related to a Resident's fall with	F 842	F842 Preparation and execution of this	

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F 842	Continued From page 54 no injury for 1 of 5 resident's reviewed for accidents (Resident #44). The finding included Resident #44 was admitted to the facility on 03/12/20 with diagnoses that included hypertension, diabetes mellitus and bipolar disorder. Review of Resident #44's medical record revealed no documentation of a fall was recorded for Resident #44 on 01/17/21. A telephone interview was conducted on 03/11/21 at 8:16 AM with Nurse #1. The Nurse explained that when there was a resident fall, one of the duties of the nurse would be to complete a change in condition assessment in the resident's medical record. She continued to explain that in completing the change in condition assessment it would automatically load the follow up documentation for the incident. The Nurse stated she remembered that Resident #44 had a fall one day in January but could not remember the exact day or what the circumstances was around the fall but that he did not have an injury related to the fall. When the Nurse was asked if she completed the change in condition assessment on Resident #44, she responded with if she had then it would be in Resident #44's medical record. During an interview with the Administrator and Director of Nursing (DON) on 03/11/21 at 6:55 PM. The DON explained that Nurse #1 should have completed the change in condition assessment in Resident #44's medical record which would have automatically uploaded more forms to be completed by the Nurse that would	F 842	plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Nurse #1 that failed to document the fall for resident #44 was educated by the NPE on 4/1/21 regarding what is a considered to be a change in condition and the importance of documenting to maintain a complete medical record and reporting to the physician and responsible party changes in condition. 2. All residents have the potential to be affected. The Administrative Nursing Team completed a review of the 24 hour reports to /8/21 from the prior 30 days to ensure all pertinent information is reflected in the nursing notes. The CNE will follow up with nursing staff as needed. 3. The licensed nurses were educated by the NPE on 4/5/21 to 4/8/21 regarding what is a considered to be a change in condition (including falls) and the importance of documenting to maintain a complete medical record and reporting to the physician and responsible party changes in condition. This education will be added to the orientation process/agenda for newly hired nurses including agency staff The nurses notes and 24 hour report will be reviewed in the daily clinical meeting to ensure that all	

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F 842	Continued From page 55 assure the incident would have been thoroughly documented. The DON stated she reviewed Resident #44's medical record earlier in the day and she knew that documentation of the Resident's fall on 01/17/21 was not in his medical record.	F 842	pertinent information is documented in the nurses notes. 4. The nurses notes of 5 residents will be audited by comparing to the 24 hour report to the nurses notes+ by the CNE per week then 10 per month until 100% compliance is maintained for two consecutive months to ensure the nurses notes reflect all pertinent information regarding the residents. The CNE will follow up with nursing staff as needed. Results of those audits will be reported to QAPI steering committee monthly for three months. The steering committee will direct further analysis and interventions based on the outcomes and direct further investigations.	